# California Health Benefits Review Program

## Analysis of California Assembly Bill (AB) 1954 Reproductive and Sexual Health

A Report to the 2015–2016 California State Legislature

April 15, 2016

CALIFORNIA
HEALTH BENEFITS REVIEW PROGRAM

# Key Findings:

## Analysis of California Assembly Bill (AB) 1954 Reproductive and Sexual Health

Summary to the 2015–2016 California State Legislature, July 2016

CALIFORNIA HEALTH BENEFITS REVIEW PROGRAM

## AT A GLANCE

Assembly Bill (AB) 1954 would require plans or policies that provide coverage for reproductive and sexual health services to all enrollees to obtain care at an out-of-network (OON) provider if timely access to an in-network provider is unavailable.

- **Enrollees covered.** CHBRP estimates that in 2016, 18.3 million Californians have state-regulated coverage that would be subject to AB 1954.
- **Impact on expenditures.** CHBRP estimates AB 1954 would increase total net annual expenditures by $22.5 million or 0.01% for enrollees with DMHC-regulated plans.
- **EHBs.** AB 1954 does not expand or mandate coverage for services; the bill allows for access to out-of-network providers for reproductive and sexual health services for which an enrollee already has coverage.
- **Medical effectiveness.** There is evidence to support the effectiveness of timely access to emergency contraception pills and IUD implantation to prevent pregnancy. There is also evidence that increasing access for services involving the collection of forensic evidence or emergency contraception following sexual assault or rape would increase the effectiveness of those services.
- **Benefit coverage.** CHBRP estimates the percent of enrollees with coverage for reproductive and sexual health care services through OON providers under specified circumstances without a referral will increase from 32% to 100%.
- **Utilization.** Postmandate, CHBRP does not estimate a change in overall utilization of reproductive and sexual health services. However, CHBRP estimates that the utilization of OON sexual health care services among the enrollees (15 years of age or older) will increase by 9%; and use of OON reproductive health care services by 8%.
- **Public Health.** Potential public health outcomes: (1) earlier diagnosis and subsequent treatment of STDs/HIV, and consequently lower severity of disease and risk of exposing others to infection; (2) decreases in unintended pregnancy rates and less physical harm from miscarriage or ectopic pregnancy complications; and (3) more reliable evidence collection in the event of rapes and sexual assaults, which could lead to the apprehension of suspects before they attack others.
- **Long-term impacts.** Long-term public health impacts may include consequences of the previously discussed short-term impacts, such as a lower birth rate, reduced prevalence of STDs/HIV, and more consistent evidence collection in rape/sexual assault cases leading to greater prosecution of the perpetrators, and reducing the risk/threat of sexual violence to nearby communities.

## BILL SUMMARY

Assembly Bill 1954 (introduced February 17, 2016) would require a DMHC-regulated plan or CDI-regulated policy to allow enrollees with coverage for reproductive and sexual health services to be covered for an OON provider if: (a) an in-network provider is unable to provide an appointment within 10 days of the initial request; (b) no in-network provider is available within a reasonable distance from the enrollee's home or work address; or (c) a provider of the enrollee's preferred gender is not available.

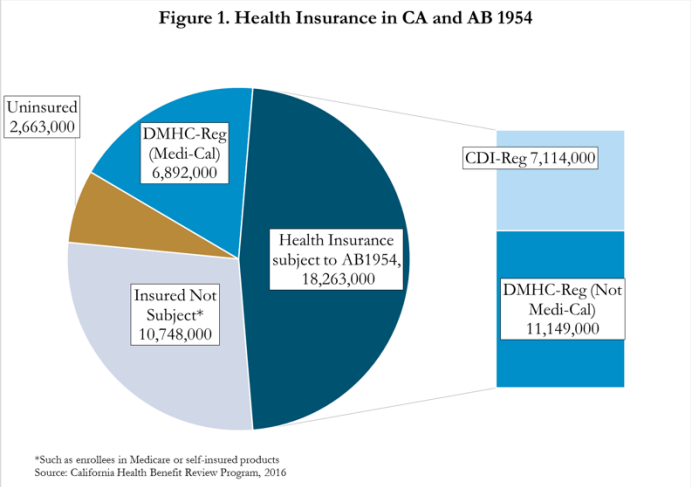
## INCREMENTAL IMPACT OF ASSEMBLY BILL (AB) 1954

### Benefit Coverage, Utilization and Cost

#### Coverage Impacts

If AB 1954 were enacted, CHBRP estimates the percentage of enrollees with coverage for reproductive and sexual health care services through OON providers under specified circumstances without a referral will increase from 32% to 100%. AB 1954 applies to DMHC-regulated plans and CDI-regulated policies, including Covered California and CalPERS HMOs, but does not apply to Medi-Cal Managed Care.

**Figure 1.** Health Insurance in CA and AB 1954




*Utilization Impacts*

CHBRP assumes that the overall utilization of reproductive and sexual health care services is not going to increase. However, CHBRP assumes that there will be a shift from using in-network services to out-of-network services. Consequently, the in-network utilization will decline and the out-of-network utilization would increase after the mandate due to the improved access to out-of-network providers without a referral. Specifically, based on the analysis of 2014 California MarketScan claim data, CHBRP estimates that the utilization of OON sexual health care services among the enrollees (15 years or older) will increase by 9 units per 1000 enrollees, and use of OON reproductive health care services by 8 units per 1000 enrollees. This is an upper bound estimate, because the out-of-pocket cost of enrollees for using OON providers may increase. Enrollees may pay out-of-pocket for the difference in charges.

## Cost Impacts

CHBRP estimates that AB 1954 would increase total net annual expenditures by $22.5 million or 0.02% for enrollees with DMHC-regulated plans. This is mainly due to an increase of out-of-pocket expenses in enrollee expenditures for paying the balance for previously noncovered OON benefits ($22.5 million). CHBRP assumes that plans will pay the same as in network rates and allow the provider to balance bill the enrollees after the mandate.

## Public Health

Potential public health outcomes of increased access to relevant sexual and reproductive health services in terms of timeliness, distance, and preferred-gender providers could include: (1) earlier diagnosis and subsequent treatment of STDs/HIV, and consequently lower severity of disease and risk of exposing others to infection for the general population of enrollees and for rape/sexual assault cases; (2) decreases in unintended pregnancy rates due to access to emergency contraception generally and for rape/sexual assault cases, and less physical harm from miscarriage or ectopic pregnancy complications; and (3) more reliable evidence collection in the event of rapes and sexual assaults, which could lead to the apprehension of suspects before they attack others.

## Medical Effectiveness

**Family planning:** Given that emergency use of contraceptive pills and IUD implantation to prevent pregnancy are both recommended within fewer than 10 days for effectiveness, there is sufficient evidence to support receiving such services sooner. Conversely, there is insufficient evidence that 10 days would change the effectiveness of abortion services unless the patient is nearing 49 days gestation.

**STD/HIV testing and treatment:** Although there is clear and convincing evidence that early access to STD/HIV testing and treatment is important in improving health outcomes, there was insufficient evidence comparing wait times in access to STD/HIV testing and treatment versus under 10 days to make conclusive decisions on medical effectiveness. However, it stands to reason that earlier access to testing and treatment upon learning of a potential exposure or the appearance of STD symptoms could lead to better health outcomes.

**Sexual assault/rape:** There is a preponderance of evidence from studies with moderate-to-strong designs that increasing access to under 10 days for services involving the collection of forensic evidence or emergency contraception following sexual assault or rape would increase medical effectiveness of these services.

**Impact of reasonable distance:** There is insufficient evidence specific to accessing a provider within a reasonable distance on the medical effectiveness of family

planning services, STD/HIV prevention and testing, or sexual assault/rape services.

**Preferred provider gender:** There is insufficient evidence on the medical effectiveness of improving more timely and local access (and access to a preferred gender provider) on sexual and reproductive health care services.

### Long-Term Impacts

CHBRP estimates that the shift in utilization from in-network to OON will be sustained over time, resulting in more timely access to sexual and reproductive health services due to fewer barriers to care. In light of evidence of medical effectiveness for more timely provision of some of the services that would be affected by this bill, including emergency contraception/IUD insertion to prevent pregnancy and sexual assault/rape care, the long-term public health impacts of AB 1954 may include consequences of the previously discussed short-term impacts, such as a lower birth rate, reduced prevalence of STDs/HIV, and more consistent evidence collection in rape/sexual assault cases leading to greater prosecution of the perpetrators, and reducing the risk/threat of sexual violence to nearby communities.

## CONTEXT FOR BILL CONSIDERATION

### Essential Health Benefits and the Affordable Care Act

AB 1954 does not expand or mandate coverage for services; the bill allows for access to out-of-network providers for reproductive and sexual health services for which an enrollee already has coverage. Therefore, AB 1954 does not exceed essential health benefits.

A Report to the California State Legislature

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April 15, 2016

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Revised on July 1, 2016

# REVISION HISTORY

| Date | Description of Revisions |
|---|---|
| 7/1/2016 | The report has been revised to correct an exclusion. This revision reflects inclusion of the health insurance of enrollees in grandfathered plans and the health insurance of enrollees aged 14 years or less as subject to the mandate. Utilization impacts remain calculated only for enrollees aged 15 years and older. The revision resulted in an increase of the estimated impact on total expenditures, from $17.8 million to $22.5 million. |

# ABOUT CHBRP

The California Health Benefits Review Program (CHBRP) was established in 2002 to provide the California Legislature with independent analysis of the medical, financial, and public health impacts of proposed health insurance benefit mandates and repeals, per its authorizing statute. The state funds CHBRP through an annual assessment on health plans and insurers in California.

An analytic staff in the University of California's Office of the President supports a task force of faculty and research staff from several campuses of the University of California to complete each CHBRP analysis. A strict conflict-of-interest policy ensures that the analyses are undertaken without bias. A certified, independent actuary helps to estimate the financial impact, and content experts with comprehensive subject-matter expertise are consulted to provide essential background and input on the analytic approach for each report.

More detailed information on CHBRP's analysis methodology, as well as all CHBRP reports and publications are available at www.chbrp.org.

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**Table 1.** (AB) 1954 Impacts on Benefit Coverage, Utilization, and Cost, 2017

| | Premandate | Postmandate | Increase/ Decrease | Change Postmandate |
|---|---|---|---|---|
| **Benefit coverage** | | | | |
| Total enrollees with health insurance subject to state-level benefit mandates (a) | 25,155,000 | 25,155,000 | 0 | 0.00% |
| Total enrollees with health insurance subject to AB 1954 | 18,263,000 | 18,263,000 | 0 | 0.00% |
| Number of enrollees with coverage for reproductive and sexual health care services | 18,263,000 | 18,263,000 | 0 | 0.00% |
| In network | 18,263,000 | 18,263,000 | 0 | 0.00% |
| Out of network | 5,780,915 | 18,263,000 | 12,482,085 | 215.92% |
| Percentage of enrollees with coverage for reproductive and sexual health care services | 100% | 100% | 0% | 0.00% |
| In network | 100% | 100% | 0% | 0.00% |
| Out of network | 32% | 100% | 68% | 215.92% |
| **Utilization and cost** | | | | |
| Total users of sexual health care services | | | | |
| In network | 3,933,527 | 3,865,687 | -67,840 | -1.72% |
| Out of network | 94,206 | 162,045 | 67,840 | 72.01% |
| Total users reproductive health care services | | | | |
| In network | 3,501,157 | 3,403,626 | -97,532 | -2.79% |
| Out of network | 135,437 | 232,969 | 97,532 | 72.01% |
| Sexual health care services utilization (units per 1,000 covered enrollees) | 652.30 | 652.30 | 0.00 | 0.00% |
| Sexual health care services utilization (units per 1,000 covered enrollees) | | | | |
| In network | 640.29 | 631.64 | -8.65 | -1.35% |
| Out of network | 12.01 | 20.66 | 8.65 | 72.01% |
| Reproductive health care services utilization (units per 1,000 covered enrollees) | 567.03 | 567.03 | 0.00 | 0.00% |
| Reproductive health care services utilization (units per 1,000 covered enrollees) | | | | |
| In network | 556.59 | 549.07 | -7.52 | -1.35% |
| Out of network | 10.44 | 17.96 | 7.52 | 72.01% |
| Average cost per service of sexual health care services | | | | |
| In network | $106.51 | $106.51 | $0.00 | 0.00% |
| Out of network | $268.39 | $268.39 | $0.00 | 0.00% |

| | Premandate | Postmandate | Increase/ Decrease | Change Postmandate |
|---|---|---|---|---|
| Average cost per service of reproductive health care services | | | | |
| In network | $141.74 | $141.74 | $0.00 | 0.00% |
| Out of network | $309.05 | $309.05 | $0.00 | 0.00% |
| Average cost share per service of sexual health care services | | | | |
| In network | $13.15 | $13.15 | $0.00 | 0.00% |
| Out of network | $66.35 | $66.35 | $0.00 | 0.00% |
| Average cost share per service of reproductive health care services | | | | |
| In network | $17.19 | $17.19 | $0.00 | 0.00% |
| Out of network | $76.21 | $76.21 | $0.00 | 0.00% |
| **Expenditures** | | | | |
| *Premium expenditures by payer* | | | | |
| Private employers for group insurance | $64,837,024,000 | $64,837,024,000 | $0 | 0.0000% |
| CalPERS HMO employer expenditures (c) | $4,756,143,000 | $4,756,143,000 | $0 | 0.0000% |
| Medi-Cal Managed Care Plan expenditures (d) | $16,670,700,000 | $16,670,700,000 | $0 | 0.0000% |
| Enrollees for individually purchased insurance | $22,073,116,000 | $22,073,116,000 | $0 | 0.0000% |
| Individually purchased — outside Exchange | $10,875,864,000 | $10,875,864,000 | $0 | 0.0000% |
| Individually purchased — Covered California | $11,197,252,000 | $11,197,252,000 | $0 | 0.0000% |
| Enrollees with group insurance, CalPERS HMOs, Covered California, and Medi-Cal Managed Care (a) (b) | $20,496,488,000 | $20,496,488,000 | $0 | 0.0000% |
| *Enrollee expenses* | | | | |
| Enrollee out-of-pocket expenses for covered benefits (deductibles, copayments, etc.) | $16,248,327,000 | $16,248,327,000 | $0 | 0.0000% |
| Enrollee expenses for noncovered benefits (e) | $0 | $22,529,000 | $22,529,000 | |
| **Total expenditures** | $145,081,798,000 | $145,104,327,000 | $22,529,000 | 0.0155% |

*Source:* California Health Benefits Review Program, 2016.

*Notes:* (a) This population includes persons with privately funded (including Covered California) and publicly funded (e.g., CalPERS HMOs, Medi-Cal Managed Care Plans) 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 health insurance.

(b) Of the CalPERS employer expenditures, this percentage reflects the share of enrollees in CalPERS HMOs as of September 30, 2015. CHBRP assumes the same ratio in 2016.

(c) Enrollee premium expenditures include contributions to employer-sponsored health insurance, health insurance purchased through Covered California, and contributions to Medi-Cal Managed Care.

(d) Includes only those expenses that are paid directly by enrollees or other sources to providers for services related to the mandated benefit that are not currently covered by insurance. 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 Care.

# POLICY CONTEXT

On February 17, 2016, the California Assembly Committee on Health requested that the California Health Benefits Review Program (CHBRP)[2] conduct an evidence-based assessment of the impacts of AB 1954 Reproductive Health Services.

If enacted, AB 1954 would affect the health insurance of approximately 12.1 million enrollees (31% of all Californians). This represents 48% of the 25.2 million Californians who will have health insurance regulated by the state that may be subject to any state health insurance law. Specifically, health care service plans regulated by the Department of Managed Health Care (DMHC), and health insurance policies regulated by the California Department of Insurance (CDI), would be subject to AB 1954.

## Bill-Specific Analysis of (AB) 1954, Reproductive and Sexual Health

### Bill Language

The full text of AB 1954 can be found in Appendix A.

For most enrollees in DMHC-regulated plans and CDI-regulated policies, health professionals and facilities are categorized as in-network or out-of-network (OON). In-network health facilities and professionals have a contract with the enrollee's plan or insurer that defines a contracted rate for payment for services. AB 1954 addresses the ability of enrollees to access OON providers for reproductive and sexual health services under certain circumstances. AB 1954 applies to plans and policies including Covered California and CalPERS HMOs, but does not apply to Medi-Cal Managed Care.

AB 1954 addresses coverage for reproductive and sexual health services, specifically those covered by Sections 6924, 6925, 6926, 6927, 6928, and 6929 of the Family Code, or Sections 121020 and 124260 of the Health and Safety Code. These include:

- Counseling services;
- Prevention or treatment of pregnancy;
- Prevention or treatment of sexually transmitted diseases;
- Diagnosis or treatment of condition and medical evidence regarding an alleged rape or sexual assault; and
- HIV testing.

AB 1954 would require that DMHC-regulated health plans and CDI-regulated policies will:

- Allow enrollees or insureds to seek care from an OON provider without prior authorization if access to an appropriate reproductive and sexual health provider is unavailable in-network in a timely manner.
- Prohibit the requirement that an enrollee or insured secure a referral from a primary care provider prior to receiving reproductive and sexual health care services.

[2] CHBRP's authorizing statute is available at www.chbrp.org/docs/authorizing_statute.pdf.

The bill deems an appropriate provider to be unavailable in the following circumstances:

- An appropriate provider is unavailable in-network in the enrollee's service region within 10 days after the enrollee's initial request for an appointment for reproductive and sexual health care services, or sooner if a medical provider indicates an earlier appointment is medically necessary. (A provider with the appropriate training and licensure, as well as the preferred gender of the enrollee.)
- An in-network provider is not available within a reasonable distance of the enrollee's work or home address. ("Reasonable distance" is the distance defined by the DMHC and CDI.)[3]

[3] www.dmhc.ca.gov/HealthCareinCalifornia/TypesofPlans.aspx#.VueCFse4-AY.

### Analytic Approach and Key Assumptions

#### *General caveat for all CHBRP analyses*

It is important to note that CHBRP's analysis of proposal benefit mandate bills address incremental effects — how the proposed legislation would impact benefit coverage, utilization, costs, and public health. CHBRP's estimates of these incremental effects are presented in this report.

#### *Bill-specific caveats*

CHBRP is aware that the bill author (Assemblymember Burke) intends to make some clarifying amendments to the bill.[3] As such, CHBRP makes the following assumptions:

- The bill's provision will not apply to long-term care (i.e., pre-natal, HIV-treatment).
- The bill will exempt specialty plans.

## Interaction With Existing Requirements

Proposed legislation can interact with state and federal requirements. When possible, CHBRP indicates possible overlaps or interactions.

### State Requirements

#### *California law and regulations*

California law requires DMHC-regulated plans and CDI-regulated policies to allow minors age 15 and over in certain circumstances to consent to reproductive and sexual health services without consent of a parent or guardian. Those services are included in Sections 6924, 6925, 6926, 6927, 6928, and 6929 of the Family Code, or Sections 121020 and 124260 of the Health and Safety Code.

AB 1954 applies to the same sections of the Family Code and Health and Safety Code, including the minimum age standard.

California Regulations require DMHC-regulated plans and CDI-covered insurance policies to arrange for the provision of access to health care services in a timely manner. Included in the pertinent regulations:

- California Code of Regulations Title 10, § 2240.15 requires insurers to provide or arrange for the provision of covered health care services in a timely manner appropriate for the nature of the covered person's condition consistent with good professional practice. Insurers shall establish and maintain provider networks, policies, procedures and quality assurance monitoring systems and processes sufficient to ensure compliance with this clinical appropriateness standard. Specifically, the regulations call for plans to provide non-urgent appointments for primary care within 10 business days from the request for an appointment and non-urgent appointments with specialist physicians within 15 days of the request for an appointment.

[3] Personal communication with Allison Ruff, staff for Assemblymember Burke, March 22, 2016.

- Similarly, Health Codes Title 28, § 1300.67.2 requires each health care service plan to have a documented system for monitoring and evaluating accessibility of care, including a system for addressing problems that develop, including waiting time and appointments.
- Further, § 1300.67.2.1 sets Geographic Accessibility Standards, including driving times and wait times for appointments.
- Section § 1300.67.2.2, Timely Access to Non-Emergency Health Care Services, confirms requirements for plans to provide or arrange for the provision of access to health care services in a timely manner, and establishes additional metrics for measuring and monitoring the adequacy of a plan's contracted provider network to provide enrollees with timely access to needed health care services. Specifically, the regulations call for plans to provide non-urgent appointments for primary care within 10 business days from the request for an appointment and non-urgent appointments with specialist physicians within 15 days of the request for an appointment.
- Further, a plan operating in an area that has a shortage of certain providers "shall ensure timely access to covered health care services as required by this section, including applicable time-elapsed standards, by referring enrollees to, or, in the case of a preferred provider network, by assisting enrollees to locate, available and accessible contracted providers in neighboring service areas consistent with patterns of practice for obtaining health care services in a timely manner appropriate for the enrollee's health needs. Plans shall arrange for the provision of specialty services from specialists outside the plan's contracted network if unavailable within the network, when medically necessary for the enrollee's condition. Enrollee costs for medically necessary referrals to non-network providers shall not exceed applicable co-payments, co-insurance and deductibles. This requirement does not prohibit a plan or its delegated provider group from accommodating an enrollee's preference to wait for a later appointment from a specific contracted provider."

AB 1954 would lower the time considered as timely access to a specialist for reproductive and sexual health services from 15 to 10 days, and would remove the requirement that an enrollee would need to contact a plan for approval to use an OON provider if an appointment cannot be obtained within 10 days from the request for the appointment.

### *Similar requirements in other states*

CHBRP is not aware of timely access standards in other states that are specific to reproductive and sexual health services as covered in AB 1954.

## Federal Requirements

### *Affordable Care Act*

The Affordable Care Act (ACA) has impacted health insurance in California, expanding the Medi-Cal program (Medicaid in California)[4] and making subsidized and nonsubsidized health insurance available through Covered California, the state's health insurance marketplace.[5]

[4] The Medi-Cal expansion is to 133% of the federal poverty level (FPL) — 138% with a 5% income disregard.
[5] The ACA requires the establishment of health insurance exchanges in every state, now referred to as health insurance marketplaces.

A number of ACA provisions have the potential to or do interact with state benefit mandates. Below is an analysis of how AB 1954 may interact with requirements of the ACA, including the requirement for certain health insurance to cover essential health benefits (EHBs).[6]

The Affordable Care Act requires health plans that started on or after September 23, 2010 cover some reproductive and sexual health services, including pregnancy prevention and treatment, and screening for certain sexually transmitted diseases (www.healthcare.gov/preventive-care-women/). Health care plans and insurance policies impacted by AB 1954 must comply with ACA requirements, and may offer coverage in excess of what is mandated by the ACA. However, no additional services are mandated by AB 1954.

## *Essential health benefits and AB 1954*

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. Health insurance offered in Covered California is required to at least meet the minimum standard of benefits as defined by the ACA as essential health benefits (EHBs), and available in the Kaiser Foundation Health Plan Small Group Health Maintenance Organization (HMO) 30 plan, the state's benchmark plan for federal EHBs.[7,8]

States may require such QHPs to offer benefits that exceed EHBs.[9] However, a state that chooses to do so must make payments to defray the cost of those additionally mandated benefits, either by paying the purchaser directly or by paying the QHP.[10,11] On the other hand, "state rules related to provider types, cost-sharing, or reimbursement methods" would *not meet* the definition of state benefit mandates that could exceed EHBs.[12]

AB 1954 does not expand or mandate coverage for services; the bill allows for access to out-of-network providers for reproductive and sexual health services for which an enrollee already has coverage.

The requirements in AB 1954, related to enrollee expenses and plan/insurer payments, appear not to exceed the essential health benefits (EHBs) requirements of the Affordable Care Act (ACA), and so would not trigger the ACA requirement that the state defray the cost of additional benefit coverage for enrollees in qualified health plans (QHPs). (Footnote: In California, QHPs are nongrandfathered, small-group and

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[6] 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. Resources on EHBs and other ACA impacts are available on the CHBRP website: www.chbrp.org/other_publications/index.php.

[7] 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: https://cciio.cms.gov/resources/files/Files2/12162011/essential_health_benefits_bulletin.pdf.

[8] H&SC Section 1367.005; IC Section 10112.27.

[9] ACA Section 1311(d)(3).

[10] State benefit mandates enacted on or before December 31, 2011, may be included in a state's EHBs, according to the U.S. Department of Health and Human Services (HHS). Patient Protection and Affordable Care Act: Standards Related to Essential Health Benefits, Actuarial Value, and Accreditation. Final Rule. Federal Register, Vol. 78, No. 37. February 25, 2013. Available at: www.gpo.gov\fdsys\pkg\FR-2013-02-25\pdf\2013-04084.pdf.

[11] However, as laid out in the Final Rule on EHBs HHS released in February 2013, state benefit mandates enacted on or before December 31, 2011, would be included in the a state's EHBs, and there would be no requirement that the state defray the costs of those state-mandated benefits. For state benefit mandates enacted after December 31, 2011, that are identified as exceeding EHBs, the state would be required to defray the cost.

[12] Essential Health Benefits. Final Rule. A state's health insurance marketplace would be responsible for determining when a state benefit mandate exceeds EHBs, and QHP issuers would be responsible for calculating the cost that must be defrayed.

individual market DMHC-regulated plans and CDI-regulated policies sold in Covered California, the state's online marketplace.)

# BACKGROUND ON REPRODUCTIVE AND SEXUAL HEALTH CARE SERVICES

As previously mentioned, AB 1954 contains provisions related to access to sexual and reproductive health care services. Pre-natal care, longer-term services (e.g., HIV treatment), fertility services, and other sexual and reproductive health specialist services beyond the scope of the aforementioned services are excluded under AB 1954, and are not included in the present analysis. Services that may be impacted by AB 1954 include:

- **Sexually transmitted disease (STD[13]) prevention and treatment services**, such as screening tests and short-term medical or surgical treatment for STDs and sexually transmitted HIV and hepatitis, including post-exposure prophylaxis (PEP) for HIV,[14] and pre/post-test counseling.
- **Prevention and treatment of pregnancy services** including family planning services, such as pregnancy testing, contraception, abortion, sterilization, related counseling/education, and treatment for spontaneous abortion/miscarriage and other pregnancy/birth complications such as ectopic pregnancy.
- **Sexual assault services**, such as post-assault medical evaluation and evidence collection, HIV/STD and pregnancy testing and treatment as described above, and counseling related to the sexual assault and any of the related sexual and reproductive health care services.

As counseling is often "packaged" into these services,[15] the *Background* section will not discuss access to counseling explicitly. California-specific data is presented for services for which it was available; otherwise, national estimates are provided. Furthermore, this bill applies to individuals age 15 and older; data including minors age 15–18 is presented when available, but many studies and databases do not include minors, so in some cases, data on adults age 18 and older is reported. The emergence of Zika as a new illness that can be transmitted sexually in California may be relevant to changes in access to care proposed by AB 1954 (Thomas, 2016). However, because of the lack of research on the pathology and low incidence to date in California (1 case) of sexually transmitted Zika, we excluded it from our analysis.

Generally, the issue of in-network provider availability may affect access to care among people with commercial insurance (Corlette et al., 2014; Garfield et al., 2014; Salganicoff and Sobel, 2016). Although cost is the main barrier to accessing health care for the uninsured, the availability of timely appointments and nearby providers may be an important barrier to care for people who have health insurance. A 2013 survey by the Kaiser Family Foundation found that 28% of adults with employer health insurance coverage had an unmet need for care; of these, 26% had delayed needed care because they could not get an appointment soon enough, 21% delayed needed care because the office was not open when they could get there, and 11% delayed needed care because of difficulty traveling to the site of care (Garfield et al., 2014). Furthermore, policy analysts have indicated that provider networks have narrowed since the

[13] Although the terms "sexually transmitted disease" (STD) and "sexually transmitted infection" (STI) are often used interchangeably, STI has been in widespread use since 1999 because it better incorporates asymptomatic infections, as compared to STD, and is used by a wide range of scientific societies and publications (World Health Organization, 2003). However, because the bill language for AB 1954 utilizes the term STD, for the purposes of this report STD is used in all analysis and narrative. HIV and hepatitis A/B/C can be transmitted multiple ways, including sexually (although sexual transmission of hepatitis C is rare and generally found in high-risk populations such as people who inject drugs), and screening for these infections is often done in the course of routine STD testing (World Health Organization, 2003). For that reason, we included HIV and hepatitis as part of STD services.

[14] Post-exposure prophylaxis (PEP) refers to the practice of prescribing a short-term regimen of antiretroviral therapy (ART) medication shortly after suspected exposure to HIV to avoid infection. Long-term treatment of people living with HIV with ART is not included in this analysis.

[15] Personal communication with content expert, KB Kohzimannil, Minneapolis MN, March 2016.

implementation of the Affordable Care Act, a result of health insurance companies reducing the number of providers they work with in their Marketplace plans to minimize the cost of premiums, which limits enrollee choices of available in-network providers (Corlette et al., 2014; Salganicoff and Sobel, 2016). California ranks fourth in the nation among states having the greatest proportion of narrow ACA marketplace provider networks after Georgia, Oklahoma, and Florida (Polsky and Weiner, 2015). The majority (75%) of California's provider networks are defined as "narrow," meaning that fewer than 25% of providers in a given area participate in a network; this includes 91% of California's HMOs and 33% of PPOs (Polsky and Weiner, 2015). However, there is conflicting evidence on whether or not these narrow networks have influenced access to care (Atwood and Sasso, 2016).

## Reproductive and Sexual Health Care Service Use and Access in California

This section presents information on these sexual and reproductive health services cited in AB 1954, including prevalence of related illnesses, use of services and relevant treatments, and access to timely and nearby services. Little service-specific data were available on how providers of a preferred gender influenced access to care for sexual and reproductive health services, although more generally it has been found women who have female obstetricians/gynecologists experience greater satisfaction with services and report better patient–provider communication (Janssen and Lagro-Janssen, 2012).

### STD Prevention, Screening, and Treatment Services

These services address the prevention, screening, and treatment of STDs such as human papilloma virus (HPV), chlamydia, gonorrhea, genital herpes, syphilis, and trichomoniasis, and related illnesses including HIV and hepatitis A/B/C, which can be transmitted sexually. Services include sexual health education and access to condoms and other forms of protection, screening tests for STDs such as pelvic exams, pap smears, and blood tests, treatment of diagnosed STDs using medication or surgical interventions, and pre-/post-test counseling. It is estimated that among the insured population in California aged 12 and older, 21% get tested for an STD each year.[16] Chlamydia is the most common STD in California with an annual incidence rate of 453 cases per 100,000 population.[17]

Access to timely screening and treatment for STDs and HIV testing is critical to preventing further spread of these diseases and limiting the health impacts on infected individuals. Timely access to care has been cited by patients of specialized STD testing and reproductive health clinics as a major reason for seeking services there instead of at their usual places of care, even among those patients who have health insurance (Hoover et al., 2015). A treatment that may be of particular importance to this bill is post-exposure prophylaxis (PEP) for HIV, an antiretroviral medication that can be initiated ideally within 3 days of a potential exposure to HIV and taken for 28 days to prevent infection, such as after learning that a recent sexual partner is HIV positive (Ford et al., 2015). HIV PEP is not for individuals who have already tested positive for HIV, and is also used for health care workers who may have been exposed to HIV on the job and with sexual assault survivors. PEP treatments for hepatitis and other STDs are also available or in development (Wood, 2015). Awareness, utilization, and access to PEP treatments are increasing, but remain understudied topics (Siegfried et al., 2015). California is one of the few states in the United States that has developed guidelines for health care providers, which may suggest greater availability of this treatment locally (Schwarzenegger et al., 2004).

[16] Data located at http://ask.chis.ucla.edu.
[17] Data located at www.cdph.ca.gov/data/statistics/Documents/STD-Data-All-STDs-Tables.pdf.

## Prevention and Treatment of Pregnancy Services

Prevention and treatment of pregnancy services include family planning services, such as pregnancy testing, the provision of contraception methods to prevent pregnancy (e.g., oral contraceptive pills, patches, injections, implants, and intrauterine devices), abortion through medication or surgical means to terminate a pregnancy, surgical sterilization, and counseling related to contraception and pregnancy. These services may also include pregnancy treatments related to complications such as spontaneous abortion (i.e., miscarriage) and ectopic pregnancies (i.e., when an embryo implants in the fallopian tube instead of the uterus). Based on 2014 CHIS data, there are 5,860,000 women in California aged 15 to 44 who were sexually active in the past year (defined as one or more sexual partners). A study of California women aged 18–44 at risk for unintended pregnancy (i.e., sexually active, not actively trying to become pregnant, and capable of becoming pregnant) found that 79% used some form of birth control; 23% used oral birth control pills, 20% used condoms, 8% used a long-acting reversible device, such as a intrauterine device (IUD), 10% had undergone female sterilization, 10% had a partner who had undergone male sterilization, and 8% used hormonal rings, patches, injectables, or other forms of birth control, whereas 21% used no method of birth control (Shih et al., 2011). Recent estimates for the number of women who use emergency contraceptives in California were not available, but nationally, it is estimated that one in nine women (11%) have used emergency contraception at some point to prevent a potential pregnancy (Daniels et al., 2013).

In 2013, there were over 818,700 pregnancies in California, nearly half (48%) of which were unintended (Kost, 2015). Of all pregnancies in the United States, two-thirds (65%) result in live birth, 18% end in abortion, and 17% end in fetal loss through miscarriage or ectopic pregnancy (Ventura et al., 2012). The abortion rate in California was 23.0 per 1,000 women aged 15–24, which was higher than the national rate of 16.9/1,000 women (Guttmacher Institute, 2015). This may be due to California's less restrictive abortion policies, such as having to wait before having an abortion performed, than surrounding states, and consequently, greater access to abortion services or women from other states coming to California to obtain an abortion (Guttmacher Institute, 2015).

Unmet need for prevention and treatment of pregnancy services among the insured population may be underestimated due to their use of specialized publicly-funded family planning clinics, such as Planned Parenthood or Title X clinics. A study of these clinics in 13 U.S. states found that most patients had private (22%) or public (35%) health insurance (Frost et al., 2012). Furthermore, frequently cited reasons privately insured women had for seeking services at these specialized family planning clinics included "accessibility" (88%), "method availability" (79%), "affordability" (73%), "hours meet my schedule" (69%), and "location is convenient" (66%) (Frost et al., 2012). Access to abortion services in California is relatively high compared to the rest of the United States; 45% of California counties have no abortion providers, and 5% of women in California live in those predominantly rural counties that lack abortion providers, whereas across the United States, 89% of counties lack abortion providers, and 38% of U.S. women live within these counties (Guttmacher Institute, 2015).

## Sexual Assault/Rape Services

Sexual assault and rape services include post-assault medical evaluation, HIV/STD/pregnancy testing, treatment for physical trauma and STD treatment/HIV PEP/emergency contraception or abortion in the event of a pregnancy, and related counseling services. Timeliness of care in the case of sexual assault or rape is critical, as viable evidence can only be collected for approximately 24 hours, emergency contraception is less effective after the first 72 hours, and early detection of STDs/HIV after an assault can improve treatment outcomes (Holmes et al., 1996; Munro et al., 2015; Reynolds et al., 2000). In 2012, California's Office of the Attorney General documented a total of 7,828 forcible rapes or attempted rapes (rate: 20.7 forcible rapes per 100,000 people); in 100% of the cases, the survivor was female

(California Office of the Attorney General, 2012). However, as few as 21% of women and 15% of men seek any kind of help after a rape; furthermore, men may be more likely to wait years to seek help (King and Woollett, 1997; Zinzow et al., 2012). This may lead to substantial underreporting of rape and sexual assault.

Access to care after a rape or sexual assault may primarily occur through emergency services, which are not a part of this bill analysis; a study of women who sought medical care after a rape found that the majority (81%) received post-rape care in a hospital setting such as an emergency room (Tjaden and Thoennes, 1998). However, the same study found that 54% of women reported receiving rape-related services from a physician outside of the hospital setting. Survivor and provider perceptions of barriers to timely medical and mental health care after a sexual assault primarily include lack of information about available resources, fears about cost for treatment especially in the context of lack of health insurance, the availability of services at night when rapes generally occur, issues with paperwork and insurance, insensitivity or inappropriateness of medical staff, or obtaining transportation to a provider (Logan et al., 2005; Ullman and Townsend, 2007). Individuals with private health insurance or governmental forms of health insurance have been shown to be twice as likely to seek mental health services after a sexual assault compared to individuals with no health insurance (Price et al., 2014).

## Burden of a Lack of Access to Reproductive and Sexual Health Care Services

The consequences of a lack of access to these reproductive and sexual health care services may include unintended pregnancy and undiagnosed or untreated pregnancy complications, undiagnosed and/or untreated STDs and HIV, and medical and mental health costs associated with sexual assault. The cost burden of **unintended pregnancy** in the U.S. is approximately $4.6 billion dollars per year, including the costs of live births, abortions, ectopic pregnancy and spontaneous abortion complications (Trussell et al., 2013). Over half (53%) of these costs can be attributed to unintended pregnancies that occur in women who fail to take contraception consistently (Trussell et al., 2013). The annual diagnoses of **STDs** and **HIV** have an associated lifetime medical costs of $15.6 billion (Owusu-Edusei et al., 2013). Finally, diverse estimates exist for the cost of **sexual assault and rape** in the United States; $1.2 billion in medical and mental health care costs has been estimated, but the total cost including lost productivity and quality of life may be as high as $10 billion or more (Miller et al., 1993). However, no studies were found that could estimate what proportion of these costs are due to a lack of timely, nearby, or appropriate access to care among the insured population compared to other factors, such as cost of services, a lack of insurance, or risk and care-seeking behaviors.

## Social Determinants of Health[18] and Disparities[19] in Access to Reproductive and Sexual Health Care Services

Per statute, CHBRP now includes discussion of disparities under the broader umbrella of social determinants of health (SDoH). SDoH include factors outside of the traditional medical care system that influence health status and health outcomes. CHBRP will consider the full range of SDoH and related

[18] CHBRP defines social determinants of health as conditions in which people are born, grow, live, work, learn, and age. These social determinants of health (economic factors, social factors, education, physical environment) are shaped by the distribution of money, power, and resources and impacted by policy (adapted from Healthy People 2020, 2015; CDC, 2014). See SDoH white paper for further information.

[19] Several competing definitions of "health disparities" exist. CHBRP relies on the following definition: "Health disparities are potentially avoidable differences in health (or health risks that policy can influence) between groups of people who are more or less advantaged socially; these differences systematically place socially disadvantaged groups" at risk for worse health outcomes (Braveman, 2006)

disparities (e.g., income, education and social construct around age, race/ethnicity, gender, and gender identity/sexual orientation) that are relevant to this bill and where evidence is available. In the case of AB 1954, evidence shows SDoH/disparities in the prevalence of health outcomes related to sexual and reproductive health services and access to timely, nearby, and appropriate sexual and reproductive health services by socioeconomic status, geography (rural vs. urban settings), age, race/ethnicity, and gender identity/sexual orientation. Although multiple disparities in need for and access to sexual and reproductive health services are described below, the most important are socioeconomic and geographical disparities in access to timely and nearby services, and age and racial/ethnic disparities in terms of preferred provider gender. Disparities in access to appropriate providers for sexual minorities are present, but it is unclear if the provisions of AB 1954 on preferred-gender providers would affect these disparities.

## Disparities in Access to Timely Reproductive and Sexual Health Care Services

### *Socioeconomic status*

Socioeconomic status may also play a role in timely access to appropriate, in-network sexual and reproductive health service providers. Lower-income individuals eligible for tax credits for Marketplace health insurance plans under the Affordable Care Act may have a limited choice of providers, as many insurance companies have reduced the size of their provider networks to keep premiums low (Corlette et al., 2014; Salganicoff and Sobel, 2016). As previously mentioned, 75% of California's ACA marketplace plans have narrow provider networks (Polsky and Weiner, 2015). Because of this, Covered California plan enrollees may not only have limited choices and options for in-network sexual and reproductive health care service providers, but also have difficulty obtaining an appointment with the provider of their choice. A survey by the Kaiser Family Foundation in 2014 found that 23% of women in marketplace plans could not get an appointment with a nearby in-network provider or the provider of their choice for any health care service, and 20% indicated that their provider of choice did not accept their insurance. In comparison, only 2% to 5% of women with private health insurance (non-marketplace) experienced these issues (Kaiser Family Foundation, 2016; Satterwhite et al., 2013).

### *Geography*

Compared to women living in urban areas, low income rural residents may have fewer sexual and reproductive health providers to choose from in general, fewer options for specialized providers, fewer resources to take time off from work and travel to distant providers, and may face greater barriers related to stigma from seeking services for sensitive conditions from sole providers in rural areas (Edwards and Tudiver, 2008; McCall-Hosenfeld and Weisman, 2011). As of 2010, there were approximately 2.46 obstetrician/gynecologist (OB/GYN) doctors per 10,000 women in California, slightly lower than the national average of 2.65 (Martin et al., 2012; Rayburn et al., 2012). There were no OB/GYNs in eight California counties (Modoc, Alpine, Trinity, Yuba, Sierra, Glenn, Colusa, and Mariposa), all of which are mostly rural and home to 0.5% of California's total population (U.S. Census Bureau, 2010). Rural women in the United States are less likely to have access to nearby family planning services, most notably to abortion service providers (Dehlendorf et al., 2010; Jones and Jerman, 2014), although as previously noted, this disparity is less pronounced in California compared to the rest of the United States. U.S. women residing in rural areas may also face unique barriers in accessing timely services after a sexual assault or rape, including travel distance to hospitals for immediate care, long waiting times to see a mental health counselor, and backlash from community or family members in the event of a loss of confidentiality from rural providers or incriminating another local resident in a rape (Logan et al., 2005).

### *Age*

Disparities in need for sexual and reproductive health services can be found for different age groups. Older women may be at greater risk for miscarriage and pregnancy complications, and the prevalence of these conditions in the U.S. has increases as the fertility rate in older women has increased (Ventura et al., 2012). Youth are at greater risk of unintended pregnancy and STD/HIV infection due to a combination of behavioral factors and less access to related care, which may be related to issues regarding a lack of knowledge about risks and care options (Kann et al., 2014). Nearly half (47%) of unintended pregnancies occur in young women age 15-24 (Finer and Zolna, 2016). Furthermore, of the estimated 20 million new STD or HIV infections per year in the U.S., 50% will occur in adolescents and young adults aged 15-24 (Satterwhite et al., 2013). Regarding access to preferred-gender providers, women younger than age 26 and women older than 40 may also be more likely to prefer a female provider for sexual and reproductive health services, although it is not clear from the evidence how this affects access to or delays in care (Janssen and Lagro-Janssen, 2012).

### *Race/ethnicity*

There are also disparities in in the need for sexual and reproductive health services by race/ethnicity; in 2011, 64% of pregnancies among African American women and 50% of pregnancies among Hispanic women were unintended, compared to 38% of pregnancies among white women (Finer and Zolna, 2016). In addition, specific racial/ethnic populations within the United States may be at greater risk for STD and HIV infection, including African American heterosexual men and women (Mojola and Everett, 2012). These racial/ethnic disparities have been attributed to multiple factors, such as socioeconomic status and a lack of access to health education, such as HIV education or knowing where to go to get services (Finer and Zolna, 2016; Kann et al., 2014). In regard to access to preferred-gender providers, women of color have been shown to be more likely to prefer a female provider for reproductive health services than white women, and women who have female obstetricians/gynecologists report higher satisfaction and better patient–provider communication, although as with age disparities for preferred-gender providers it is not clear if or how this preference affects access to or delays in care (Becker and Tsui, 2008; Janssen and Lagro-Janssen, 2012).

### *Gender identity/sexual orientation*

Disparities in prevalence of STDs/HIV and access to sexual and reproductive services exist for several sexual minority groups, including gay, lesbian, bisexual, and transgender (LGBT) individuals. Compared to heterosexual men, gay and bisexual men are five to eight times more likely to report ever being diagnosed with an STD or HIV across racial-ethnic categories. Furthermore, bisexual women, especially women of color, are between two and six times more likely to report ever having an HIV/STD infection than heterosexual white women (Mojola and Everett, 2012). Finally, gay, lesbian, and bisexual individuals may be at greater risk of sexual victimization, including sexual assault and rape, than the general population, and consequently, more likely to require timely access to related care and counseling services (Conron et al., 2010; Mojola and Everett, 2012). The LGBT community, particularly the transgender population, faces a lack of knowledgeable providers who can provide appropriate services, which impedes access to health care services in general and for reproductive and sexual health services (Mayer et al., 2008; Roberts and Fantz, 2014).

# MEDICAL EFFECTIVENESS

AB 1954 aims to increase access to reproductive and sexual health care services through provisions that allow for out of network care (OON) in specified circumstances without need for a referral. The focus of the medical effectiveness review is to summarize findings from the literature on the effectiveness of the following factors as they pertain to the existing sexual and reproductive service categories as proposed in the bill language:

- Access to timely care (i.e. Impacts of delayed care)
- Access to providers within a reasonable distance
- Access to providers of preferred gender

The services covered by AB 1954 are STD/HIV prevention and testing services, family planning services, sexual assault services, and counseling related to sexual or reproductive health and their associated services.

## Research Approach and Methods

This medical effectiveness review summarizes findings from the literature on the effectiveness of increased access to reproductive and sexual health care services as specified in AB 1954. Studies on access to sexual and reproductive services were identified though searches of relevant databases of peer-reviewed literature listed in Appendix B. Special attention was given to studies that examined the impact of increased access for individuals with existing health insurance coverage. The search was limited to abstracts of studies published in English. Due to the existence of a high quality systematic review conducted in 2000, the medical effectiveness search was limited to studies published from 2000 to present. Databases searched included PubMed (MEDLINE), Cochrane Library, and Embase (if available). Of the 1,105 articles identified in the literature review, 21 were included in the medical effectiveness review of this report. Articles were excluded from this review if they related to reproductive health specialists or fertility treatments.

## Study Findings

### Access to Timely Care

#### *Reproductive health services*

##### Family planning and abortion

There are three types of family planning methods/contraceptives that were deemed most sensitive to timely access because of their administration postcoitally and will be reviewed in this section: Emergency contraception pills (ECPs); emergency insertion of the Copper T intrauterine device (IUD); and abortion.

- Emergency contraceptive pills (ECPs)
    - Types of ECPs. In the United States, there are two different kinds of emergency contraceptive pills available: ulipristal acetate (UA; brand name: ella) and progestin-only (brand names: Plan B One-Step, Next Choice One Dose, My Way, and Levonorgestrel tablets). Progestin-only emergency contraceptive pills taken within the first 24 hours after sex reduce risk of pregnancy by up to 95% (Trussel, 2016). In California, people of any

age can buy Plan B One-Step without a prescription. The generic forms, Next Choice, Next Choice One Dose, My Way and Levonorgestrel are approved for sale without a prescription to those who are 17 and older (http://sexetc.org/states/california/). The ECP, ella, is only available with a prescription regardless of age

  - Relative effectiveness of ECPs. Although progestin-only ECPs are available without a prescription and have been shown to be 95% effective, they are not as effective as their UA and combined counterparts that require a prescription. The risk of pregnancy after taking ella within 24 hours after sex is about 65% lower than the risk after taking progestin-only pills; if taken within 72 hours after sex, the risk is 42% lower. Emergency contraceptive pills containing both progestin and estrogen (known as “combined” pills) reduce the risk of pregnancy by 75% compared to progestin-only pills. Therefore, although progestin-only ECPs are available without a prescription, making timely access to a provider less relevant, timely access to a provider is required to obtain the most effective forms of ECPs, which are available by prescription only.

  - Critical administration times for ECPs. Several studies indicated that both the combined and Levonorgestrel regimens are more effective the sooner after sex the pills are taken (within 72 hours) and moderately effective if started between 72-120 hours. In clinical studies, the effectiveness of ella did not decline over a 5-day period. However, the effectiveness of ECPs diminishes after 5 days (Trussell, 2016), and are more effective the sooner they are used (Ott and Sucato, 2014). Because emergency contraception is the only contraceptive method that can be effective after sex has taken place, it is especially important for women who have been raped or coerced into sexual activity (Westley et al., 2013).

- Copper-T IUDs. Emergency insertion of a Copper-T IUD reduces the risk of pregnancy by more than 99%. One systematic review of IUDs as emergency contraception found a pregnancy rate of 0.1% (Cleland et al., 2012). Implantation is recommended up to only 5 days after unprotected intercourse (CDC, 2015).

- Abortion. Medication abortion is an effective and safe procedure. When using mifepristone and misoprostol in the first trimester, failure of a medication abortion — defined as the need for aspiration owing to complications or ongoing pregnancy — occurs in 4.8% of cases and hospitalization in .3%. Medication abortions are time sensitive. In abortions conducted after 49 days gestation, the efficacy of the mifepristone and misoprostol regimen decreases and the likelihood of continuing pregnancy increases (ACOG, 2014). The effectiveness and safety of first-trimester vacuum aspiration and second-trimester dilation and evacuation (D&E) have been well established. The risk of a minor complication in the first trimester is 8.46 per 1,000 vacuum aspirations, and the majority risk is 0.7 per 100,000 legal abortions. Although complication rates increase in the second trimester, abortion remains safer than childbirth at all gestational ages (Renner et al., 2014). A systematic literature review in 2013 found that younger women are more likely to present in the second trimester compared with older women; this decreases access to effective first-trimester medical abortion and has been identified as the most important risk factor for abortion-related complications and mortality. Adolescents often present with severe complications of unsafe abortion because they delay care, seek care from unskilled providers, and do not access services when complications arise. Additional barriers for youth are that California state regulation (Family Code 6925) prohibits abortions to minors without the consent of a parent or guardian other than as provided in Section 123450 of the Health and Safety Code, which states the minor can petition the juvenile court to assist her in confidentiality if she elects not to seek the consent of one or both of her parents or her guardian. This regulation process would hinder timely access to abortion services to minors in this situation.

Given that emergency use of contraceptive pills and IUD implantation to prevent pregnancy are both recommended within fewer than 10 days for effectiveness, there is sufficient evidence to support receiving such services sooner. Conversely, there is insufficient evidence that 10 days would change the effectiveness of abortion services unless the patient is nearing 49 days gestation.

**Figure 2.** Summary of Findings: Timeliness of Use of ECPs and IUDs

| Treatment | Conclusion |
|---|---|
| **Evidence about the impact of timeliness of use of ECPs and IUD implantation to prevent pregnancy** | Increasing timeliness of administration of ECPs and implantation of an IUD is associated with increased effectiveness |


*Source:* California Health Benefits Review Program.

## *Sexual health services*

### STD/HIV prevention and testing

There was general consensus that access to STD (and HIV) screening and treatment should be as soon as possible to eradicate or slow infection and to stop further transmission (Ferreira et al., 2013; Nakanjako et al., 2009). The National Institute of Allergy and Infectious Diseases stated that early screening for HIV infection was crucial to afford patients effective treatment and also for the benefit of the patients' sexual partners. In a 2011 worldwide clinical trial, researchers found that HIV-infected men and women who were able to start oral antiretroviral medicines early in the state of HIV progression actually reduced their risk of transmitting the virus to partners by 96% (NIAID, 2011).

For persons who have been exposed to HIV, post-exposure prophylaxis (PEP) is available, which involves taking anti-HIV medications as soon as possible (within 3 days) after expose to HIV. PEP must begin within 72 hours of exposure, before the virus has time to make too many copies of itself in the body. PEP consists of 2–3 antiretroviral medications and must be taken for 28 days (www.aids.gov/hiv-aids-basics/prevention/reduce-your-risk/post-exposure-prophylaxis/).

Furthermore, earlier knowledge of one's infection status can help uninfected persons make behavioral changes to reduce the risk for infection and can help infected persons reduce the likelihood of medical sequelae and transmission of infection to others (CDC, 2012). Each STD has a unique testing window between the time of exposure and when a test can detect infection, ranging from days to months (CDC, 2015). Despite this variability, the CDC recommends testing with a physical examination as soon after suspected exposure as possible as there may be previous infection and this would prevent further delay in treatment (CDC, 2010).

Although there is clear and convincing evidence that early access to STD/HIV testing and treatment is important in improving health outcomes, there was insufficient evidence comparing wait times in access to STD/HIV testing and treatment over versus under 10 days to make conclusive decisions on medical effectiveness. However, it stands to reason that earlier access to testing and treatment upon learning of a potential exposure or the appearance of STD symptoms could lead to better health outcomes.

### Sexual assault/rape

According to the Rape, Abuse, & Incest National Network website, sexual assault forensic exams begin with immediate care of injuries, an examination, and collection of DNA evidence within 72 hours so that it can be analyzed by a crime lab: DNA evidence can be collected from blood, saliva, sweat, urine, skin tissue, and semen. Follow-up care includes prevention treatment for STIs and emergency contraception to prevent pregnancy (RAINN, 2016a).

Following rape or assault, the survivor's first instinctual reaction is to shower or wash — metaphorically, physically and psychologically cleansing themselves of the abuse suffered but in the process, also washing away any DNA evidence. Survivors should refrain from changing clothes, washing, drying or brushing their hair; move, discard or touch any object the offender may have handled or clean the area in which the incident took place. For all of these reasons, it is imperative that the survivor have access to services as soon as possible (RAINN, 2016a).

The National Institute of Justice (2014) found that DNA is relatively stable (Taylor, 2010). It is most likely that forensic samples collected from a rape survivor will yield results: however, time factors, chemical factors (such as washing using soaps and detergents), external factors (such as temperature and humidity) and internal factors (other bodily fluids) may affect the validity of a sample. DNA remains viable from 12 hours to seven days depending on the location and type of material, though the earlier samples are collected and tested the higher the chances of yielding reliable results (RAINN, 2016b).

In addition to the time-critical forensic issues detailed above, all factors regarding emergency contraception also would apply in relevant situations. As mentioned in the Family Planning section above three types of family planning methods/contraceptives are sensitive to timely access because of their administration postcoitally: Emergency contraception pills (ECPs); emergency insertion of the Copper T Intrauterine Device (IUD); and abortion. Emergency use of contraceptive pills and IUD implantation to prevent pregnancy are both recommended within fewer than 10 days for effectiveness.

There is preponderance of evidence from studies with moderate to strong designs that increasing access to under 10 days for services involving the collection of forensic evidence or emergency contraception following sexual assault or rape would increase medical effectiveness of these services. However, survivors of sexual assault or rape may opt not to make an appointment for these services, but rather seek urgent care.

**Figure 3.** Summary of Findings: Timeliness of Services after Sexual Assault/Rape

| Treatment | Conclusion |
|---|---|
| **Evidence about the impact of timeliness of services after sexual assault/rape** | Increasing timeliness of services is associated with increased effectiveness |


*Source:* California Health Benefits Review Program.

## Access to Provider Within a Reasonable Distance

### *Reproductive health services*

#### Family planning

Multiple studies have concluded that services should be in close proximity to the young person's home location or a school-based service. A survey study reported that proximity to a clinic was linked to greater use (Parkes et al., 2004). However, closeness to home may not always be preferred, rather being close to school or a friend's house to ensure greater anonymity and to avoid seeing people they know. Studies in a rural area and among minority ethnic young people described the perception among them of having a lack of choice regarding which service they could access.

CHBRP concludes that there is insufficient evidence specific to accessing a provider within a reasonable distance on the medical effectiveness of family planning services.

### *Sexual health services*

#### STD/HIV prevention and testing

No studies were identified that examined the relationship between distance of health care provider and rates of STD/HIV prevention and testing.

CHBRP concludes that there is insufficient evidence specific to accessing a provider within a reasonable distance on the medical effectiveness of STD/HIV prevention and testing.

#### Sexual assault/rape

Rural settings often have fewer physical and mental health providers, and those that are present may lack experience in treatment of sexual assault cases and have limited access to appropriate referral services (McCall-Hosenfeld et al., 2015). No specific studies were found linking the distance to a provider to effectiveness of sexual assault care; however, distance to travel to a provider has been cited as a barrier to timely access to such care in rural settings (Chuang et al., 2012; Logan et al., 2005).

CHBRP concludes that there is insufficient evidence that accessing a provider within a reasonable distance on medical effectiveness of sexual assault/rape services.

## Access to a Provider of Preferred Gender

A study by Schmittdiel in 2000 found that female patients were more likely than male patients to have chosen their primary care physician (50.5% vs 41.9%) and when they did choose, were more likely to select a female physician (36.4% vs 12.5%). Patients of female physicians are more likely to receive preventive services, such as breast and pelvic examinations, Pap tests, mammograms, rectal examinations, and blood pressure measurements than patients of male physicians (Franks and Bertakis, 2003). Female physicians have significantly longer visits than their male colleagues with the performance of gender-specific (breast and pelvic) physical examinations. For non-gender– related prevention interventions, such as blood pressure measurement, cholesterol testing, and sigmoidoscopy, only blood pressure testing showed a modest physician gender effect. The physician gender effect on prevention may be related to a number of factors. It may be easier for female physicians to perform cervical and breast screening exams because they are in gender concordance with their patients. Other researchers

have failed to identify any significant difference between gender-concordant and gender-discordant encounters in the performance of pelvic or breast examinations, flu shots, or cholesterol check. Despite these conflicting findings, it seems clear that physician gender is important component in the delivery of preventive services. However, patient factors may also play an important role. For genital and rectal examinations, patients have been shown to prefer a physician of the same gender. In summary, gender concordance, in addition to the performance of the pelvic examination, rather than physician gender alone, contributes significantly to the differences in duration of visit and performance of other preventive services.

Although there was evidence from one study examining the role of gender preference, CHBRP concludes that this is insufficient evidence to draw conclusions regarding the impact on medical effectiveness of having access to a preferred gender provider on sexual and reproductive health care services.

CHBRP concludes that there is insufficient evidence on the medical effectiveness of improving more timely and local access (and access to a preferred gender provider) on sexual and reproductive health care services.

# AB 1954 IMPACTS ON BENEFIT COVERAGE, UTILIZATION, AND COST, 2017

As noted, AB 1954 aims to increase access to reproductive and sexual health care services through provisions that allow for out of network care (OON) in specified circumstances without a referral. This section reports the potential incremental impact of (AB) 1954 on estimated baseline benefit coverage, utilization, and overall cost. CHBRP groups related services into *sexual health care services*, which include sexually transmitted disease (STD) prevention and treatment services and *reproductive health care services*, which includes pregnancy prevention and treatment services, such as family planning services and sexual assault services. For further details on the underlying data sources and methods, please see Appendix B.

## Benefit Coverage

### Premandate (Baseline) Benefit Coverage

Currently, CHBRP estimates 100% of the 18.3 million enrollees subject to (AB) 1954 have coverage for reproductive and sexual health care services; and 32% of the enrollees have coverage through OON providers under specified circumstances without a referral.

Current coverage of the proposed mandate was determined by a survey of the two large providers of health insurance in California. Responses to this survey represent approximately 11% of the CDI-regulated market and 61% of DMHC-regulated market. Combined, responses to this survey represents 55% of enrollees in the privately funded market subject to state mandates. The estimates were also based on the assumptions that HMOs, including HMO and Point of Service (POS) plans, are not in compliance and non-HMOs, including Preferred Provider Organization (PPO) and fee-for-service (FFS) policies are in compliance. Since most of the policies in CDI-regulated market are either PPOs or FFS, CHBRP assumes that they are in compliance.

### Postmandate Benefit Coverage

If AB 1954 were enacted, CHBRP estimates the percent of enrollees with coverage for reproductive and sexual health care services through OON providers under specified circumstances without a referral will increase from 32% to 100%. The estimates were also based on the assumptions that HMOs, including HMO and POS plans need to be in compliance. AB 1954 only applies to grandfathered and nongrandfathered plans and policies including Covered California and CalPERS HMOs, but does not apply to Medi-Cal Managed Care.

## Utilization

### Premandate (Baseline) Utilization

Using the MarketScan California claim data, CHBRP estimates that there are 4 million users of sexual health care services among the enrollees subject to AB 1954, of which approximately 12.1 per 1,000 enrollees used OON services. Also, there are 3.6 million users of reproductive health care services, of which approximately 10.4 per 1,000 enrollees used OON services.

### Postmandate Utilization

CHBRP assumes that the overall utilization of reproductive and sexual health care services is not going to increase. However, CHBRP assumes that there will be a shift from using in-network services to OON services. The rationales for the assumptions of no overall utilization increase but a shift from in- to OON utilization are as follows: 1) The analyses of the MarketScan California claim data indicate that the percentages of total and ONN users of sexual and reproductive health care services between HMO and PPO enrollees are similar. Specifically, there are 24.5% users of the services among HMOs and 23.5% users among PPOs; and 0.21% OON users among HMOs and 1.15% among PPOs. 2) There is an existing law for enrollees to access OON providers, although the enrollee who cannot get timely access (i.e. within 10 days for primary care or with 15 days for specialist care) must contact the plan, and the plan must facilitate an appointment in- or OON (§ 1300.67.2.2 Timely Access to Non-Emergency Health Care Services). AB 1954 will allow an enrollee who cannot get timely access to see an OON provider without an approval or a referral. Although CHBRP cannot quantify the potential change, the mandate could result in some enrollees accessing certain services a few days earlier. And 3) Since AB 1954 is silent on the cost sharing provisions, CHBRP assumes that health plans will only pay OON services at in-network payment rates. The enrollees will pay out-of-pocket for the difference in charges, which will discourage some enrollees from seeking OON services.

Consequently, CHBRP estimates that the in-network utilization will decline and the OON utilization would increase after the mandate due to the improved access to OON providers without a referral. Specifically, based on the analysis of 2014 California MarketScan claim data, CHBRP estimates that the utilization of OON sexual health care services among the enrollees will increase by 9 units per 1,000 enrollees; and use of OON reproductive health care services by 8 units per 1,000 enrollees. This is an upper bound estimate, as the out-of-pocket cost of enrollees for using OON providers may increase. Enrollees may pay out-of-pocket for the difference in charges.

#### *Impact on access and health treatment/service availability*

CHBRP assumes that the mandate will increase access to reproductive and sexual health care services, especially to OON providers, under specified circumstances without a referral. Specifically, AB 1954 will improve the access for enrollees when an appropriate provider is unavailable in-network in the enrollee's service region within 10 days after the enrollee's initial request for reproductive and sexual health care services, or sooner if a medical provider indicates an earlier appointment is medically necessary; or an in-network provider is not available within a reasonable distance of the enrollee's work or home address (e.g., within 15 miles). Though there are no existing data to verify the sufficiency of in-network and OON reproductive and sexual health care services providers in California, CHBRP does not anticipate any impacts on the service availability after the mandate because facilities that provide reproductive and sexual health care services exist. CHBRP expects that persons with coverage for OON providers would find a facility providing reproductive and sexual health care services.

## Per-Unit Cost

### Premandate (Baseline) and Postmandate Per-Unit Cost

CHBRP estimates premandate (baseline) per-unit cost based on the analysis of 2014 California MarketScan claim data. The per-unit cost estimates ($106.51 in-network and $268.39 OON per sexual health care service; and $141.74 in-network and $309.05 OON per reproductive health care service) are based on the average of most commonly used procedures for reproductive and sexual health care services. The differences in the unit cost may be due the differences in charge and service mix between

in and OON services. Since HMOs are under-represented in the MarketScan data, the cost estimates are driven by larger shares of services receiving greater (OON) reimbursements in PPO market. These costs include those for counselling, lab tests, and related procedures provided on the same date of service, but exclude certain medication and facility costs, which could not be accurately allocated between these procedures and other procedures performed on the same day. Please see the details of included services in Appendix C. The per-unit cost was trended forward to 2017 using a 2.1% annual trend based on the 2015 consumer price index for professional medical services. CHBRP estimates that the per unit cost for in- and OON reproductive and sexual health care services will not change in the first 12 months postmandate. However, the enrollees may face higher out-of-pocket cost to cover the differences of the charges between in and OON providers. CHBRP's estimates for the per-unit cost are also summarized in Table 1.

# Premiums and Expenditures

## Premandate (Baseline) Expenditures

Table 2 presents per member per month (PMPM) premandate estimates for premiums and expenditures by market segment for DMHC-regulated plans and CDI-regulated policies.

PMPM by market segment is as follows for DMHC-regulated plans and CDI-regulated policies, respectively:

- Large group: $553.67 and $662.37.
- Small group: $470.64 and $585.28.
- Individual market: $423.95 and $365.22.

Total current annual expenditures for all DMHC-regulated plans and CDI-regulated policies is $145.08 billion.

## Postmandate Expenditures

### *Changes in total expenditures*

(AB) 1954 would increaseincrease total net annual expenditures by $22.5 million, or 0.02%, for enrollees with DMHC-regulated plans. This is mainly due to an increase of out-of-pocket expenses in enrollee expenditures for paying the balance for previously noncovered OON benefits ($22.5 million). CHBRP assumes that plans will pay the same as in network rates and allow the provider to balance bill the enrollees after the mandate.

### *Postmandate premium expenditures and PMPM amounts per category of payer*

Note that the total population in Table 3 on page 26, reflects the full 18.26 million enrollees in DMHC-regulated plans and CDI-regulated policies subject to (AB) 1954.

CHBRP usually assumes an increase in total annual health insurance premiums paid by employers and enrollees due to the assumed increase in utilization and the shift of cost sharing amounts previously paid by enrollees into premiums. For AB 1954, CHBRP assumes no increase in premiums, but an increase in enrollees' out-of-pocket expenses. The rationales for the assumptions are that there will be no overall

utilization increase but a shift from in-network to OON utilization; and plans will pay the in-network rates and allow the providers to bill the enrollees for the remaining balance after the mandate.

Among publicly funded DMHC-regulated health plans, such as CalPERS HMOs, the impact of AB 1954 will be the same. There will be no expected impact on Medi-Cal Managed Care because AB 1954 does not apply to Medi-Cal Managed Care.

### *Potential cost offsets or savings in the first 12 months after enactment*

CHBRP estimates that there may be cost offsets or savings in the first 12 months after enactment. For instance, a study published in 2008 showed that the average charges for an abortion at 10 weeks is $543 compared with $1,562 for an abortion at 20 weeks.[28] Also, as indicated in Medical Effectiveness section, emergency use of contraceptive pills and IUD implantation are both effective in preventing unintended pregnancies, if they are used within fewer than 10 days. A study also showed that emergency contraceptive pills could save $2.56 for every dollar spent for users.[30] However, since no information is available on the delayed access to these reproductive and sexual health care services due to inaccessibility of OON providers without a referral, CHBRP is not able to estimate the potential cost offsets or savings in the first 12 months after enactment.

### *Postmandate administrative expenses and other expenses*

CHBRP usually estimates that the increase in administrative costs of DMHC-regulated plans and/or CDI-regulated policies will remain proportional to the increase in premiums. CHBRP assumes that if health care costs increase as a result of increased utilization or changes in unit costs, there is a corresponding proportional increase in administrative costs. CHBRP assumes that the administrative cost portion of premiums is unchanged. All health plans and insurers include a component for administration and profit in their premiums. Since CHBRP assumes that there will be no premium and utilization changes and current systems for reimbursement for OON providers do exist, there will be no increase in administrative cost after the mandate. Plans need to update their policies but the extra cost for that is minimal.

## Related Considerations for Policymakers

### Cost of Exceeding Essential Health Benefits

As explained in the *Policy Context* section, coverage for OON reproductive and sexual health care services would not be expected to exceed the Affordable Care Act's essential health benefits (EHBs).

### Postmandate Changes in Uninsured and Public Program Enrollment

### *Changes in the number of uninsured persons*[20]

CHBRP estimates no premium increases for each market segment; so there would not be a measurable impact on the number of persons who are uninsured. CHBRP does not anticipate loss of health insurance, changes in availability of the benefit beyond those subject to the mandate, changes in offer rates of health insurance, changes in employer contribution rates, changes in take-up of health insurance

[20] See also CHBRP's *Criteria and Methods for Estimating the Impact of Mandates on the Number of Uninsured*, available at www.chbrp.org/analysis_methodology/cost_impact_analysis.php.

by employees, or purchase of individual market policies, due to the small size of the increase in premiums after the mandate.

### *Changes in public program enrollment*

CHBRP estimates that the mandate would produce no measurable impact on enrollment in publicly funded insurance programs or on utilization of covered benefits in the publicly funded insurance market.

## How Lack of Benefit Coverage Results in Cost Shifts to Other Payers

AB 1954 would not result in a shift in payment or service delivery to public payers. CHBRP assumes that enrollees who do not have OON coverage may delay use of these services or pay for these service directly (e.g., self-pay).

**Table 2.** Baseline (Premandate) Per Member Per Month Premiums and Total Expenditures by Market Segment, California, 2016

| | DMHC-Regulated | | | | | | CDI-Regulated | | | |
|---|---|---|---|---|---|---|---|---|---|---|
| | Privately Funded Plans (by Market) (a) | | | Publicly Funded Plans | | | Privately Funded Plans (by Market) (a) | | | |
| | *Large Group* | *Small Group* | *Individual* | *CalPERS HMOs (b)* | *MCMC (Under 65) (c)* | *MCMC (65+) (c)* | *Large Group* | *Small Group* | *Individual* | **Total** |
| **Enrollee counts** | | | | | | | | | | |
| Total enrollees in plans/policies subject to state mandates (d) | 9,138,000 | 2,805,000 | 3,840,000 | 861,000 | 6,331,000 | 561,000 | 309,000 | 731,000 | 579,000 | 25,155,000 |
| Total enrollees in plans/policies subject to (AB) 1954 | 9,138,000 | 2,805,000 | 3,840,000 | 861,000 | 0 | 0 | 309,000 | 731,000 | 579,000 | 18,263,000 |
| **Premium costs** | | | | | | | | | | |
| Average portion of premium paid by employer | $444.39 | $309.74 | $0.00 | $460.33 | $180.00 | $445.00 | $523.71 | $426.22 | $0.00 | $86,263,866,000 |
| Average portion of premium paid by employee | $109.27 | $160.90 | $423.95 | $115.08 | $0.00 | $0.00 | $138.66 | $159.06 | $365.22 | $42,569,604,000 |
| Total premium | **$553.67** | **$470.64** | **$423.95** | **$575.41** | **$180.00** | **$445.00** | **$662.37** | **$585.28** | **$365.22** | **$128,833,470,000** |
| **Enrollee expenses** | | | | | | | | | | |
| Enrollee expenses for covered benefits (deductibles, copays, etc.) | $44.43 | $93.55 | $112.36 | $31.43 | $0.00 | $0.00 | $111.69 | $177.13 | $108.98 | $16,248,327,000 |
| Enrollee expenses for benefits not covered (e) | $0.00 | $0.00 | $0.00 | $0.00 | $0.00 | $0.00 | $0.00 | $0.00 | $0.00 | $0 |
| **Total expenditures** | **$598.10** | **$564.19** | **$536.30** | **$606.84** | **$180.00** | **$445.00** | **$774.06** | **$762.41** | **$474.20** | **$145,081,797,000** |

*Source:* California Health Benefits Review Program, 2016.

*Notes:* (a) Includes enrollees with grandfathered and nongrandfathered health insurance, both on Covered California and outside the health insurance marketplace.

(b) As of September 30, 2015, 57%, or 462,580, CalPERS members were state retirees, state employees, or their dependents. CHBRP assumes the same ratio for 2017.

(c) Medi-Cal Managed Care Plan expenditures for members over 65 include those who are also Medicare beneficiaries. This population does not include enrollees in COHS.

(d) This population includes both persons who obtain health insurance using private funds (group and individual) and through public funds (e.g., CalPERS HMOs, Medi-Cal Managed Care Plans). Only those enrolled in health plans or policies regulated by the DMHC or CDI are included. Population includes all enrollees in state-regulated plans or policies aged 0 to 64 years, and enrollees 65 years or older covered by employer-sponsored health insurance.

(e) Includes only those expenses that are paid directly by enrollees or other sources to providers for services related to the mandated benefit that are not currently covered by insurance. 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; COHS = County Operated Health Systems; DMHC = Department of Managed Health Care; MCMC = Medi-Cal Managed Care.

**Table 3.** Postmandate Impacts of the Mandate on Per Member Per Month Premiums and Total Expenditures by Market Segment, California, 2017

| | DMHC-Regulated | | | | | | CDI-Regulated | | | |
|---|---|---|---|---|---|---|---|---|---|---|
| | Privately Funded Plans (by Market) (a) | | | Publicly Funded Plans | | | Privately Funded Plans (by Market)(a) | | | |
| | *Large Group* | *Small Group* | *Individual* | *CalPERS HMOs (b)* | *MCMC (Under 65 )(c)* | *MCMC (65+) (c)* | *Large Group* | *Small Group* | *Individual* | **Total** |
| **Enrollee counts** | | | | | | | | | | |
| Total enrollees in plans/policies subject to state mandates (d) | 9,138,000 | 2,805,000 | 3,840,000 | 861,000 | 6,331,000 | 561,000 | 309,000 | 731,000 | 579,000 | 25,155,000 |
| Total enrollees in plans/policies subject to (AB) 1954 | 9,138,000 | 2,805,000 | 3,840,000 | 861,000 | 0 | 0 | 309,000 | 731,000 | 579,000 | 18,263,000 |
| **Premium costs** | | | | | | | | | | |
| Average portion of premium paid by employer | $0.0000 | $0.0000 | $0.0000 | $0.0000 | $0.0000 | $0.0000 | $0.0000 | $0.0000 | $0.0000 | $0 |
| Average portion of premium paid by employee | $0.0000 | $0.0000 | $0.0000 | $0.0000 | $0.0000 | $0.0000 | $0.0000 | $0.0000 | $0.0000 | $0 |
| Total premium | $0.0000 | $0.0000 | $0.0000 | $0.0000 | $0.0000 | $0.0000 | $0.0000 | $0.0000 | $0.0000 | **$0** |
| **Enrollee expenses** | | | | | | | | | | |
| Enrollee expenses for covered benefits (deductibles, copays, etc.) | $0.0000 | $0.0000 | $0.0000 | $0.0000 | $0.0000 | $0.0000 | $0.0000 | $0.0000 | $0.0000 | $0 |
| Enrollee expenses for benefits not covered(e) | $0.1093 | $0.1093 | $0.1111 | $0.1093 | $0.0000 | $0.0000 | $0.0092 | $0.0000 | $0.0834 | $22,529,000 |
| **Total expenditures** | $0.11 | $0.11 | $0.11 | $0.11 | $0.00 | $0.00 | $0.01 | $0.00 | $0.08 | **$22,529,000** |
| **Postmandate percent change** | | | | | | | | | | |
| Insured premiums | 0.0000% | 0.0000% | 0.0000% | 0.0000% | 0.0000% | 0.0000% | 0.0000% | 0.0000% | 0.0000% | 0.0000% |
| **Total expenditures** | 0.0183% | 0.0194% | 0.0207% | 0.0180% | 0.0000% | 0.0000% | 0.0012% | 0.0000% | 0.0176% | 0.0155% |

*Source:* California Health Benefits Review Program, 2016.

*Notes:* (a) Includes enrollees with grandfathered and nongrandfathered health insurance, inside and outside the exchange.

(b) As of September 30, 2013, 57.5%, or 462,580 CalPERS members were state retirees, state employees, or their dependents. CHBRP assumes the same ratio for 2015.

(c) Medi-Cal Managed Care Plan expenditures for members over 65 include those who are also Medicare beneficiaries. This population does not include enrollees in COHS..

(d) This population includes both persons who obtain health insurance using private funds (group and individual) and through public funds (e.g., CalPERS HMOs, Medi-Cal Managed Care Plans). Only those enrolled in health plans or policies regulated by the DMHC or CDI are included. Population includes all enrollees in state-regulated plans or policies aged 0 to 64 years, and enrollees 65 years or older covered by employer-sponsored health insurance.

(e) Includes only those expenses that are paid directly by enrollees or other sources to providers for services related to the mandated benefit that are not currently covered by insurance. 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; COHS = County Operated Health Systems; DMHC = Department of Managed Health Care; MCMC = Medi-Cal Managed Care.

# PUBLIC HEALTH IMPACTS

The public health impact analysis includes estimates on mandate-relevant health outcomes, potential treatment harms, social determinants of health (including potential disparities), financial burden, premature death, and economic loss in the short and long term. This section estimates the short term impact[21] of AB 1954 on estimated public health outcomes, social determinants of health (SDoH), and disparities. See the *Long-Term Impacts* section for discussion of premature death, economic loss, and SDoH/disparities beyond the first 12 months of the bill implementation.

AB 1954 would allow commercial health plan enrollees to seek OON sexual and reproductive health care services in the absence of timely access to these services from an appropriate in-network provider who is located within a reasonable distance of the enrollee's home or work. Furthermore, the bill would prohibit referral requirements for these services.

## Estimated Public Health Outcomes

Potential public health outcomes of increased access to relevant sexual and reproductive health services in terms of timeliness, distance, and preferred-gender providers could include 1) earlier diagnosis and subsequent treatment of STDs/HIV, and consequently lower severity of disease and risk of exposing others to infection for the general population of enrollees and for rape/sexual assault cases, 2) decreases in unintended pregnancy rates due to access to emergency contraception generally and for rape/sexual assault cases, and less physical harm from miscarriage or ectopic pregnancy complications, and 3) more reliable evidence collection in the event of rapes and sexual assaults, which could lead to the apprehension of suspects before they attack others.

As presented in the *Medical Effectiveness section,* there was a preponderance of evidence to suggest that timely access to sexual assault/rape services increased the medical effectiveness of these treatments for pregnancy prevention and evidence collection. Furthermore, sufficient evidence was found suggesting that timely access (within 10 days) to emergency contraception and IUD implantation increased the medical effectiveness of these treatments for pregnancy prevention. There was insufficient evidence to suggest that increased access to nearby (within 25 miles of patients' home or work) and preferred-gender providers would have an impact on the medical effectiveness of these treatments, or that timely access (within 10 days) to an abortion provider would make a significant difference in medical effectiveness.

As presented in the *Benefit Coverage, Utilization, and Cost Impacts* section, 18.3 million enrollees will be affected by AB 1954. CHBRP estimates that utilization of reproductive health services overall will not change; although the utilization of OON STD prevention and treatment services among the enrollees will increase by 8% and use of OON pregnancy prevention and treatment services by 9%, this only represents a shift in utilization from in-network to OON. However, this shift may mean that these enrollees are able to access sexual and reproductive health services sooner, due to timeliness, greater convenience, and an accordance with their gender preferences.

It stands to reason that increased access to timely, nearby, and gender-preferred sexual and reproductive health services and providers has the potential to improve quality of life for enrollees affected by AB 1954. In addition, some public health outcomes may improve in the first year post-mandate, including unintended pregnancy rates and STD/HIV morbidity, both in general and in the context of sexual assault/rape.

[21] CHBRP defines short term impacts as changes occurring within 12 months of bill implementation.

As described in the *Medical Effectiveness* section, there is a preponderance of evidence to suggest that timely access (within 10 days) to sexual assault/rape services is medically effective, and sufficient evidence to suggest the same for that emergency contraception and IUD implantation. Although CHBRP estimates no net change in utilization, enrollees may be able to access sexual and reproductive health services sooner or more conveniently, preventing delays. Therefore, it stands to reason that public health impacts in the first year, postmandate, may include improved prevention of unintended pregnancies and STD/HIV morbidity, both in general and in the context of sexual assault/rape.

## Social Determinants of Health and Disparities

CHBRP defines social determinants of health (SDoH) as conditions in which people are born, grow, live, work, learn, and age. These social determinants of health (e.g., economic factors, social factors, education, physical environment) are shaped by the distribution of money, power, and resources and impacted by policy (adapted from Healthy People 2020, 2015; CDC, 2014). These factors generally occur prior to or outside of the health care system and are highly correlated with downstream events such as avoidable illnesses and premature death. However, the relationship between SDOH and health status/outcomes is complex and, periodically, health insurance mandates can influence SDOH.[22] CHBRP will consider the full range of SDoH (e.g., income, education, or social construct around age, race/ethnicity, gender, and gender identity/sexual orientation) that are relevant to this bill and where evidence is available.

Evidence presented in the *Background* section indicates that the most important disparities related to timely and nearby access to care for sexual and reproductive health services described in AB 1954 are found among low-socioeconomic status individuals and rural residents, particularly women in these two groups. In addition, the youngest and oldest groups of women and women of color may be more likely to have preferences for provider gender for sexual and reproductive health services. Therefore, CHBRP estimates that AB 1954 could mediate the effects of these disparities/SDoH by increasing commercial health insurance plan enrollees' coverage for a broader selection of OON sexual and reproductive health care service providers, which may allow individuals with barriers to care related to socioeconomic status, geographic location/transportation, cultural beliefs, or stigma around sensitive services to access timely, nearby, and appropriate services and providers. Specific impacts are discussed below.

### *Impact on socioeconomic and geographic disparities*

Disparities in access to timely pregnancy treatment/prevention and sexual assault/rape-related services among rural living and low-socioeconomic-status individuals, especially women, may improve due to having increased options for timely and nearby services by going OON, reducing barriers regarding geographic location, transportation and narrowing provider networks among post-ACA plans for low-income individuals.

### *Impact on age and racial/ethnic disparities*

Although it is not known how preferences for provider gender affect access to sexual and reproductive health services, it stands to reason that AB 1954 may reduce disparities in access to reproductive and sexual health services among younger (age 26 and younger) and older (age 40 and older) women and women of color due to increased access to OON female providers if no male providers are available in-

[22] For more information about SDoH see CHBRP's publication: *Incorporating Relevant Social Determinants of Health Into CHBRP Benefit Mandate Analyses.*

network. Disparities in access to appropriate providers for sexual minorities are present, but it is unclear whether the provisions of AB 1954 on preferred-gender providers would affect these disparities.

## Estimated Impact on Financial Burden

When possible, CHBRP estimates the marginal impact of mandates on financial burden, defined as uncovered medical expenses paid by the enrollee as well as out-of-pocket expenses (e.g., deductibles, copayments, and co-insurance). CHBRP estimates that AB 1954 would increase the financial burden of the 12.5 million enrollees who will gain access to OON providers through a $22.5 million increase in out-of-pocket costs for using OON services. However, because the bill does not address cost-sharing, CHBRP is unable to estimate how much of this cost enrollees would actually pay for going to OON providers under the provisions described in AB 1954.

CHBRP estimates that AB 1954 may increase out-of-pocket costs for among the 12.5 million enrollees who will gain access to OON providers and choose to pay higher out-of-pocket costs for OON access that is sooner, closer, or in accordance with their gender preference.

# LONG-TERM IMPACTS OF AB 1954

In this section, CHBRP estimates the long-term impact[23] of (AB) 1954, defined as impacts occurring beyond the first 12 months of implementation. These estimates are qualitative and based on the existing evidence available in the literature. CHBRP does not provide quantitative estimates of long-term impacts because of unknown improvements in clinical care, changes in prices, implementation of other complementary or conflicting policies, and other unexpected factors.

## Long-Term Public Health Impacts

Some interventions in proposed mandates provide immediate measurable impacts (e.g., maternity service coverage or acute care treatments) while other interventions may take years to make a measurable impact (e.g., coverage for tobacco cessation or vaccinations). When possible, CHBRP estimates the long-term effects of a proposed mandate (beyond CHBRP's 12-month analytic timeframe) to capture possible impacts to the public's health that would be attributable to the mandate, including impacts on premature death and economic loss.

In the case of AB 1954, CHBRP estimates that the shift in utilization from in-network to OON will be sustained over time, resulting in more timely access to sexual and reproductive health services due to fewer barriers to care. In light of evidence of medical effectiveness for more timely provision of some of the services that would be affected by this bill, including emergency contraception/IUD insertion to prevent pregnancy and sexual assault/rape care, the long-term public health impacts of AB 1954 may include consequences of the previously discussed short-term impacts, such as a lower birth rate, reduced prevalence of STDs/HIV, and more consistent evidence collection in rape/sexual assault cases leading to greater prosecution of the perpetrators, and reducing the risk/threat of sexual violence to nearby communities.

## Impacts on the Social Determinants of Health and Disparities

CHBRP defines social determinants of health (SDoH) as conditions in which people are born, grow, live, work, learn, and age. These social determinants of health (e.g., economic factors, social factors, education, physical environment) are shaped by the distribution of money, power, and resources and impacted by policy (adapted from Healthy People 2020, 2015; CDC, 2014). These factors generally occur prior to or outside of the health care system and are highly correlated with downstream events such as avoidable illnesses and premature death. However, the relationship between SDOH and health status/outcomes is complex; periodically, health insurance mandates can influence SDOH.[24]

It stands to reason that in the long-term, the effect of AB 1954 on access to sexual and reproductive health services could lead to lessening disparities among youth, racial/ethnic minorities, women of color, and individuals of low-socioeconomic status in the prevalence of unintended pregnancy and STDs/HIV as access to these services is increased and sustained over time.

[23] See also CHBRP's *Criteria and Guidelines for the Analysis of Long-Term Impacts on Healthcare Costs and Public Health*, available at www.chbrp.org/analysis_methodology/cost_impact_analysis.php.
[24] For more information about SDoH see CHBRP's publication: *Incorporating Relevant Social Determinants of Health Into CHBRP Benefit Mandate Analyses.*

# Long-Term Utilization and Cost Impacts

## Utilization Impacts

In the 12 months following enactment, CHBRP estimates that the overall utilization of reproductive and sexual health care services is not going to increase. However, OON utilization may increase after the mandate due to the improved access to OON providers without a referral. Specifically, based on the analysis of 2014 California MarketScan claims data, CHBRP estimates that the utilization of OON sexual health care services among the enrollees will increase by 9 units per 1,000 enrollees and use of OON reproductive health care services by 8 units per 1,000 enrollees. This is an upper bound estimate, as the out-of-pocket cost of enrollees for using OON providers may increase. In later years, similar patterns of changes are expected.

## Cost Impacts

Studies show that the timely access to reproductive and sexual health care services are cost effective. As mentioned in public health section that the cost burden of unintended pregnancy in the U.S. is approximately $4.6 billion dollars per year, including the costs of live births, abortions, ectopic pregnancy and spontaneous abortion complications. Over half (53%) of these costs can be attributed to unintended pregnancies that occur in women who fail to take contraception consistently (Trussell et al., 2013). The cost effectiveness of contraceptives has been demonstrated through several studies.[31] For instance, using a decision-analytic model, one study showed that extending contraceptive coverage both saves money and improves outcomes for Oregon state insurance plan providers. The authors estimated the proposed policy would prevent an additional 72 pregnancies per 1,000 women over 5 years and save an additional $489 per woman enrolled over 5 years while increasing QALYs.[32]

# Other Long-Term Impacts

AB 1954 may also interact with existing/upcoming legislation. We do not yet know how AB 1954 will interact with existing legislation that allows emergency contraception pills to be obtained over-the-counter or with SB493, a new law that will allow pharmacists to prescribe hormonal contraceptives and allow women to bypass their doctors to obtain these prescriptions; it is possible that these laws affecting access to contraception and emergency contraception could mitigate the effects of AB 1954.

# APPENDIX A TEXT OF BILL ANALYZED

On February 17, 2016, the California AssemblyAssembly Committee on Health requested that CHBRP analyze (AB) 1954.

CALIFORNIA LEGISLATURE— 2015–2016 REGULAR SESSION

**ASSEMBLY BILL** **No. 1954**

**Introduced by Assembly Member Burke**

February 12, 2016

An act to add Section 1367.31 to the Health and Safety Code, and to add Section 10123.202 to the Insurance Code, relating to health care coverage.

LEGISLATIVE COUNSEL'S DIGEST

AB 1954, as introduced, Burke. Health care coverage: reproductive health care services.
Existing law, the Knox-Keene Health Care Service Plan Act of 1975, provides for the licensure and regulation of health care service plans by the Department of Managed Health Care and makes a willful violation of the act a crime. Existing law provides for the regulation of health insurers by the Department of Insurance.

This bill would require every health care service plan contract or health insurance policy issued, amended, renewed, or delivered on or after January 1, 2017, to provide coverage for reproductive and sexual health care services, as defined, through OON providers under specified circumstances. The bill would prohibit those plan contracts or insurance policies from requiring an enrollee or insured to receive a referral in order to receive reproductive or sexual health care services. Because a willful violation of these provisions by a health care service plan would be a crime, the bill would impose a state-mandated local program.
The California Constitution requires the state to reimburse local agencies and school districts for certain costs mandated by the state. Statutory provisions establish procedures for making that reimbursement.

This bill would provide that no reimbursement is required by this act for a specified reason.
DIGEST KEY
Vote: MAJORITY Appropriation: NO Fiscal Committee: YES Local Program: YES

BILL TEXT
THE PEOPLE OF THE STATE OF CALIFORNIA DO ENACT AS FOLLOWS:

**SECTION 1.**
This act shall be known and may be cited as the Direct Access to Reproductive Health Care Act.

**SEC. 2.**
(a) The Legislature hereby finds and declares all of the following:
(1) For many women, reproductive health care is primary health care.
(2) According to the Guttmacher Institute, one-half of all pregnancies in the United States each year, more than three million pregnancies, are unintended. By 45 years of age, more than one-half of all women in the United States will have experienced an unintended pregnancy, and three in 10 will have had an abortion.
(3) The inability to access comprehensive reproductive health care in a timely manner can lead to negative health outcomes including increased risk for unintended pregnancy, sexually transmitted diseases, and delayed care for critical and time-sensitive reproductive health services.
(4) Providing timely access to comprehensive reproductive health services is cost effective.
(5) California has a long history of, and commitment to, expanding access to services that aim to reduce the risk of unintended pregnancies, improve reproductive and sexual health outcomes, and reduce costs.
(6) Recognizing the importance of timely access to comprehensive reproductive health services, the Legislature and the United States Congress passed measures to allow Medi-Cal enrollees to go OON for sensitive services and enable women to access care provided by an obstetrician/gynecologist (OB/GYN) without a referral.
(7) The Legislature has also passed measures to help health plan enrollees and insureds access timely health care by setting standards and policies regarding wait times for an appointment.
(8) Despite these advances, there are wide variances in network adequacy and health care service plan contracts and health insurance policies regarding referral requirements for reproductive and sexual health care services.
(b) It is hereby the intent of the Legislature in enacting this act to build on current state and federal law to increase timely, equal, and direct access to time-sensitive and comprehensive reproductive and sexual health care services for enrollees in health care service plans or insureds under health insurance policies by doing both of the following:
(1) Allowing enrollees or insureds to seek care from an OON provider if access to an appropriate reproductive and sexual health provider is unavailable in-network in a timely manner.
(2) Prohibiting health care service plans or insurers from requiring an enrollee or insured to secure a referral from a primary care provider prior to receiving reproductive and sexual health care services.

**SEC. 3.**
Section 1367.31 is added to the Health and Safety Code, to read:

1367.31.

(a) Every health care service plan contract issued, amended, renewed, or delivered on or after January 1, 2017, shall provide coverage for reproductive and sexual health care services provided by an OON provider in an enrollee's service region under either of the following circumstances:

(1) Access to an appropriate provider is unavailable in-network in the enrollee's service region within 10 days after the enrollee's initial request for reproductive and sexual health care services, or sooner if a medical provider indicates an earlier appointment is medically necessary.

(2) An in-network provider is not available within a reasonable distance of the enrollee's work or home address.

(b) Every health care service plan contract issued, amended, renewed, or delivered on or after January 1, 2017, shall be prohibited from requiring an enrollee to receive a referral prior to receiving coverage or services for reproductive and sexual health care.

(c) For the purposes of this section:

(1) "Appropriate provider" means either of the following:

(A) A provider with the training and licensure necessary to ably provide the covered time-sensitive reproductive and sexual health care services, treatment, and devices requested by the enrollee in the clinical setting in which he or she practices.

(B) A provider that meets the standards set forth in subparagraph (A), and is selected by an enrollee based on the provider's gender and the enrollee's preference to be treated by a provider of that gender.

(2) "Reasonable distance" is the distance defined by the Department of Managed Health Care.

(3) "Reproductive and sexual health care services" are all reproductive and sexual health services described in Sections 6924, 6925, 6926, 6927, 6928, and 6929 of the Family Code, or Sections 121020 and 124260 of the Health and Safety Code, obtained by a patient at or above the minimum age specified in that section.

(d) This section shall not apply to any health care service plan that is governed by Section 14131 of the Welfare and Institutions Code.

**SEC. 4.**

Section 10123.202 is added to the Insurance Code, to read:

10123.202.

(a) Every health insurance policy issued, amended, renewed, or delivered on or after January 1, 2017, shall provide coverage for reproductive and sexual health care services provided by an OON provider in an insured's service region under either of the following circumstances:

(1) Access to an appropriate provider is unavailable in-network in the insured's service region within 10 days after the insured's initial request for reproductive and sexual health care services, or sooner if a medical provider indicates an earlier appointment is medically necessary.

(2) An in-network provider is not available within a reasonable distance of the insured's work or home address.

(b) Every health insurance policy issued, amended, renewed, or delivered on or after January 1, 2017, shall be prohibited from requiring an insured to receive a referral prior to receiving coverage or services for reproductive and sexual health care.

(c) For the purposes of this section:
(1) “Appropriate provider” means either of the following:
(A) A provider with the training and licensure necessary to ably provide the covered time-sensitive reproductive and sexual health care services, treatment, and devices requested by the insured in the clinical setting in which he or she practices.
(B) A provider that meets the standards set forth in subparagraph (A), and is selected by an insured based on the provider’s gender and the insured’s preference to be treated by a provider of that gender.
(2) “Reasonable distance” is the distance defined by the Department of Insurance.
(3) “Reproductive and sexual health care services” are all reproductive and sexual health services described in Sections 6924, 6925, 6926, 6927, 6928, and 6929 of the Family Code, or Sections 121020 and 124260 of the Health and Safety Code, obtained by a patient at or above the minimum age specified in that section.

**SEC. 5.**
No reimbursement is required by this act pursuant to Section 6 of Article XIII B of the California Constitution because the only costs that may be incurred by a local agency or school district will be incurred because this act creates a new crime or infraction, eliminates a crime or infraction, or changes the penalty for a crime or infraction, within the meaning of Section 17556 of the Government Code, or changes the definition of a crime within the meaning of Section 6 of Article XIII B of the California Constitution

# APPENDIX B LITERATURE REVIEW METHODS

## Medical Effectiveness

Appendix B describes methods used in the medical effectiveness literature review conducted for AB 1954. A discussion of CHBRP's system for grading evidence, as well as lists of MeSH Terms, Publication Types, and Keywords, follows.

The literature search was limited to studies published in English, for which abstracts were available, from 2010 to present.

The following databases of peer-reviewed literature were searched: MEDLINE (PubMed), Business Sources Complete, the Cochrane Library (includes Cochrane Register of Controlled Clinical Trials,

Cochrane Database of Systematic Reviews, Database of Abstracts of Reviews of Effects (DARE), Health Technology Assessment Database, and NHS Economic Evaluation Database, EconLit, Web of Science (includes Science Citation Index Expanded and the Social Science Citation Index), Embase, Cumulative Index of Nursing and Allied Health Literature, Pharmaceuticals – BIOSIS, Pharmaceuticals – International Pharmaceutical Abstracts (if available), and Pharmaceuticals – Micromedex (if available). In addition, websites maintained by the following organizations that index or publish systematic reviews and evidence-based guidelines were searched: National Institutes of Health, Institute for Clinical Systems Improvement, and the World Health Organization.

Two reviewers screened the title and abstract of each citation retrieved by the literature search to determine eligibility for inclusion. The reviewers acquired the full text of articles that were deemed eligible for inclusion in the review and reapplied the initial eligibility criteria. Abstracts for 122 articles were identified. Eight meta-analyses, systematic reviews, narrative reviews, RCTs, and nonrandomized studies with comparison groups were retrieved and reviewed.

## Evidence Grading System

In making a "call" for each outcome measure, the medical effectiveness lead and the content expert consider the number of studies as well the strength of the evidence. Further information about the criteria CHBRP uses to evaluate evidence of medical effectiveness can be found in CHBRP's Medical effectiveness Analysis Research Approach.[25] To grade the evidence for each outcome measured, the team uses a grading system that has the following categories:

- • Research design;
- • Consistency of findings;
- • Generalizability of findings to the population whose coverage would be affected by a mandate; and
- • Cumulative impact of evidence.

CHBRP uses a hierarchy to classify studies' research designs by the strength of the evidence they provide regarding a treatment's effects.

[25] Available at: www.chbrp.org/analysis_methodology/docs/medeffect_methods_detail.pdf.

CHBRP evaluates consistency of findings across three dimensions: statistical significance, direction of effect, and size of effect.

The grading system also contains an overall conclusion that encompasses findings in these five domains. The conclusion is a statement that captures the strength, consistency, and generalizability of the evidence of an intervention's effect on an outcome. The following terms are used to characterize the body of evidence regarding an outcome:

- • Clear and convincing evidence;
- • Preponderance of evidence;
- • Ambiguous/conflicting evidence; and
- • Insufficient evidence.

A grade of *clear and convincing evidence* indicates that there are multiple studies of a treatment and that the large majority of studies have strong research designs, consistently find that the treatment is either effective or not effective, and have findings that are highly generalizable to the population whose coverage would be affected. This grade is assigned in cases in which it is unlikely that publication of additional studies would change CHBRP's conclusion about the effectiveness of a treatment.

A grade of *preponderance of evidence* indicates that the majority of the studies reviewed are consistent in their findings that treatment is either effective or not effective and that the findings are generalizable to the population whose coverage would be affected. Bodies of evidence that are graded as *preponderance of evidence* are further subdivided into three categories based on the strength of their research designs: strong research designs, moderate research designs, and weak research designs.

A grade of *ambiguous/conflicting evidence* indicates that although some studies included in the medical effectiveness review find that a treatment is effective, a similar number of studies with equally strong research designs suggest the treatment is not effective.

A grade of *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 have weak research designs. It does not indicate that a treatment is not effective.

In addition to grading the strength of evidence regarding a treatment's effect on specific outcomes, CHBRP also assigns an overall grade to the whole body of evidence included in the medical effectiveness review. A statement of the overall grade is included in the Executive Summary and in the Medical Effectiveness section of the text of the report. The statement is accompanied by a graphic to help readers visualize the conclusion.

## Search Terms

The search terms used to locate studies relevant to AB 1954 were as follows:

Keywords used to search PubMed, Cochrane Library, Web of Science, EconLit, and other relevant websites:

**Keywords:**

- Family Planning
- Contraception
- Abortion
- Contraception Counseling
- Abortion Counseling
- Pregnancy Testing
- Pregnancy Counseling
- Prenatal Care
- Antenatal Care
- Perinatal Care
- Miscarriage
- Pregnancy/Birth Complications
- Sexually Transmitted Diseases/Infections Screening
- Sexually Transmitted Diseases/Infections Testing
- Sexually Transmitted Diseases/Infections Treatment
- Sexually Transmitted Diseases/Infections Counseling
- HIV Screening
- HIV Testing
- HIV Treatment
- HIV Counseling
- Sexual Assault Medical Evaluation
- Sexual Assault Counseling
- Rape Counseling
- All above* outcomes plus those listed below

**Outcomes:**

- Access
- Timeliness
- Gender preference

# APPENDIX C COST IMPACT ANALYSIS: DATA SOURCES, CAVEATS, AND ASSUMPTIONS

This appendix describes data sources, estimation methodology, as well as general and mandate-specific caveats and assumptions used in conducting the cost impact analysis. For additional information on the cost model and underlying methodology, please refer to the CHBRP website at: www.chbrp.org/analysis_methodology/cost_impact_analysis.php.

The cost analysis in this report was prepared by the members of the cost team, which consists of CHBRP task force members and contributors from the University of California, Los Angeles, and the University of California, Davis, as well as contracted actuarial firms, Milliman, Inc, and PricewaterhouseCoopers (PwC).[26]

## Data Sources

This subsection discusses the variety of data sources CHBRP uses. Key sources and data items are listed below, in Table C-1.

**Table C-1**. Data for 2017 Projections

| Data Source | Items |
|---|---|
| California Department of Health Care Services (DHCS) administrative data for the Medi-Cal program, data available as of end of December 2014 | Distribution of enrollees by managed care or FFS distribution by age: 0–17; 18–64; 65+<br>Medi-Cal Managed Care premiums |
| California Department of Managed Health Care (DMHC) data from the interactive website "Health Plan Financial Summary Report," August–October, 2015 | Distribution of DMHC-regulated plans by market segment* |
| California Department of Insurance (CDI) Statistical Analysis Division data; data as of December 31, 2015 | Distribution of CDI-regulated policies by market segment |
| California Health Benefits Review Program (CHBRP) Annual Enrollment and Premium Survey of California's largest (by enrollment) health care service plans and health insurers; data as of September 30, 2015; responders' data represent approximately 97% of persons not associated with CalPERS or Medi-Cal with health insurance subject to state mandates( full-service (nonspecialty) DMHC-regulated plan enrollees and of full-service (nonspecialty) CDI-regulated policy enrollees). | Enrollment by:<br>• Size of firm (2–50 as small group and 51+ as large group)<br>• DHMC vs. CDI regulated<br>• Grandfathered vs. nongrandfathered<br><br>Premiums for individual policies by:<br>• DMHC vs. CDI regulated<br>• Grandfathered vs. nongrandfathered |

[26] CHBRP's authorizing statute, available at www.chbrp.org/docs/authorizing_statute.pdf, requires that CHBRP use a certified actuary or "other person with relevant knowledge and expertise" to determine financial impact.

| Data Source | Items |
|---|---|
| California Employer Health Benefits Survey, 2014 (conducted by NORC and funded by CHCF) | Enrollment by HMO/POS, PPO/indemnity self-insured, fully insured,<br>Premiums (not self-insured) by:<br>• Size of firm (3–25 as small group and 25+ as large group)<br>• Family vs. single<br>• HMO/POS vs. PPO/indemnity vs. HDHP employer vs. employer premium share |
| California Health Interview Survey (CHIS) | Uninsured, age: 65+<br>Medi-Cal (non-Medicare), age: 65+<br>Other public, age: 65+<br>Employer-sponsored insurance, age: 65+ |
| California Public Employees' Retirement System (CalPERS) data, enrollment as of October 1, 2015 | CalPERS HMO and PPO enrollment<br>• Age: 0–17; 18–64; 65+<br>• HMO premiums |
| California Simulation of Insurance Markets (CalSIM) (projections for 2017) | Uninsured, age: 0–17; 18–64<br>Medi-Cal (non-Medicare) (a), age: 0–17; 18–64<br>Other public (b), age: 0–64<br>Individual market, age: 0–17; 18–64<br>Small group, age: 0–17; 18–64<br>Large group, age: 0–17; 18–64 |
| Centers for Medicare and Medicaid (CMS) administrative data for the Medicare program, annually (if available) as of end of September | HMO vs. FFS distribution for those 65+ (noninstitutionalized) |
| PwC estimate | Medical trend influencing annual premium increases |

*Notes:* (*) CHBRP assumes DMHC-regulated PPO group enrollees and POS enrollees are in the large-group segment.

*Key:* CDI = California Department of Insurance; CHCF = California HealthCare Foundation; CHIS = California Health Interview Survey; CMS = Centers for Medicare & Medicaid Services; DHCS = Department of Health Care Services; DMHC = Department of Managed Health Care; FFS = fee-for-service; HMO = health maintenance organization; NORC = National Opinion Research Center; POS = point of service; PPO = preferred provider organization.

Further discussion of external and internal data follows.

### *Internal data*

- CHBRP's Annual Enrollment and Premium Survey collects data from the six largest providers of health insurance in California (including Aetna, Anthem Blue Cross of California, Blue Shield of California, CIGNA, Health Net, and Kaiser Foundation Health Plan,) to obtain estimates of enrollment not associated with CalPERS or Medi-Cal by purchaser (i.e., large and small group and individual), state regulator (DMHC or CDI), grandfathered and nongrandfathered status, and average premiums. CalSIM and market trends were applied to project 2017 health insurance enrollment in DMHC-regulated plans and CDI-regulated policies.

- CHBRP's other surveys of the largest plans/insurers collect information on benefit coverage relevant to proposed benefit mandates CHBRP has been asked to analyze. In each report, CHBRP indicates the proportion of enrollees—statewide and by market segment—represented by responses to CHBRP's bill-specific coverage surveys. The proportions are derived from data provided by CDI and DMHC.

### *External sources*

- California Department of Health Care Services (DHCS) data are used to estimate enrollment in Medi-Cal Managed Care (beneficiaries enrolled in Two-Plan Model, Geographic Managed Care, and County Operated Health System plans), which may be subject to state benefit mandates, as well as enrollment in Medi-Cal Fee For Service (FFS), which is not. The data are available at: www.dhcs.ca.gov/dataandstats/statistics/Pages/Monthly_Trend_Report.aspx.

- California Employer Health Benefits Survey data are used to make a number of estimates, including: premiums for employment-based enrollment in DMHC-regulated health care service plans (primarily health maintenance organizations [HMOs] and point of service [POS] plans) and premiums for employment-based enrollment in CDI-regulated health insurance policies regulated by the (primarily preferred provider organizations [PPOs]). Premiums for fee-for-service (FFS) policies are no longer available due to scarcity of these policies in California. This annual survey is currently released by the California Health Care Foundation/National Opinion Research Center (CHCF/NORC) and is similar to the national employer survey released annually by the Kaiser Family Foundation and the Health Research and Educational Trust. More information on the CHCF/NORC data is available at: www.chcf.org/publications/2014/01/employer-health-benefits.

- California Health Interview Survey (CHIS) data are used to estimate the number of Californians aged 65 and older, and the number of Californians dually eligible for both Medi-Cal and Medicare coverage. CHIS data are also used to determine the number of Californians with incomes below 400% of the federal poverty level. CHIS is a continuous survey that provides detailed information on demographics, health insurance coverage, health status, and access to care. More information on CHIS is available at: www.chis.ucla.edu.

- California Public Employees Retirement System (CalPERS) data are used to estimate premiums and enrollment in DMHC-regulated plans, which may be subject to state benefit mandates, as well as enrollment in CalPERS' self-insured plans, which is not. CalPERS does not currently offer enrollment in CDI-regulated policies. Data are provided for DMHC-regulated plans enrolling non-Medicare beneficiaries. In addition, CHBRP obtains information on current scope of benefits from evidence of coverage (EOC) documents publicly available at: www.calpers.ca.gov. California Simulation of Insurance Markets (CalSIM) estimates are used to project health insurance status of Californians aged 64 and under. CalSIM is a microsimulation model that projects the effects of the Affordable Care Act on firms and individuals. More information on CalSIM is available at: http://healthpolicy.ucla.edu/programs/health-economics/projects/CalSIM/Pages/default.aspx.

- To estimate the premium impact of certain mandates, PwC's projections may derive from its proprietary comprehensive pricing model, which provides benchmark data and pricing capabilities for commercial health plans. The pricing model factors in health plan features such as deductibles, copays, out-of-pocket maximums, covered services, and degree of health care management. The pricing model uses normative data and benefit details to arrive at estimates of allowed and net benefit costs. The normative benchmarking utilization metrics within the pricing model are developed from a database of commercial (under 65) health plan experience representing approximately 20 million annual lives.

- The MarketScan databases, which reflect the health care claims experience of employees and dependents covered by the health benefit programs of large employers, are used to estimate utilization and unit cost. These claims data are collected from insurance companies, Blue Cross Blue Shield plans, and third party administrators. These data represent the medical experience of insured employees and their dependents for active employees, early retirees, individuals with COBRA continuation coverage, and Medicare-eligible retirees with employer-provided Medicare Supplemental plans. No Medicaid or Workers Compensation data are included.
- Ingenix MDR Charge Payment System, which includes information about professional fees paid for health care services, based upon claims from commercial insurance companies, HMOs, and self-insured health plans.

## Projecting 2017

This subsection discusses adjustments made to CHBRP's Cost and Coverage Model to project 2017, the period when mandates proposed in 2016 would, if enacted, generally take effect. It is important to emphasize that CHBRP's analysis of specific mandate bills typically addresses the incremental effects of a mandate—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 the *Benefit Coverage, Utilization, and Cost Impacts* section of this report.

### *Baseline premium rate development methodology*

The key components of the baseline model for utilization and expenditures are estimates of the per member per month (PMPM) values for each of the following:

- Insurance premiums PMPM;
- Gross claims costs PMPM;
- Member cost sharing PMPM; and
- Health care costs paid by the health plan or insurer.

For each market segment, we first obtained an estimate of the insurance premium PMPM by taking the 2015 reported premium from the abovementioned data sources and trending that value to 2017. CHBRP uses trend rates published in the PwC's "Behind the Numbers" health care trend report to estimate the health care costs for each market segment in 2017.

The large-group market segments for each regulator (CDI and DMHC) are split into grandfathered and nongrandfathered status. For the small-group and individual markets, further splits are made to indicate association with Covered California, the state's health insurance marketplace. Doing so allows CHBRP to separately calculate the impact of ACA and of specific mandates, both of which may apply differently among these subgroups. The premium rate data received from the CHCF/NORC California Employer Health Benefits survey did not split the premiums based on grandfathered or exchange status. However, CHBRP's Annual Enrollment and Premium (AEP) survey asked California's largest health care service plans and health insurers to provide their average premium rates separately for grandfathered and nongrandfathered plans. The ratios from the CHBRP survey data were then applied to the CHCH/NORC aggregate premium rates for large and small group, to estimate premium rates for grandfathered and nongrandfathered plans that were consistent with the NORC results. For the individual market, the premium rates received from CHBRP's AEP survey were used directly.

The remaining three values were then estimated by the following formulas:

- Health care costs paid by the health plan = insurance premiums PMPM × (1 − profit/administration load);
- Gross claims costs PMPM = health care costs paid by the health plan ÷ percentage paid by health plan; and
- Member cost sharing PMPM = gross claims costs × (1 − percentage paid by health plan).

In the above formulas, the quantity "profit/administration load" is the assumed percentage of a typical premium that is allocated to the health plan/insurer's administration and profit. These values vary by insurance category, and under the ACA, are limited by the minimum medical loss ratio requirement. CHBRP estimated these values based on actuarial expertise at PwC, and their associated expertise in health care.

In the above formulas, the quantity "percentage paid by health plan" is the assumed percentage of gross health care costs that are paid by the health plan, as opposed to the amount paid by member cost sharing (deductibles, copays, etc.). In ACA terminology, this quantity is known as the plan's "actuarial value." These values vary by insurance category. For each insurance category, estimated the member cost sharing for the average or typical plan in that category is based on the actuarial value of the plan. For "metal tier" plans, the average cost share is calculated as 100% minus the plan actuarial value. For non-"metal tier" plans, Milliman estimated the actuarial value using the Milliman Health Cost Guidelines to estimate the percentage of gross health care costs that are paid by the carrier.

## General Caveats and Assumptions

This subsection discusses the general caveats and assumptions relevant to all CHBRP reports. The projected costs are estimates of costs that would result if a certain set of assumptions were exactly realized. Actual costs will differ from these estimates for a wide variety of reasons, including:

- Prevalence of mandated benefits before and after the mandate may be different from CHBRP assumptions.
- Utilization of mandated benefits (and, therefore, the services covered by the benefit) before and after the mandate may be different from CHBRP assumptions.
- Random fluctuations in the utilization and cost of health care services may occur.

Additional assumptions that underlie the cost estimates presented in this report are:

- Cost impacts are shown only for plans and policies subject to state benefit mandate laws.
- Cost impacts are only for the first year after enactment of the proposed mandate.
- Employers and employees will share proportionately (on a percentage basis) in premium rate increases resulting from the mandate. In other words, the distribution of the premium paid by the subscriber (or employee) and the employer will be unaffected by the mandate.
- For state-sponsored programs for the uninsured, the state share will continue to be equal to the absolute dollar amount of funds dedicated to the program.
- When cost savings are estimated, they reflect savings realized for 1 year. Potential long-term cost savings or impacts are estimated if existing data and literature sources are available and provide adequate detail for estimating long-term impacts. For more information on CHBRP's criteria for

estimating long-term impacts, please see: www.chbrp.org/analysis_methodology/docs/longterm_impacts08.pdf.

There are other variables that may affect costs, but which CHBRP did not consider in the estimates presented in this report. Such variables include, but are not limited to:

- Population shifts by type of health insurance: If a mandate increases health insurance costs, some employer groups and individuals may elect to drop their health insurance. Employers may also switch to self-funding to avoid having to comply with the mandate.
- Changes in benefits: To help offset the premium increase resulting from a mandate, deductibles or copayments may be increased. Such changes would have a direct impact on the distribution of costs between health plans/insurers and enrollees, and may also result in utilization reductions (i.e., high levels of cost sharing result in lower utilization of health care services). CHBRP did not include the effects of such potential benefit changes in its analysis.
- Adverse selection: Theoretically, persons or employer groups who had previously foregone health insurance may elect, postmandate, to enroll in a health plan or policy because they perceive that it is now to their economic benefit to do so.
- Medical management: Health plans/insurers may react to the mandate by tightening medical management of the mandated benefit. This would tend to dampen the CHBRP cost estimates. The dampening would be more pronounced on the plan/policy types that previously had the least effective medical management (i.e., PPO plans).
- Geographic and delivery systems variation: Variation exists in existing utilization and costs, and in the impact of the mandate, by geographic area and by delivery system models. Even within the health insurance plan/policy types CHBRP modeled (HMO, including HMO and POS plans, and non-HMO, including PPO and FFS policies), there are likely variations in utilization and costs. Utilization also differs within California due to differences in the health status of the local population, provider practice patterns, and the level of managed care available in each community. The average cost per service would also vary due to different underlying cost levels experienced by providers throughout California and the market dynamic in negotiations between providers and health plans/insurers. Both the baseline costs prior to the mandate and the estimated cost impact of the mandate could vary within the state due to geographic and delivery system differences. For purposes of this analysis, however, CHBRP has estimated the impact on a statewide level.
- Compliance with the mandate: For estimating the postmandate impacts, CHBRP typically assumes that plans and policies subject to the mandate will be in compliance with the benefit coverage requirements of the bill. Therefore, the typical postmandate coverage rates for persons enrolled in health insurance plans/policies subject to the mandate are assumed to be 100%.

## Analysis Specific Caveats and Assumptions

This subsection discusses the caveats and assumptions relevant to specifically to an analysis of AB 1954:

- The 2014 MarketScan Commercial Claims and Encounters Database procedure and ICD-9 diagnosis codes used to define Reproductive Health Services were identified by a content expert and supplemented by external research.
- Reproductive and Sexual Health Care Services were categorized into two service groups:

  - Prevention or Treatment of Pregnancy including treatment regarding an alleged rape or assault and abortions and including Counseling Services related to pregnancy treatment or prevention, but excluding long term treatments such as pre-natal care
  - Prevention or Treatment of sexually transmitted diseases, including testing for HIV and Hepatitis A, B and C and including Counseling Services related to sexually transmitted diseases treatment or prevention, but excluding prescription drugs or injectable medications and treatment for long-term conditions such as HIV and Hepatitis C

- Medi-Cal plans would be excluded from this mandate. Consequently, 73% of total enrollees with health insurance subject to state level benefit mandates will be subject to AB 1954.
- The 2014 MarketScan Commercial Claims and Encounters Database was segregated into two age groups, 15-17 Years old and 18 Years and Over (18-64), and were further categorized into services performed by in network providers and out of network providers based on designations within the MarketScan database. These age groups were selected for consistency with the population age bands (0-17, 18-64, 65+) used by CalSIM which underlie the CHBRP cost model.
- Using data output from the 2014 MarketScan Commercial Claims and Encounters Database, claims were divided into: in network and OON services, and by age 15–17 and age 18–64. The total units of services, allowed costs, and total cost sharing were calculated by service category for each combination of in/out of network and age grouping.
- Based on California MarketScan data, 30% of enrollees Age 15-17 and 43% of enrollees Age 18-64 use reproductive health services. In the aggregate, 33% of California enrollees age 15 and over used reproductive health services in 2014.
- Baseline cost was trended at a 2.1% annual rate of increase from 2014 to 2017 based on the 2015 medical CPI rate. No trend was applied to the utilization of reproductive health services.
- CHBRP assumed that 100% of enrollees with coverage subject to AB 1954 have coverage for In-Network Reproductive Health Services pre and post mandate.
- Since HMOs are under-represented in the MarketScan data, research was performed to estimate HMO market share in California so that the magnitude of potential shifts from in-network to OON services could be more accurately estimated. California market share by plan type was obtained from a January 2016 California Healthcare Foundation reference document ”California Health Insurers, Enrollment.” To develop the baseline data for Reproductive Health Services, CHBRP used the MarketScan data to separately develop in-and OON utilization, unit costs, and cost sharing by plan type. The MarketScan data indicated that 1.3% of Reproductive Health Services are received OON in HMOs and 3.2% are received OON in PPOs. The HMO and PPO data were weighted together using the California market share by plan type resulting in average OON utilization of 1.8%.
- CHBRP assumed that OON average unit cost and average cost share of services that shifted from in network to OON would be equivalent to the In-network amounts, and that enrollees would be responsible for enrollee charges in excess of in network reimbursement in addition to the cost share. OON charges were assumed to be 150% of in-network unit costs. CHBRP also assumed that the mix of services shifting to OON would be comparable to the mix of services performed at network providers premandate rather than the more limited set of services performed OON premandate.
- Postmandate, CHBRP assumed that all plan types will have OON utilization for reproductive health services at a level similar to the PPO premandate level. Utilization and cost impacts were

modeled by shifting utilization from in network to OON so that the percentage of reproductive health services performed OON equaled the PPO average of 3.2%. In-network unit costs and cost sharing were applied to the services that were assumed to shift to OON, and enrollee costs due to balance billing for services performed by OON providers were modeled.

- Postmandate, CHBRP estimates that the impact of AB 1954 will be:
  - Out-of-network utilization (units per 1,000 covered enrollees) increases for both prevention or treatment of pregnancy and prevention or treatment of sexually transmitted diseases due to the increased availability of OON coverage for reproductive health services. In-network utilization is assumed to decrease from the shift to OON services. In aggregate, there is no estimated change in utilization post mandate.
  - Average unit cost for services provided in network are not expected to change postmandate nor are OON average unit costs expected to change. However, because services are assumed to shift to OON, which, based on MarketScan data, are generally higher in cost, the overall average unit cost could increase. However, the increase in average unit cost could be limited if plans pay the same as in network and allow the provider to balance bill enrollees.

## Determining Public Demand for the Proposed Mandate

This subsection discusses public demand for the benefits (AB) 1954 would mandate. Considering the criteria specified by CHBRP's authorizing statute, CHBRP reviews public demand for benefits relevant to a proposed mandate in two ways. CHBRP:

- Considers the bargaining history of organized labor; and
- Compares the benefits provided by self-insured health plans or policies (which are not regulated by the DMHC or CDI and therefore not subject to state-level mandates) with the benefits that are provided by plans or policies that would be subject to the mandate.

On the basis of conversations with the largest collective bargaining agents in California, CHBRP concluded that unions currently do not include cost sharing arrangements for access to OON Reproductive and Sexual Health Services in their health insurance negotiations. In general, unions negotiate for broader contract provisions such as coverage for dependents, premiums, deductibles, and broad coinsurance levels.

Among publicly funded self-insured health insurance policies, the preferred provider organization (PPO) plans offered by CalPERS currently have the largest number of enrollees. CHBRP does not have sufficient information to determine the impact on the CalPERS PPOs.

To further investigate public demand, CHBRP used the bill-specific coverage survey to ask carriers who act as third-party administrators for (non-CalPERS) self-insured group health insurance programs whether the relevant benefit coverage differed from what is offered in group market plans or policies that would be subject to the mandate. CHBRP does not have sufficient responses to determine differences.

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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, PricewaterhouseCoopers, 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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The California Health Benefits Review Program is administered by UC Health at the University of California, Office of the President. UC Health is led by John D. Stobo, MD, Executive Vice President.

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A group of faculty and staff undertakes most of the analysis that informs reports by the California Health Benefits Review Program (CHBRP). The CHBRP Faculty Task Force comprises rotating representatives from six University of California (UC) campuses. In addition to these representatives, there are other ongoing contributors to CHBRP from UC. This larger group provides advice to the CHBRP staff on the overall administration of the program and conducts much of the analysis.

CHBRP staff coordinates the efforts of the Faculty Task Force, works with Task Force members in preparing parts of the analysis, and coordinates all external communications, including those with the California Legislature.

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CHBRP assumes full responsibility for the report and the accuracy of its contents. All CHBRP bill analyses and other publications are available at www.chbrp.org.

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