

# California Health Benefits Review Program

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## *Executive Summary*

## Analysis of Senate Bill 1053: Health Care Coverage: Contraceptives

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A Report to the 2013-2014 California Legislature

April 20, 2014

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## KEY FINDINGS

# Analysis of California Senate Bill (SB) 1053: Health Care Coverage: Contraceptives

SUMMARY TO THE 2013-14 CALIFORNIA LEGISLATURE • APRIL 20, 2014



## AT A GLANCE

SB 1053 (amended April 9, 2014) would require state-regulated health plans and insurers to cover all FDA approved contraceptive drugs, devices, products, and voluntary sterilization procedures in each contraceptive category outlined by the FDA, as well as contraceptive education and counseling.

- **Enrollees covered.** CHBRP estimates that in 2015, 16.2 million of 23.4 million Californians have state-regulated coverage that would be subject to the requirements of SB 1053.
- **Impact on expenditures.** Expenditures are estimated to increase by \$31,201,000 or 0.024%, mainly due to the increased utilization of contraceptives as a result of SB 1053.
- **Cost savings.** Cost savings due to averted deliveries through increased use of contraceptives are estimated to be \$149,065,150 in the first year postmandate.
- **EHBs.** SB 1053's coverage mandate could exceed California's definition of essential health benefits (EHBs).
- **Medical effectiveness.** Based on a comparison of unintended pregnancy rates, it is reasonable to conclude that using any of the FDA approved contraceptive methods is more effective than not using any contraception in preventing unintended pregnancies. Furthermore, methods such as IUD and sterilization offer a much higher rate of protection against unwanted pregnancy than more commonly used methods such as condoms and oral contraceptives.
- **Benefit coverage.** CHBRP estimates that coverage for female contraceptives would increase from 97.5% to 100% among enrollees, while coverage for vasectomies would shift from 99.3% to 100% and coverage for male condoms would shift from 0% to 100%.
- **Utilization.** CHBRP estimates a 7.4% increase in contraceptive utilization overall due to SB 1053, resulting in an additional 183,332 individuals using contraceptives. The largest increase in utilization will occur for male condom use, due to a 100% increase in coverage.
- **Public health.** Due to increased contraceptive use, CHBRP estimates that SB 1053 will result in 51,298 averted unintended pregnancies; among those averted pregnancies, CHBRP estimates 20,006 averted abortions.
- **Long-term impacts.** CHBRP projects that SB 1053 would result in a decrease in the rate of unintended pregnancies and abortions over the long-term, resulting in a corresponding decrease in the risk of maternal mortality, adverse child health outcomes, behavioral problems in children, and negative psychological outcomes associated with unintended pregnancies for both mothers and children. Avoiding unintended pregnancies also helps women to delay childbearing and pursue additional education, spend additional time in their careers and have increased earning power over the long term.
- **Interaction with existing state mandates.** SB 1053 would modify California's existing contraceptive law, which currently requires health plans and insurers to cover a variety of prescription drug contraceptives.

## BILL SUMMARY

SB 1053 would require all DMHC-regulated plans and CDI-regulated policies issued, amended, renewed, or delivered on January 1, 2015, to provide coverage for all Food and Drug Administration (FDA) approved contraceptive drugs, devices, products, and voluntary sterilization procedures in each contraceptive category outlined by the FDA, as well as contraceptive education and counseling.

SB 1053 would prohibit nongrandfathered group or individual health plans and policies from imposing cost-sharing requirements in providing contraceptive coverage, consistent with existing requirements in the Affordable Care Act (ACA).

SB 1053 also preserves existing language in both state law and in the ACA that exempts certain religious employers from providing this coverage to their employees.

## BACKGROUND ON FDA APPROVED CONTRACEPTIVES

The language in SB 1053 explicitly requires coverage for all FDA approved contraceptive drugs, devices, products, and voluntary sterilization procedures. The list of contraceptives currently approved by the FDA includes 20 different contraceptive types in five different contraceptive method categories. The list includes the following:

- **Barrier contraceptive methods** such as male condoms, female condoms, diaphragms, sponges, cervical caps, and spermicide
- **Hormonal contraceptive methods** such as oral contraceptives, patches, contraceptive rings, and injections
- **Emergency contraceptives** such as Plan B® or Ella®
- **Implanted device contraceptives** such as IUDs and implantable rods
- **Permanent contraceptive methods** such as male and female sterilization surgery and female sterilization implants

## CHBRP KEY FINDINGS: INCREMENTAL IMPACT OF SB 1053

### Benefit Coverage, Utilization and Cost

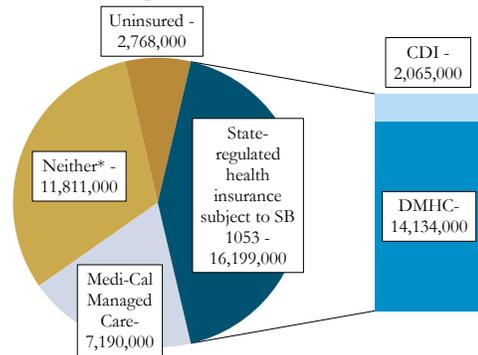
**Coverage Impacts:** Out of the 23.4 million enrollees in DMHC-regulated plans and CDI-regulated policies subject to state mandates, 16.2 million enrollees are subject to SB 1053. As illustrated below in Figure 1, this includes all DMHC-regulated plans and/or CDI-regulated policies, exempting managed care plans purchased by DHCS for Medi-Cal beneficiaries.

Currently, 97.5% of the 16.2 million enrollees have coverage for any female contraceptives without cost-sharing, including coverage through a family member. Among these 16.2 million enrollees, 99.3% have coverage for vasectomies with a certain level of cost-sharing. Zero percent of these enrollees have coverage for male condoms.

Because SB 1053 would expand coverage to all FDA approved contraceptives, CHBRP estimates that coverage for contraceptives would increase:

- From 97.5% to 100% among female enrollees utilizing female contraceptives.
- From 99.3% to 100% for vasectomies among male enrollees utilizing vasectomies.
- From 0% to 100% among male enrollees utilizing male condoms.

**Figure 1. SB 1053's Interaction with California Health Insurance Coverage**



Source: California Health Benefits Review Program, 2014

Notes: \*Neither = Federally regulated health insurance, such as Medicare, veterans, or self-insured plans

**Utilization Impacts:** CHBRP estimates a 7.4% increase in contraceptive utilization overall, resulting in an additional 183,332 individuals using contraceptives.

**Cost Impacts:** SB 1053 would shift some contraceptive costs from enrollees to health plans and insurers through reduced cost sharing. CHBRP estimates a reduction in out-of-pocket expenses of approximately \$50.2 million consisting of a reduction of \$46.5 million in enrollee expenditures for previously noncovered benefits and a reduction of nearly \$3.7 million in enrollee out-of-pocket expenditures for previously covered benefits.

Total annual expenditures are estimated to increase by \$31,201,000 or 0.024%, mainly due to the increased utilization of contraceptives.

The mandate is estimated to increase premiums by about \$81,397,000 or 0.083%. The distribution of the impact on premiums is as follows:

- Total premiums for private employers are estimated to increase by \$46,320,000 or 0.085%
- Enrollee contributions toward premiums for group insurance are estimated to increase by \$18,475,000 or 0.083%
- Total premiums for those with individually purchased insurance are estimated to increase by \$13,985,000 or 0.083%.
- Total premiums for CalPERS HMO employer expenditures are estimated to increase by \$2,617,000 or 0.061%.

The estimated premium increases would not have a measurable impact on the number of persons who are uninsured.

## Medical Effectiveness

Most of the effectiveness research related to contraceptive methods is not classified as high quality as defined by CHBRP methodology. This is due, in part, to the prevailing opinion that it is unethical to randomize women who do not want to get pregnant into groups using a placebo contraceptive. Therefore, the comparison between a selected contraceptive and no contraceptive has to be estimated indirectly using published data on pregnancy rates among women using no contraception.

Over the course of a year, sexually active women of reproductive age not using contraceptive methods have an 85% chance of becoming pregnant. Among sexually active women with previous contraceptive use, the unintended pregnancy rate is 46%. These are the baseline rates from which to compare effectiveness of each of the contraceptives required by SB 1053.

Unintended pregnancy rates based on typical use of most of the FDA approved contraceptives range from 0.05% to 24%. Based on the results of these comparisons, it is reasonable to conclude that using any of the FDA approved contraceptive methods is more effective than not using any contraception in preventing unintended pregnancies. However, the varying rates of effectiveness between different methods should be noted. A comparison of pregnancy rates for different FDA approved contraceptive methods revealed that implanted devices (such as IUDs or implantable rods) and sterilization methods (such as vasectomy and tubal ligation) were far more effective at preventing unwanted pregnancy than barrier methods (male and female condoms, cervical caps, and sponges) or hormonal methods (pills, patches, and rings).

## Public Health

Unintended Pregnancy Rates: Assuming typical use of each contraceptive method among the additional projected contraceptive users, CHBRP estimates that SB 1053 will result in 51,298 averted unintended pregnancies and among those averted pregnancies, 20,006 averted abortions.

The reduction in unintended pregnancies will also result in a reduction in negative health outcomes associated with unintended pregnancy, including delayed prenatal care, low-birthweight, and preterm birth.

Risks and Harms of Contraceptives: The use of contraceptives is not without harm, particularly among users of hormonal methods. The additional enrollees using hormonal contraceptive methods may be at higher risk of cardiovascular disease and side effects such as headache and weight gain. Additionally, some enrollees newly using barrier methods or some IUDs

may be at increased risk of allergic reaction (to latex, copper, etc.) and additional enrollees obtaining sterilization may be at increased risk of possible postoperative complications (however, these complications are rare).

No single contraceptive method is highly effective at preventing both unintended pregnancy and protecting against sexually transmitted infections (STIs). Male condoms remain the primary method protecting against STIs. While SB 1053 may increase utilization of more effective contraceptive methods, such as oral contraceptives and IUDs, research has found that individuals using more effective methods as their primary birth control are less likely to use male condoms consistently, which could theoretically increase the risk of acquiring an STI.

Financial Burden: The mandate would expand coverage and reduce cost-sharing, lowering financial burden among enrollees using contraceptives by \$50.2 million in the first year, post-mandate. The mandate would eliminate cost-sharing for male contraceptives, including vasectomy, which has been previously covered but with some level of cost-sharing.

Racial and Ethnic Disparities: Although there are racial/ethnic disparities in contraceptive utilization, and an increase in utilization is projected, CHBRP is unable to project utilization by race/ethnicity. To the extent that SB 1053 increases utilization of more effective contraceptive methods, such as IUDs, in African Americans and Asians and Native Hawaiians and other Pacific Islanders, CHBRP estimates a reduction in the racial/ethnic disparity in the first year, postmandate; however, the magnitude is unknown.

## Long-term Impacts

Unintended Pregnancy Rates & Abortion: Assuming that SB 1053 increases utilization of contraceptives beyond the first year postmandate, CHBRP estimates that passage of SB 1053 may result in a decrease in the rate of unintended pregnancies and abortion in the long term, and thus substantial long-term cost reductions.

Maternal Mortality and Child Health Outcomes: Assuming that SB 1053 increases utilization of contraceptives beyond the first year postmandate, a decrease in the rate of unintended pregnancies will decrease the risk of maternal mortality, adverse child health outcomes, behavioral problems in children, and negative psychological outcomes associated with unintended pregnancies for both mothers and children.

## CONTEXT FOR BILL CONSIDERATION: INTERACTION WITH THE AFFORDABLE CARE ACT

### SB 1053 and Preventive Services

The requirements of SB 1053 would interact with the ACA’s preventive services requirement, which requires that nongrandfathered group and individual health insurance plans and policies cover certain preventive services without cost sharing. One of the four sources that the ACA refers to in determining which preventive services are required is the Health Resources and Services Administration (HRSA)–supported health plan coverage guidelines for women’s preventive services.

The HRSA-supported health plan coverage guidelines for women’s preventive services includes language that would require plans to cover “all FDA approved contraceptive methods, as prescribed by a physician”. The language of SB 1053 explicitly requires coverage of all FDA approved drugs, devices, and products, as well as sterilization procedures, in each FDA approved contraceptive category. Depending on how the HRSA guidelines are interpreted, SB 1053’s coverage mandate could be broader than what is required by the ACA.

In addition, SB 1053 would require coverage for all FDA approved male contraceptives, such as vasectomies and male condoms. Federal guidance on the preventive services requirement in the ACA has explicitly excluded coverage for male contraceptives as part of the HRSA guidelines, so the language of SB 1053 would require plans to cover a broader range of male contraceptives than what is currently required in federal law.

### SB 1053 and Essential Health Benefits

The ACA requires nongrandfathered small-group and individual market health insurance — including, but not limited to, qualified health plans (QHPs) sold in Covered California — to cover 10 specified categories of EHBs. California has selected the Kaiser Foundation Health Plan Small Group Health Maintenance Organization (HMO) 30 plan as its benchmark plan defining which benefits are included in EHBs within California.

In addition to the benefits described in Kaiser HMO 30, EHBs also include all benefits mandated to be covered by statutes enacted before December 31, 2011. This includes the federal preventive services requirement described in the section above.

Since the requirements of SB 1053 are potentially broader than what is required in the HRSA-supported guidelines for women’s preventive services, CHBRP believes that the requirements of SB 1053 could exceed EHBs. Specifically, the language of SB 1053 would require all health plans and insurers to provide

coverage for all FDA approved contraceptive “drugs, devices, products, and sterilization procedures” within each FDA approved contraceptive method category. The HRSA preventive services guidelines requires coverage of “all FDA approved contraceptive methods.” To the extent that these guidelines are interpreted to mean that coverage must be provided for “at least one” contraceptive type within each method category, then the requirements of SB 1053 could exceed what is currently being required by EHBs.

Additionally, the HRSA preventive services guidelines do not require plans and insurers to provide coverage for male contraceptives, such as condoms and vasectomies. Both Basic Health Care Services and Kaiser HMO 30 include coverage for vasectomies with cost-sharing requirements, but do not include coverage for male condoms. Since SB 1053 would require all plans and insurers to provide coverage for all FDA approved male contraceptives, including male condoms, CHBRP believes that the bill’s mandate would likely exceed the current requirements of EHBs.

**Table 1.** SB 1053 and Essential Health Benefits

Bill Provision	EHB Interaction	Rationale
Coverage of all FDA approved drugs, devices, products, and sterilization procedures in each contraceptive method category	Could exceed EHBs	This provision could be interpreted as more explicit and broader than the ACA’s preventive services requirement.
Coverage of all FDA approved male contraceptives (male condoms and vasectomy)	Would likely exceed EHBs	SB 1053’s requirement to cover male condoms is not included in either California’s Basic Health Care Services or the California EHB benchmark plan, Kaiser Small Group 30 HMO.

*Source:* California Health Benefits Review Program, 2014.

**A Report to the 2013–2014 California State Legislature**

**Analysis of Senate Bill 1053  
Health Care Coverage: Contraceptives**

**April 20, 2014**

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# EXECUTIVE SUMMARY

## California Health Benefits Review Program Analysis of Senate Bill 1053

The California Senate Committee on Health requested on February 18, 2014, that the California Health Benefits Review Program (CHBRP) conduct an evidence-based assessment of the medical, financial, and public health impacts of Senate Bill (SB) 1053, Health Care Coverage: Contraceptives. In response to this request, CHBRP undertook an analysis pursuant to the provisions of the program's authorizing statute,<sup>1</sup> which allows for the review of benefit mandates affecting health insurance regulated by the state. CHBRP subsequently received a request from the Senate Health Committee to analyze the April 9, 2014, amended version of the bill, and the analysis in this report reflects changes in the amended language.<sup>2</sup>

State benefit mandates apply to a subset of health insurance in California, those regulated by one of California's two health insurance regulators<sup>3</sup>: the California Department of Managed Health Care (DMHC)<sup>4</sup> and the California Department of Insurance (CDI).<sup>5</sup> In 2015, CHBRP estimates that approximately 23.4 million Californians (60%) will have health insurance that may be subject to any state health benefit mandate law.<sup>6</sup> Of the rest of the state's population, a portion will be uninsured (and therefore will have no health insurance subject to any benefit mandate), and another portion will have health insurance subject to other state laws or only to federal laws.

The mandate in SB 1053 would affect the health insurance of approximately 16.2 million enrollees (41% of all Californians).<sup>7</sup> Both DMHC and the California Department of Health Care Services (DHCS) have confirmed that SB 1053's language referring to "group" plans would not require compliance from plans enrolling Medi-Cal beneficiaries into Medi-Cal Managed Care<sup>8,9</sup>. Therefore, all DMHC-regulated plans and/or CDI-regulated policies, except managed care plans purchased by the DHCS for Medi-Cal beneficiaries, would be subject to SB 1053.

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<sup>1</sup> Available at: [www.chbrp.org/docs/authorizing\\_statute.pdf](http://www.chbrp.org/docs/authorizing_statute.pdf).

<sup>2</sup> The amended version (4/9/14) of SB 1053 reduced CHBRP's estimates of the public health impacts found in the original bill. More details on these differences can be found in Appendix G.

<sup>3</sup> California has a bifurcated system of regulation for health insurance. The Department of Managed Health Care (DMHC) regulates health care service plans, which offer benefit coverage to their enrollees through health plan contracts. The California Department of Insurance (CDI) regulates health insurers, which offer benefit coverage to their enrollees through health insurance policies.

<sup>4</sup> DMHC was established in 2000 to enforce the Knox-Keene Health Care Service Plan of 1975; see Health and Safety Code (H&SC) Section 1340.

<sup>5</sup> CDI licenses "disability insurers." Disability insurers may offer forms of insurance that are not health insurance. This report considers only the impact of the benefit mandate on health insurance policies, as defined in Insurance Code (IC) Section 106(b) or subdivision (a) of Section 10198.6.

<sup>6</sup> CHBRP's estimates are available at: [www.chbrp.org/other\\_publications/index.php](http://www.chbrp.org/other_publications/index.php).

<sup>7</sup> CHBRP's analysis of SB 1053 assumed that grandfathered plans would be included in the coverage mandate required by SB 1053, based on internal interpretation of the bill language and consultation with DMHC. CDI provided a different interpretation, stating that grandfathered CDI-regulated policies would not fall under the bill's requirements.

<sup>8</sup> Personal communication, S. Lowenstein, DMHC, January 2014.

<sup>9</sup> Personal communication, C. Robinson, Department of Health Care Services, citing Sec. 2791 of the federal Public Health Service Act, January 2014.

## **Developing Estimates for 2015 and the Effects of the Affordable Care Act**

The Affordable Care Act (ACA)<sup>10</sup> is substantially affecting health insurance and its regulatory environment in California. As of January 2014, an expansion of the Medi-Cal program, California's Medicaid program,<sup>11</sup> and the availability of subsidized and unsubsidized health insurance purchased through Covered California,<sup>12</sup> the state's newly established state health insurance marketplace, are significantly increasing the number of people with health insurance in California, and across the United States.

State health insurance marketplaces, such as Covered California, are responsible for certifying and selling qualified health plans (QHPs) in the small-group and individual markets.<sup>13</sup> QHPs sold through Covered California are DMHC-regulated plans or CDI-regulated policies, and as such will be subject to California state benefit mandates.

It is important to note that CHBRP's analysis of proposed benefit mandate bills typically address the incremental effects of the proposed bills — specifically, how the proposed mandate would impact benefit coverage, utilization, costs, and public health, holding all other factors constant. CHBRP's estimates of these incremental effects are presented in this report. In order to accommodate continuing changes in health insurance enrollment, CHBRP is relying on projections from the California Simulation of Insurance Markets (CalSIM) model<sup>14</sup> to help estimate baseline enrollment for 2015. From this projected baseline, CHBRP estimates the incremental impact of proposed benefit mandates that could be in effect after January 2015. CHBRP's methods for estimating baseline 2015 enrollment from CalSIM projections are provided in further detail in Appendix D.

### **Bill-Specific Analysis of SB 1053**

A link to the full text of SB 1053 can be found in Appendix A.

SB 1053 would require all DMHC-regulated plans and CDI-regulated policies issued, amended, renewed, or delivered on or after January 1, 2015, to provide coverage for all Food and Drug Administration (FDA) approved contraceptive drugs, devices, products<sup>15</sup>, and voluntary

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<sup>10</sup> The federal "Patient Protection and Affordable Care Act" (P.L.111-148) and the "Health Care and Education Reconciliation Act" (P.L. 111-152) were enacted in March 2010. Together, these laws are referred to as the Affordable Care Act (ACA).

<sup>11</sup> The Medicaid expansion, which California will pursue, is to 133% of the federal poverty level (FPL) — 138% with a 5% income disregard.

<sup>12</sup> The California Health Benefits Exchange Authorizing Statute is available here:

[www.healthexchange.ca.gov/Documents/California%20Codes%20Governing%20the%20Health%20Benefit%20Exchange.pdf](http://www.healthexchange.ca.gov/Documents/California%20Codes%20Governing%20the%20Health%20Benefit%20Exchange.pdf).

<sup>13</sup> Effective 2017, states may allow large-group purchasing through health insurance marketplaces, which may make some large-group plans and policies subject to the requirement to provide essential health benefits [ACA Section 1312(f)(2)(B)].

<sup>14</sup> CalSIM was developed jointly and is operated by the University of California, Los Angeles Center for Health Policy Research and the University of California, Berkeley Center for Labor Research. The model estimates the impact of provisions in the ACA on employer decisions to offer, and individual decisions to obtain, health insurance.

<sup>15</sup> The amended version of SB 1053 preserves existing prescription requirements for over-the-counter (OTC) contraceptives.

sterilization procedures in each contraceptive category outlined by the FDA, as well as contraceptive education and counseling.<sup>16</sup>

SB 1053 would prohibit nongrandfathered<sup>17</sup> group or individual health plans and policies from imposing cost-sharing requirements in providing contraceptive coverage, consistent with existing requirements in the ACA.<sup>18</sup>

SB 1053 also preserves existing language in both state law and in the ACA that exempts certain religious employers from providing this coverage to their employees.

### Analytic Approach and Key Assumptions

#### *FDA approved contraceptives*

The language in SB 1053 is explicit about which particular contraceptives are included in the bill's mandate, specifically citing all FDA approved contraceptive drugs, devices, products, and sterilization procedures.<sup>19</sup> The list of contraceptives currently approved by the FDA includes 20 different contraceptive types in five different contraceptive method categories. More detail on each of the contraceptive types listed below can also be found in the *Medical Effectiveness* and *Public Health Impacts* sections of this report. The full list of FDA approved contraceptive types, broken out by method category, includes the following:

- **Barrier contraceptive methods:** male condoms, female condoms, diaphragms, sponges, cervical caps, and spermicide
- **Hormonal contraceptive methods:** oral contraceptives, patches, contraceptive rings, and injections
- **Emergency contraceptives:** levonorgestrel (known as Plan B<sup>®</sup>, Plan B One-Step<sup>®</sup>, Next Choice, Next Choice One Step) and ulipristal acetate (Ella<sup>®</sup>)
- **Implanted device contraceptives:** copper IUD (ParaGard<sup>®</sup>), the levonorgestrel-releasing IUD (Mirena<sup>®</sup>, Skyla<sup>®</sup>) and the etonogestrel implantable rod (Implanon<sup>®</sup>, Nexplanon<sup>®</sup>)
- **Permanent contraceptive methods:** vasectomy, laparoscopic surgical sterilization and hysteroscopic surgical sterilization implant (Essure<sup>®</sup>).

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<sup>16</sup> A full list of FDA approved contraceptive drugs, devices, products, and sterilization procedures can be found here: [www.fda.gov/ForConsumers/ByAudience/ForWomen/FreePublications/ucm313215.htm](http://www.fda.gov/ForConsumers/ByAudience/ForWomen/FreePublications/ucm313215.htm).

<sup>17</sup> A grandfathered health plan is defined as: "A group health plan that was created — or an individual health insurance policy that was purchased — on or before March 23, 2010. Grandfathered plans are exempted from many changes required under the ACA. Plans or policies may lose their "grandfathered" status if they make certain significant changes that reduce benefits or increase costs to consumers". More information on this definition can be found here: [www.healthcare.gov/glossary/grandfathered-health-plan/](http://www.healthcare.gov/glossary/grandfathered-health-plan/).

<sup>18</sup> Centers for Medicare & Medicaid Services' FAQs issued after passage of the ACA provides guidelines for health plans in covering contraceptives, including around cost-sharing requirements. These guidelines can be found here: [www.cms.gov/CCIIO/Resources/Fact-Sheets-and-FAQs/aca\\_implementation\\_faqs12.html](http://www.cms.gov/CCIIO/Resources/Fact-Sheets-and-FAQs/aca_implementation_faqs12.html).

<sup>19</sup> For this analysis, CHBRP assumed that the bill would not require coverage of each brand of all FDA approved contraceptive drugs, devices, or products.

## Interaction With Other California Requirements

SB 1053 would amend California's existing contraceptive coverage law.<sup>20</sup>

The existing law requires all health plans and policies that provide coverage for outpatient prescription drugs to include coverage for "a variety of FDA approved prescription contraceptive methods" in their drug formulary. Since the language in SB 1053 includes a requirement for plans and policies to cover the full spectrum of FDA approved contraceptive devices, products, and sterilization procedures and is not simply limited to requiring contraceptive drugs, the bill would impose a broader coverage mandate than existing California law.

## Requirements in Other States

CHBRP is currently aware of at least 26 states (including California) that have passed health insurance benefit mandates related to contraception coverage in the past. Two additional states have mandated coverage of contraceptives through either administrative ruling or Attorney General opinion (NCSL, 2012).<sup>21</sup> These coverage mandates generally require plans that are already providing coverage for prescription drug contraceptives to also cover a wider range of FDA approved contraceptive drugs, devices, and products. However, there is some unique variation in the coverage required in states that have contraceptive mandates. For example, of the 28 states that have a contraceptive coverage requirement, 17 also require coverage of outpatient services related to specific contraceptive types (such as the cost of inserting an IUD). In two states, emergency contraception is excluded from their contraceptive coverage requirement. Additionally, one state excludes dependent minors from their coverage requirement (Guttmacher Institute, 2014).

## Background on Contraceptives and Unintended Pregnancy

An unintended pregnancy is defined as one that is "mistimed, unplanned or unwanted at the time of conception" (CDC, 2014a). In California, 516,000 pregnancies each year are unintended, accounting for 53% of all pregnancies occurring in the state (Kost, 2013). Women are considered at risk of unintended pregnancy if they are of reproductive age and sexually active with male partners. Consistent use of effective contraception greatly reduces this risk of pregnancy. Although utilization of contraception is high (65% of the overall U.S. population), there is still a large proportion of sexually active heterosexual females aged 15 to 44 years who are at risk of an unintended pregnancy. In the United States, nearly two-thirds of women at risk of an unintended pregnancy consistently use contraception throughout any given year and account for only 5% of unintended pregnancies. In comparison, 19% of women at risk use contraception inconsistently or incorrectly throughout any given year and 16% do not use any contraception for a month or longer during the year; these women account for 43% and 52% of all unintended pregnancies

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<sup>20</sup> H&SC Section 1367.25 and IC Sections 10123.196, as enacted by AB 39 (1999).

<sup>21</sup> National Conference of State Legislatures (NCSL). Insurance Coverage for Contraception Laws. February 2012. Available at: <http://www.ncsl.org/research/health/insurance-coverage-for-contraception-state-laws.aspx>. Accessed on March 11, 2014.<sup>21</sup> States with contraceptive coverage requirements as of March 2014 include: AZ, AK, CA, CO, CT, DE, GA, HI, IA, IL, MA, MD, MN, MS, NC, NH, NJ, NM, NV, NY, OR, RI, VT, WA, WV, and WI. Additionally, Michigan has passed an administrative ruling, and Montana has issued an Attorney General opinion, both requiring insurers in their states to provide contraceptive coverage.

respectively (Guttmacher Institute, 2013b). Assuming national contraception utilization rates are similar to those in California, the 35% of women using contraception inconsistently, incorrectly, or not at all would most benefit from SB 1053 by expanding access to a wide range of contraceptive method options with no cost sharing, including long-acting reversible contraceptives such as IUDs, which do not rely on user compliance. This would affect current rates of both unintended pregnancy and abortion.

Contraceptive use also has broad benefits, beyond preventing unintended pregnancies. It allows women to plan for pregnancy and achieve desired birth spacing, which positively impacts maternal and fetal health outcomes and maternal socioeconomic status. Contraceptive use also has noncontraceptive health benefits, including reducing menstruation-related symptoms, reducing risk of some cancers, and protecting against sexually transmitted infections.

### **Medical Effectiveness**

Most of the effectiveness research related to contraceptive methods is not classified as high quality as defined by CHBRP methodology. This is due, in part, to the prevailing opinion that it is not ethical to randomize women who do not want to get pregnant into groups using a placebo contraceptive. Therefore, the comparison between a selected contraceptive and no contraceptive has to be estimated indirectly using published data on pregnancy rates among women using no contraception. Based on the results of these comparisons, it is reasonable to conclude that using any of the contraceptive methods listed below is more effective than not using any contraception in preventing unintended pregnancies. The specific rates of unintended pregnancies for each type of contraceptive are listed below.

### **Summary of findings**

- Over the course of a year, sexually active women of reproductive age not using contraceptive methods have an 85% chance of becoming pregnant. Among sexually active women with previous contraceptive use, the unintended pregnancy rate is 46% over the course of a year.
- **Contraceptive counseling** is recommended for all women of reproductive age so that they can be informed of the benefits and risks of all contraceptive methods to aid in selection of their optimal method.
- **Barrier contraceptive methods.** There are six FDA approved barrier methods: male condom, female condom, diaphragm, sponge, cervical cap, and spermicide. Unintended pregnancy rates over the course of a year for barrier methods range from 12% to 24%.
- **Hormonal contraceptive methods.** The FDA approved hormonal methods are oral contraceptives, contraceptive patch (Ortho Evra<sup>®</sup>), the vaginal contraceptive ring (NuvaRing<sup>®</sup>), and contraceptive injections (Depo-Provera<sup>®</sup>, Depo-Subq Provera<sup>®</sup>). Over the course of a year, unintended pregnancy rates for hormonal contraceptive methods range from 6% to 9%.
- **Emergency contraception.** There are two types of emergency contraceptive pills: levonorgestrel (Plan B<sup>®</sup>, Plan B One-Step<sup>®</sup>, Next Choice, Next Choice One Step) and ulipristal acetate (Ella<sup>®</sup>). Among women taking emergency contraceptive pills, 1.8% to 2.6%

became pregnant. The copper intrauterine device (IUD) (ParaGard<sup>®</sup>) is also used for emergency contraception although it is not FDA approved for this purpose.

- **Implanted devices.** The FDA approved types are the copper IUD (ParaGard<sup>®</sup>), the levonorgestrel-releasing IUD (Mirena<sup>®</sup>) the low dose levonorgestrel-releasing IUD (Skyla<sup>®</sup>) and the etonogestrel implantable rod (Implanon<sup>®</sup>, Nexplanon<sup>®</sup>). Over the course of a year, unintended pregnancy rates for these contraceptives range from 0.05% to 0.8%.
- **Permanent contraceptive methods** include surgical sterilization for men (vasectomy), laparoscopic sterilization for women (tubal ligation), and hysteroscopic permanent sterilization implant for women (Essure<sup>®</sup>). Over the course of a year, unintended pregnancy rates for sterilization range from 0.1% to 0.5%.
- Comparative effectiveness of contraceptive methods:
  - Although very few direct comparison trials exist, large observational studies indicate that implanted long-acting reversible contraceptives such as IUDs and contraceptive implants and sterilization are more effective compared to hormonal contraception methods, and that barrier methods are the least effective form of contraception.
  - A meta-analysis of two randomized comparative effectiveness trials of ulipristal acetate and levonorgestrel found that ulipristal acetate users had lower rates of unintended pregnancy.
- There is a preponderance of evidence from studies with weak designs<sup>22</sup> that lowering or eliminating patient copayments for IUDs is associated with higher IUD utilization and is associated with a utilization shift from less to more effective contraception.

### **Benefit Coverage, Utilization, and Cost Impacts**

To perform the cost analysis for SB 1053, CHBRP measured current cost sharing (as a percentage of the total cost) for contraceptives. CHBRP modeled compliance with the mandate as resulting in the expansion of benefit coverage, and the prohibition of any cost sharing for covered contraceptives.

Table 1 summarizes the estimated benefit coverage, utilization, and cost impacts of SB 1053.

#### *Coverage impacts*

- Out of the 23.4 million enrollees in DMHC-regulated plans and CDI-regulated policies subject to state mandates, 16.2 million enrollees are subject to SB 1053.
- Currently, 97.5% of 16.2 million enrollees have coverage for *any* female contraceptives without cost sharing, including coverage through a family member. Among these 16.2 million enrollees, 99.3% have coverage for vasectomies with a certain level of cost sharing. Zero percent of these enrollees have coverage for male condoms.

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<sup>22</sup> CHBRP classifies nonrandomized/observational studies that do not have a concurrent comparison group (e.g., studies with before-after designs, studies with historical comparison groups) as studies of weak design.

- Because SB 1053 would expand contraceptive coverage, CHBRP estimates that 100% of these 16.2 million enrollees will have coverage for *all* contraceptive methods without any cost sharing after the mandate.
- CHBRP estimates that coverage for contraceptives would increase:
  - From 97.7% to 100% among female enrollees utilizing female contraceptives.
  - From 99.3% to 100% for vasectomies among male enrollees utilizing vasectomies.
  - From 0% to 100% among male enrollees utilizing male condoms.

### *Utilization impacts*

- CHBRP estimates that 183,332 enrollees would newly use contraceptives following the implementation of SB 1053 - this would be an increase of 7.4% compared to the 2,480,122 enrollees using contraceptives in 2014 regardless of coverage.
- CHBRP estimates that 1,209,662 covered female enrollees would use contraceptives following the implementation of SB 1053 - this would be an increase of 80,190 or 7.1% compared to the 1,129,472 covered females who used contraceptives in 2014.
- CHBRP projects that 53,785 or 4.65% additional female enrollees will newly use contraceptives in 2015 following the implementation of SB 1053, compared to the 1,155,877 female enrollees using contraceptives in 2014 regardless of coverage.
- CHBRP estimates that 1,453,972 covered male enrollees would use contraceptives following the implementation of SB 1053. This is an increase of 1,425,110 or 4,969% compared to the 28,862 covered males using contraceptives in 2014, when male condoms were not a covered benefit.
- Although the number of covered users is expected to increase substantially (as described above) CHBRP projects that 129,547 or 9.78% additional male enrollees will newly use contraceptives in 2015 following the implementation of SB 1053, compared to the 1,324,245 male enrollees using contraceptives in 2014 regardless of coverage. These utilization impacts are estimated based on the two sets of assumptions below:
  - For all contraceptive types except male condoms, CHBRP applied premandate utilization rates among enrollees with coverage for all enrollees after the mandate regardless of coverage status in the premandate period.<sup>23</sup> These premandate utilization rates among enrollees with coverage are based on Milliman's analysis of 2012 California claims data, as explained above.
  - CHBRP estimates a 10% increase in male condom utilization based on increased awareness and marketing of the mandate in SB 1053.<sup>24</sup>

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<sup>23</sup> It should be noted that the mandate allows females with coverage to obtain a prescription for male condoms and that coverage estimates include those with coverage through a family member.

<sup>24</sup> CHBRP analyses in the past have utilized a 10% estimated increase in utilization due to awareness and marketing of a particular benefit mandate.

### *Cost impacts*

- CHBRP assumes that the mandate will have no impact on the per-unit costs for any specific contraceptive type.
- Total net annual expenditures are estimated to increase by \$31,201,000 or 0.024% for enrollees with DMHC-regulated plans and CDI-regulated policies.
  - This estimate is based on a \$81,397,000 increase in total health insurance premiums paid by employers and enrollees for newly covered benefits, partially offset by a decrease in enrollee expenditures for previously noncovered benefits (\$46,546,000) and a decrease in enrollee out-of-pocket expenditures for previously covered benefits in the forms of deductibles and copayments (\$3,650,000)
  - CHBRP estimates the reduced medical expenditures of averted deliveries during the first year to be \$149,065,150 due to the projected increase in utilization of contraceptives.
- The mandate is estimated to increase premiums by about \$81,397,000 (0.083%). The distribution of the impact on premiums is as follows:
  - Total premiums for private employers are estimated to increase by \$46,320,000 (0.085%).
  - Enrollee contributions toward premiums for group insurance are estimated to increase by \$18,475,000 or 0.083%.
  - Total premiums for those with individually purchased insurance are estimated to increase by \$13,985,000 or 0.083%.
  - Total premiums for CalPERS HMO employer expenditures are estimated to increase by \$2,617,000 or 0.061%.
- The expected average increase in premiums across the commercial market segments is between 0.073% and .111% (or \$0.35 and \$0.71) per member per month (PMPM).
- The expected average increase in insurance premiums is 0.061% for CalPERS HMOs plans. For these publicly funded plans, the increase is estimated at \$0.32 per member per month (PMPM).
- The estimated premium increases would not have a measurable impact on the number of persons who are uninsured.

### **Public Health Impacts**

#### *Short-term impacts*

- Based on established contraceptive effectiveness rates, estimates of unintended pregnancy outcomes from the literature, and projected increases in utilization, CHBRP calculated the estimated number of unintended pregnancies and abortions averted by the mandate. Assuming typical use of each contraceptive method among the projected additional contraceptive users, CHBRP estimates that SB 1053 will result in 51,298 averted unintended pregnancies and 20,006 averted abortions.

- The reduction in unintended pregnancies will also result in a reduction in negative health outcomes associated with unintended pregnancy, including delayed prenatal care, low birthweight, and preterm birth.
- There are broad contraceptive and noncontraceptive benefits beyond preventing unintended pregnancies. Contraceptive use allows for delayed childbearing and achieving desired birth spacing, which is associated with improved maternal and fetal health outcomes, as well as noncontraceptive health benefits, including treating menstruation-related symptoms, reducing risk of some cancers, and protecting against sexually transmitted infections.
- The use of contraceptives is not without harm, particularly among users of hormonal methods. The additional enrollees using hormonal contraceptive methods may be at higher risk of cardiovascular disease and side effects such as headache and weight gain. Additionally, some enrollees newly using barrier methods or some IUDs may be at increased risk of allergic reaction (to latex, copper, etc.) and additional enrollees obtaining sterilization may be at increased risk of possible postoperative complications (however, these complications are rare). Any contraceptive-related harm must be weighed against the broad contraceptive and noncontraceptive benefits of use.
- No single contraceptive method is highly effective at preventing both unintended pregnancy and protecting against sexually transmitted infections. While newer contraceptive methods such as IUDs are highly effective at preventing unintended pregnancy, male condoms remain the primary method protecting against sexually transmitted infections. While this mandate may increase utilization of more effective contraceptive methods, such as oral contraceptives and IUDs, research has found that individuals using an effective method as their primary birth control method are less likely to use male condoms consistently, which could theoretically increase the risk of acquiring a sexually transmitted infection.
- The mandate would shift some contraceptive costs from enrollees to health plans and insurers through reduced cost sharing. CHBRP estimates a reduction in out-of-pocket expenses of approximately \$50.2 million consisting of a reduction of \$46.5 million in enrollee expenditures for previously noncovered benefits and a reduction of nearly \$3.7 million in enrollee out-of-pocket expenditures for previously covered benefits.
- While there are gender disparities in the utilization of sterilization and this mandate would eliminate cost sharing for male sterilization, CHBRP does not estimate a significant increase in male sterilization due to this mandate; therefore, SB 1053 would not impact gender disparities.
- Although there are racial/ethnic disparities in contraceptive utilization and unintended pregnancy rates, and an increase in utilization is projected, CHBRP is unable to project utilization by race/ethnicity due to an unknown baseline racial/ethnic distribution of the insured population affected by the mandate. To the extent that SB 1053 reduces disparities that are due to coverage differences (but not due to preferences about specific contraceptive coverage) and increases utilization of more effective contraceptive methods such as IUDs, CHBRP estimates a reduction in the racial/ethnic disparity in contraceptive use and unintended pregnancy in the first year, postmandate; however, the magnitude is unknown.

### *Long-term impacts*

- In the long term, assuming that SB 1053 increases utilization of contraceptives beyond the first year postmandate, CHBRP projects a decrease in the rate of unintended pregnancies and abortions.
- In the long term, assuming that SB 1053 increases utilization of contraceptives beyond the first year postmandate, a decrease in the rate of unintended pregnancies will decrease the risk of maternal mortality, adverse child health outcomes, behavioral problems in children, and negative psychological outcomes associated with unintended pregnancies for both the mothers and children. An increase in contraceptive utilization would also allow women to delay childbearing and pursue additional education, spend additional time in their careers and have increased earning power. Additionally, the increased contraceptive utilization is likely to produce substantial long-term cost reduction due to averted deliveries.
- The use of contraceptives is not without harm; however, any harm must be weighed against the broad health benefits of contraceptive use. In the long term, assuming that SB 1053 increases utilization of contraceptives beyond the first year postmandate, individuals using contraceptives may be at higher risk of cardiovascular disease associated with the use of specific contraceptives. While increased condom use is associated with decreased risk of acquiring a sexually transmitted infection (STI) and some research indicates that increased utilization of effective contraceptive methods decreases condom use, CHBRP cannot estimate the increased utilization of specific contraceptive methods beyond the first year postmandate and therefore cannot estimate the directionality of any impact on STIs.

### **Interaction With the Federal Affordable Care Act**

SB 1053 may interact with requirements in the ACA, including the federal requirement for health plans and insurers to provide coverage of specified preventive services without cost sharing, and the requirement for certain health insurance to cover “essential health benefits” (EHBs).<sup>25</sup>

### **SB 1053 and Preventive Services**

The ACA requires that nongrandfathered group and individual health insurance plans and policies cover certain preventive services without cost sharing when delivered by in-network providers and as soon as 12 months after a recommendation appears in one of four specified sources. One of the sources that the ACA refers to in determining which preventive services are required is the Health Resources and Services Administration (HRSA)-supported health plan coverage guidelines for women’s preventive services.<sup>26</sup>

The HRSA-supported health plan coverage guidelines for women’s preventive services includes language that would require plans and insurers to cover “all FDA approved contraceptive methods, as prescribed by a physician.” Depending on how this language is interpreted, these guidelines could require all FDA approved contraceptive types to be covered, or they could be

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<sup>25</sup> Resources on EHBs and other ACA impacts are available on the CHBRP website: [www.chbrp.org/other\\_publications/index.php](http://www.chbrp.org/other_publications/index.php).

<sup>26</sup> Available at: [www.hrsa.gov/womensguidelines/](http://www.hrsa.gov/womensguidelines/).

interpreted to require a broad spectrum of FDA approved contraceptives, including at least one contraceptive type in each FDA approved contraceptive method category. The language of SB 1053 explicitly requires coverage of *all* FDA approved drugs, devices, and products, as well as voluntary sterilization procedures, in each FDA approved contraceptive category. Depending on how the HRSA guidelines are interpreted, SB 1053's coverage mandate could be broader than what is required by the ACA.

In addition, SB 1053 would require coverage for all FDA approved male contraceptives, such as vasectomies and male condoms. Federal guidance on the preventive services requirement in the ACA has explicitly excluded coverage for male contraceptives as part of the HRSA guidelines, so the language of SB 1053 would require plans to cover a broader range of male contraceptives than what is currently required in federal law.<sup>27</sup>

### SB 1053 and Essential Health Benefits

The ACA requires nongrandfathered small-group and individual market health insurance — including, but not limited to, QHPs sold in Covered California — to cover 10 specified categories of EHBs.<sup>28</sup> California has selected the Kaiser Foundation Health Plan Small Group Health Maintenance Organization (HMO) 30 plan as its benchmark plan.<sup>29,30</sup>

In addition to the benefits described in California's benchmark plan, Kaiser HMO 30, EHBs also include all benefits mandated to be covered by statutes enacted before December 31, 2011. This includes the federal preventive services requirement described in the section above.

Since the requirements of SB 1053 are potentially broader than what is required in the HRSA-supported health plan coverage guidelines for women's preventive services, CHBRP believes that the requirements of SB 1053 could exceed EHBs. Specifically, the language of SB 1053 would require all health plans and insurers to provide coverage for all FDA approved contraceptive "drugs, devices, products, and voluntary sterilization procedures" within each FDA approved contraceptive method category. The HRSA preventive services guidelines requires coverage of "all FDA approved contraceptive methods." To the extent that these guidelines are interpreted to mean that coverage must be provided for "at least one" contraceptive type within each method category, then the requirements of SB 1053 could exceed what is currently being required by EHBs.

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<sup>27</sup> Department of Health and Human Services, Coverage of Certain Preventive Services Under the Affordable Care Act; Final Rules. Federal Register, Vol. 78, No. 127. Tuesday, July 2, 2013. Available at: [www.gpo.gov/fdsys/pkg/FR-2013-07-02/pdf/2013-15866.pdf](http://www.gpo.gov/fdsys/pkg/FR-2013-07-02/pdf/2013-15866.pdf). Accessed March 11, 2014.

<sup>28</sup> The 10 specified categories of essential health benefits (EHBs) are: ambulatory patient services; emergency services; hospitalization; maternity and newborn care; mental health and substance use disorder services, including behavioral health treatment; prescription drugs; rehabilitative and habilitative services and devices; laboratory services; preventive and wellness services and chronic disease management; and pediatric services, including oral and vision care. [ACA Section 1302(b)].

<sup>29</sup> The U.S. Department of Health and Human Services (HHS) has allowed each state to define its own EHBs for 2014 and 2015 by selecting one of a set of specified benchmark plan options. CCIIO, Essential Health Benefits Bulletin. Available at: [http://cciio.cms.gov/resources/files/Files2/12162011/essential\\_health\\_benefits\\_bulletin.pdf](http://cciio.cms.gov/resources/files/Files2/12162011/essential_health_benefits_bulletin.pdf). Accessed December 16, 2011.

<sup>30</sup> H&SC Section 1367.005; IC Section 10112.27.

Additionally, the HRSA preventive services guidelines do not require plans and insurers to provide coverage for male contraceptives, such as condoms and vasectomies. Both Basic Health Care Services and Kaiser HMO 30 include coverage for vasectomies with cost-sharing requirements, but do not include coverage for male condoms. Since SB 1053 would require all plans and insurers to provide coverage for all FDA approved male contraceptives, including male condoms, CHBRP believes that the bill's mandate would likely exceed the current requirements of EHBs.

Since the requirements of SB 1053 could be interpreted as broader than what is currently required in the EHB benefit package in California, the bill could exceed EHBs due to its requirement to cover all FDA approved contraceptive drugs, devices, products, and voluntary sterilization procedures.

SB 1053 would likely exceed EHBs due to its requirement for plans and insurers to provide coverage for male condoms, which are not currently required by EHBs as defined by California law.

**Table 1. SB 1053 Impacts on Benefit Coverage, Utilization, and Cost, 2015**

	Premandate	Postmandate	Increase/ Decrease	Change Postmandate
<b>Benefit coverage</b>				
Total enrollees with health insurance subject to state-level benefit mandates (a)	23,389,000	23,389,000	0.0%	0.000%
Total enrollees with health insurance subject to SB 1053	16,199,000	16,199,000	0.0%	0.000%
Number of enrollees with coverage for female contraceptives	15,798,200	16,199,000	400,800	2.537%
Number of enrollees with coverage for male contraceptives: condoms	-	16,199,000	16,199,000	0.000%
Number of enrollees with coverage for male contraceptives: vasectomies	16,086,758	16,199,000	112,242	0.698%
Percentage of enrollees with coverage for female contraceptives	97.5%	100.0%	2.5%	2.537%
Percentage of enrollees with coverage for male contraceptives: condoms	0.0%	100.0%	100.0%	0.000%
Percentage of enrollees with coverage for male contraceptives: vasectomies	99.3%	100.0%	0.7%	0.698%
<b>Utilization and cost</b>				
Number of Female Enrollees using benefit				
With Coverage	1,129,472	1,209,662	80,190	7.100%
Without Coverage	26,405	-	(26,405)	-100.000%
Average Annual Cost per Female Enrollee using Contraceptive Benefit				
With Coverage	\$624	\$628	\$4	0.605%
Without Coverage	\$600	\$0	-\$600	-100.000%
Number of Male Enrollees using Benefit				
With Coverage	28,682	1,453,792	1,425,110	4968.611%
Without Coverage	1,295,562	-	(1,295,562)	-100.000%

**Table 1. SB 1053 Impacts on Benefit Coverage, Utilization, and Cost, 2015 (Cont'd)**

	Premandate	Postmandate	Increase/ Decrease	Change Postmandate
<b>Benefit coverage</b>				
Average Annual Cost for Male Enrollees using Contraceptive Benefit				
With Coverage	\$948	\$42	-\$906	-95.577%
Without Coverage	\$24	\$0	-\$24	-100.000%
<b>Expenditures</b>				
<i>Premium expenditures by payer</i>				
Private employers for group insurance	\$54,590,722,000	\$54,637,042,000	\$46,320,000	0.085%
CalPERS HMO employer expenditures (c)	\$4,297,494,000	\$4,300,111,000	\$2,617,000	0.061%
Medi-Cal Managed Care Plan expenditures	\$17,504,711,000	\$17,504,711,000	\$0	0.000%
Enrollees for individually purchased insurance	\$16,930,080,000	\$16,944,065,000	\$13,985,000	0.083%
Enrollees with group insurance, CalPERS HMOs, Covered California, and Medi-Cal Managed Care (a) (b)	\$22,232,708,000	\$22,251,183,000	\$18,475,000	0.083%
<i>Enrollee expenses</i>				
Enrollee out-of-pocket expenses for covered benefits (deductibles, copayments, etc.)	\$12,867,143,000	\$12,863,493,000	-\$3,650,000	-0.028%
Enrollee expenses for noncovered benefits (d)	\$46,546,000	\$0	-\$46,546,000	-100.000%
<b>Total expenditures</b>	\$128,469,404,000	\$128,500,605,500	\$31,201,000	0.024%

Source: California Health Benefits Review Program, 2014.

Notes: (a) This population includes persons with privately funded and publicly funded (e.g., CalPERS HMOs, Medi-Cal Managed care Plans, Healthy Families Program) health insurance products regulated by DMHC or CDI. Population includes enrollees aged 0 to 64 years and enrollees 65 years or older covered by employer-sponsored insurance.

(b) Premium expenditures by enrollees include employee contributions to employer-sponsored health insurance and enrollee contributions for publicly purchased insurance.

(c) Of the increase in CalPERS employer expenditures, about 57% or \$1,492,000 would be state expenditures for CalPERS members who are state employees, state retirees, or their dependents. This percentage reflects the share of enrollees in CalPERS HMOs as of September 30, 2013. CHBRP assumes the same ratio in 2015.

(d) Includes only those expenses that are paid directly by enrollees to providers for services related to the mandated benefit that are not currently covered by insurance. In addition, this only includes those expenses that will be newly covered postmandate. Other components of expenditures in this table include all health care services covered by insurance

Key: CalPERS HMOs=California Public Employees' Retirement System Health Maintenance Organizations; CDI=California Department of Insurance; DMHC=Department of Managed Health.

## ACKNOWLEDGMENTS

This report provides an analysis of the medical, financial, and public health impacts of Senate Bill 1053. In response to a request from the California Senate Committee on Health on February 19, 2014, the California Health Benefits Review Program (CHBRP) undertook this analysis pursuant to the program's authorizing statute, which established CHBRP to provide independent and impartial analysis of proposed health insurance benefit mandates and repeals. CHBRP subsequently received a request from the Senate Health Committee to analyze the April 9, 2014 amended version of the bill, and the analysis in this report reflects changes in the amended language.

Sara McMenamin, PhD, and Steven Tally, PhD, of the University of California, San Diego, prepared the medical effectiveness analysis. Penny Coppernoll-Blach, MLIS, of the University of California, San Diego, conducted the literature search. Joy Melnikow, MD, MPH, and Meghan Soulsby, MPH, of the University of California, Davis, prepared the public health impact analysis. Byung-Kwang (BK) Yoo, MD, MS, PhD, of the University of California, Davis, and Riti Shimkhada, PhD, of the University of California, Los Angeles, prepared the cost impact analysis. Susan Pantely, FSA, MAAA and Casey Word, ASA, MAAA of Milliman, provided actuarial analysis. Content experts Sheila K. Mody, MD, MPH, of the University of California, San Diego, and James Trussell, PhD, of Princeton University provided technical assistance with the literature review and expert input on the analytic approach. Nimit Ruparel, MPP, and Garen Corbett, MS, of CHBRP staff prepared the *Introduction* and synthesized the individual sections into a single report. A subcommittee of CHBRP's National Advisory Council (see final pages of this report) and a member of the CHBRP Faculty Task Force, Theodore Ganiats, MD, of the University of California, San Diego, reviewed the analysis for its accuracy, completeness, clarity, and responsiveness to the Legislature's request.

CHBRP gratefully acknowledges all of these contributions but assumes full responsibility for all of the report and its contents. Please direct any questions concerning this report to:

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## California Health Benefits Review Program Committees and Staff

A group of faculty, researchers, and staff complete the analysis that informs California Health Benefits Review Program (CHBRP) reports. The CHBRP **Faculty Task Force** comprises rotating senior faculty from University of California (UC) campuses. In addition to these representatives, there are other ongoing contributors to CHBRP from UC that conduct much of the analysis. The **CHBRP staff** coordinates the efforts of the Faculty Task Force, works with Task Force members in preparing parts of the analysis, and manages all external communications, including those with the California Legislature. As required by CHBRP's authorizing legislation, UC contracts with a certified actuary, Milliman Inc., to assist in assessing the financial impact of each legislative proposal mandating or repealing a health insurance benefit.

The **National Advisory Council** provides expert reviews of draft analyses and offers general guidance on the program to CHBRP staff and the Faculty Task Force. CHBRP is grateful for the valuable assistance of its National Advisory Council. CHBRP assumes full responsibility for the report and the accuracy of its contents.

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