§ 1367.25. Contraceptive coverage

(a) A group health care service plan contract, except for a specialized health care service plan contract, that is issued, amended, renewed, or delivered on or after January 1, 2000, to December 31, 2015, inclusive, and an individual health care service plan contract that is amended, renewed, or delivered on or after January 1, 2000, to December 31, 2015, inclusive, except for a specialized health care service plan contract, shall provide coverage for the following, under general terms and conditions applicable to all benefits:

(1) A health care service plan contract that provides coverage for outpatient prescription drug benefits shall include coverage for a variety of federal Food and Drug Administration (FDA)-approved prescription contraceptive methods designated by the plan. In the event the patient's participating provider, acting within the provider's scope of practice, determines that none of the methods designated by the plan is medically appropriate for the patient's medical or personal history, the plan shall also provide coverage for another FDA-approved, medically appropriate prescription contraceptive method prescribed by the patient's provider.

(2) Benefits for an enrollee under this subdivision shall be the same for an enrollee's covered spouse and covered nonspouse dependents.

(b)(1) A health care service plan contract, except for a specialized health care service plan contract, that is issued, amended, renewed, or delivered on or after January 1, 2016, shall provide coverage for all of the following services and contraceptive methods for all subscribers and enrollees:

(A)(i) Except as provided in clause (ii) and in subparagraphs (B) and (C) of paragraph (2), all FDA-approved contraceptive drugs, devices, and other products including all FDA-approved contraceptive drugs, devices, and products available over the counter, as prescribed by the enrollee's provider.

(ii) For any health care service plan contract described in paragraph (1) that is issued, amended, renewed, or delivered on or after January 1, 2024, both of the following conditions shall apply:

(I) A prescription shall not be required to trigger coverage of over-the-counter FDA-approved contraceptive drugs, devices, and products.

(II) Point-of-sale coverage for over-the-counter FDA-approved contraceptive drugs, devices, and products shall be provided at in-network pharmacies without cost sharing or medical management restrictions.

(B) Voluntary tubal ligation and other similar sterilization procedures.

(C) Clinical services related to the provision or use of contraception, including consultations, examinations, procedures, device insertion, ultrasound, anesthesia, patient education, referrals, and counseling.

(D) Followup services related to the drugs, devices, products, and procedures covered under this subdivision, including, but not limited to, management of side effects, counseling for continued adherence, and device removal.

(2)(A) Except for a grandfathered health plan, a health care service plan subject to this subdivision shall not impose a deductible, coinsurance, copayment, or any other cost-sharing requirement on the coverage provided pursuant to this subdivision. Cost sharing shall not be imposed on any Medi-Cal beneficiary.

(B) If the FDA has approved one or more therapeutic equivalents, as that term is defined by the FDA, of a contraceptive drug, device, or product, a health care service plan is not required to cover all of those therapeutically equivalent versions in accordance with this subdivision, as long as at least one is covered without cost sharing in accordance with this subdivision. If there is no therapeutic equivalent generic substitute available in the market, a health care service plan shall provide coverage without cost sharing for the original, brand name contraceptive.

(C) If a covered therapeutic equivalent of a drug, device, or product is deemed medically inadvisable by the enrollee's provider, a health care service plan shall defer to the determination and judgment of the provider and provide coverage for the alternative prescribed contraceptive drug, device, product, or service without imposing any cost-sharing requirements. Medical inadvisability may include considerations such as severity of side effects, differences in permanence or reversibility of contraceptives, and ability to adhere to the appropriate use of the drug or item, as determined by the provider. The department may promulgate regulations establishing an easily accessible, transparent, and sufficiently expedient process that is not unduly burdensome, including timeframes, for an enrollee, an enrollee's designee, or an enrollee's provider to request coverage of an alternative prescribed contraceptive. A request for coverage under this subparagraph that is submitted by an enrollee, an enrollee's designee, or provider shall be approved by the health care service plan in compliance with the time limits in Section 1367.241 and, as applicable, with the plan's Medi-Cal managed care contract.

(3) Except as otherwise authorized under this section, a health care service plan shall not infringe upon an enrollee's choice of contraceptive drug, device, or product and shall not impose any restrictions or delays on the coverage required under this subdivision, including prior authorization, step therapy, or other utilization control techniques.

(4) Benefits for an enrollee under this subdivision shall be the same for an enrollee's covered spouse and covered nonspouse dependents.

(5) For purposes of this subdivision, "health care service plan" shall include Medi-Cal managed care plans that contract with the State Department of Health Care Services pursuant to Chapter 7 (commencing with Section 14000) and Chapter 8 (commencing with Section 14200) of Part 3 of

Division 9 of the Welfare and Institutions Code, to the extent that the benefits described in this subdivision are made the financial responsibility of the Medi-Cal managed care plan under its comprehensive risk contract with the State Department of Health Care Services. If some or all of the benefits described in this subdivision are not the financial responsibility of the Medi-Cal managed care plan, as determined by the State Department of Health Care Services, those benefits shall be available to Medi-Cal beneficiaries on a fee-for-service basis pursuant to subdivision (n) of Section 14132 of the Welfare and Institutions Code

(c)(1) Notwithstanding any other provision of this section, a religious employer may request a health care service plan contract without coverage for FDA-approved contraceptive methods that are contrary to the religious employer's religious tenets. If so requested, a health care service plan contract shall be provided without coverage for contraceptive methods. The exclusion from coverage under this provision shall not apply to a contraceptive drug, device, procedure, or other product that is used for purposes other than contraception.

(2) For purposes of this section, a "religious employer" is an entity for which each of the following is true:

(A) The inculcation of religious values is the purpose of the entity.

(B) The entity primarily employs persons who share the religious tenets of the entity.

(C) The entity serves primarily persons who share the religious tenets of the entity.

(D) The entity is a nonprofit organization as described in Section 6033(a)(3)(A)(i) or (iii) of the Internal Revenue Code of 1986, as amended.

(d)(1) Every health care service plan contract that is issued, amended, renewed, or delivered on or after January 1, 2017, shall cover up to a 12-month supply of FDA-approved, self-administered hormonal contraceptives when dispensed or furnished at one time for an enrollee by a provider, pharmacist, or at a location licensed or otherwise authorized to dispense drugs or supplies.

(2) This subdivision shall not be construed to require a health care service plan contract to cover contraceptives provided by an out-of-network provider, pharmacy, or location licensed or otherwise authorized to dispense drugs or supplies, except as may be otherwise authorized by state or federal law or by the plan's policies governing out-of-network coverage.

(3) This subdivision shall not be construed to require a provider to prescribe, furnish, or dispense 12 months of self-administered hormonal contraceptives at one time.

(4) A health care service plan subject to this subdivision, shall not impose utilization controls or other forms of medical management limiting the supply of FDA-approved, self-administered hormonal contraceptives that may be dispensed or furnished by a provider or pharmacist, or at a location licensed or otherwise authorized to dispense drugs or supplies to an amount that is less than a 12-month supply, and shall not require an enrollee to make any formal request for such coverage other than a pharmacy claim.

(e) This section shall not be construed to exclude coverage for contraceptive supplies as prescribed by a provider, acting within the provider's scope of

practice, for reasons other than contraceptive purposes, such as decreasing the risk of ovarian cancer or eliminating symptoms of menopause, or for contraception that is necessary to preserve the life or health of an enrollee.

(f) This section shall not be construed to deny or restrict in any way the department's authority to ensure plan compliance with this chapter when a plan provides coverage for contraceptive drugs, devices, and products.

(g) This section shall not be construed to require an individual or group health care service plan contract to cover experimental or investigational treatments.

(h) For purposes of this section, the following definitions apply:

(1) "Grandfathered health plan" has the meaning set forth in Section 1251 of PPACA.

(2) "PPACA" means the federal Patient Protection and Affordable Care Act (Public Law 111-148), as amended by the federal Health Care and Education Reconciliation Act of 2010 (Public Law 111-152), and any rules, regulations, or guidance issued thereunder.

(3) With respect to health care service plan contracts issued, amended, or renewed on or after January 1, 2016, "provider" means an individual who is certified or licensed to furnish family planning services within their scope of practice pursuant to Division 2 (commencing with Section 500) of the Business and Professions Code, including a pharmacist authorized pursuant to Section 4052 or 4052.3 of the Business and Professions Code, or an initiative act referred to in that division, or Division 2.5 (commencing with Section 1797) of this code.

(4) For purposes of this section, "over-the-counter FDA-approved contraceptive drugs, devices, and products" and "over-the-counter birth control methods" are limited to those included as essential health benefits pursuant to Section 1367.005.

HISTORY:

Added Stats 1999 ch 532 § 2 (AB 39). Amended Stats 2000 ch 857 § 32 (AB 2903); Stats 2002 ch 791 § 4 (SB 842); Stats 2014 ch 576 § 2 (SB 1053), effective January 1, 2015; Stats 2015 ch 303 § 255 (AB 731), effective January 1, 2016; Stats 2016 ch 499 § 3 (SB 999); Stats 2022 ch 630 § 13 (SB 523), effective January 1, 2023.

§ 1367.251. Deductible, coinsurance, copayment and cost sharing requirements for abortion and abortion related services

(a)(1) A health care service plan, except for a specialized health care service plan contract, that is issued, amended, renewed, or delivered on or after January 1, 2023, shall not impose a deductible, coinsurance, copayment, or any other cost-sharing requirement on coverage for all abortion and abortion-related services, including preabortion and followup services.

(2) Except as otherwise authorized by this section, a health care service plan shall not impose any utilization management or utilization review, including prior authorization and annual or lifetime limits consistent with Sections 1367.001 and 1367.005, on the coverage for outpatient abortion services.

(3) Medi-Cal managed care plans that contract with the State Department of Health Care Services pursuant to Chapter 7 (commencing with Section 14000) and Chapter 8 (commencing with Section 14200) of Part 3 of

Division 9 of the Welfare and Institutions Code and their contracting providers, independent practice associations, preferred provider groups, and all delegated entities that provide physician services, utilization management, or utilization review shall be subject to this section.

(4) If a health care service plan delegates responsibilities under this section to a contracted entity, including a medical group or independent practice association, the delegated entity shall comply with this section.

(b) This section does not deny or restrict in any way the department's authority to ensure plan compliance with this chapter when a health care service plan provides coverage for abortion services.

(c) This section does not require an individual or group health care service plan contract to cover an experimental or investigational treatment.

(d) For purposes of this section, "abortion" means any medical treatment intended to induce the termination of a pregnancy except for the purpose of producing a live birth.

(e) For a health care service plan contract that is a high deductible health plan, as defined in Section 223(c)(2) of Title 26 of the United States Code, the cost-sharing limits in paragraph (1) of subdivision (a) shall apply once an enrollee's deductible has been satisfied for the benefit year.

(f)(1) Notwithstanding Chapter 3.5 (commencing with Section 11340) of Part 1 of Division 3 of Title 2 of the Government Code, the department may interpret and implement this section, in consultation with the State Department of Health Care Services and the Department of Insurance, by means of plan letters or similar guidance without taking any further regulatory action. The department shall adopt regulations on or before January 1, 2026, in accordance with the requirements of Chapter 3.5 (commencing with Section 11340) of Part 1 of Division 3 of Title 2 of the Government Code.

(2) Notwithstanding Chapter 3.5 (commencing with Section 11340) of Part 1 of Division 3 of Title 2 of the Government Code, the State Department of Health Care Services may implement this section, consistent with any guidance issued by the department pursuant to paragraph (1), to the extent that guidance does not exceed Medi-Cal program coverage of abortion and abortion-related services, by means of plan letters, plan or provider bulletins, or similar guidance issued to Medi-Cal managed care plans that contract with the State Department of Health Care Services pursuant to Chapter 7 (commencing with Section 14000) and Chapter 8 (commencing with Section 14200) of Part 3 of Division 9 of the Welfare and Institutions Code, without taking any further regulatory action.

HISTORY:

Added Stats 2022 ch 11 § 1 (SB 245), effective January 1, 2023.