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.

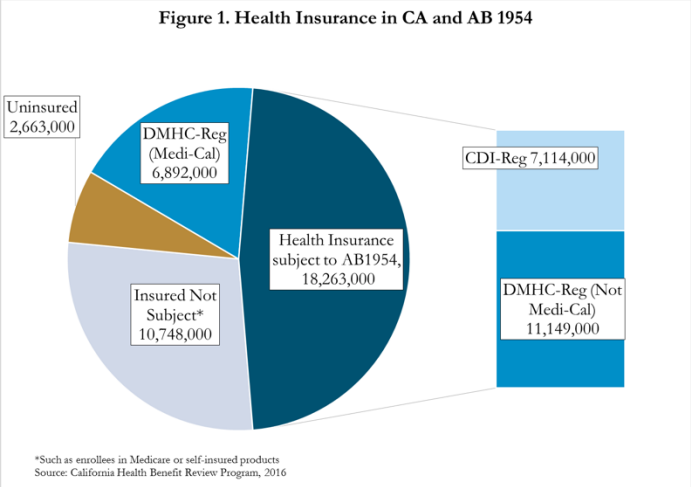
INCREMENTAL IMPACT OF ASSEMBLY BILL (AB) 1954

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.