Key Findings

Analysis of California Assembly Bill 1520
Prostate Cancer: Screening

Summary to the 2021–2022 California State Legislature, April 20, 2021

SUMMARY

The version of California Assembly Bill (AB) 1520 analyzed by CHBRP would prohibit cost sharing on coverage for prostate cancer screening for enrollees with a prostate who are either aged 55 years or older, or aged 40 years or older and considered high risk. Under AB 1520, the high-risk population includes but is not limited to Black individuals with a prostate, individuals with genetic predisposition or family history of prostate cancer, and veterans.

In 2022, AB 1520 would apply to the benefit coverage of 64% of the 21.9 million Californians enrolled in state-regulated health insurance.

Benefit Coverage: At baseline, CHBRP estimates approximately 97% of enrollees with health insurance subject to AB 1520 have no cost sharing for prostate cancer screening. AB 1520 appears not to exceed the definition of essential health benefits (EHBs) in California.

Medical Effectiveness: CHBRP found *insufficient evidence* on the impacts of cost sharing for prostate cancer screening on health outcomes and utilization of other health services. CHBRP also found *insufficient evidence* that digital rectal exams (DREs) affect health outcomes and subsequent utilization of health services, and *inconclusive evidence* that prostate-specific antigen (PSA) tests are effective at improving health outcomes. There is a *preponderance of evidence* that PSA tests contribute to utilization of other health services, and *limited evidence* of such impacts on Black men. There is *clear and convincing evidence* that PSA tests contribute to false positives and overdiagnosis.

Cost and Health Impacts: At baseline, there are 447,690 prostate cancer screenings annually. Among enrollees with cost sharing at baseline, there are 14,302 prostate cancer screenings annually (3.19% of total). Postmandate, AB 1520 would eliminate cost sharing for 3.19% of prostate cancer screenings, with no change in expected utilization. CHBRP estimates no measurable public health impact on access to, or subsequent rates of, prostate cancer screening.

CONTEXT

Prostate cancer occurs in the prostate, a small gland that is part of the male reproductive system. It is about the shape and size of a walnut, and rests below the bladder and in front of the rectum, surrounding part of the urethra. Prostate cancer is the second most prevalent type of organ cancer among all Californians (25,880 cases diagnosed in 2020).[1] The leading known risk factors for prostate cancer include increasing age, genetic mutations in DNA repair genes, having first-degree relative with prostate cancer, and race (Black men experience higher rates of prostate cancer compared with men of other races).

Prostate cancer screening is conducted on asymptomatic men to detect cancer at its earliest stage with the goal of reducing prostate cancer mortality. The most common method for prostate cancer screening is the prostate-specific antigen (PSA) test, which is typically combined with a digital rectal exam (DRE). DREs are more often included in a regular annual physical and are not usually performed specifically as a prostate cancer screening.

In 2018, the United States Preventive Service Task Force (USPSTF) updated their recommendation for PSA tests to be a C rating for men aged 55 to 69 years and D rating for men aged 70 years or older. For services with a C rating the USPSTF "recommends selectively offering or providing [the] service to individual patients based on professional judgment and patient preferences. There is at least moderate certainty that the net benefit is small." For services with a D rating the USPSTF "recommends against the service. There is moderate or high certainty that the service has no net benefit or that the harms outweigh the benefits."

BILL SUMMARY

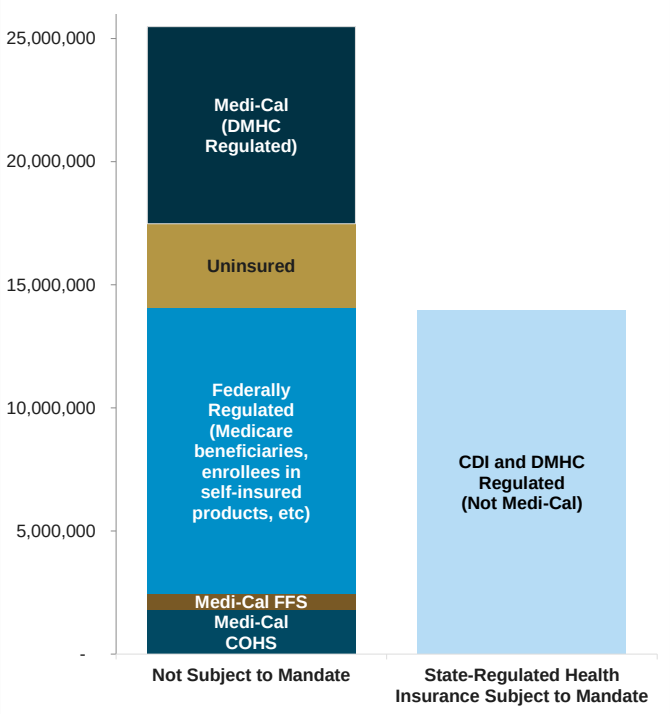
AB 1520 would prohibit cost sharing for prostate cancer screening, including but not limited to screening with PSA testing and DREs for enrollees aged 55 years or older or high-risk enrollees aged 40 years or older. Under AB 1520, the high-risk population includes but is not limited to persons with a prostate who are Black,

[1] Refer to CHBRP's full report for full citations and references.

have a family history of prostate cancer, have a genetic predisposition to prostate cancer, or are veterans.

As noted in Figure A, AB 1520 would apply to the benefit coverage of commercial and California Public Employees' Retirement System (CalPERS) enrollees in group and individual health plans[2] and health insurance policies regulated by the California Department of Managed Health Care (DMHC) and the California Department of Insurance (CDI).

Figure A. Health Insurance in CA and AB 1520



Source: California Health Benefits Review Program, 2021.

IMPACTS

Benefit Coverage, Utilization, and Cost

Benefit Coverage

At baseline, CHBRP estimates that approximately 97% of enrollees with health insurance subject to AB 1520 have coverage for prostate cancer screening with no cost sharing.

Utilization

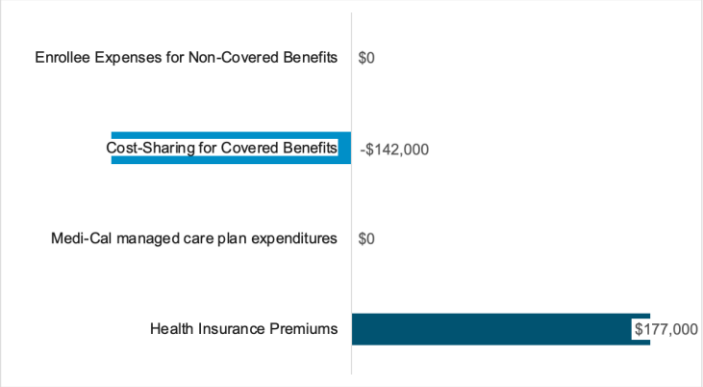
Among enrollees with no cost sharing at baseline, there are 447,690 prostate cancer screenings annually (444,721 PSA tests and 2,969 DREs). Among enrollees with cost sharing at baseline, there are 14,302 prostate cancer screenings annually (14,207 PSA tests and 95 DREs; 3.19% of the total number of screenings).

Postmandate, all enrollees would no cost sharing for coverage of prostate cancer screenings, for a total of 461,992 PSA tests and DREs annually performed with no cost sharing. Because of a lack of evidence in the research literature of cost sharing being a barrier to obtaining a PSA test or DRE, and with confirmatory input from the content expert, CHBRP projects no change in utilization postmandate.

Expenditures

AB 1520 would increase total annual expenditures of $35,000 (<0.0001%). This is due to a $177,000 estimated increase in total health insurance premiums paid by employers and enrollees for newly covered benefits, adjusted by an estimated decrease in enrollee expenses for covered benefits of $142,000 (Figure B).

Figure B. Expenditure Impacts of AB 1520



Source: California Health Benefits Review Program, 2021.

Medi-Cal

Medi-Cal beneficiaries enrolled in DMHC-regulated plans would not be subject to AB 1520 because the bill specifies that it is applicable to group and individual plans and policies. Medi-Cal beneficiaries are enrolled in neither.

[2] Medi-Cal beneficiaries enrolled in DMHC-regulated plans would not be subject to AB 1520 because the bill specifies that it is applicable to group and individual plans and policies. Medi-Cal beneficiaries are enrolled in neither.

CalPERS

AB 1520 would not impact CalPERS enrollees' benefit coverage, since these plans already include coverage for prostate cancer screening with no cost sharing.

Number of Uninsured in California

Because the change in average premiums does not exceed 1% for any market segment, CHBRP would expect no measurable change in the number of uninsured persons due to the enactment of AB 1520.

Medical Effectiveness

CHBRP found *insufficient evidence*[3] on the impacts of cost sharing for PSA tests or DREs on health outcomes, access to care, and the subsequent utilization of additional health services.

The primary outcomes of interest for prostate cancer screening are the utilization of other health services, such as biopsy, and the associated health outcomes including prostate cancer incidence, cumulative incidence of metastatic disease, prostate cancer–specific mortality, and all-cause mortality. Harms were measured by frequency of false-positive PSA screening and overdiagnosis.

There is *insufficient evidence* that DREs affects health outcomes and subsequent utilization of other health services.

With regard to outcomes related to PSA tests, CHBRP found:

- There is *inconclusive evidence*[4] that PSA tests are effective at improving health outcomes, including mortality rates.
- There is a *preponderance of evidence*[5] that PSA tests for prostate cancer screening contribute to the utilization of other health services following a positive PSA test, such as biopsy; there is *limited evidence*[6] of such impacts on Black men.
- There is *clear and convincing evidence*[7] that PSA tests contribute to false positives and over diagnosis which contributes to unnecessary additional testing and treatments that can be associated with substantial harms.

Public Health

CHBRP estimates that, postmandate, AB 1520 would not change utilization, but it would eliminate the average $10 cost sharing amount affecting 14,302 of the 461,992 prostate cancer screening services that would have been charged to enrollees at baseline. CHBRP found insufficient evidence to determine the impacts of cost sharing on health outcomes, access to care, and utilization of services. Therefore, CHBRP estimates no measurable short-term public health impact on access to, or subsequent rates of, prostate cancer screening.

Although disparities related to prostate cancer screening exist among Black and Hispanic men, AB 1520 does not address the barriers that prevent these men from obtaining prostate cancer screening (i.e., medical mistrust, lack of health insurance and access to care, and fear of cancer diagnosis or manipulation of the prostate). Given these findings, CHBRP estimates no measurable public health impact from AB 1520 on disparities related to prostate cancer screening rates in California.

Long-Term Impacts

The impacts of AB 1520 are unlikely to be different in subsequent years, assuming the same prostate cancer screening tools are available. Thus, CHBRP expects no change in utilization in the long term. Similarly, the potential expenditure increases as a result of removal of cost sharing for prostate cancer screening are likely to be similar in subsequent years.

Due to insufficient evidence on the impacts of cost sharing for prostate cancer screening on health outcomes, access to care, and subsequent utilization of additional health services, and no change in utilization

[3] *Insufficient evidence* indicates that there is not enough evidence available to know whether or not a treatment is effective, either because there are too few studies of the treatment or because the available studies are not of high quality. It does not indicate that a treatment is not effective.
[4] *Inconclusive evidence* indicates that although some studies included in the medical effectiveness review find that a treatment is effective, a similar number of studies of equal quality suggest the treatment is not effective.
[5] *Preponderance of evidence* indicates that the majority of the studies reviewed are consistent in their findings that treatment is either effective or not effective.
[6] *Limited evidence* indicates that the studies have limited generalizability to the population of interest and/or the studies have a fatal flaw in research design or implementation.
[7] *Clear and convincing* evidence indicates that there are multiple studies of a treatment and that the large majority of studies are of high quality and consistently find that the treatment is either effective or not effective.

rates in the long term, CHBRP projects AB 1520 would have no measurable long-term public health impact on access to or subsequent rates of prostate cancer screening.

Essential Health Benefits and the Affordable Care Act

AB 1520 would not require coverage for a new state benefit mandate and instead modifies cost-sharing terms and conditions of an already covered benefit. Therefore, AB 1520 appears not to exceed the definition of EHBs in California.