Date of Hearing: June 28, 2016

ASSEMBLY COMMITTEE ON BUSINESS AND PROFESSIONS
Rudy Salas, Chair
SB 999(Pavley) – As Amended June 20, 2016

SENATE VOTE: 29-6

NOTE: *This bill is double-referred, having been previously heard by the Assembly Committee on Health on June 14, 2016 and approved on a 13-0 vote.*

SUBJECT: Health insurance: contraceptives: annual supply

SUMMARY: Authorizes a pharmacist to dispense a 12-month supply of United States Food and Drug Administration (FDA)-approved, self-administered hormonal contraceptives and requires insurance to cover the cost.

EXISTING LAW:

1) Establishes the Department of Managed Care (DMHC) to regulate health plans under the Knox-Keene Health Care Service Plan Act of 1975 and the Department of Insurance (CDI) to regulate health insurers under the Insurance Code. (Health and Safety Code §§ 1340, *et seq.*)

2) Establishes the Medi-Cal program, which is administered by the State Department of Health Care Services (DHCS), under which qualified low-income persons receive health care benefits and, in part, governed and funded by federal Medicaid program provisions. (Welfare and Institutions Code §§ 14000, *et seq.*)

3) Establishes the Board of Pharmacy (BOP) to regulate the practice of pharmacy, including the licensure of pharmacists. (Business and Professions Code (BPC) §§ 4000, *et seq*.)

4) Requires a health plan contract, or a group or individual policy of disability insurance, except for a specialized health plan contract or a specialized health insurance policy, that is issued, amended, renewed, or delivered on or after January 1, 2016, to provide coverage for all of the following services and contraceptive methods for women: (Insurance Code (INS) § 10123.196(b)(1))

    a) All FDA-approved contraceptive drugs, devices, and other products for women, including all FDA-approved contraceptive drugs, devices, and products available over the counter, as prescribed by the enrollee's or insured's provider;

    b) Voluntary sterilization procedures;

    c) Patient education and counseling on contraception; and,

    d) Follow-up services related to the drugs, devices, products, and procedures, including, but not limited to, management of side effects, counseling for continued adherence, and device insertion and removal.

5) Prohibits a health plan or disability insurer from imposing a deductible, coinsurance, copayment, or any other cost-sharing requirement on the coverage provided pursuant to

contraceptive coverage, except in the case of a grandfathered health plan. Prohibits cost sharing from being imposed on any Medi-Cal beneficiary. (INS § 10123.196(b)(2))

6) Permits a religious employer to request a health plan contract or disability insurance policy without coverage for FDA-approved contraceptive methods that are contrary to the religious employer's religious tenets, and requires a health plan contract or disability insurance policy to be provided without coverage for contraceptive methods, if requested. (INS § 10123.196(e))

7) Establishes as California's essential health benefits (EHBs) as the Kaiser Small Group HMO plan, along with the following 10 federally mandated benefits under the Patient Protection and Affordable Care Act (ACA), as well as other existing state mandated benefits: (INS § 10112.27)

   a) Ambulatory patient services;

   b) Emergency services;

   c) Hospitalization;

   d) Maternity and newborn care;

   e) Mental health and substance use disorder services, including behavioral health treatment;

   f) Prescription drugs;

   g) Rehabilitative and habilitative services and devices;

   h) Laboratory services;

   i) Preventive and wellness services and chronic disease management; and,

   j) Pediatric services, including oral and vision care.

8) Permits a pharmacist to dispense no more than a 90-day supply of a dangerous drug other than a controlled substance pursuant to a valid prescription that specifies an initial quantity of less than a 90-day supply followed by periodic refills of that amount, if specified requirements are satisfied, such as the patient has completed an initial 30-day supply of the dangerous drug. Prohibits a pharmacist from dispensing a greater supply of a dangerous drug if the prescriber personally indicates, either orally or in his or her own handwriting, "No change to quantity," or words of similar meaning. (BPC § 4064.5)

9) Permits a pharmacist to furnish self-administered hormonal contraceptives in accordance with standardized procedures or protocols developed and approved by both the BOP and the Medical Board of California in consultation with the American Congress of Obstetricians and Gynecologists (ACOG), the California Pharmacists Association, and other appropriate entities. (BPC § 4052.3)

10) Requires the standardized procedure or protocol in 9) above to require that the patient use a self-screening tool that will identify patient risk factors for use of self-administered hormonal contraceptives, based on the current United States Medical Eligibility Criteria for

Contraceptive Use developed by the federal Centers for Disease Control and Prevention (CDC), and that the pharmacist refer the patient to the patient's primary care provider or, if the patient does not have a primary care provider, to nearby clinics, upon furnishing a self-administered hormonal contraceptive, or if it is determined that use of a self-administered hormonal contraceptive is not recommended. (BPC § 4052.3(a)(1))

11) Requires the pharmacist to provide the patient a standardized fact sheet that includes, but is not limited to, the indications and contraindications for use of the drug, the appropriate method for using the drug, the need for medical follow-up, and other appropriate information, developed, as specified. (BPC § 4052.3(c))

THIS BILL:

1) Requires health care service plan (health plan) contracts and health insurance policies, issued, amended, renewed, or delivered on or after January 1, 2017, to provide coverage for up to a 12-month supply of FDA-approved contraceptives when dispensed at one time for an enrollee by a provider, pharmacist, or at a location licensed or otherwise authorized to dispense drugs or supplies.

2) Prohibits construing this bill to require contraceptive coverage by an out-of-network provider, pharmacy, or location licensed or otherwise authorized to dispense drugs or supplies, except as otherwise authorized by state or federal law or by the health plan's policies regarding out-of-network coverage.

3) Prohibits construing this bill to require a provider to prescribe, furnish, or dispense 12 months of contraceptives at one time.

4) Provides that a pharmacist furnishing self-administered hormonal contraction pursuant to the BOP protocols may dispense, at the patient's request, up to a 12-month supply at one time.

FISCAL EFFECT: According to the Senate Committee on Appropriations, this bill will result in:

1) Minor costs to review information from health insurers by the [CDI].

2) No significant costs are anticipated to review health plan information by the [DMHC].

3) No significant costs or savings are projected for the Medi-Cal program. According to an analysis of the bill by the California Health Benefits Review Program, utilization of hormonal contraceptives by Medi-Cal enrollees is not expected to increase significantly. This is because Medi-Cal already covers up to a 12-month supply of oral contraceptives and utilization of the other covered forms of contraception is very low. Therefore, there is no significant increase in utilization anticipated nor is there an anticipated reduction in health care services related to unintended pregnancy.

4) Annual premium savings to the CalPERS system of about $2 million per year, due to reduced health care costs associated with unintended pregnancies. About half of those savings would accrue to the state General Fund and special funds and half would accrue to local governments.

5) No state costs to subsidize coverage through Covered California are anticipated. Under federal law, the costs of any state-imposed benefit mandate that exceeds the essential health benefits included in the state's benchmark plan is a state responsibility. In other words, if the state imposes a new benefit mandate on health plans or health insurers that sell coverage through Covered California, the state is obligated to pay for the cost to subsidize that benefit mandate for enrollees receiving federal subsidies. Because the bill does not impose a new benefit mandate, but only changes the terms of an existing mandate to cover contraceptives, the bill does not expand the state's essential health benefits.

COMMENTS:

Purpose. This bill is sponsored by Planned Parenthood Affiliates of California, the California Family Health Council, and NARAL, Pro-Choice America. According to the author, "SB 999 addresses a leading barrier to obtaining consistent access to contraception by changing the timing of contraception dispensing. Under current law, health insurance companies and plans must limit their coverage of birth control to a one-or- three- month supply. This practice can lead to unwanted gaps in use and increase unintended pregnancies. Inconsistent supplies of birth control are problematic for many women who have unpredictable work hours, difficulty accessing transportation, or other barriers preventing them from accessing a provider, pharmacy or clinic, in a timely manner. By allowing women to receive up to a 12 month supply of birth control at one time, women can better control their birth control use. The CA Health Benefits Review Panel estimates that under the bill, costs to employers and consumers would be reduced by over $42 million annually, with 15,000 fewer unintended pregnancies, and 7000 fewer abortions each year. The report cited that the program found no difference in medical health risks in 3, 6, or 12 month dispensation. Given that California has a continued access to care crisis, a provider shortage and high rates of unintended pregnancy, California must continue to find inventive ways to remove barriers to providing consistent contraception."

Background. *Methods of Birth Control.* Contraceptives prescribed by a healthcare provider are in hormonal or non-hormonal forms. Hormonal contraceptives are made up of female sex hormones: estrogen or progestin (a synthetic form of progesterone). The most popular hormonal contraceptive is the combination pill, or oral contraceptive. Other hormonal contraceptives include injected progestins, subdermal implants that release progestins, transdermal patch, and vaginal rings. Non-hormonal methods include use of an intrauterine device, cervical cap, diaphragm, and contraceptive sponge.

Pharmacists' Procedures and Protocols for Furnishing Hormonal Contraceptives. Section 4052.3(a)(1) of the BPC authorizes a pharmacist to furnish self-administered hormonal contraceptives in accordance with a protocol approved by the BOP and the MBC. The purpose of the protocol is to ensure timely access to self-administered hormonal contraception medication and that the patient receives adequate information to successfully comply with therapy.

When a patient requests self-administered hormonal contraception, the pharmacist measures and record the patient's seated blood pressure, if combined hormonal contraceptives are requested or recommended. The pharmacist also ensures that the patient is appropriately trained in the administration of the requested or recommended contraceptive medication, and has the patient complete an annual self-screening tool that will identify patient risk factors for use of self-administered hormonal contraceptives, based on the current United States Medical Eligibility

Criteria (USMEC) for Contraceptive Use developed by the federal Centers for Disease Control and Prevention.

Health Insurance Plans. Under current law, health insurance companies and plans must limit their coverage of birth control to a one or three month supply. This practice can lead to unwanted gaps in birth control use and an increased incidence of unintended pregnancies. According to the author, inconsistent supplies of birth control are particularly problematic for many women who have unpredictable work hours, difficulty accessing transportation, or other barriers preventing them from accessing a provider, pharmacy, or clinic, in a timely manner.

Studies and Reports of the Impact of Annual Dispensing of Hormonal Contraceptives. In 2013, the CDC recommended that women be provided with a year's supply of self-administered hormonal contraceptives. In January of 2015, the ACOG issued guidelines that recommend that payment and practice policies support annual dispensing of contraceptives.

According to a study from the University of California San Francisco (UCSF), women who received a full year's worth of pills at one time were 30 percent less likely to have an unintended pregnancy than women who received either a one-month or three-month supply of pills. California's Family Pact Program for low-income women has successfully provided annual dispensing of contraception the last two decades. In addition, as of February 5, 2016, the DHCS is now requiring all Medi-Cal managed care plans to pay for 12 month dispensing.

On March 28, 2016, the California Health Benefits Review Program (CHBRP) released its analysis of SB 999. The report cited, "there is a preponderance of evidence that annual dispensing leads to a reduction in unintended pregnancy and related outcomes." It estimated that costs to employers and consumers would be reduced by over $42 million annually, and estimated that as a result of the bill, there would be 15,000 fewer unintended pregnancies, and 7000 fewer abortions each year. In addition, the report cited that the program found no difference in medical health risks in three, six, or twelve month dispensation.

Other States. This past year, both Oregon and the District of Columbia enacted new laws requiring the annual dispensing of contraception. Similar legislation is being considered in Colorado Washington, Wisconsin, New York, and Hawaii.

REGISTERED SUPPORT:

Alameda County Board of Supervisors
American Congress of Obstetricians and Gynecologists
California Academy of Family Physicians
California Pan Ethnic Health Network
City Council of West Hollywood
Having Our Say
Health Access
March of Dimes California
Planned Parenthood Affiliates of California
Planned Parenthood Pasadena and San Gabriel Valley
Planned Parenthood LA County
Planned Parenthood San Bernardino
Planned Parenthood Ventura
Planned Parenthood San Luis Obispo

Planned Parenthood Mar Monte
Planned Parenthood Northern California Action Fund
Planned Parenthood Community Action Fund of Orange and San Bernardino
Santa Clara County Democratic Activists for Women Now

REGISTERED OPPOSITION:

Association of California Life and Health Insurance Companies

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