Key Findings

Analysis of California Assembly Bill 1645
Health Care Coverage: Cost Sharing

Summary to the 2023–2024 California State Legislature, April 19, 2023

CALIFORNIA HEALTH BENEFITS REVIEW PROGRAM

AT A GLANCE

For commercial/CalPERS enrollees in plans and policies regulated by California Department of Managed Health Care (DMHC) or California Department of Insurance (CDI), AB 1645 would prohibit cost sharing and make other requirements for coverage of recommended sexually transmitted infection (STI) screening. For enrollees in nongrandfathered plans and policies, AB 1645 would also prohibit cost sharing for office visit and related services for other recommended preventive services

Benefit Coverage: At baseline, 0% of commercial/CalPERS enrollees have benefit coverage fully compliant with the requirements of AB 1645 with regard to STIs and cost sharing and only 18% have insurance that is fully compliant with the requirements of AB 1645 with regard to being able to see an out-of-network (OON) provider without prior authorization. Postmandate, 100% would. At baseline, 99% of commercial/CalPERS enrollees have coverage fully compliant with the requirements of AB 1645 regarding other preventive services. Postmandate, 100% would.

Medical Effectiveness: The recommended preventive services and STI screenings have *clear and convincing* evidence of medical effectiveness.

Cost and Health Impacts[1]: STI screening for through use of home test kits, through in-network providers, and through out-of-network providers would increase, as would treatments. Use of other preventive services would also increase. AB 1645 would increase total net annual expenditures by $20,065,000 (0.0136%). As effective screening and treatments are available, STI transmission would decline, leading to improved health outcomes. As other preventive services are medically effective, other health outcomes would also improve.

CONTEXT

Sexually transmitted infection (STI) screening is commonly recommended for

- Chlamydia
- Gonorrhea
- Syphilis
- Hepatitis B and C
- Human immunodeficiency virus (HIV)
- Human papillomavirus (HPV)

Recommendations vary as to which groups of persons should be screened and as to how often screenings should occur.

In addition to STI screenings, preventive services that are commonly recommended include:

- Screening to detect cancer
- Counseling to reduce risky behaviors
- Contraception to prevent pregnancy
- Services to promote healthy pregnancy and postpartum period
- Well baby and well child check-ups
- Vaccinations against disease
- Prevention of cardiovascular disease
- Tests to detect chronic diseases
- Screening for mental health conditions

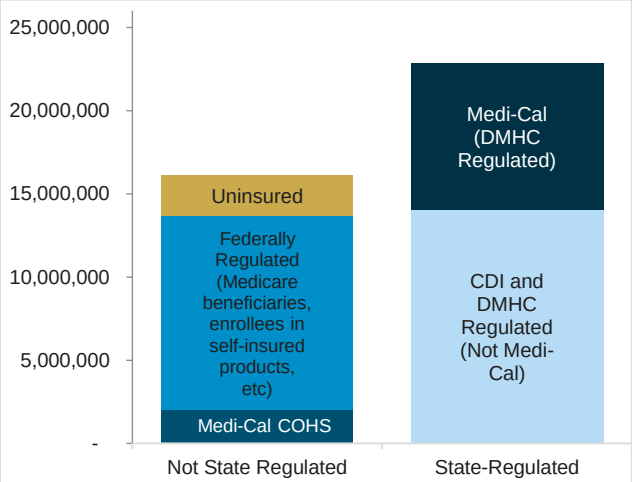
As is the case for STI screening, these recommendations may not be for applicable for all people. For example, cancer screening recommendations vary by gender, age, and other risk factors.

Of the 14,025,000 commercial/CalPERS enrollees in plans and policies regulated by California Department of Managed Health Care (DMHC) or California Department of Insurance (CDI), approximately 938,000 (7%) are in a plan or policy with grandfathered[2] status.

[1] Similar cost and health impacts could be expected for the following year, though possible changes in medical science and other aspects of health make stability of impacts less certain as time goes by.

[2] A grandfathered health plan is "a group health plan that was created – or an individual health insurance policy that was purchased – on or before March 23, 2010. Plans or policies may lose their 'grandfathered' status if they make certain significant changes that reduce benefits or increase costs to consumers." Available at: www.healthcare.gov/glossary/grandfathered-health-plan.

Figure A. Health Insurance in CA



Source: California Health Benefits Review Program, 2023.

BILL SUMMARY

As well as addressing coverage for other recommended preventive services, the California Preventive Services addresses STI screenings recommended by the United States Preventive Services Task Force (USPSTF). For commercial/CalPERS enrollees in nongrandfathered plans and policies regulated by DMHC or CDI, SB 1645 would alter the current California Preventive Services mandate to:

- Make compliance in no less than 90 days required for modified or upgraded preventive service recommendations.
- Prohibit the application of cost sharing for coverage of office visits and/or any item or service associated with provision of the referenced preventative items and services.
- Specify required compliance with existing California mandates that also address preventive services.

For commercial/CalPERS enrollees in grandfathered and nongrandfathered plans and policies regulated by DMHC or CDI, SB 1645 would create a new Sexually Transmitted Infections (STI) Screening mandate, which would:

- Prohibit cost sharing for STI screenings recommended by the Centers for Disease Control and Prevention (CDC); and
- Require coverage without utilization management for such screenings when accessed through any provider on Covered California's list of Essential Community Providers,[3] and require those providers to be reimbursed at the median contracted rate in the geographic area.

As previously noted, recommendations can vary by gender, age, and other risk factors. The addition of the CDC recommendations to the USPSTF recommendations would expand the risk groups covered for the following STIs:

1. Screening for **chlamydia** and **gonorrhea** for men who have sex with men (MSM), MSM on PrEP,[4] with HIV infection, or with multiple partners (every 3 to 6 months); transgender and gender diverse: consider screening at rectal site based on behaviors and exposure.
2. Screening for **syphilis** for transgender and gender diverse people at least annually
3. Screening for **hepatitis B** for women with >1 sex partner in the previous 6 months
4. Annual screening for **hepatitis C** for in MSM with HIV infection
5. **HIV** screening for transgender persons
6. Digital anorectal screening for **HPV** for MSM

The California Preventive Services mandate (as AB 1645 would alter it) specifies that deductibles remain applicable for enrollees in health savings account (HSA) qualified high deductible health plan (HDHP) if not applying the deductible would disqualify the plan as a federally recognized HSA-HDHP. AB 1645 includes the same specification in the new STI Screening mandate.

ANALYTIC APPROACH AND KEY ASSUMPTIONS

Although for this analysis, CHBRP has assumed that:

- Both mandates would allow billing for an office visit if services other than preventive services were delivered.
- The new STI Screening mandate, like the altered Preventive Services mandate, would require compliance connected to new STI screening recommendations in 1 year or less after publication of the recommendation and requiring compliance

[3]Covered California's Consolidated Essential Community Provider List. https://hbex.coveredca.com/stakeholders/plan-management/ecp-list/.

[4] PrEP (pre-exposure prophylaxis) is a long-term drug regimen recommended to prevent HIV infection in populations that have repeated, intimate exposure to HIV-positive individuals or other high-risk individuals of unknown HIV status. Recommended screening is 3 months for individuals on PrEP.

connected to modified or upgraded STI screening recommendations in 90 days or less.

IMPACTS

Medical Effectiveness

Based on the recommendations from the four entities referenced by the California Preventive Services mandates – as well as recommendations from the CDC – CHBRP considers all of the recommended preventive services and STI screenings to have *clear and convincing* evidence of medical effectiveness.

Although CHBRP found *insufficient* evidence that the prohibition of cost sharing would substantially impact utilization, this conclusion is based on a generalized summary across a variety of preventive services. The body of literature on this topic is of a widely varied nature with regard to both the preventive services of focus, and the quality of the research. The findings also differ considerably with regard to the specific preventive services with some finding more consistent utilization increases than others.

Benefit Coverage, Utilization, and Cost

Benefit Coverage – STIs

For STI screening, at baseline, 0% of the 14 million commercial/CalPERS enrollees have insurance that is fully compliant with the requirements of AB 1645 with regard to cost sharing and only 18% have insurance that is fully compliant with the requirements of AB 1645 with regard to being able to see an out-of-network (OON) provider without prior authorization. Postmandate, all commercial/CalPERS enrollees would have benefit coverage compliant with the STI Screening mandate AB 1645 would create.

Utilization – STIs

CHBRP estimates 25% of all STI testing and treatment is done on a self-pay basis among insured enrollees at baseline and postmandate due to privacy preferences. Thus, 75% are purchased with insurance, and only this subset will experience changes due to removal of cost-sharing and prior authorization. However, this is an overall estimate and varies across the following categories. Each is explained below.

CHBRP estimates that home test kits are used for approximately 10% of all STI tests. CHBRP also estimates that home tests kits are disproportionately preferred by individuals who wish to remain anonymous, such that, among commercial/CalPERS enrollees, 75% of home test kits are purchased by enrollees without using insurance benefits. Thus, 25% of home test kits are purchased using insurance benefits. Given this estimate regarding the proportion of enrollees who prefer testing anonymity, the removal of cost sharing and prior authorization will only impact the baseline 25% of home kits purchased with insurance, increasing utilization by 2.7%.

Among commercial/CalPERS enrollees, utilization management testing limits for STI screening from in-network (INN) providers occurs for <1% of enrollees. Thus, the postmandate impact is the combined effect of the removal of cost sharing and removal of these testing limits, where the relevant expansion of risk groups is based on the most recent CDC STI screening recommendations, and where the size of each risk group in California is based on estimates from the California Health Interview Survey. In addition, CHBRP estimates 3% of INN covered screening will move to OON covered screening. This will result in a net increase in utilization of 0.52%.

Approximately 82% of commercial/CalPERS enrollees are subject to prior authorization before STI screening by an OON is covered (in other words, 18% of enrollees have benefits that do not require prior authorization). The removal of prior authorization and frequency limits combined with the removal of cost sharing will result in an increase of covered STI screening through OON providers increasing by 22%.

AB 1645 will not significantly change the proportion of individuals who choose to remain anonymous regarding STI screening and thus do not use insurance benefits to obtain STI screening. Enrollees making this choice are likely to use essential community providers. However, these enrollees are largely unlikely to use the expanded coverage mandated by AB 1645, as doing so would remove their anonymity.

The primary purpose of STI screening is to identify and treat new STI cases, which both helps the infected person and decreases the spread of the disease. Evidence suggests that not all who test positive for STIs go on to get treatment. CHBRP has assumed an increase in STI screening due to AB 1645 would increase treatment for HIV, hepatitis C, and all other STIs. For HIV and hepatitis C, due to the lower prevalence of disease, treatment is not expected to increase to the same degree as for other STIs. Given the wider spread of HIV testing programs, the likelihood of finding a new positive due to increased testing due to this bill is smaller than that for hepatitis C, which is not as widely tested.

Benefit Coverage – Other Preventive Services

For preventive services other than STI screening, at baseline, 99% of commercial/CalPERS enrollees in nongrandfathered plans or policies have coverage fully compliant with the requirements AB 1645 would create through an altered California Preventive Services mandate. Postmandate, all commercial/CalPERS enrollees in nongrandfathered plans or policies would have benefit coverage compliant with AB 1645.

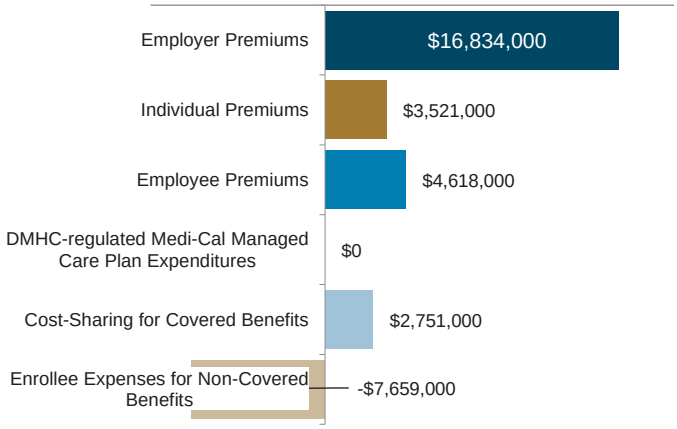
Utilization – Other preventive Services

Use of other preventive services by commercial/CalPERS enrollees is expected to increase by 0.06%. There are too many integral services to list, but examples include administration of the flu vaccine; administration of, and associated lab tests that precede, a colonoscopy; etc.

Expenditures

AB 1645 would increase total net annual expenditures by $20,065,000, or 0.0136%, for enrollees with DMHC-regulated plans and CDI-regulated policies.

Figure B. Expenditure Impacts of AB 1645



Source: California Health Benefits Review Program, 2023.

As cost sharing is prohibited for STI screening but is not prohibited for STI treatments, and as increased screening would result in more treatment, there would be a net increase in cost sharing.

Public Health

In the first year postmandate, CHBRP estimates an additional 116,300 tests will be conducted to screen for STIs and that an additional 93,000 treatments for STIs including HIV will be delivered. As there is clear and convincing evidence that there are STI screening and treatments that are medically effective at identifying and treating STIs, disease transmission is expected to decline, leading to improved health outcomes.

In the first-year post-mandate, CHBRP estimates an additional approximately 15,704 other preventive services will be provided. There is clear and convincing evidence that there are preventive services that are medically effective at improving health and preventing disease. Therefore, it is estimated that health outcomes will improve overall as a result of AB 1645.

Long-Term Impacts

AB 1645 would increase utilization of STI screening, STI treatment, and other preventive services. Therefore, projected long-term public health impacts may include a reduction in future STI transmissions (such as a reduction in the prevalence of syphilis leading to a reduction in congenital syphilis leading to a subsequent reduction in the number of overall adverse health outcomes among both mother and infant in the long-term), and an overall reduction in downstream effects such as impact on premature death and economic loss. Long-term impacts from increased other preventive services is expected as well such as potential increases in counseling related to smoking cessation leading to a reduction of lung cancer in the long-term or potential increases in HPV vaccinations leading to a reduction in cervical cancer in the future.