California Health Benefits Review Program

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

A Report to the 2023–2024 California State Legislature

April 19, 2023

CALIFORNIA
HEALTH BENEFITS REVIEW PROGRAM

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

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

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, 93.2% 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 $35,795,000 (0.02%). 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

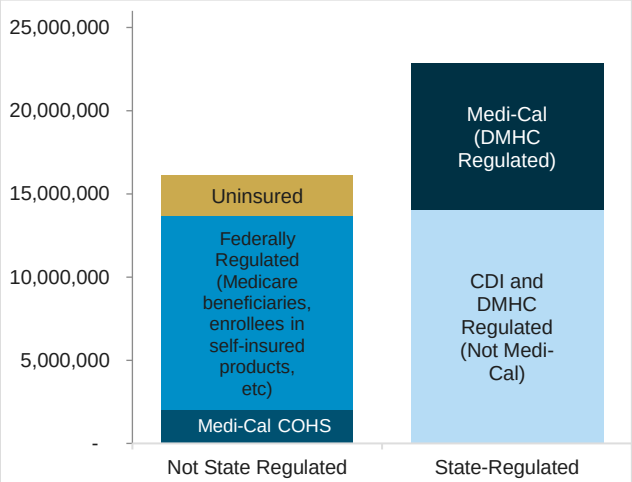
As is the case for STI screening, these recommendations may not be for applicable for all people. For example, cancer screening recommendations vary by gender, age, and other risk factors.

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 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 are 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

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 AB 1645.

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 kids 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

At baseline, 92.7% of commercial/CalPERS enrollees have coverage fully compliant with the requirements of AB 1645. Postmandate, all commercial/CalPERS enrollees would have benefit coverage compliant with AB 1645.

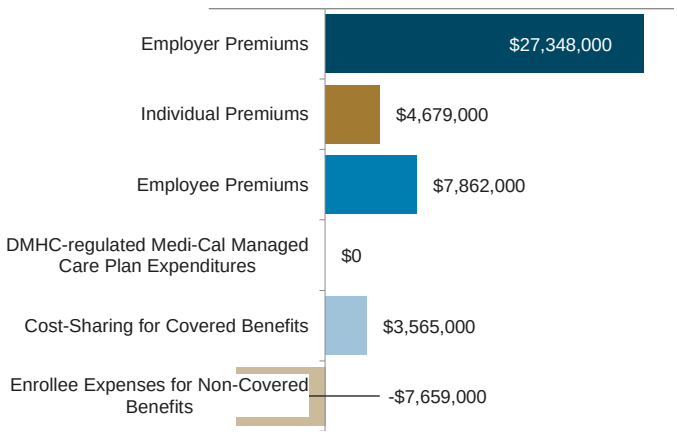
Utilization – Other preventive Services

Use of other preventive services by commercial/CalPERS enrollees is expected to increase by 0.39%. 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 $35,795,000, or 0.02%, for enrollees with DMHC-regulated plans and CDI-regulated policies. This is due to an increase in total health insurance premiums paid by employers and enrollees for newly covered benefits, adjusted by a net decrease in cost sharing and enrollee expenses for noncovered benefits.

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 116,400 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 both STI screening (117,200 tests), STI treatment (92,900 treatments), and other preventive services (116,000 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.

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

An analytic staff based at the University of California, Berkeley, supports a task force of faculty and research staff from multiple University of California campuses 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. 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, authorizing statute, as well as all CHBRP reports and other publications, are available at www.chbrp.org.

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Table 1. Impacts of AB 1645 on Benefit Coverage, Utilization, and Cost, 2024

	Baseline (2024)	Postmandate Year 1 (2024)	Increase/ Decrease	Change Postmandate
Benefit Coverage				
Total enrollees with health insurance subject to state-level benefit mandates (a)	22,842,000	22,842,000	0	0.00%
Total enrollees with health insurance subject to AB 1645 re STIs	14,025,000	14,025,000	0	0.00%
Total enrollees with OON benefits with no prior authorization requirement	3,069,496	14,025,000	10,955,504	356.92%
Total commercial/CalPERS enrollees with health insurance fully compliant re STIs and cost sharing	0	14,025,000	14,025,000	0.00%
Totally commercial/CalPERS enrollees with health insurance fully compliant re STIs and OON screening/tests	0	14,025,000	14,025,000	0.00%
Total commercial/CalPERS enrollees with health insurance subject to AB 1645 re other preventive services	14,025,000	14,025,000	0	0.00%
Total commercial/CalPERS enrollees with health insurance fully compliant re other preventive services	13,068,302	14,025,000	956,698	7.32%
Utilization and Cost				
STI screening utilization per 1,000 enrollees:				
Home test kits				
Self-pay (b)	131.8	131.8	—	0.00%
Covered	43.9	45.1	1.19	2.70%
INN screening/tests				
Self-pay (b)	—	—	—	0.00%
Covered	1,172.5	1,178.6	6.1	0.52%
OON screening/tests				
Self-pay (b)	396.2	393.7	-2.5	−0.62%
Covered	16.1	19.6	3.5	22.07%
STI treatment (excluding HIV and hepatitis C) (g)				
Self-pay (b)	83.6	77.6	-6.1	−7.27%
Covered	250.9	263.6	12.6	5.04%
HIV treatment (for antiretroviral treatment, not prevention) (g)	27.6	27.7	0.1	0.21%
Hepatitis C treatment (per 8-week treatment cycle) (g)	0.5	0.5	0.0	0.90%
Average unit costs				
Home test kits				
Self-pay (b)	$44.86	$44.86	$0.00	0.00%

Covered	$40.70	$40.70	$0.00	0.00%
INN screening				
Self-pay (b)	$40.70	$40.70	$0.00	0.00%
Covered	$40.70	$40.70	$0.00	0.00%
OON screening				
Self-pay (b)	$44.86	$44.86	$0.00	0.00%
Covered	$44.86	$40.70	-$4.15	−9.26%
STI treatment (excluding HIV and hepatitis C) (g)				
Self-pay (b)	$71.57	$71.57	$0.00	0.00%
Covered	$71.57	$71.57	$0.00	0.00%
HIV treatment (monthly drug cost for antiretroviral treatment, not prevention) (g)	$2,078	$2,078	$0.00	0.00%
Hepatitis C treatment (per 8-week treatment cycle) (g)	$26,445	$26,445	$0.00	0.00%
Other preventive services utilization and average unit cost				
Other preventive service utilization per 1000 enrollees	2,125.8	2,134.1	8.3	0.39%
Preventive service average unit cost	$157.12	$157.02	-$0.09	−0.06%
Expenditures				
Premiums				
Employer-sponsored (b)	$57,647,993,000	$57,674,328,000	$26,335,000	0.05%
CalPERS employer (c)	$6,158,262,000	$6,159,275,000	$1,013,000	0.02%
Medi-Cal (excludes COHS) (d)	$29,618,383,000	$29,618,383,000	$0	0.00%
Enrollee premiums (expenditures)				
Enrollees, individually purchased insurance	$21,229,233,000	$21,233,912,000	$4,679,000	0.02%
Outside Covered California	$4,867,955,000	$4,870,138,000	$2,183,000	0.04%
Through Covered California	$16,361,278,000	$16,363,774,000	$2,496,000	0.02%
Enrollees, group insurance (e)	$18,263,775,000	$18,271,637,000	$7,862,000	0.04%
Enrollee out-of-pocket expenses				
Cost sharing for covered benefits (deductibles, copayments, etc.)	$13,857,141,000	$13,860,706,000	$3,565,000	0.03%
Expenses for noncovered benefits (f) (g)	$416,143,000	$408,484,000	−$7,659,000	−1.84%
Total expenditures	$147,190,930,000	$147,226,725,000	$35,795,000	0.02%

Source: California Health Benefits Review Program, 2023.

Notes: (a) Enrollees in plans and policies regulated by DMHC or CDI aged 0 to 64 years as well as enrollees 65 years or older in employer-sponsored health insurance. This group includes commercial enrollees (including those associated with Covered California or CalPERS) and Medi-Cal beneficiaries enrolled in DMHC-regulated plans.

(b) Some portion of self-pay testing and treatments may be provided for free via community STI clinics that typically provide free testing, although treatments for HIV and HCV are generally too expensive to be free.

(c) Includes only CalPERS enrollees in DMHC-regulated plans. Approximately 51.1% are state retirees, state employees, or their dependents. About one in five (22.5%) of these enrollees has a pharmacy benefit not subject to DMHC. CHBRP has projected no impact for those enrollees. However, CalPERS could, postmandate, require equivalent coverage for all its members (which could increase the total impact on CalPERS).

(d) Includes only Medi-Cal beneficiaries enrolled in DMHC-regulated plans. In addition, CHBRP is estimating it seems likely that there would also be a proportional increase of $0 million for Medi-Cal beneficiaries enrolled in COHS managed care.
(e) Enrollee premium expenditures include contributions by enrollees to employer (or union or other organization)-sponsored health insurance, health insurance purchased through Covered California, and any contributions to enrollment through Medi-Cal to a DMHC-regulated plan.
(f) Includes only expenses paid directly by enrollees (or other sources) to providers for services related to the mandated benefit that are not covered by insurance at baseline. 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.
(g) Some (or some portion) of STI medication may be covered through Drug Medi-Cal or through the Family Planning, Access, Care, and Treatment (PACT) program. For this analysis, the relevant medications were assumed to be covered by the Med-Cal beneficiary's DMHC-regulated plan.
Key: CalPERS = California Public Employees' Retirement System Health Maintenance Organizations; CDI = California Department of Insurance; COHS = County Operated Health Systems; DMHC = Department of Managed Health; INN = in-network; OON = out-of-network; STI = sexually transmitted infection.

POLICY CONTEXT

The California Assembly Committee on Health has requested that the California Health Benefits Review Program (CHBRP)5 conduct an evidence-based assessment of the medical, financial, and public health impacts of AB 1645, Preventive Services and Cost Sharing.

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 grandfathered6 status.7

SB 1645 would alter a current benefit mandate and add new one.

Under the current California Preventive Services mandate8:

- For commercial/CalPERS enrollees in nongrandfathered CDI-regulated policies and DMHC-regulated plans:
  - The application of cost sharing to coverage for preventative items and services recommended by the United States Preventive Services Task Force (USPSTF), Advisory Committee on Immunization Practices (ACIP), or Health Resources and Services Administration (HRSA) is prohibited – beginning in the plan or policy year that follows publication of the recommendation.
  - Application of a deductible is allowed 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.

SB 1645 would alter the California Preventive Services mandate to:

- Make compliance in no less than 90 days required for modified or upgraded preventive service recommendations (but would not alter the timing requirements for new 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.[9]

SB 1645 would create a new Sexually Transmitted Infections (STI) Screening mandate, which would:

- For commercial/CalPERS enrollees in all CDI-regulated policies and DMHC-regulated plans grandfathered and nongrandfathered:
  - Prohibit the application of cost sharing to coverage for STI screening – unless not applying the deductible for an enrollee in an HSA-HDHP would disqualify the plan as a federally recognized HSA-HDHP.

[5] CHBRP's authorizing statute is available at www.chbrp.org/about_chbrp/faqs/index.php.
[6] 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.
[7] See CHBRP's resource *Sources of Health Insurance in California*, available at https://www.chbrp.org/other-publications/resourceshttps://www.chbrp.org/other-publications/resources.
[8] Preventive Services mandate HSC 1367.002 and INS 10112.2.
[9] HIV Prophylaxis mandate HSC 1342.74 and INS 10123.1933; STI mandate HSC 1367.0021 and INS 10112.20; STIs Home Test Kits mandate HSC 1367.34 and INS 10123.208; Colorectal Cancer Screening mandate HSC 1367.668 and 10123.207; Contraceptives mandate HSC 1367.25 and INS 10123.196.

- add the CDC STI screening recommendations to this list of preventive services referenced in coverage mandates in California Prohibit cost sharing for coverage for STI screenings or any related items or services, regardless of:
  - The location or method of sample collection or processing, including at locations that are both clinical and nonclinical in nature, regardless of whether a location constitutes a health care setting.
  - The screening test, testing method or algorithm, or method of sample collection or processing.
  - The identity or qualifications of the individual who collected or processed a sample.
  - The clinical circumstances of screening, including whether or not a screening was based on risk of infection, or there was an emergent or urgent need for immediate or prompt screening or the results of screening.
- When accessed through an essential community provider listed on the California Health Benefit Exchange's Essential Community Provider List,[10] or when accessed through an in-network (INN) provider, prohibit, for coverage of STI screenings and for any related items:
  - Prior authorization or other utilization review requirements
  - Limits on frequency, method, treatment, or setting
  - Limits on confirmatory or post-treatment retesting of an asymptomatic patient
  - Limits based on risk of infection, sexual behavior, sexual orientation, gender, or anatomical sites of screening.
  - Any other limits on the coverage or provision of sexually transmitted infections screening as a preventive item or service under this section or other mandates related to STI screening,[11] or that constitutes a discriminatory benefit design or marketing practice as prohibited by this chapter.
- Require that out-of-network (OON) essential community providers be reimbursed at the median contracted rate in the general geographic region

The full text of AB 1645 can be found in Appendix A.

Appendix D provides an overview of the cost-sharing and utilization management, which are addressed by AB 1645.

Relevant Populations

If enacted, AB 1645 would apply to the health insurance of approximately 14,026.000 enrollees (36% of all Californians). This represents 44% of the 22.8 million Californians who will have health insurance regulated by the state that may be subject to any state health benefit mandate law, which includes health insurance regulated by the California Department of Managed Health Care (DMHC) or the California Department of Insurance (CDI). If enacted, the law would apply to the health insurance of enrollees in

[10] Covered California's Consolidated Essential Community Provider List. https://hbex.coveredca.com/stakeholders/plan-management/ecp-list/.
[11] STI mandate HSC 1367.0021 and INS 10112.20; STIs Home Test Kits mandate HSC 1367.34 and INS 10123.208.

DMHC-regulated plans and CDI-regulated policies. Because the mandate AB 1645 would alter and the one it would create specify "group and individual" plans and policies, the health insurance of Medi-Cal beneficiaries enrolled in DMHC-regulated plans would not be subject to AB 1645's requirements.[12]

Analytic Approach and Key Assumptions

For this analysis, CHBRP has assumed that:

- Both mandates would allow billing for an office visit if services other than preventive services are delivered.
- The new STI Screening mandate would align with the altered Preventive Services mandate, requiring compliance connected to new STI screening recommendations in one year or less after publication of the recommendation and requiring compliance connected to modified or upgraded STI screening recommendations in 90 days or less.

Interaction With Existing State and Federal Requirements

Health benefit mandates may interact and align with the following state and federal mandates or provisions.

California Policy Landscape

California law and regulations

As noted above, AB 1645 would alter the current California Preventive Services mandate. Also as noted above, AB 1645 identifies a number of other mandates that could interact with the requirements AB 1645 would create.

As per the model two-plan contract,[13] DMHC-regulated plans enrolling Medi-Cal beneficiaries must cover OON STI services provided by local health department (LHD) clinics, family planning clinics, or through other community STI service providers.

Similar requirements in other states

CHBRP is unaware of similar bills being proposed in other states.

Federal Policy Landscape

Affordable Care Act

A number of Affordable Care Act (ACA) provisions have the potential to or do interact with state benefit mandates. Below is an analysis of how AB 1645 may interact with requirements of the ACA as presently

[12] Personal communication, W. White, California Department of Health Care Services, March 2020.
[13] See Exhibit A, Attachment 9 in the boilerplate contract, available at www.dhcs.ca.gov/provgovpart/Pages/MMCDBoilerplateContracts.aspx.

exist in federal law, including the requirement for certain health insurance to cover essential health benefits (EHBs).[14,15]

Essential Health Benefits

In California, nongrandfathered[16] individual and small-group health insurance is generally required to cover essential health benefits (EHBs).[17] In 2024, approximately 12.1% of all Californians will be enrolled in a plan or policy that must cover EHBs.[18]

States may require state-regulated health insurance to offer benefits that exceed EHBs.[19,20,21] Should California do so, the state could be required to defray the cost of additionally mandated benefits for enrollees in health plans or policies purchased through Covered California, the state's health insurance marketplace. However, state benefit mandates specifying provider types, cost sharing, or other details of existing benefit coverage would not meet the definition of state benefit mandates that could exceed EHBs.[22]

AB 1645 would not require coverage for a new state benefit mandate and appears not to exceed the definition of EHBs in California.

Federally Selected Preventive Services

On March 30, 2023, the district court judge in Braidwood Management Inc et al v. Becerra et al[23] issued a nationwide induction barring enforcement of the Federal Preventive Services mandate.

[14] The ACA requires nongrandfathered small-group and individual market health insurance – including, but not limited to, qualified health plans sold in Covered California – to cover 10 specified categories of EHBs. Policy and issue briefs on EHBs and other ACA impacts are available on the CHBRP website: www.chbrp.org/other_publications/index.php.
[15] Although many provisions of the ACA have been codified in California law, the ACA was established by the federal government, and therefore, CHBRP generally discusses the ACA as a federal law.
[16] 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.
[17] For more detail, see CHBRP's issue brief, *California State Benefit Mandates and the Affordable Care Act's Essential Health Benefits*, available at https://chbrp.org/other_publications/index.php.
[18] See CHBRP's resource, *Sources of Health Insurance in California* and CHBRP's issue brief *California State Benefit Mandates and the Affordable Care Act's Essential Health Benefits*, both available at https://chbrp.org/other_publications/index.php.
[19] ACA Section 1311(d)(3).
[20] 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.
[21] However, as laid out in the Final Rule on EHBs U.S. Department of Health and Human Services (HHS) released in February 2013, state benefit mandates enacted on or before December 31, 2011, would be included in the 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.
[22] Essential Health Benefits. Final Rule. A state's health insurance marketplace would be responsible for determining when a state benefit mandate exceeds EHBs, and qualified health plan issuers would be responsible for calculating the cost that must be defrayed. 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.
[23] United States District Court, Northern District of Texas, Fort Worth Division, ase number 4:20-cv-00283-O.

The Federal Preventive Services mandate was established by the ACA had required that nongrandfathered group and individual health insurance plans and policies cover certain preventive services without cost sharing when delivered by in-network providers and as soon as 12 months after a recommendation is issued by any the four sources that are also referenced by the California Preventive Services mandate:[24]

The California Preventive Services mandate, which AB 1645 would alter, is aligned with, but independent of, the Federal Preventive Services mandate. Both the Department of Health Care Services (DHCS)[25] and CDI[26] have indicated that requirements of the California Preventive Services mandate remains in effect for the health insurance of enrollees in plans and policies regulated by DMHC or CDI.

[24] More information is available in CHBRP's resource: *The Federal Preventive Services Benefit Mandate and Related California Mandates*, available at www.chbrp.org/other_publications/index.php.
[25] www.dmhc.ca.gov/Portals/0/Docs/OPL/APL%2023-009%20-%20Health%20Plan%20Coverage%20of%20Preventive%20Services%20(3_30_2023).pdf.
[26] www.insurance.ca.gov/0400-news/0100-press-releases/2023/statement015-2023.cfm.

BACKGROUND ON PREVENTIVE SERVICES INCLUDING STI SCREENING

AB 1645 includes language that addresses cost sharing and other limitations to coverage for sexually transmitted infection (STI) screenings recommended by United States Preventive Services Task Force (USPSTF) and/or the Centers for Disease Control and Prevention (CDC) (see Table D1 in Appendix D) as well as other preventive services identified by the California Preventive Services Mandate.[27] This background section provides information related to clinical preventive services in general, and more specifically preventive services related to STIs to provide context for the consideration of *Medical Effectiveness,* the *Benefit Coverage, Utilization, and Cost Impacts,* and the *Public Health Impacts* sections.

Preventive Services

Preventive services are services such as screening tests and counseling that aim to prevent illness and disease. Multiple sources make recommendations as to who should use which preventive services when, including:

- The USPSTF A and B recommendations[28]:
    - Includes counseling and screening for conditions such as cancer, cardiovascular disease, depression, diabetes, obesity, osteoporosis, and STIs and behaviors related to tobacco, alcohol, and drug use. The USPSTF offers recommendations for screenings of individuals that may be at higher risk for certain adverse health outcomes due to age, gender, and current health conditions.
- The Health Resources and Services Administration (HRSA)-supported health plan coverage recommendations for women's preventive services[29]
    - Includes preventive services that address mental health, sexual health (contraception and STI screening), cancer (breast, cervical), and overall wellness among women in general, and specific services for pregnant (diabetes, mental health, STI screening) and postpartum (breast feeding services and supplies, diabetes screening) women.
- The HRSA-supported comprehensive recommendations for infants, children, and adolescents,[30,31] which include:
    - These recommendations include The Bright Futures Recommendations for Pediatric Preventive Health Care, and the Secretary's Advisory Committee on Heritable Disorders in Newborns and Children. The Bright Futures recommendations provide recommendations for preventive care screenings and routine visits for newborns through age of 21 years. The recommendations of the Secretary's Advisory Committee on Heritable Disorders in Newborns and Children focus on the implementation of a uniform screening panel in every newborn screening program, enabling screening for 36 core disorders and 26 secondary disorders. Beyond newborn screening, the committee also provides recommendations regarding medical foods, specific health conditions, and health care reform.
- The Advisory Committee on Immunization Practices (ACIP)[32] recommendations adopted by the CDC:

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[27] https://files4.1.revize.com/chbrpnew/Federal%20Preventive%20Services%20Mandate%20and%20California%20Mandates%20032822.pdf.

[28] www.uspreventiveservicestaskforce.org/uspstf/recommendation-topics/information-for-consumers.

[29] www.hrsa.gov/womens-guidelines.

[30] https://www.hhs.gov/about/news/2022/01/11/hrsa-updates-affordable-care-act-preventive-health-care-guidelines-improve-care-women-children.html.

[31] https://www.hrsa.gov/advisory-committees/heritable-disorders/recommendations-reports.

[32] https://www.cdc.gov/vaccines/acip/recommendations.html.

- The recommendations provided the recommended immunizations, immunization schedules, and catch-up immunization schedules for both children and adults. Recommendations also provide guidance in regards to vulnerable populations or emergency situations.

As mentioned in the *Policy Context* section, preventive services recommended in any of these four sources are required to be covered without cost-sharing. These requirements go into effect as soon as 12 months after a recommendation is issued. New recommendations or updated recommendations do appear periodically, as the sources consider changes in the health of the population and advances in science. AB 1645 would add the CDC STI screening recommendations to this list of preventive services referenced in coverage mandates in California. AB 1645 would not change the timing requirement for new recommendations but would require that coverage be compliant within 90 days of issue when an existing recommendation is modified or upgraded.

The sections that follow provide background information on both STI screening as well as other preventive services previously mentioned that are relevant to AB 1645. The STIs selected for discussion in this section are limited to the seven STIs for which the CDC recommendations exceed the USPSTF A- and B-level recommendations (i.e. what AB 1645 is expected to primarily impact).

Sexually Transmitted Infections

STIs are a type of infection caused by a pathogen (e.g., bacterium, virus, or other microorganism) that can be transmitted or acquired via direct genital, oral, or anal sexual contact from person to person (CDC, 2015b). Based on 2020 CDC STI reporting surveillance data, California ranks among the median range of all states for rates of chlamydia (32nd) and gonorrhea (25th). However, California continues to be ranked among the top states for adult syphilis (7th), and congenital syphilis (6th) (CDC, 2022a). In 2020, these STIs combined for a total of 265,292 cases with an additional estimated 4,000 new cases of HIV and 35,000 new cases of hepatitis C each year in California (CDPH, 2022) (see Table 2).

Bacterial STIs, such as gonorrhea, chlamydia, and syphilis, have been increasing significantly in California and across the United States, with noticeable spikes in gonorrhea (rose from 164.5 to 198.5 per 100,000 from 2016 to 2020) and syphilis (rose from 44.8 to 66.9 per 100,000 from 2016 to 2020) (CDC, 2022c). In 2018, the number of infants born with congenital syphilis increased 40 percent nationwide, with 25 percent of cases stemming from California (CDPH, 2021). Viral STIs such as HIV and HPV have been increasing at a steady and consistent rate between 2016-2020 where HIV prevalence rates rose an average of 2.8% per year and approximately 47,000 new cases of HPV each year (CDPH, 2022; National Cancer Institute, 2023). These increased rates have largely been attributed to COVID-19 and the reduced frequency of in-person health care services, lack of STI testing and laboratory supplies, lapses in insurance coverage due to unemployment, and diversion of health care workers from STI work to COVID-19 response teams (CDC, 2022b).

Prevalence for STIs

Table 2 presents the prevalence for the STIs for which screening is recommended by USPSTF and/or CDC. Prevention.

Table 2. Prevalence or Incidence of Selected STIs in California, 2018 and 2020

	Incidence Rate (Unless Otherwise Specified)	Number of Cases
Bacterial	**Rate (per 100,000 population)**	**Cases**
Chlamydia - 2020 (a)	452.2 per 100,000	178,679

Gonorrhea – 2020 (a)	198.5 per 100,000	78,444
Syphilis (all stages) - 2020(a)	19.5 per 100,000	7,688
Congenital- 2020 (a)	107.7 per 100,000 live births	481
Viral		
Chronic hepatitis B - 2018 (b)	24.8 per 100,000	9,778
Chronic hepatitis C – 2018 (b)	89 per 100,000	35,488
Human immunodeficiency virus (HIV) - 2020 (c)	9.9 per 100,000	3,965
Human papillomavirus (HPV) – 2018 (d)	27,122 per 100,000(f)	10,799,238(f)
HPV-associated cancer – 2018 (e)	10.8 per 100,000	4643

Sources: California Health Benefits Review Program, 2020, adapted from (a) CDC, 2022a; (b) CDPH, 2018a; (c) CDPH, 2022; (d) McQuillan et al., 2018; (e) U.S. Cancer Statistics Working Group, 2019.

*Notes: (*f) Indicates prevalence rate and estimated total number infected in 2018.

Prevention, Screening, and Testing for STIs

Prevention, screening, and/or testing for STIs recommended by the four preventive services organizations as described above are also recommended by the CDC (Workowski et al., 2021). As part of routine health care visits, the CDC recommends that providers obtain sexual history and address risk reduction through the provision of prevention counseling. Per the USPSTF, high-intensity behavioral counseling is recommended for sexually active adolescents and young adults who are at an increased risk for acquiring STIs due to a combination of factors, including behavioral, biological, and cultural reasons (CDC, 2015b, 2017a).

Methods to prevent acquisition or transmission of STIs are broad and diverse and vary in efficacy. These include routine screening in populations at higher risk for STIs, pre-exposure vaccinations, abstinence, reduction in the number of concurrent sexual partners at one time, utilization of male or female condoms, male circumcision, prompt testing of symptomatic persons and persons who have potential exposures, and/or post-exposure prophylaxis (PEP) for HIV and STIs (CDC, 2015b).

Screening recommendations for STIs

The current California Preventive Services Mandate refers to the USPSTF STI screening recommendations. As mentioned in the *Policy Context* section, the CDC also produces STI screening recommendations that are more expansive than the USPSTF recommendations (Workowski et al., 2021). A comparison between these two sets of recommendations is presented in (see Table D1 in Appendix D). The primary difference between these two recommendations is in relation to the specific groups of people for whom screening is recommended. In addition to STI screenings recommended by the USPSTF, the CDC recommends STI screenings for these additional groups:

- Screening for **chlamydia** and **gonorrhea** for men who have sex with men (MSM), MSM on pre-exposure prophylaxis (PrEP),[33] with HIV infection, or with multiple

[33] 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.

partners (every 3 to 6 months), transgender and gender diverse: consider screening at rectal site based on behaviors and exposure. Retesting at 3 months for anyone with a diagnosis.
    - Screening for **syphilis** for transgender and gender diverse people at least annually
    - Screening for **hepatitis B** for women with >1 sex partner in the previous 6 months
    - Annual screening for **hepatitis C** for in MSM with HIV infection
    - **HIV** screening for transgender persons
    - Digital anorectal screening for **HPV** for MSM

This report will only cover the seven STIs mentioned above for which the screening is recommended by both the USPSTF and the CDC, but where the CDC recommendations are more expansive than the USPSTF recommendations (i.e., for populations in which screening will be newly covered).

Barriers to Accessing STI Screening

A number of barriers have been identified in accessing STI testing and related services, both in clinical and home settings, including clinic inaccessibility; lack of knowledge and/or awareness; concerns about patient privacy and confidentiality; patient stigma and/or embarrassment; patient discomfort; patient perceptions of risk and discrimination; lack of time needed to attend appointments; as well as lack of financial resources or insurance needed to pay for related health care costs (Parrish and Kent, 2008; Paudyal et al., 2015). In addition, barriers to accessing at home-test kits also exist. Despite local health departments (LHD) across the nation understanding the need to implement innovative STI testing strategies that also reduce stigma related to seeking testing and treatment, lack of funding mechanisms to support the provision of home-to-lab testing (i.e., inability to purchase sufficient test kits and required development of eligibility criteria), administrative roadblocks (i.e., difficulty in establishing order mechanisms for home-to-lab testing, insufficient staffing capacity, and low organizational buy-in), and limited validation of STI home-to-lab test kits by public health laboratories were cited as leading barriers to implementation (Zigman, 2020).

Other Preventive Services

As described previously, there are many different types of preventive services, other than STI screenings, that are covered by the recommendations Federal Preventive Services Mandate. The major types of recommended preventive services are described below:

- 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; and
- Screening for mental health conditions.

Similar to recommendations for STI screening, it is important to note that recommendations for preventive services may not be for applicable for all people. For example, cancer screening recommendations vary by gender, age, and other risk factors.

Utilization of and Barriers to Accessing Preventive Services

Preventive services are typically provided as part of a routine health care check-up. It is estimated that more than half (57.5%) of insured Californians age 0-64 years have a routine check-up with a doctor each year (UCLA, 2021). In addition, it is estimated that in 2020 62.4% of Californians received colorectal screening, 76.2% received breast cancer screening, and 79.3% had pap test for cervical cancer in alignment with USPSTF recommendations (CDC, 2015a). Despite this higher utilization of individual preventive services, it is estimated that only 8% of U.S. adults ages 35 years and older had received all of their recommended high-priority, appropriate preventive services (Borsky et al., 2018). Barriers to accessing preventive services include out of pocket costs, lack of primary care providers, and a lack of awareness and understanding the importance of preventive services (OASH, 2022). These barriers can be broken down to individual factors such as family and work responsibilities, not being able to find a trustworthy, cultural and linguistically compatible provider, perceived discrimination, unclear coverage and possible treatment costs, and an inability to attend appointments due to hours of operation or lack of transportation (Allen et al., 2017).

Disparities[34]

Disparities are noticeable and preventable or modifiable differences between groups of people. Health insurance benefit mandates or related legislation may impact disparities. Where intersections between health insurance benefit mandates and social determinants or systemic factors exist, CHBRP describes relevant literature.

CHBRP found literature identifying disparities in preventive service use and STI rates and screening by race/ethnicity, sex, gender, age, gender identity, sexual orientation, being in a correctional facility, and socioeconomic status.

Disparities in STI Rates

Race or ethnicity

In 2018, racial disparities were found among Blacks, Hispanics/Latinos, and Native Hawaiians and Other Pacific Islanders (not inclusive of Asians) specific to select STIs required to be reported to the CDC (i.e., chlamydia, gonorrhea, syphilis, and congenital syphilis) within the United States (CDC, 2020b, 2020c, 2020d). Similarly, racial and ethnic disparities in rates of STIs – especially among Black/African Americans and Hispanic/Latinos – have been identified in California since at least 2009 (California Health Report, 2017).

Sex or gender[35]

Chlamydia and gonorrhea disproportionately affect women (including pregnant women),[36] as women often present as asymptomatic during early infection, leading to the development of more serious health consequences (CDC, 2017b). If left untreated, these infections may lead to pelvic inflammatory disease, a very severe disease that can result in infertility and/or ectopic pregnancy among women (CDC, 2017b).

[34] Several competing definitions of "health disparities" exist. CHBRP relies on the following definition: Health disparity is defined as the differences, whether unjust or not, in health status or outcomes within a population. (Wyatt et al., 2016).
[35] CHBRP uses the National Institutes of Health (NIH) distinction between "sex" and "gender": "'Sex' refers to biological differences between females and males, including chromosomes, sex organs, and endogenous hormonal profiles. 'Gender' refers to socially constructed and enacted roles and behaviors which occur in a historical and cultural context and vary across societies and over time." (NIH, 2019).
[36] We use the term women here to match the terminology used in the USPSTF guidelines and discuss other people with a uterus that may not identify as a woman in the section on Gender Identity.

Pregnant women[37] are at increased risk for STIs and can experience severe complications due to intrauterine (i.e., within the uterus) or perinatally transmitted (i.e., mother-to-child transmission) STIs (CDC, 2015b). Factors related to increased risk among pregnant women are broad and may vary by STI. For example, specific to gonorrhea among pregnant women, risk factors may include living in a high-morbidity area; prevalence of current or previous coexisting STIs; having multiple concurrent sex partners; and/or opting out of using barrier protection.

Age

Nearly half of all newly diagnosed/reported STIs are among adolescents and young adults (AYA) ages 15 to 24 years in the United States (Kreisel et al., 2021). In California, female AYA had the highest incidence rates of chlamydia compared to all other age groups, equal to 6,213 per 100,000 in 2018 (CDPH, 2019a). Similarly, Californian AYA accounted for the highest incidence rates of gonorrhea (834 per 100,000) compared to all other age groups in 2018 (CDPH, 2019a). High-risk factors include having more than one sexual partner at one time, having sequential sexual partnerships during a condensed period of time, opting out of or failing to use barrier protection appropriately, and facing multiple barriers to accessing primary care services (e.g., lack of access to quality STI prevention, treatment, and management; inability to pay; lack of transportation; and schedule conflicts related to clinic hours of operation and work/school schedules (CDC, 2017c).

Gender identity or sexual orientation[38]

Transgender persons are defined as individuals who identify with a sex that varies from what they were assigned at birth given their anatomy (CDC, 2015b). For example, transgender women (also referred to as trans-women or transgender male to female) identify as women despite being assigned as male at birth due their anatomy. Similarly, transgender men (also known as trans-men or transgender female to male) identify as men despite being assigned as female at birth due their anatomy. It's important to note that gender identity is separate from sexual orientation, and transgender persons may use varied and fluid terminology to identify themselves throughout their life course (CDC, 2015b). Among the few studies reporting on STI prevalence among transgender persons, evidence suggests that transgender women are at higher risk for STIs (such as HIV) given their diverse sexual practices and preferences (such as having sex with men, women, or both at the same time, or identifying as heterosexual, gay, lesbian, queer, or bisexual) and increased engagement in risky sexual behaviors (CDC, 2015b; Operario et al., 2008).

According to the CDC (2017c), disparities exist among men who have sex with men (MSM) in comparison to women and men who have sex with women. MSM are defined as a broad and diverse group of individuals who have varied sexual behaviors, identities, and individualized health care needs (CDC, 2015b). Disparities among MSM reflect those observed in the general population, in which STIs disproportionately affect racial minority and Hispanic MSM as well as MSM of lower socioeconomic status, and young MSM (CDC, 2017a). Within California, nearly 7 out of 10 early syphilis male cases were among MSM in 2018 (CDPH, 2020). The higher burden of STIs of MSM may be indicative of having a broad and diverse sexual network; increased likelihood for substance use; increased rates of practicing unsafe sexual practices including anal sex; reduced access to screening, treatment, and management; and/or having differential experiences with stigma and discrimination (CDC, 2017a).

Women who have sex with women (WSW) are a diverse group of individuals who have varied sexual identities, sexual behaviors and practices, as well as risk behaviors (CDC, 2015b). According to the CDC (2015), studies have reported that some WSW, specifically adolescents and young women and women with concurrent female and male sexual partners, are at increased risk for STIs and HIV. Factors related

[37] CHBRP uses the term "pregnant women," but recognizes that some individuals may identify as male or nonbinary and may also have female reproductive organs.

[38] CHBRP defines gender identity as one's internal sense of one's own gender, or the gender in which a person identifies, whether it be male, female, or nonbinary. Gender identity and sexual orientation are different facets of one's identity; an individual's gender does not determine a person's sexual orientation (i.e., a person's emotional, romantic, or sexual attraction to other people) (ACOG, 2022; CDC, ~~2022e~~2022d).

to increased risk among WSW include having diverse sexual practices; increased risk behaviors; and opting out of using barrier protection such as gloves, condoms, and/or dental dams.

Persons in Correctional Facilities

Multiple studies have reported that incarcerated individuals – especially individuals aged 35 years and younger – are at high risk for STIs, including HIV and viral hepatitis (CDC, 2015b). Incarcerated individuals disproportionately draw from populations with lower socioeconomic status and those living in urban areas. As reported in Hogben and Leichliter (2008), incarceration can also lead to the disruption of sexual networks and contribute to the maintenance of poverty, thereby leading to further economic disadvantage among individuals living in poverty, which is also known to be associated with STI acquisition (see socioeconomic status summary below).

Socioeconomic Status

Socioeconomic status (SES) is defined as an individual's or population's position within a social structure and is typically measured as a combination of education, income, and/or occupation (Winkleby et al., 1992). Studies have indicated an association between low SES and the acquisition of STIs (Dean and Fenton, 2010; Hogben and Leichliter, 2008). Researchers found that a lack of resources and inequality of resource distribution increased the likelihood for risky sexual behavior, lack of access to health care services, as well as increased STI rates. Moreover, poverty and lack of employment were also found to be associated with an increased likelihood for having a broader and more diverse sexual network.

Disparities in Conditions Targeted by Preventive Services

It was not possible to summarize the literature on the disparities for each condition that is the target of a preventive services (i.e. disparities in different types of cancer, different types of communicable diseases, etc.). Instead a description of the disparities in utilization of preventive services, including STI testing is provided below.

Disparities in Accessing Preventive Services and STI Testing

The disparities in preventive services use by race and ethnicity is well documented. For example, Black and Latino adults report lower receipt of immunizations and Asians are less likely to receive a mammogram compared to white adults (Chen et al., 2005). Additional disparities in preventive service utilization is seen by income with adults with higher incomes (>138% FPL vs. <138% FPL) reporting higher rates of receipt of the following recommended preventive services: colon cancer screening, cervical cancer screening, breast cancer screening, pneumococcal vaccination, influenza vaccination, and diabetes screening (Song et al., 2021). Conversely, it was reported that adults with lower incomes had higher rates of HIV screening (Song et al., 2021). Receipt of preventive services also varies by location. Adults living in urban areas had higher rates of six out of seven recommended preventive services (colon cancer screening, cervical cancer screening, breast cancer screening, pneumococcal vaccination, influenza vaccination, and HIV testing compared to those living in rural areas (Song et al., 2021).

Disparities in accessing STI testing and related services exist among racial/ethnic and sexual orientation minority groups (i.e., WSW and MSM) as these populations are more likely to be uninsured compared to non-Hispanic Whites; women in different-sex relationships; or men in different-sex relationships, respectively (Berchick et al., 2019; Buchmueller and Carpenter, 2010; DHHS, 2020). Therefore, given disparities in access to health care coverage, these populations have limited access to health care services (e.g., access to STI testing) (DHCS, 2020). Identified barriers to health care access include lack of transportation and childcare, inability to take time away from work, communication and/or language barriers, discrimination, medical mistrust, and racism (DHCS, 2020).

MEDICAL EFFECTIVENESS

As discussed in the *Policy Context* section, AB 1645 includes language that addresses cost-sharing and other limitations to coverage for sexually transmitted infection (STIs) screenings recommended by USPSTF and/or CDC (see Table D1 in Appendix D) as well as other preventive services identified by both the California Preventive Services Mandate.

Research Approach and Methods

Relevant studies were identified through searches of PubMed. The search was limited to abstracts of studies published in English. The search was limited to studies published from 2010 to present.

The medical effectiveness literature review returned abstracts for 96 articles, of which 46 were reviewed for inclusion in this report. A total of 16 studies were included in the medical effectiveness review. The other articles were eliminated because they did not focus on the impact of cost sharing or reduction in out-of-pocket expenses on utilization, were of poor quality, or were editorial in nature. A more thorough description of the methods used to conduct the medical effectiveness review and the process used to grade the evidence for each outcome measure is presented in Appendix B.

The conclusions below are based on the best available evidence from peer-reviewed and grey literature.[39] Unpublished studies are not reviewed because the results of such studies, if they exist, cannot be obtained within the 60-day timeframe for CHBRP reports.

Key Questions

1. What is the effectiveness of recommended preventive services?
2. What is the effectiveness of recommended STI screening?
3. What is the effect of cost sharing on utilization of preventative services?
4. What is the effect of cost sharing on utilization of STI screening?

Methodological Considerations

Based on the recommendations from the four entities referenced by the CA and Federal Preventive Services mandates – as well as recommendations from the CDC – CHBRP considers all of these services to have clear and convincing evidence of medical effectiveness. As such, the review does not examine other factors such as the effectiveness of the screening techniques, or adherence to proscribed regimens. Additionally, the types of studies included in this analysis and upon which the conclusions rely, differ from other analyses as well. Specifically, the gold standard for many CHBRP analyses with regard to medical effectiveness is the randomized controlled trial. However, as it is not feasible (or ethical) to randomly assign groups of individuals to either have cost sharing or not, most studies report on utilization data from large medical system or claims databases, or on regional or national survey/interview data. This results in a literature base that is not as rigorous and thereby limiting the certainty of conclusions drawn from the evidence.

[39] Grey literature consists of material that is not published commercially or indexed systematically in bibliographic databases. For more information on CHBRP's use of grey literature, visit http://chbrp.com/analysis_methodology/medical_effectiveness_analysis.php.

Outcomes Assessed

The main outcome for this analysis was utilization rates or indicators of utilization for STI screening services and/or preventive services. The seven STIs of interest were syphilis, chlamydial infections, gonococcal infections, hepatitis B and C, HIV, and human papilloma virus. As it would be impractical to include an analysis of all possible non-STI preventative services potentially impacted by AB 1645, exemplars are analyzed for some of the most commonly utilized services. These are breast cancer screening (mammography/MRI), Pap smear, and screening for colorectal cancer (colonoscopy). Additionally, an assessment of the effectiveness of recommended preventive services and STI screenings is provided.[40]

Study Findings

This following section summarizes CHBRP's findings regarding the strength of evidence for the impact of cost sharing on the utilization of STI screening for the seven included STIs and for relevant preventive services that are most likely to be affected by AB 1645. Each section is accompanied by a corresponding figure. The title of the figure indicates the test, treatment, or service for which evidence is summarized. The statement in the box above the figure presents CHBRP's conclusion regarding the strength of evidence about the effect of a particular test, treatment, or service based on a specific relevant outcome and the number of studies on which CHBRP's conclusion is based. Definitions of CHBRP's grading scale terms is included in the box below, and more information is included in Appendix B.

The following terms are used to characterize the body of evidence regarding an outcome:

Clear and convincing evidence indicates that there are multiple studies of a treatment and that the large majority of studies are of high quality and consistently find that the treatment is either effective or not effective.

Preponderance of evidence indicates that the majority of the studies reviewed are consistent in their findings that treatment is either effective or not effective.

Limited evidence indicates that the studies have limited generalizability to the population of interest and/or the studies have a fatal flaw in research design or implementation.

Inconclusive evidence indicates that although some studies included in the medical effectiveness review find that a treatment is effective, a similar number of studies of equal quality suggest the treatment is not effective.

Insufficient evidence indicates that there is not enough evidence available to know whether or not a treatment is effective, either because there are too few studies of the treatment or because the available studies are not of high quality. It does not indicate that a treatment is not effective.

More information is available in Appendix B.

Effectiveness of Recommended Preventive Services

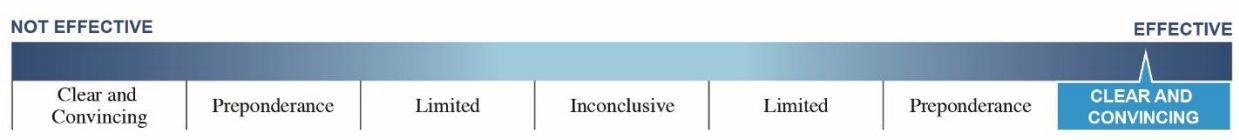
For many of our research questions to be addressed in this specific analysis, CHBRP benefits from pre-existing recommendations from the U.S. Preventive Services Taskforce (USPTF). These

[40] Although AB 1645 would also introduce prohibitions on utilization management in addition to cost sharing, this medical effectiveness analysis focuses on utilization of preventive services and STI screenings after cost sharing prohibitions due to a lack of literature regarding the impact of the prohibition of utilization management.

recommendations are the result of a rigorous review and development process that relies on expert review and documentation of current evidence.

The workgroups comprised multidisciplinary experts from federal, state, and local providers, as well as clinicians and researchers. Much like the standard CHBRP review and analysis process, the workgroups combined the results of systematic reviews of testing and treatments for each preventive service, with expert experience, opinion, and consensus. As such, CHBRP relies on the expertise and rigor of the selection process for the preventive services recommended in the USPTF recommendations and defer to their assumption of effectiveness.

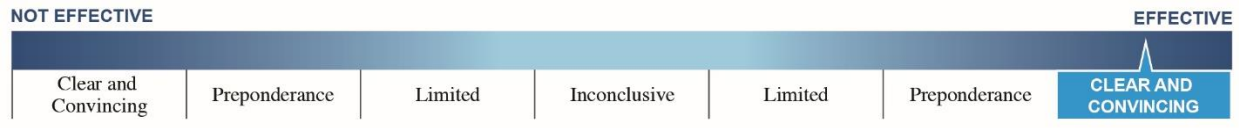
Summary of findings on the medical effectiveness of recommended preventive services. CHBRP concludes there is *clear and convincing evidence* on the effectiveness of the recommended preventive services.



Effectiveness of Recommended STI Screening

As with the existing recommendations for preventive services, for STI screening CHBRP defers to pre-existing work done by and on behalf of the CDC and compiled in their 2021 STD Treatment Guidelines. These recommendations were developed by workgroups of subject matter experts in cooperation with CDC staff. The workgroups comprised multidisciplinary experts from federal, state, and local providers, as well as clinicians and researchers. Much like the standard CHBRP review and analysis process, the workgroups combined the results of systematic reviews of testing and treatments for each STI, with expert experience, opinion, and consensus. As such, the treatments and tests recommended in the treatment recommendations are deemed to be the current gold standard with regard to testing and treatment of STIs, and further review of the literature was not required.

Summary of findings on the medical effectiveness of STI screening. CHBRP concludes there is *clear and convincing evidence* on the effectiveness of recommended STI screening and other recommended preventive services.



What Is the Impact of Cost Sharing on the Utilization of Preventive Services?

CHBRP found 12 studies, including two systematic or rapid reviews, examining the impact of cost sharing on various non-STI preventive services. The most common categories are cancer-related, including mammography, women's reproductive services, Pap smear, and colonoscopy. Other categories covered by various studies in this review are general preventive procedures such as blood pressure check, cholesterol check, and flu vaccination.

A rapid review of the literature regarding the impact of cost-sharing elimination on the utilization of preventive services was conducted by Norris and colleagues in 2022 (Norris et al., 2022). They summarized the results of 35 articles covering the areas of cancer screenings, contraceptives, and other preventive services. The included studies varied with regard to design, however; as is typical for utilization studies, they were largely cross-sectional or retrospective cohort in nature, with the exceptions being three randomized controlled trials. They found the impact of cost-sharing elimination varied by clinical service. Almost half (44%) of the articles summarizing breast cancer screening reported at least some increase in screening rates after the elimination of cost sharing. A combined 50% of studies (28% reported no change, and 22% decrease) reported no change or decreases in screening rates. For cervical cancer, similar mixed results were reported with two of five included articles reporting increases in screening rates and the remaining 3 reporting no change. For colorectal cancer, a review of 14 studies had similar mixed results with five (35.7%) reporting increases in screening rates and the remainder of the studies reporting no changes or decreases in rates. For the various other preventive services, the elimination of cost sharing seemed to have a more pronounced effect, with both reviewed articles for cholesterol screening and both for blood pressure checks reporting significant increases in utilization rates.

Other various individual studies provide support for the mixed findings reported by the rapid review by Norris and colleagues reported above with regard to breast cancer screening. Trivedi and colleagues (Trivedi et al., 2018) examined utilization data on screening mammography for 15,000 women after the elimination of cost sharing post-ACA for Medicaid patients. They reported an overall increase in rates of screening mammography (59.9% to 65.4%), but the impact was far less for Hispanic women and women with less educational attainment. Another study of Medicare utilization data on over 50,000 women examined changes in mammography screening rates after the elimination of cost sharing for women who previously had low screening adherence. They reported a small decrease in screening rates pre- and post–cost-sharing elimination, although the decrease was smaller for women with previously low rates (Jena et al., 2017). Another study examining changes in mammography screening rates also report a lack of significant increase post-ACA (Carlos et al., 2019). Another study utilized the Medical Expenditure Panel survey (MEPS) dataset for over 16,000 women, which included self-reported reported receipt of mammogram and Pap smear after the elimination of cost sharing post-ACA. They reported no significant changes in mammography or Pap test rates (Alharbi et al., 2019).

Another study looking at changes in utilization rates for women's reproductive preventive services post-ACA for 5,600 hundred women, reported that, with the exception of sterilization, women were no more likely to receive preventive services after the ACA mandate eliminating associated out of pocket costs (Arora and Desai, 2016). The only marked change in utilization was for sterilization procedures, increasing from 0.7% to 2.3%. Dalton et al. (Dalton et al., 2018) examined health plan data from over 2 million women and found that the elimination of costs for women's annual preventive exams was significantly associated with increases in their use for women with low to moderate out-of-pocket costs, but the effect size was low, especially given the large sample size. For women with high out-of-pocket costs, they reported a decrease in utilization rates.

A systematic review (Xu et al., 2020) examined changes in colorectal screening rates for Medicaid patients after the elimination of associated out-of-pocket costs due to the passage of the ACA. All studies examined pre-/post-utilization information from claims databases or MEPS data. They reported only 2 of 11 studies reported significant, but modest, increases in screening rates. A further five found nonsignificant increases in rates, three found nonsignificant decreases, and one reported a significant decrease in screening rates. This agrees with an earlier utilization retrospective study from a large health plan that found a small, but statistically significant, increase (1.5%) in screening rates after eliminating copays for colonoscopy screening (Khatami et al., 2012). Another study of utilization data pre- and post-ACA reported significantly increased colorectal cancer screening rates, but these increases were most pronounced for those with low SES, and were not significant for those with more education, income, and private insurance (Fedewa et al., 2015). Another large study examining claims data supplemented by survey-based information assessed the impact of the ACA policy changes on a number of preventive procedures. Both data sources reported no changes in utilization rates for biannual mammograms, Pap smear, and coloscopy after the elimination of cost sharing (Xu et al., 2019).

Han and colleagues (Han et al., 2015) examined change in utilization of commonly recommended preventive services before (2009) and after (2011-2012) the passage of the ACA. Their data source was the MEPS, a nationally representative survey of the U.S. population. They found significant increases in utilization rates for privately insured adults aged 18 to 64 years for blood pressure checks, cholesterol checks, and flu vaccinations. Adults over age 64 years with Medicare also had increased utilization for cholesterol checks. They reported no significant changes in utilization for cancer screening.

Summary of findings regarding the impact of cost sharing on the utilization of preventive services: CHBRP finds the evidence from 12 studies, including two reviews, to be *inconclusive* that the removal of cost sharing would lead to a change in utilization rates for preventive services.

Figure 1. Effect of Cost Sharing on the Utilization of Preventive Services

Impact of Cost-Sharing on Utilization of STI Screening

CHBRP identified no studies that *specifically* assessed the potential impact of cost sharing, or the elimination of cost sharing, on utilization for STI screening. However, there are studies on related outcomes that can prove information that can inform this area.

Out-of-pocket expenses are often identified as a potential barrier to screening. In one study, researchers surveyed 1,722 patients at STI clinics in 21 metropolitan statistical areas thought to have the highest rates of highly prevalent STIs. Among those patients who reported they were not willing to use their health insurance at STI clinics, about one-third reported cost concerns (out of pocket) to be a major factor. It should be noted that the most commonly cited reason for not using their health insurance was privacy concerns (Pearson et al., 2016). In another study examining insurance claims data post-ACA, researchers reported that out-of-pocket expenses at initial screening visits were related to the likelihood of rescreening or following up on initial results (Shi et al., 2013).

There is further evidence that any sort of financial requirement can constitute a burden on patients reducing the likelihood to pursue screening. Drainoni and colleagues (Drainoni et al., 2014) observed both STI rates (volume) and screening rates after the elimination of state-funded coverage for these services, and the institution of a flat fee. They reported a decrease of 20% in STI clinic patient volume after the institution of the flat fee. However, institution of a financial obligation not previously required is different than the elimination or prohibition of a current fee such as a cost- sharing requirement.

Researchers have reported a general unwillingness to use insurance for STI screening regardless of the presence of cost sharing or other out-of-pocket expenses. In one study at a large STI clinic in Rhode Island, researchers reviewed utilization and insurance status information as well as information collected through questionnaires (Montgomery et al., 2017). They reported that 57% of insured patients reportedly were unwilling to use their insurance for STI care, citing stigma and confidentiality concerns. They further reported that a total of 31% of insured patients identified cost sharing, in the form of a copay, deductible, or both, as a barrier to insurance use for STI care. This agrees with previous research reporting that between 33% and 66% of patients are unwilling to use their health insurance for STI-related care (Hoover et al., 2015).

Summary of findings regarding the impact of cost sharing on the utilization of STI screening services: Although there is some evidence from five studies that cost and financial factors can be related to the utilization of STI screening services, CHBRP concludes there is *insufficient evidence* on the effect

of the prohibition of cost sharing on utilization rates. It should be noted that no evidence of effect does not mean there is no effect but rather may reflect the absence of relevant studies.

Figure 2. Effect of Cost Sharing on STI Screening Utilization

Summary of Findings

Based on the recommendations from the four entities referenced by the CA and Federal 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.

CHBRP found *inconclusive evidence* from 12 studies that the prohibition of cost sharing would impact utilization rates for preventive services. The majority of reviewed studies examined the impact of the similar cost-sharing prohibition instituted by the implementation of the ACA for Medicaid patients. Most of these studies reported either no change in utilization for common preventive services, or very small effect sizes when there was significant change.

CHBRP found *insufficient evidence* from five studies on factors related to cost sharing and utilization rates for STI screening services. Although the reviewed studies provide some evidence that out-of-pocket expenses can be a factor, there were no studies identified that looked specifically at the change in utilization rates after prohibiting or otherwise eliminating cost sharing. Furthermore, the reviewed studies provide evidence that other factors besides cost, such as confidentiality and reluctance to use insurance for these services, play a major role.

It should be noted that, although CHBRP concludes there to be 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. This results in an overall body of evidence with considerable “noise” and often conflicting results. The findings also differ considerably with regard to the specific preventive services with some finding more consistent utilization increases than others. However, there is little doubt there will be at least some increases for the recommended preventive services and STI screenings. As noted earlier in this section, lack of evidence of effect does not mean there is no effect but rather may reflect the absence of relevant studies.

BENEFIT COVERAGE, UTILIZATION, AND COST IMPACTS

As discussed in the *Policy Context* section, AB 1645 would create benefit coverage requirements related to sexually transmitted infection (STI) screening[41] and other preventive services.

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 928,000 (7%) are in a plan or policy with grandfathered[42] status. AB 1645 would differently impact benefit coverage of enrollees in grandfathered and nongrandfathered plans and policies as follows:

1. Enrollees in Nongrandfathered Plans and Policies:
    a. For all enrollees, for the seven STI screenings (chlamydia, gonorrhea, syphilis, hepatitis B, hepatis C, HIV, and human papilloma virus) recommended by the United States Preventive Services Task Force (USPSTF) and the Centers for Disease Control and Prevention (CDC) there are:
        i. New utilization management (UM) prohibitions (see Table 3 below);
        ii. New office visit cost-sharing prohibition; and
        iii. New requirement for coverage at providers listed on Covered California's Essential Community Provider List.[43]
    b. For enrollees in high-risk groups, for the seven STI screenings for which the CDC "high risk" recommendations exceed the USPSTF recommendations there are:
        i. New all other cost-sharing prohibitions.
    c. For all enrollees, for other California Preventive Services[44] there is a:
        i. New office visit cost-sharing prohibition.
2. Enrollees in Grandfathered Plans and Policies:
    a. For all enrollees, for the seven STI screenings recommended by the USPSTF and the CDC there are:
        i. New utilization management (UM) prohibitions (see Table 3 below);
        ii. New office visit cost-sharing prohibition;
        iii. New all other cost-sharing prohibitions; and
        iv. New requirement for coverage at providers listed on Covered California's Essential Community Provider List.[43]
    b. For all enrollees, for other California Preventive Services[44] there are:
        i. New office visit cost-sharing prohibition; and

[41] Screening primarily refers to asymptomatic screening but does include some diagnostic tests. However, CHBRP is unable to distinguish the exact proportion of tests that are diagnostic.
[42] 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.
[43] https://hbex.coveredca.com/stakeholders/plan-management/ecp-list/.
[44] See CHBRP's resource *The Federal Preventive Services Benefit Mandate and Related California Mandates* available at https://www.chbrp.org/other-publications/resources.

ii. New all other cost-sharing prohibitions.

Irrespective of whether an enrollee's plan or policy is grandfathered and nongrandfathered, AB 1645 would expand the risk categories for coverage of STI screening to be consistent with CDC STI screening recommendations as follows:

- Screening for **chlamydia** and **gonorrhea** for men who have sex with men (MSM), MSM on pre-exposure prophylaxis (PrEP),[45] 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;
- Screening for **syphilis** for transgender and gender diverse people at least annually;
- Screening for **hepatitis B** for Women with >1 sex partner in the previous 6 months;
- Annual screening for **hepatitis C** for in MSM with HIV infection;
- **HIV** screening for transgender persons; and
- Digital anorectal screening for **HPV** for MSM.

Table 3 lists the proportion of commercial/CalPERS enrollees who currently are subject to utilization management for STI screening, including prior authorization requirements, testing frequency limits, and any other limits. AB 1645 would prohibit all such utilization management for STI screening.

Table 3. Commercial/CalPERS Enrollees for Whom Utilization Management Is Applicable for STI Screening Accessed Through INN and OON Providers

	Accessed Through INN Provider		Accessed Through OON Provider	
	Prior Authorization Requirements	Limits (a)	Prior Authorization Requirements (b)	Limits (a)
STI screening (c) Chlamydial infections Gonococcal infections Syphilis Hepatitis B Hepatitis C HIV Human papilloma virus	0%	<1%	82%	<1%

Source: California Health Benefits Review Program, 2024.
Notes: (a) The only limits identified were the restriction of coverage to persons for whom USPSTF recommends the screening.
(b)These are enrollees whose coverage does not generally extend to services from *OON providers*
(c) There is not a similar set of changes for California Preventive Services.
Key: CalPERS = California Public Employees' Retirement System; INN = in network; OON = out of network; STI = sexually transmitted infection.

Regarding the expansion of enrollee coverage to include STI screening provided by providers listed on California Health Benefit Exchange's Essential Community Provider List, [46] AB 1645 requires these providers to be paid at the median contracted rate.

AB 1645 also requires compliance in no less than 90 days for modified or upgraded preventive service recommendations. CHBRP is unable to determine the utilization or cost impact of this mandate without information on how and when preventive service recommendations may be modified or upgraded. Thus,

[45] 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.
[46] For more detail, see Covered California's Consolidated Essential Community Provider List, available at https://hbex.coveredca.com/stakeholders/plan-management/ecp-list/.

while CHBRP estimates an increase in both utilization and costs when preventive service recommendations expand, CHBRP also estimates a decrease in both utilization and costs when preventive service recommendations are reduced.

In addition to commercial enrollees, more than 73% of enrollees associated with the California Public Enrollees' Retirement System (CalPERS) and more than 80% of Medi-Cal beneficiaries are enrolled in DMHC-regulated plans.[47] As noted in the *Policy Context* section, AB 1645 would impact CalPERS enrollees, but because the mandate AB 1645 specifies "group and individual" plans and policies, the health insurance of Medi-Cal beneficiaries enrolled in DMHC-regulated plans would not be subject to AB 1645's requirements.[48]

This section reports the potential incremental impacts of AB 1645 on estimated baseline benefit coverage, utilization, and overall cost.

Analytic Approach and Key Assumptions

CHBRP has made several analytic assumptions, including the following:

- The mandate AB 1645 would create (STI Screening mandate) and the mandate it would alter (California Preventive Services mandate) are relevant to STI screening tests. Screening primarily refers to asymptomatic screening but does include some diagnostic tests. However, CHBRP is unable to distinguish the exact proportion of tests that are diagnostic.
- The mandate AB 1645 would create and the mandate it would alter allows billing for an office visit if services other than preventive services are delivered.
- No preventive services recommendations from the CDC or USPSTF are additionally modified or upgraded during the period covered by this analysis.
- AB 1645 will not alter clinician or patient knowledge regarding STI screening.

For further details on the underlying data sources and methods used in this analysis, please see Appendix C.

Baseline and Postmandate Benefit Coverage – STIs

At baseline, 0% of the 14,025,000 commercial/CalPERS enrollees have insurance that is fully compliant with the requirements of AB 1645 with regard to cost sharing, and only 18% or 3.1 million of commercial/ CalPERS enrollees 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 AB 1645. See Table 1.

Baseline and Postmandate Utilization – STIs

Utilization for STI screening can be accessed in three ways:

- Home test kits;
- In-network (INN) providers; and

[47] For more detail, see CHBRP's resource, *Sources of Health Insurance in California*, available at http://chbrp.org/other_publications/index.php.
[48] Personal communication, W. White, California Department of Health Care Services, March 2020.

- Out-of-network (OON) providers.

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.[49] Thus, 75% of all STI testing and treatment are purchased with insurance, and only this subset will experience changes in utilization from baseline to postmandate. However, utilization will vary significantly across the above categories. Each is explained below.

Home Test Kits

CHBRP estimates that home test kits are used for approximately 10% of all STI tests.[50] CHBRP also estimates that home tests kids are disproportionately preferred by individuals who wish to remain anonymous, such that, among commercial/CalPERS enrollees, 25% of home test kits are purchased by enrollees without using insurance benefits.[51] Thus, 75% of home test kits are purchased by enrollees 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 75% of home test kits purchased with insurance, increasing utilization by 2.7%. This increase in utilization is based on estimates of expected trends in utilization and cost for this group. See Appendix C for more information.

In-Network Providers

Among commercial/CalPERS enrollees, utilization management testing limits for STI screening from INN providers occurs for <1% of enrollees as shown in Table 3. Thus, utilization management testing limits were assumed to be zero for STI screening from INN providers. Thus, the postmandate impact is the combined effect of the removal of cost sharing and the relevant expansion of risk groups, where the relevant risk groups are based on the most recent CDC STI screening recommendations, and the size of each risk group in California is based on estimates from the California Health Interview Survey. CHBRP thus estimates a net increase in INN covered STI screening utilization of 0.52% as shown in Table 1. This is based on CHBRP assumptions that: (1) due to the availability of covered OON STI screening services, 1.5% of covered INN STI screening will move to covered OON STI screening services; and (2) the availability of Community Essential Providers will increase STI screenings and associated services by 3%, of which half will come from baseline covered INN services and half from new utilization. These assumptions were based on content expert information.[52] See Appendix C for more information.

Out-of-Network Providers

As shown in Table 3, 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 and the relevant expansion of risk groups will increase utilization by 22.07% as shown in Table 1. This is based on the following CHBRP estimates: (1) the availability of covered OON STI screening services would increase the utilization of covered OON STI screening services by 3%; (2) the availability

[49] This is based on previous content expert input on the specific issue of the proportion of STI tests performed privately even when insurance is available. See *SB 306 Health Care: STD Testing*, available at https://www.chbrp.org/sites/default/files/bill-documents/SB306/sb306-FullReport.pdf.
[50] This is based on previous content expert input and literature review on the specific issue of the proportion of STI tests performed at home. See *SB 306 Health Care: STD Testing*, available at https://www.chbrp.org/sites/default/files/bill-documents/SB306/sb306-FullReport.pdf.
[51] This is based on previous content expert input on the specific issue of the proportion of home test kits for which enrollees use insurance coverage. See *SB 306 Health Care: STD Testing*, available at https://www.chbrp.org/sites/default/files/bill-documents/SB306/sb306-FullReport.pdf.
[52] This is based on previous content expert input on STI testing due to similar changes in insurance coverage. See *AB 2204 Sexually Transmitted Diseases*, available at https://www.chbrp.org/sites/default/files/bill-documents/AB2204/ab2204-FullReport.pdf

of Community Essential Providers would increase utilization of STI screening services by 3%; and (3) there will be a shift from self-pay STI screening to covered OON STI screening of 0.6%. These estimates are based on content expert information[53] and the expansion of risk groups, where the relevant risk groups are based on the most recent CDC STI screening recommendations, and the size of each risk group in California is based on estimates from the California Health Interview Survey. See Appendix C for more information.

Enrollees in Grandfathered and Nongrandfathered Plans and Policies

The utilization increases in STI screenings vary for qualifying enrollees covered by grandfathered plan and policies as compared to qualifying enrollees covered by nongrandfathered plans and policies. CHBRP assumed that AB 1645 would increase utilization of STI screenings among qualifying enrollees of grandfathered plans with cost sharing on these services by 25% due to the cost sharing prohibition mandated by AB 1645. The total impact of this assumption on STI screening utilization across all populations is approximately 0.8%.

Postmandate increased utilization of STI screening by STI is presented in Table 4. This only includes the seven STIs for which screening recommended by the CDC is more expansive than the USPSTF. Note that Table 3 presents utilization as per 1,000 enrollees rather than number of enrollees because many enrollees utilize multiple tests per year. Thus, it is more meaningful to estimate utilization as utilization per 1,000 enrollees than the number enrollees receiving tests.

Table 4. Increase in Covered STI Screening Utilization per 1,000 Enrollees Among Commercial/CalPERS Enrollees

	Baseline	Postmandate
Chlamydial infections	342.22	345.23
Gonococcal infections	337.79	340.76
Syphilis	170.72	172.22
Hepatitis (B and C)	224.40	226.37
HIV	15.50	15.63
Human papilloma virus	141.87	143.11

Source: California Health Benefits Review Program, 2024.
Note: Number of tests may not correspond to the population prevalence reported in the *Background* section, as some STIs are more often diagnosed through a medical examination of symptoms rather than a STI test. This table excludes self-pay screening.
Key: CalPERS = California Public Employees' Retirement System; STI = sexually transmitted infection.

Note that the differences in baseline screenings/tests between the seven STIs are not primarily an issue of benefit coverage. Some additional reasons[54] for the differences include the following:

- A combined swab test is frequently used for chlamydial and gonococcal infections, making their figures similar.
- A blood test is required for syphilis, and it is not always performed at the same time as the swab test for chlamydial and gonococcal infections.

[53] This is based on previous content expert input on STI testing due to similar changes in insurance coverage. See *AB 2204 Sexually Transmitted Diseases*, available at https://www.chbrp.org/sites/default/files/bill-documents/AB2204/ab2204-FullReport.pdfhttps://www.chbrp.org/sites/default/files/bill-documents/AB2204/ab2204-FullReport.pdf.
[54] Personal communication, P. Kissinger, March 2023.

- Enrollees (and other patients) continue to strongly value anonymity for HIV tests, making use of coverage less likely for HIV than for other STI screening.

Increases in the Utilization of STI Treatment for STIs Identified by Screening

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 (Schwebke et al., 1997). Based on content expert input for a closely related CHBRP analysis,[55] CHBRP has assumed the increase in STI screening due to AB 1645 would increase treatment for HIV by 0.2%, treatment for hepatitis C by 0.9%, and treatment for all other STIs by 5%. CHBRP also estimates a reduction in self-pay (free STI clinics) of 7.27%. For HIV and hepatitis C, due to the lower prevalence of infection, 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 (McQuillan et al., 2021; Schillie et al. 2020). See Appendix C for more information.

Baseline and Postmandate Unit Cost – STIs

CHBRP has determined there will be no change in postmandate per-unit cost for STI screening or STI treatment with one exception. Covered OON STI screening will decrease by 9.26%

Baseline and Postmandate Benefit Coverage – Other Preventive Services

At baseline, 93.2% of commercial/CalPERS enrollees have coverage fully compliant with the requirements of AB 1645. Approximately 1 million commercial/CalPERS enrollees have noncompliant insurance. See Table 1. Postmandate, all commercial/CalPERS enrollees would have benefit coverage compliant with AB 1645. See Table 1.

Baseline and Postmandate Utilization – Other Preventive Services

Note that this section presents utilization as per 1,000 enrollees rather than number of enrollees since many enrollees utilize multiple preventive services each year. Thus, it is more meaningful to estimate utilization as utilization per 1,000 enrollees than the number enrollees receiving other preventive services. In addition, as noted in the *Medical Effectiveness* section, although there is limited evidence of the effect of cost sharing on the utilization of other preventive services in the peer-reviewed literature, this does not imply that there is no effect but rather may reflect the absence of relevant studies. CHBRP has thus used Milliman's proprietary 2023 Commercial Health Guidelines™ to estimate of the impact of prohibiting cost sharing for office visits for preventive services and other services that are integral to the provision of preventive services. Based on this approach, use of other preventive services by commercial/CalPERS enrollees is expected to increase by 0.39% or approximately 116,000 preventive services. 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.

Enrollees in Grandfathered and Nongrandfathered Plans and Policies

The utilization change in other preventive services varies for qualifying enrollees covered by grandfathered plans and policies as compared to qualifying enrollees covered by nongrandfathered plans and policies. CHBRP assumed that AB 1645 would increase utilization of other preventive services

[55] This was used due to a lack of evidence from literature including a lack of information from *Medical Effectiveness* findings. See *SB 306 Health Care: STD Testing*, available at https://www.chbrp.org/sites/default/files/bill-documents/SB306/sb306-FullReport.pdf: https://www.chbrp.org/sites/default/files/bill-documents/SB306/sb306-FullReport.pdf.

among qualifying enrollees of grandfathered plans with cost sharing for these services between 0% and 7%. The total impact of this assumption on preventive services utilization across all populations is approximately 0.4%.

Baseline and Postmandate Per-Unit Cost – Other Preventive Services

CHBRP estimates that there will be very small decrease in the average unit cost of preventive services of 0.06%. This is due to changes in the mix of increases in immunizations, well-baby examinations, and physical examinations, the most common categories of preventive services that will occur due the reduction in cost sharing.

Baseline and Postmandate Expenditures – STIs and Other Preventive Services

Table 5 and Table 6 present baseline totals and postmandate expenditures changes by market segments for DMHC-regulated plans and CDI-regulated policies. The tables present per member per month (PMPM) premiums, enrollee expenses for both covered and noncovered benefits, and total expenditures (premiums as well as enrollee expenses).

AB 1645 would increase total net annual expenditures by $35,797,000, or 0.0243%, for enrollees with DMHC-regulated plans and CDI-regulated policies as shown in Table 6. This is due to a $38,891,000 increase in total health insurance premiums paid by employers and enrollees for newly covered benefits, adjusted by a net decrease in cost sharing and enrollee expenses for covered and/or noncovered benefits.

Premiums

Increases in premiums as a result of AB 1645 would vary by market segment. Note that such changes are related to the number of enrollees (see Table 1, Table 5, and Table 6), with health insurance that would be subject to AB 1645.

Table 7 and Table 8 further divide premiums into grandfathered and nongrandfathered small group and individual plans. Per member per month premium increases range from a high of $2.1644 in DMHC-regulated grandfathered small-group plans to a low of $0.0813 in CDI-regulated Individual nongrandfathered Mirror Plans.

For enrollees associated with CalPERS in DMHC-regulated plans, per member per month premium increases are virtually identical at $0.0957 as shown in Table 6. For Medi-Cal beneficiaries enrolled in DMHC-regulated plans, there is no impact of AB 1645.

Among DMHC-regulated commercial small-group nongrandfathered plans associated with Covered California, per member per month premiums are expected to rise by $0.1023, similar to the $0.1001 premium increase for identical DMHC-regulated individual nongrandfathered policies associated with Covered California as shown in Table 7. Table 8 shows that the CDI-regulated versions of these categories will see rises of $0.0975 and $0.0863, respectively.

Enrollee Expenses

AB 1645–related changes in cost sharing for covered benefits (deductibles, copays, etc.) and out-of-pocket expenses for noncovered benefits would vary by market segment. Note that such changes are related to the number of enrollees (see Table 1, Table 5, and Table 6) with health insurance that would be subject to AB 1645 and expected to use the relevant STI screenings/tests, STI treatments, and other preventive services during the year after enactment. Also note that decreases in expenses for non-covered benefits would be greater, on a per-person basis, for enrollees in grandfathered plans/policies.

As cost sharing is not prohibited for STI treatments, and as increased screening would result in more treatment, there would be a net increase in cost sharing of 0.03%. Enrollee expenses for noncovered benefits would decrease by 1.8%.

Average enrollee out-of-pocket expenses per user

Among the commercial/CalPERS enrollees who would use an STI screening test and for whom cost sharing would change, postmandate, the reduction in cost sharing would vary. Examples of the postmandate cost sharing reductions would include $5.00 for an STI panel (CPT 80061) or $36.51 for an office visit (CPT 99214).

Among the commercial/CalPERS enrollees who would use other preventive services and for whom cost sharing would change, postmandate, the reduction in cost sharing would vary. Examples of the postmandate cost sharing reductions would include $1.00 for a developmental test (CPT 96110) or as much as $72.78 for antepartum care (CPT 59426).

Postmandate Administrative Expenses and Other Expenses

CHBRP 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.

Other Considerations for Policymakers

In addition to the impacts a bill may have on benefit coverage, utilization, and cost, related considerations for policymakers are discussed below.

Postmandate Changes in the Number of Uninsured Persons

Because the change in average premiums does not exceed 1% for any market segment (see Table 1, Table 5, and Table 6), CHBRP would expect no measurable change in the number of uninsured persons due to the enactment of AB 1645.

Changes in Public Program Enrollment

CHBRP estimates that the mandate would produce no measurable impact on enrollment in publicly funded insurance programs due to the enactment of AB 1645.

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

Although a significant amount of self-pay currently exists among enrollees in DMHC-regulated plans or CDI-regulated policies, research literature suggests that only some is related to the out-of-pocket cost of STI tests or treatments (Montgomery, et al. 2021; Pearson et al., 2016; Washburn et al., 2014). Privacy concerns are common reasons for wanting to pay out-of-pocket even when insurance coverage exists. STI clinics commonly have state or county contracts that reduce out-of-pocket costs for tests and treatments, but CHBRP is unable to quantify the amount of these contracts. The result of the state or county funding, though, is that STI screening and treatment is largely made available to the public for no out-of-pocket cost, regardless of insurance status. The point of these contracts is to reduce barriers for accessing this care, including those that insurance carriers may impose with their in-network

requirements. STI clinics would also be able to absorb increases in utilization because of this continued state and county support, as they continue to serve more of the public regardless of insurance status.

If AB 1645 were enacted, it is unlikely that these sources of state and county funding would decrease, as STI clinics would still have the job of providing services to the uninsured and to enrollees with Medi-Cal coverage. Thus, an enrollee may face lower out-of-pocket costs if they report being uninsured to the STI clinic, rather than going through their insurance coverage and paying any copays that may be required.

Table 5. Baseline Per Member Per Month Premiums and Total Expenditures by Market Segment, California, 2024

	DMHC-Regulated						CDI-Regulated			
	Commercial Plans (by Market) (a)			Publicly Funded Plans			Commercial Policies (by Market) (a)			
	Large Group	*Small Group*	*Individual*	*CalPERS (b)*	*Medi-Cal (Excludes COHS) (c)*		*Large Group*	*Small Group*	*Individual*	**Total**
					Under 65	*65+*				
Enrollee counts										
Total enrollees in plans/policies subject to state mandates (d)	7,780,000	2,212,000	2,618,000	882,000	8,043,000	774,000	371,000	35,000	127,000	22,842,000
Total enrollees in plans/policies subject to AB 1645	7,780,000	2,212,000	2,618,000	882,000	0	0	371,000	35,000	127,000	14,025,000
Premiums										
Average portion of premium paid by employer (e)	$473.17	$417.10	$0.00	$581.85	$254.61	$543.16	$490.57	$517.32	$0.00	$93,424,638,000
Average portion of premium paid by enrollee	$122.17	$180.13	$645.33	$113.49	$0.00	$0.00	$180.61	$168.99	$626.90	$39,493,007,000
Total premium	**$595.34**	**$597.23**	**$645.33**	**$695.34**	**$254.61**	**$543.16**	**$671.18**	**$686.31**	**$626.90**	**$132,917,645,000**
Enrollee expenses										
Cost sharing for covered benefits (deductibles, copays, etc.)	$40.98	$127.06	$168.73	$49.17	$0.00	$0.00	$99.22	$184.48	$208.51	$13,857,141,000
Expenses for noncovered benefits (f)	$2.47	$2.47	$2.48	$2.48	$0.00	$0.00	$2.48	$2.48	$2.48	$416,761,000
Total expenditures	**$638.80**	**$726.76**	**$816.54**	**$746.98**	**$254.61**	**$543.16**	**$772.88**	**$873.28**	**$837.88**	**$147,190,929,000**

Source: California Health Benefits Review Program, 2023.

Note: (a) Includes enrollees with grandfathered and nongrandfathered health insurance acquired outside or through Covered California (the state's health insurance marketplace).
(b) Includes only CalPERS enrollees in DMHC-regulated plans. Approximately 51.7% are state retirees, state employees, or their dependents. About one in five (22.5%) of these enrollees has a pharmacy benefit not subject to DMHC. CHBRP has projected no impact for those enrollees. However, CalPERS could, postmandate, require equivalent coverage for all its members (which could increase the total impact on CalPERS).
(c) Includes only Medi-Cal beneficiaries enrolled in DMHC-regulated plans. Includes those who are also Medicare beneficiaries.

(d) Enrollees in plans and policies regulated by DMHC or CDI. Includes those associated with Covered California, CalPERS, or Medi-Cal.
(e) In some cases, a union or other organization - or Medi-Cal for its beneficiaries.
(f) 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 covered by insurance at baseline. This only includes those expenses that will be newly covered, postmandate. Other components of expenditures in this table includes all health care services covered by insurance.
Key: CalPERS = California Public Employees' Retirement System Health Maintenance Organizations; CDI = California Department of Insurance; COHS = County Operated Health Systems; DMHC = Department of Managed Health.

Table 6. Postmandate Changes in Per Member Per Month Premiums and Total Expenditures by Market Segment, California, 2024

	DMHC-Regulated						CDI-Regulated			
	Commercial Plans (by Market) (a)			Publicly Funded Plans			Commercial Policies (by Market) (a)			
	Large Group	*Small Group*	*Individual*	*CalPERS (b)*	*Medi-Cal (Excludes COHS) (c)*		*Large Group*	*Small Group*	*Individual*	**Total**
					Under 65	*65+*				
Enrollee counts										
Total enrollees in plans/policies subject to state mandates (d)	7,780,000	2,212,000	2,618,000	882,000	8,043,000	774,000	371,000	35,000	127,000	22,842,000
Total enrollees in plans/policies subject to AB 1645	7,780,000	2,212,000	2,618,000	882,000	0	0	371,000	35,000	127,000	14,025,000
Premiums										
Average portion of premium paid by employer (e)	$0.2272	$0.1791	$0.0000	$0.0957	$0.0000	$0.0000	$0.0765	$0.0734	$0.0000	$27,348,000
Average portion of premium paid by enrollee	$0.0587	$0.0774	$0.1445	$0.0187	$0.0000	$0.0000	$0.0282	$0.0240	$0.0923	$12,542,000
Total premium	$0.2858	$0.2565	$0.1445	$0.1144	$0.0000	$0.0000	$0.1047	$0.0974	$0.0923	**$39,891,000**
Enrollee expenses										
Cost sharing for covered benefits (deductibles, copays, etc.)	$0.0162	$0.0326	$0.0310	$0.0081	$0.0000	$0.0000	$0.0155	$0.0266	$0.0307	$3,565,000
Expenses for noncovered benefits (f)	-$0.0455	-$0.0455	-$0.0455	-$0.0456	$0.0000	$0.0000	−$0.0456	−$0.0456	−$0.0456	−$7,659,000
Total expenditures	$0.2566	$0.2436	$0.1299	$0.0769	$0.0000	$0.0000	$0.0746	$0.0784	$0.0774	**$35,797,000**
Percent change										
Premiums	0.0480%	0.0429%	0.0224%	0.0164%	0.0000%	0.0000%	0.0156%	0.0142%	0.0147%	0.0300%
Total expenditures	0.0402%	0.0335%	0.0159%	0.0103%	0.0000%	0.0000%	0.0097%	0.0090%	0.0092%	0.0243%

Source: California Health Benefits Review Program, 2023.
Note: (a) Includes enrollees with grandfathered and nongrandfathered health insurance acquired outside or through Covered California (the state's health insurance marketplace).

(b) Includes only CalPERS enrollees in DMHC-regulated plans. Approximately 51.7% are state retirees, state employees, or their dependents. About one in five (22.5%) of these enrollees has a pharmacy benefit not subject to DMHC. CHBRP has projected no impact for those enrollees. However, CalPERS could, postmandate, require equivalent coverage for all its members (which could increase the total impact on CalPERS).
(c) Includes only Medi-Cal beneficiaries enrolled in DMHC-regulated plans. Includes those who are also Medicare beneficiaries.
(d) Enrollees in plans and policies regulated by DMHC or CDI. Includes those associated with Covered California, CalPERS, or Medi-Cal.
(e) In some cases, a union or other organization - or Medi-Cal for its beneficiaries.
(f) 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 covered by insurance at baseline. This only includes those expenses that will be newly covered, postmandate. Other components of expenditures in this table includes all health care services covered by insurance.
Key: CalPERS = California Public Employees' Retirement System Health Maintenance Organizations; CDI = California Department of Insurance; COHS = County Operated Health Systems; DMHC = Department of Managed Health.

Table 7. Postmandate Changes in Per Member Per Month Premiums and Total Expenditures, DMHC-Regulated Market Segment, California, 2024

	Commercial DMHC-Regulated							
	Small Group				Individual			
	Grandfathered	*Nongrandfathered*			*Grandfathered*	*Nongrandfathered*		
		Covered California	*Mirror Plans*	*Other*		*Covered California*	*Mirror Plans*	*Other*
Enrollee counts								
Total enrollees in plans/policies subject to state mandates (a)	165,000	80,000	634,000	1,333,000	57,000	2,031,000	358,000	172,000
Total enrollees in plans/policies subject to AB1645	165,000	80,000	634,000	1,333,000	57,000	2,031,000	358,000	172,000
Premium costs								
Average portion of premium paid by employer (b)	$1.5116	$0.0715	$0.0710	$0.0721	$0.0000	$0.0000	$0.0000	$0.0000
Average portion of premium paid by enrollee	$0.6528	$0.0309	$0.0307	$0.0311	$2.2032	$0.1001	$0.0942	$0.0912
Total premium	**$2.1644**	**$0.1023**	**$0.1017**	**$0.1032**	**$2.2032**	**$0.1001**	**$0.0942**	**$0.0912**
Enrollee expenses								
Cost sharing for covered benefits (deductibles, copays, etc.)	$0.1515	$0.0233	$0.0238	$0.0226	$0.2440	$0.0251	$0.0298	$0.0322
Expenses for noncovered benefits (c)	-$0.0448	-$0.0456	-$0.0456	-$0.0456	-$0.0447	-$0.0456	-$0.0456	-$0.0456
Total expenditures	**$2.2711**	**$0.0801**	**$0.0799**	**$0.0802**	**$2.4024**	**$0.0796**	**$0.0784**	**$0.0778**
Postmandate percentage change								
Percent change insured premiums	0.3887%	0.0180%	0.0186%	0.0164%	0.4777%	0.1790%	0.1808%	0.1937%

Percent change total expenditures	**0.3797%**	**0.0114%**	**0.0118%**	**0.0104%**	**0.4495%**	**0.1508%**	**0.1519%**	**0.1626%**

Source: California Health Benefits Review Program, 2023.
Note: (a) Enrollees in plans and policies regulated by DMHC or CDI. Includes those associated with Covered California, CalPERS, or Medi-Cal.
(b) In some cases, a union or other organization – or Medi-Cal for its beneficiaries.
(c) 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 covered by insurance at baseline. This only includes those expenses that will be newly covered, postmandate. Other components of expenditures in this table includes all health care services covered by insurance.
Key: CalPERS = California Public Employees' Retirement System Health Maintenance Organizations; CDI = California Department of Insurance; COHS = County Operated Health Systems; DMHC = Department of Managed Health.

Table 8. Postmandate Changes in Per Member Per Month Premiums and Total Expenditures by CDI-Regulated Market Segment, California, 2024

	Commercial CDI-Regulated							
	Small Group				Individual			
	Grandfathered (a)	*Nongrandfathered*			*Grandfathered*	*Nongrandfathered*		
		Covered California	*Mirror Plans*	*Other*		*Covered California*	*Mirror Plans*	*Other*
Enrollee counts								
Total enrollees in plans/policies subject to state mandates (b)		1,000	17,000	17,000	56,000	55,000	6,000	10,000
Total enrollees in plans/policies subject to AB1645		1,000	17,000	17,000	56,000	55,000	6,000	10,000
Premium costs								
Average portion of premium paid by employer (c)		$0.0735	$0.0766	$0.0702	$0.0000	$0.0000	$0.0000	$0.0000
Average portion of premium paid by enrollee		$0.0240	$0.0250	$0.0229	$0.0999	$0.0863	$0.0813	$0.0893
Total premium		**$0.0975**	**$0.1016**	**$0.0932**	**$0.0999**	**$0.0863**	**$0.0813**	**$0.0893**
Enrollee expenses								
Cost-sharing for covered benefits (deductibles, copays, etc.)		$0.0265	$0.0232	$0.0300	$0.0246	$0.0354	$0.0394	$0.0331
Expenses for noncovered benefits (d)		-$0.0456	-$0.0456	-$0.0456	-$0.0456	-$0.0456	-$0.0456	-$0.0456
Total expenditures		**$0.0784**	**$0.0793**	**$0.0776**	**$0.0789**	**$0.0762**	**$0.0752**	**$0.0768**
Postmandate percentage change								
Percent change insured premiums		0.0135%	0.0131%	0.0157%	0.0153%	0.0161%	0.0164%	0.0085%

Percent change total expenditures	**0.0085%**	**0.0083%**	**0.0099%**	**0.0096%**	**0.0100%**	**0.0102%**	**0.0053%**

Source: California Health Benefits Review Program, 2023.
Note: (a) Fewer than 500 enrollees.
(b) Enrollees in plans and policies regulated by DMHC or CDI. Includes those associated with Covered California, CalPERS, or Medi-Cal.
(c) In some cases, a union or other organization - or Medi-Cal for its beneficiaries.
(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 covered by insurance at baseline. This only includes those expenses that will be newly covered, postmandate. Other components of expenditures in this table includes all health care services covered by insurance.
Key: CalPERS = California Public Employees' Retirement System Health Maintenance Organizations; CDI = California Department of Insurance; COHS = County Operated Health Systems; DMHC = Department of Managed Health.

PUBLIC HEALTH IMPACTS

As discussed in the *Policy Context* section, AB 1645 includes language that addresses cost-sharing and other limitations to coverage for sexually transmitted infection (STIs) screenings recommended by USPSTF and/or CDC (see Table D1 in Appendix D) as well as other preventive services identified by the California Preventive Services mandate.

The public health impact analysis includes estimated impacts in the short term (within 12 months of implementation) and in the long term (beyond the first 12 months postmandate). This section estimates the short-term impact[56] of AB 1645 on STI screening and treatment and other preventive services. See *Long-Term Impacts* for discussion of premature death, economic loss, social determinants of health.

Estimated Public Health Outcomes

Preventive Services

As presented in the *Medical Effectiveness* section, there is clear and convincing evidence based on the United States Preventive Services Task Force recommendations that A- and B-level preventive services are effective in improving health and preventing disease. As presented in the *Benefit Coverage, Utilization, and Cost Impacts* section, AB 1645 is expected to result in an increase in provision of an additional approximately 116,400 preventive services such as cancer screenings, well baby visits, and annual exams (as derived from the Utilization and Cost subsection of Table 1). Note, while it is expected that utilization will increase by 116,400 preventive services, as patients typically engage in more than one preventive service at an office visit, this will impact much fewer than 116,400 people. Although it was beyond the scope of this review to break out each preventive service individually and estimate specific impacts to the health of the population, it is estimated that these additional preventive services will lead to improved health outcomes overall.

In the first-year postmandate, CHBRP estimates an additional approximately 116,400 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.

Sexually Transmitted Infections

As presented in *Medical Effectiveness*, there is clear and convincing evidence based on the CDC's *Sexually Transmission Infections Treatment Guidelines, 2021* that the recommended tests and treatments are effective and that untreated STIs can lead to serious complications. As presented in the *Benefit Coverage, Utilization, and Cost Impacts* section, AB 1645 is expected to increase screening for STIs of 116,300 (as derived from the Utilization and Cost subsection of Table 1). It is likely that patients could receive multiple tests in the same visit, therefore the number of people with additional STI screening is likely much less.

Per the 2021 CDC Guidelines, recommended testing and treatments for STIs relevant to this analysis promote a reduction, elimination, and/or shortened duration of related symptoms (e.g., reduction in warts); control in infection; suppression of viral replication; reduction in transmission of disease to a noninfected sexual partner; and/or cure rates of 92% to 100% based on the type of STI (e.g., receipt of recommended treatments for chlamydia can result in cure rates of 97% to 98%). Given the anticipated increase in utilization, it is estimated that there will be an accompanying increase in treatment for HIV, hepatitis C, and other STIs such as gonorrhea, chlamydia, syphilis, and hepatitis B, and HPV, and a subsequent decrease in short- and long-term health outcomes based on the type of STI.

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

In the first year postmandate, CHBRP estimates an additional 116,300 tests will be conducted to screen for STIs and that additional 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.

Impact on Disparities[57]

As reported in the *Background* section, disparities in the use of preventive services generally and STI screening specifically exist by race/ethnicity; age; sex; and gender identity/sexual orientation; socioeconomic status, and incarceration status. As AB 1645 specifically expands STI screening for MSM and transgender and gender diverse individuals, it is possible that disparities in STIs by gender identity and sexual orientation may decrease as a result of this mandate. It is unknown to what extent disparities among other groups for STIs or other conditions for which preventive services are used would change in the first 12 months postmandate.

A number of disparities in preventive services utilization and prevalence of STIs exist in the United States; and it is possible that disparities in STIs by gender identity and sexual orientation may decrease as a result of AB 1645.

[57] For details about CHBRP's methodological approach to analyzing disparities, see the *Benefit Mandate Structure and Unequal Racial/Ethnic Health Impacts* document here: https://www.chbrp.org/about/analysis-methodology/public-health-impact-analysishttps://www.chbrp.org/about/analysis-methodology/public-health-impact-analysis.

LONG-TERM IMPACTS

In this section, CHBRP estimates the long-term impact of AB 1645, which CHBRP defines as impacts occurring beyond the first 12 months after 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 Utilization and Cost Impacts

Utilization Impacts

CHBRP expects long-term utilization to be similar to the first year of postmandate utilization.

Cost Impacts

CHBRP expects long-term costs to be similar to the first year of postmandate utilization.

Long-Term Public Health Impacts

Some interventions in proposed mandates provide immediate measurable impacts (e.g., maternity service coverage or acute care treatments), whereas 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 (beyond 12 months postmandate) to the public's health that would be attributable to the mandate, including impacts disparities, premature death, and economic loss.

In the case of AB 1645 CHBRP estimates the change in utilization would increase for both STI screening, STI treatment, and 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.

Impacts on Premature Death and Economic Loss of Additional Sexually Transmitted Infection Screening/Tests

Premature death

Premature death is often defined as death occurring before the age of 75 years (NCI, 2019).[58] In California, it is estimated that there were nearly 5,300 years of potential life lost (YPLL) per 100,000 population each year between 2015 and 2017 (CDPH, 2019b; County Health Rankings, 2019).[59] As premature death associated with STIs can occur long after acute infection, incidence rates attributed to STI infection can be hard to estimate and/or be inaccurately reported (McElligott, 2014). For example, while syphilis can result in death, other STIs, such as HPV, HIV, and hepatitis B, can result in death due

[58] For more information about CHBRP's public health methodology, see http://chbrp.com/analysis_methodology/public_health_impact_analysis.php.
[59] The overall impact of premature death due to a particular disease can be measured in years of potential life lost prior to age 75 and summed for the population (generally referred to as "YPLL") (Gardner and Sanborn, 1990).

to secondary sequelae (McElligott, 2014). Moreover, gonococcal, and/or chlamydial infections may result in death due to pathogenic infection and/or from secondary sequelae (e.g., ectopic pregnancy) (McElligott, 2014). Although the aforementioned STIs can result in death, surveillance data can be inaccurate or underreported as a result of failing to record the prevalence of STI(s) on death certificates (McElligott, 2014). Mortality is a relevant outcome primarily for the following four specific STIs: hepatitis B, HIV, HPV, and syphilis. The estimates of premature death due to these four STIs in addition to the estimates for two selected preventive services (tobacco dependence treatment and HPV immunization) are provided below.

- The age-adjusted mortality rate for hepatitis B in the United States was 0.46 per 100,000 persons in 2017 (CDC, 2019). Within California, 61 deaths in 2017 were attributed to hepatitis B per the CDC WONDER online database (CDC, 2020a). While some acute HBV infections can resolve on their own, others can develop into chronic infection, in which approximately 1% of reported cases across the United States can lead to liver failure and/or death (CDC, 2015b).
- According to the California Department of Public Health (CDPH, 2018b), the annual number of deaths of persons with HIV infection increased from 1,774 in 2014 to 1,872 in 2018 (equal to 4.7 per 100,000 population). Note: these data on deaths of persons with diagnosed HIV infection represent all causes of death and may not be related to HIV infection (CDPH, 2018b).
- If left untreated, syphilis can result in severe health outcomes, especially among pregnant mothers; in fact, congenital syphilis can result in miscarriage; stillbirth; premature birth or low birth weight; and/or infant death shortly after birth (CDC, 2015b). According to the California Department of Public Health, of the 329 cases of congenital syphilis, 19 cases resulted in still births and 3 cases resulted in neonatal deaths (CDPH, 2018c).
- If left untreated, HPV can increase the risk for several types of cancer that can lead to mortality, such as cervical, anal, and oropharyngeal cancers, with 100%, 91%, and 70% of all cases, respectively, attributed to HPV (CDC, 2015b, 2019). In 2014, 472 deaths in California were attributed to cervical cancer – a known HPV-associated cancer. In 2014, 130 deaths were attributed to anal cancer, and an additional 1,027 deaths were attributed to oropharyngeal cancers (ACS et al., 2017).
- Tobacco use is the number one cause of preventable death and disability in the United States (CDC, 2021). It is estimated that there are more than 40,000 adults in California who die each year from their own tobacco use (CTK, 2023). In addition, it is estimated that more than 440,000 children currently alive in California will ultimately die prematurely from tobacco use (CTK, 2023).

There is clear and convincing evidence that screening and treatment for STIs and other preventive services reduces the premature mortality associated with various diseases. Therefore, it is possible that AB 1645 will lead to a reduction in premature death for the enrollees who will newly receive preventive services in California, although the exact impact is unknown.

Economic loss

Economic loss associated with disease is generally presented in the literature as an estimation of the value of the YPLL in dollar amounts (i.e., valuation of a population's lost years of work over a lifetime). In addition, morbidity associated with the disease or condition of interest can also result in lost productivity by causing a worker to miss days of work due to illness or acting as a caregiver for someone else who is ill.

While there is no estimate of the economic loss associated with STIs or other preventable diseases overall, researchers have attempted to estimate the economic loss (both direct and indirect) associated with individual STIs and diseases. For example, Chesson et al. (2008) estimated the economic losses associated with cervical cancer, syphilis, congenital syphilis, chlamydia, gonorrhea, and HIV. These estimates consisted of direct medical costs and the indirect costs related to a reduction in productivity due to premature mortality. CHBRP translated these findings on costs per case into 2020 dollars and calculated the following California-level estimates using rates of state-wide prevalence.

- For each case of syphilis, approximately $734 in direct and $144 in indirect costs would be avoided per individual case prevented. The total burden across California is estimated at $21,954,175.
- For each case of congenital syphilis, approximately $8,646 in direct and $77,526 in indirect costs would be avoided per individual case prevented. The total burden across California is estimated at $28,350,494.
- For each case of gonorrhea, approximately $440 in direct and $219 in indirect costs would be avoided per individual case prevented among females. The total burden across California for both males and females is estimated at $24,333,068.
- For each case of chlamydia, approximately $404 in direct and $190 in indirect costs would be avoided per individual case prevented among females. The total burden across California for both males and females is estimated at $89,055,987.
- For each case of HIV, approximately $254,000 in direct and $1.1 million in indirect costs would be avoided per individual case prevented. The total burden across California is estimated at $178,429,778,573.
- It is estimated that California spends $15.44 billion each year in health care costs treating tobacco related disease (CTK, 2023).

APPENDIX A TEXT OF BILL ANALYZED

On February 21, 2023, the California Assembly Committee on Health requested that CHBRP analyze AB 1645, as introduced on February 17, 2023

ASSEMBLY BILL **NO. 1645**

Introduced by Assembly Member Zbur

February 17, 2023

An act to amend Section 1367.002 of, and to add Section 1367.0021 to, the Health and Safety Code, and to amend Section 10112.2 of, and to add Section 10112.20 to, the Insurance Code, relating to health care coverage.

LEGISLATIVE COUNSEL'S DIGEST

AB 1645, as introduced, Zbur. Health care coverage: cost sharing.

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. Existing law requires a group or individual nongrandfathered health care service plan contract or health insurance policy to provide coverage for, and prohibits a contract or policy from imposing cost-sharing requirements for, specified preventive care services and screenings.

This bill would prohibit a group or individual nongrandfathered health care service plan contract or health insurance policy issued, amended, or renewed on or after January 1, 2024, from imposing a cost-sharing requirement for office visits for the above-described preventive care services and screenings and for items or services that are integral to their provision. The bill would prohibit those contracts and policies from imposing a cost-sharing requirement, utilization review, or other specified limits on a recommended sexually transmitted infections screening, and from imposing a cost-sharing requirement for any items and services integral to a sexually transmitted infections screening, as specified. The bill would require a plan or insurer to directly reimburse a nonparticipating provider or facility of sexually transmitted infections screening that meets specified criteria its median contracted rate in the general geographic region for screening tests and integral items and services rendered, and would prohibit a nonparticipating provider from billing or collecting a cost-sharing amount for a sexually transmitted infections screening from an enrollee or insured. Because a violation of the bill’s requirements 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.

Vote: majority Appropriation: no Fiscal Committee: yes Local Program: yes

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

SECTION 1. Section 1367.002 of the Health and Safety Code is amended to read:

1367.002. (a) A group or individual ~~nongrandfathered~~ health care service plan contract shall, at a minimum, provide coverage ~~for~~ *for,* and shall not impose any cost-sharing requirements ~~for~~ *for,* any of the following:

(1) Evidence-based items or services that have in effect a rating of "A" or "B" in the recommendations of the United States Preventive Services Task Force, as periodically updated.

(2) Immunizations that have in effect a recommendation, as periodically updated, from the Advisory Committee on Immunization Practices of the federal Centers for Disease Control and Prevention with respect to the individual involved.

(3) With respect to infants, children, and adolescents, evidence-informed preventive care and screenings provided in the comprehensive guidelines, as periodically updated, supported by the United States Health Resources and Services Administration.

(4) With respect to women, those additional preventive care and screenings not described in paragraph (1) as provided for in comprehensive guidelines supported by the United States Health Resources and Services Administration for purposes of this paragraph.

(5) For the purposes of this ~~section, the~~ *section:*

(A) The current recommendations of the United States Preventive Services Task Force regarding breast cancer screening, mammography, and prevention shall be considered the most ~~current other than~~ *current, not including* those issued in or around November 2009.

(B) A health care service plan contract issued, amended, or renewed on or after January 1, 2024, shall not impose any cost-sharing requirement for office visits that are associated with the provision of an item or service that is required by this subdivision, or for any items or services that are integral to the provision of an item or service that is required by this subdivision, regardless of whether the office visit

or integral item or service is billed, or tracked as individual encounter data, separately from an item or service that is required by this subdivision.

(i) "Integral item or service" means an item, service, prescription drug, device, or product, or nonprescription drug, device, or product, that is a current, generally accepted standard of care or clinical practice for the provision of an item or service that is required by this subdivision.

(ii) "Current, generally accepted standard of care or clinical practice" means standards of care and clinical practice that are generally accepted by health care providers practicing in relevant clinical specialties, such as family medicine, pediatrics, preventive medicine, infectious diseases, obstetrics and gynecology, and public health. Valid, evidence-based sources establishing current, generally accepted standards of care and clinical practice include peer-reviewed scientific studies and medical literature, the most recently updated clinical practice guidelines and recommendations of nonprofit health care provider professional associations, specialty societies and federal government agencies, including the American College of Obstetricians and Gynecologists and the federal Centers for Disease Control and Prevention, and product labeling approved by the United States Food and Drug Administration.

(b) This section does not prohibit a health care service plan ~~contract from providing~~ *from doing either of the following:*

(1) Providing coverage for *preventive items or* services in addition to those ~~recommended by the United States Preventive Services Task Force or to deny~~ *required by subdivision (a).*

(2) Denying coverage for services that are not recommended by the United States Preventive Services Task ~~Force.~~ *Force, except as provided by subdivision (d).*

(c) A health care service plan shall provide coverage pursuant to subdivision (a) for plan years that begin on or after the date that is one year after the date ~~the~~ *that a novel* recommendation or guideline is issued. *A health care service plan shall provide coverage for modified or upgraded recommendations or guidelines pursuant to subdivision (a) no later than the first day of the plan year after the modification or upgrade was adopted or 90 days after the date on which the modification or upgrade was adopted, whichever is earlier in the calendar year.*

(1) A health care service plan that is required to provide coverage for any items and services specified in a recommendation or guideline described in subdivision (a) on the first day of a plan year shall provide coverage through the last day of the plan year, even if the recommendation or guideline changes or is no longer described in subdivision (a) during the plan year.

(2) Notwithstanding paragraph (1), if a recommendation or guideline described in paragraph (1) of subdivision (a) that was in effect on the first day of a plan year is

downgraded to a "D" rating, or if any item or service associated with any recommendation or guideline specified in subdivision (a) is subject to a safety recall or is otherwise determined to pose a significant safety concern by a federal agency authorized to regulate the item or service during a plan year, a health care service plan is not required to cover the item or service through the last day of the plan year.

(d) (1) A health care service plan contract shall cover items and services pursuant to this section in accordance with an applicable requirement of this chapter, including Sections 1342.74 on prophylaxis of HIV infection, 1367.0021 on sexually transmitted infections screening, 1367.34 as added by Section 3 of Chapter 486 of the Statutes of 2021 on home test kits for sexually transmitted diseases, and 1367.668 on colorectal cancer screening.

(2) Notwithstanding paragraph (1), Section 1367.25 shall exclusively govern the coverage of contraceptive drugs, devices, and products pursuant to this chapter.

~~(d)~~

(e) This section does not apply to a *health care service plan contract that is a grandfathered health plan, or to a* specialized health care service plan that does not cover an essential health benefit, as defined in Section 1367.005. ~~This~~ *The cost-sharing requirements of this* section shall only apply to a health savings account-eligible health care service plan to the extent it does not fail to be treated as a high deductible health plan under Section 223 of Title 26 of the United States Code.

~~(e)~~

(f) The department shall coordinate with the Department of Insurance if it adopts regulations to implement this section.

SEC. 2. Section 1367.0021 is added to the Health and Safety Code, to read:

1367.0021. (a) In addition to the items and services that are required by Section 1367.002, a group or individual health care service plan contract issued, amended, or renewed on or after January 1, 2024, shall not impose a cost-sharing requirement on a sexually transmitted infections screening that is recommended by the federal Centers for Disease Control and Prevention (CDC) in the most recently updated version of its Sexually Transmitted Infections Treatment Guidelines, as subsequently modified by any published updates in the Morbidity and Mortality Weekly Report or similar method of official public communication. If a screening recommendation of the United States Preventive Services Task Force conflicts with that of the CDC, or omits a CDC screening recommendation, a health care service plan contract shall not require any cost sharing for a sexually transmitted infections screening, or for any items and services that are integral to a screening, that is performed by an essential community provider or participating provider, facility, or processing laboratory consistent with the CDC's recommendation.

(b) Notwithstanding Section 2713 of the federal Public Health Service Act (42 U.S.C. Sec. 300gg), a health care service plan contract issued, amended, or renewed on or after January 1, 2024, shall not require or impose any of the following for coverage of sexually transmitted infections

screening, or of any items and services that are integral to a screening, that is performed by an essential community provider or participating provider, facility, or processing laboratory:

(1) Prior authorization or other utilization review requirements.

(2) Limits on frequency, method, treatment, or setting.

(3) Limits on confirmatory or post-treatment retesting of an asymptomatic patient.

(4) Limits that are based on risk of infection, sexual behavior, sexual orientation, gender, or anatomical sites of screening.

(5) Any other limits on the coverage or provision of sexually transmitted infections screening as a preventive item or service under this section, Section 1367.002, or Section 1367.34 as added by Section 3 of Chapter 486 of the Statutes of 2021, as a preventive basic health care service, or that constitutes a discriminatory benefit design or marketing practice as prohibited by this chapter.

(c) A health care service plan contract issued, amended, or renewed on or after January 1, 2024, shall not impose a cost-sharing requirement for sexually transmitted infections screening, or for any items and services that are integral to a screening, under this section, Section 1367.002, or Section 1367.34 as added by Section 3 of Chapter 486 of the Statutes of 2021, regardless of any of the following:

(1) The location or method of sample collection or processing, including at locations that are both clinical and nonclinical in nature, regardless of whether a location constitutes a health care setting.

(2) The screening test, testing method or algorithm, or method of sample collection or processing.

(3) The identity or qualifications of the individual who collected or processed a sample.

(4) The clinical circumstances of screening, including whether or not a screening was based on risk of infection, or there was an emergent or urgent need for immediate or prompt screening or the results of screening.

(d) A health care service plan shall directly reimburse a nonparticipating provider or facility of sexually transmitted infections screening its median contracted rate in the general geographic region for screening tests and integral items and services rendered, if the provider or facility was an essential community provider when the screening tests and integral items and services were rendered. If a nonparticipating essential community provider does not generate the results of screening, the provider shall submit the samples to a participating processing laboratory. A nonparticipating essential community provider shall not bill or collect any cost-sharing amounts from an enrollee for a sexually transmitted infections screening, or for integral items and services,

under this section, Section 1367.002, or Section 1367.34 as added by Section 3 of Chapter 486 of the Statutes of 2021.

(e) For purposes of this section:

(1) "Essential community provider" means a provider or facility that is eligible for listing, and is listed, on the California Health Benefit Exchange's Essential Community Provider List.

(2) "General geographic region" has the same meaning as provided by Section 1371.31 and the regulations promulgated thereunder.

(3) "Gender" means sex, including gender identity and gender expression.

(4) "Gender expression" means gender-related appearance and behavior, whether or not stereotypically associated with assigned sex at birth.

(5) "Utilization review" has the same meaning as defined by Section 1374.721 and any regulations promulgated thereunder.

(f) This section does not apply to a specialized health care service plan contract that does not cover an essential health benefit, as defined by Section 1367.005. If a health care service plan contract is a high deductible health plan under the definition set forth in Section 223(c)(2) of Title 26 of the United States Code, the contract shall not impose a deductible on sexually transmitted infections screening, or on integral items and services, under this section, Section 1367.002, or Section 1367.34 as added by Section 3 of Chapter 486 of the Statutes of 2021, unless not applying the deductible would conflict with federal requirements for high deductible health plans.

SEC. 3. Section 10112.2 of the Insurance Code is amended to read:

10112.2. (a) A group or individual ~~nongrandfathered~~ health insurance policy shall, at a minimum, provide coverage ~~for~~ *for*, and shall not impose any cost-sharing requirements ~~for~~ *for*, any of the following:

(1) Evidence-based items or services that have in effect a rating of "A" or "B" in the recommendations of the United States Preventive Services Task Force, as periodically updated.

(2) Immunizations that have in effect a recommendation, as periodically updated, from the Advisory Committee on Immunization Practices of the federal Centers for Disease Control and Prevention with respect to the individual involved.

(3) With respect to infants, children, and adolescents, evidence-informed preventive care and screenings provided in the comprehensive guidelines, as periodically updated, supported by the United States Health Resources and Services Administration.

(4) With respect to women, those additional preventive care and screenings not described in paragraph (1) as provided for in comprehensive guidelines supported by the United States Health Resources and Services Administration for purposes of this paragraph.

(5) For the purposes of this ~~section, the~~ *section:*

(A) The current recommendations of the United States Preventive Services Task Force regarding breast cancer screening, mammography, and prevention shall be considered the most ~~current other than~~ *current, not including* those issued in or around November 2009.

(B) A health insurance policy issued, amended, or renewed on or after January 1, 2024, shall not impose any cost-sharing requirement for office visits that are associated with the provision of an item or service that is required by this subdivision, or for any items or services that are integral to the provision of an item or service that is required by this subdivision, regardless of whether the office visit or integral item or service is billed, or tracked as individual encounter data, separately from an item or service that is required by this subdivision.

(i) "Integral item or service" means an item, service, prescription drug, device, or product, or nonprescription drug, device, or product, that is a current, generally accepted standard of care or clinical practice for the provision of an item or service that is required by this subdivision.

(ii) "Current, generally accepted standard of care or clinical practice" means standards of care and clinical practice that are generally accepted by health care providers practicing in relevant clinical specialties, such as family medicine, pediatrics, preventive medicine, infectious diseases, obstetrics and gynecology, and public health. Valid, evidence-based sources establishing current, generally accepted standards of care and clinical practice include peer-reviewed scientific studies and medical literature, the most recently updated clinical practice guidelines and recommendations of nonprofit health care provider professional associations, specialty societies and federal government agencies, including the American College of Obstetricians and Gynecologists and the federal Centers for Disease Control and Prevention, and product labeling approved by the United States Food and Drug Administration.

(b) This section does not prohibit a health ~~insurance policy from providing~~ *insurer from doing either of the following:*

(1) Providing coverage for services in addition to those ~~recommended by the United States Preventive Services Task Force or to deny~~ *required by subdivision (a).*

(2) Denying coverage for services that are not recommended by the United States Preventive Services Task ~~Force.~~ *Force, except as provided by subdivision (d).*

(c) A health insurer shall provide coverage pursuant to subdivision (a) for policy years that begin on or after the date that is one year after the date ~~the~~ *that a novel* recommendation or guideline is issued. *A health insurer shall provide coverage for modified or upgraded recommendations or guidelines pursuant to subdivision (a) no later than the first day of the plan year after the modification or upgrade was adopted or 90 days after the date on which the modification or upgrade was adopted, whichever is earlier in the calendar year.*

(1) A health insurer that is required to provide coverage for any items and services specified in a recommendation or guideline described in subdivision (a) on the first day of a policy year shall provide coverage through the last day of the policy year, even if the recommendation or guideline changes or is no longer described in subdivision (a) during the policy year.

(2) Notwithstanding paragraph (1), if a recommendation or guideline described in paragraph (1) of subdivision (a) that was in effect on the first day of a policy year is downgraded to a "D" rating, or if any item or service associated with any recommendation or guideline specified in subdivision (a) is subject to a safety recall or is otherwise determined to pose a significant safety concern by a federal agency authorized to regulate the item or service during a policy year, a health insurer is not required to cover the item or service through the last day of the policy year.

(d) (1) A health insurance policy shall cover items and services pursuant to this section in accordance with an applicable requirement of this part, including Sections 10112.20 on sexually transmitted infections screening, 10123.1933 on prophylaxis of HIV infection, 10123.207 on colorectal cancer screening, and 10123.208 on home test kits for sexually transmitted diseases.

(2) Notwithstanding paragraph (1), Section 10123.196 shall exclusively govern the coverage of contraceptive drugs, devices, and products pursuant to this part.

~~(d)~~

(e) This section does not apply to a *health insurance policy that is a grandfathered health plan, or to a* specialized health insurance policy that does not cover an essential health benefit, as defined in Section 10112.27. ~~This~~ *The cost-sharing requirements of this* section shall only apply to a health savings account-eligible health insurance policy to the extent it does not fail to be treated as a high deductible health ~~insurance policy~~ *plan* under Section 223 of Title 26 of the United States Code.

~~(e)~~

(f) The department shall coordinate with the Department of Managed Health Care if it adopts regulations to implement this section.

(g) The commissioner and department may exercise the authority provided by this code and the Administrative Procedure Act (Chapter 3.5 (commencing with Section 11340), Chapter 4.5 (commencing with Section 11400), and Chapter 5 (commencing with Section 11500) of Part 1 of Division 3 of Title 2 of the Government Code) to implement and enforce this section and all related sections, including those referenced herein. If the commissioner assesses a civil penalty for a violation, any hearing that is requested by the insurer shall be conducted by an administrative law judge of the Administrative Hearing Bureau of the department under the formal procedure of Chapter 5. This subdivision does not impair or restrict the commissioner's authority pursuant to another provision of this code or the Administrative Procedure Act.

SEC. 4. Section 10112.20 is added to the Insurance Code, immediately following Section 10112.2, to read:

10112.20. (a) In addition to the items and services that are required by Section 10112.2, a group or individual health insurance policy issued, amended, or renewed on or after January 1, 2024, shall not impose a cost-sharing requirement on a sexually transmitted infections screening that is recommended by the federal Centers for Disease Control and Prevention (CDC) in the most recently updated version of its Sexually Transmitted Infections Treatment Guidelines, as subsequently modified by any published updates in the Morbidity and Mortality Weekly Report or similar method of official public communication. If a screening recommendation of the United States Preventive Services Task Force conflicts with that of the CDC, or omits a CDC screening recommendation, a health insurance policy shall not require any cost sharing for a sexually transmitted infections screening, or for any items and services that are integral to a screening, that is performed by an essential community provider or participating provider, facility, or processing laboratory consistent with the CDC's recommendation.

(b) Notwithstanding Section 2713 of the federal Public Health Service Act (42 U.S.C. Sec. 300gg), a health insurance policy issued, amended, or renewed on or after January 1, 2024, shall not require or impose any of the following for coverage of sexually transmitted infections screening, or of any items and services that are integral to a screening, that is performed by an essential community provider or participating provider, facility, or processing laboratory:

(1) Prior authorization or other utilization review requirements.

(2) Limits on frequency, method, treatment, or setting.

(3) Limits on confirmatory or post-treatment retesting of an asymptomatic patient.

(4) Limits that are based on risk of infection, sexual behavior, sexual orientation, gender, or anatomical sites of screening.

(5) Any other limits on the coverage or provision of sexually transmitted infections screening as a preventive item or service under this section, Section 10112.2, or Section 10123.208, as a preventive basic health care service, or that constitutes a discriminatory benefit design or marketing practice as prohibited by this chapter.

(c) A health insurance policy issued, amended, or renewed on or after January 1, 2024, shall not impose a cost-sharing requirement for sexually transmitted infections screening, or for any items and services that are integral to a screening, under this section, Section 10112.2, or Section 10123.208, regardless of any of the following:

(1) The location or method of sample collection or processing, including at locations that are both clinical and nonclinical in nature, regardless of whether a location constitutes a health care setting.

(2) The screening test, testing method or algorithm, or method of sample collection or processing.

(3) The identity or qualifications of the individual who collected or processed a sample.

(4) The clinical circumstances of screening, including whether or not a screening was based on risk of infection, or there was an emergent or urgent need for immediate or prompt screening or the results of screening.

(d) A health insurer shall directly reimburse a nonparticipating provider or facility of sexually transmitted infections screening its median contracted rate in the general geographic region for screening tests and integral items and services rendered, if the provider or facility was an essential community provider when the screening tests and integral items and services were rendered. If a nonparticipating essential community provider does not generate the results of screening, the provider shall submit the samples to a participating processing laboratory. A nonparticipating essential community provider shall not bill or collect any cost sharing amounts from an insured for a sexually transmitted infections screening, or for integral items and services, under this section, Section 10112.2, or Section 10123.208.

(e) For purposes of this section:

(1) “Essential community provider” means a provider or facility that is eligible for listing, and is listed, on the California Health Benefit Exchange’s Essential Community Provider List.

(2) “General geographic region” has the same meaning as provided by Section 10112.82 and the regulations promulgated thereunder.

(3) “Gender” means sex, including gender identity and gender expression.

(4) “Gender expression” means gender-related appearance and behavior, whether or not stereotypically associated with assigned sex at birth.

(5) “Utilization review” has the same meaning as defined by Section 10144.52 and any regulations promulgated thereunder.

(f) This section does not apply to a specialized health insurance policy that does not cover an essential health benefit, as defined by Section 10112.27. If a health insurance policy is a high deductible health plan under the definition set forth in Section 223(c)(2) of Title 26 of the United States Code, the policy shall not impose a deductible on sexually transmitted infections screening, or on integral items and services, under this section, Section 10112.2, or Section 10123.208, unless not applying the deductible would conflict with federal requirements for high deductible health plans.

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

This appendix describes methods used in the literature review conducted for this report. A discussion of CHBRP's system for medical effectiveness grading evidence, as well as lists of MeSH Terms, publication types, and keywords, follows.

Studies of the effects of the effects of cost sharing on the utilization of preventive services and STI screening were identified through searches of PubMed (MEDLINE) and the Cochrane Library. The search was limited to abstracts of studies published in English. The search was limited to studies published from 2012. Due to the focus on utilization and screening rates, the majority of the literature examined claims data and included few randomized controlled trials.

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.

Medical Effectiveness Review

The medical effectiveness literature review returned abstracts for 96 articles, of which 46 were reviewed for inclusion in this report. A total of 18 studies were included in the medical effectiveness review for AB 1645.

Medical Effectiveness 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*.[60] To grade the evidence for each outcome measured, the team uses a grading system that has the following categories:

- Research design;
- Statistical significance;
- Direction of effect;
- Size of effect; and
- Generalizability of findings.

The grading system also contains an overall conclusion that encompasses findings in these five domains. The conclusion is a statement that captures the strength and consistency 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;*
- *Limited evidence;*
- *Inconclusive 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 are of high quality and consistently find that the treatment is either effective or not effective.

[60] Available at: http://chbrp.com/analysis_methodology/medical_effectiveness_analysis.php.

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.

A grade of *limited evidence* indicates that the studies had limited generalizability to the population of interest and/or the studies had a fatal flaw in research design or implementation.

A grade of *inconclusive evidence* indicates that although some studies included in the medical effectiveness review find that a treatment is effective, a similar number of studies of equal quality suggest the treatment is not effective.

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 are not of high quality. It does not indicate that a treatment is not effective.

Search Terms

Medical Effectiveness Keywords

All were cross searched with the terms “utilization,” “prohibition,” “elimination.”

- Cost sharing
- Medicare/Cal
- Preventive screening
- Preventive services
- Affordable care act
- ACA
- Out of pocket * utilization
- Deductible
- Insurance
- STI
- Screening
- Testing
- STD
- Sexually transmitted infection
- Sexually transmitted disease
- Barriers
- Copayment
- Coinsurance

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

With the assistance of CHBRP's contracted actuarial firm, Milliman, Inc, the cost analysis presented in this report was prepared by the faculty and researchers connected to CHBRP's Task Force with expertise in health economics.[61] Information on the generally used data sources and estimation methods, as well as caveats and assumptions generally applicable to CHBRP's cost impacts analyses are available at CHBRP's website.[62]

This appendix describes analysis-specific data sources, estimation methods, caveats, and assumptions used in preparing this cost impact analysis.

Analysis-Specific Data Sources

Current coverage of and cost-sharing requirements for office visits and associated services relating to Federally mandated Preventive Services and STI screening was assessed by a survey of the largest commercial in California. Responses to this survey represented 52.9% of commercial enrollees with health insurance that can be subject to state benefit mandates.

For this analysis, CHBRP relied on CPT® codes to identify relevant services. CPT copyright 2023 American Medical Association. All rights reserved. Fee schedules, relative value units, conversion factors and/or related components are not assigned by the AMA, are not part of CPT, and the AMA is not recommending their use. The AMA does not directly or indirectly practice medicine or dispense medical services. The AMA assumes no liability for data contained or not contained herein. CPT is a registered trademark of the American Medical Association.

Overview of Analytical Approach

AB 1645 will impact benefit coverage, utilization and cost sharing via multiple distinct elements applicable to various groups of enrollees.

1. Nongrandfathered Plans and Policies:
    a. For all enrollees, for the seven STI screenings (chlamydia, gonorrhea, syphilis, hepatitis B and C, HIV, and human papilloma virus) recommended by the USPSTF and the CDC
        i. New utilization management (UM) prohibitions
        ii. New office visit cost-sharing prohibition
        iii. New requirement for coverage at providers listed on Covered California's Essential Community Provider List
    b. For enrollees in high-risk groups for the seven STI screenings for which the CDC "high risk" parameters exceed the USPSTF parameters,
        i. New all other cost-sharing prohibitions
    c. For all enrollees, for other Federal Preventive Services

[61] CHBRP's authorizing statute, available at https://chbrp.org/about_chbrp/index.php, requires that CHBRP use a certified actuary or "other person with relevant knowledge and expertise" to determine financial impact.
[62] See method documents posted at https://www.chbrp.org/about/analysis-methodology/cost-impact-analysishttps://www.chbrp.org/about/analysis-methodology/cost-impact-analysis; in particular, see *Cost Analyses: Data Sources, Caveats, and Assumptions*.

i. New office visit cost-sharing prohibition

2. Grandfathered Plans and Policies:

a. For all enrollees, for the seven STI screenings recommended by the USPSTF and the CDC

i. New utilization management (UM) prohibitions

ii. New office visit cost-sharing prohibition

iii. New all other cost-sharing prohibitions

iv. New requirement for coverage at providers listed on Covered California's Essential Community Provider List

b. For all enrollees, for other Federal Preventive Services

i. New office visit cost-sharing prohibition

ii. New all other cost-sharing prohibitions

CHBRP performed a test-specific analysis of the STI-related elements of AB 1645 using Milliman's proprietary 2021 Milliman Consolidated Health Cost Guidelines Sources Database™ (CHSD) for commercial members in California and adjustments for each of the coverage expansions under this bill. For the other preventive services, however, CHBRP eschewed the detailed analysis in favor of a general model of the impact of AB 1645 on Preventive Services using Milliman's 2023 Commercial Health Cost Guidelines (HCG).

Detailed Cost Notes Regarding Analysis-Specific Caveats and Assumptions

Methodology and Assumptions for Baseline Benefit Coverage

- The population subject to the mandated offering includes all individuals with commercial health insurance regulated by the DMHC or CDI, and CalPERS plans regulated by the DMHC.
- CHBRP surveyed managed commercial plans and insurers to determine coverage and cost-sharing requirements for office visits and other services related to STI screenings and preventive services. The responses indicated 100% coverage for all California Preventive Services--related office visits and associated services. These services were provided free of cost sharing for enrollees in nongrandfathered plans, and between 0% and 7% of those enrolled in grandfathered plans, depending on market segment.
- No respondents indicated full compliance with the requirements of AB 1645 related to STI screenings.

Methodology and Assumptions for Baseline Utilization

- CHBRP identified the average annual utilization rates for STI screening and associated office visits and services in Milliman's proprietary 2021 Milliman Consolidated Health Cost Guidelines Sources Database™ (CHSD) for commercial members in California. STI screenings were identified by CPT code, as shown in **Table C.1**:

Table C.1: Sexually Transmitted Infection Screening CPT Codes[63]

STI	Codes
Chlamydial infections	86631, 86632, 87110, 87270, 87320, 87490, 87491, 87492, 87810
Gonococcal infections	87590, 87591, 87592, 87850
Syphilis	86592, 86593
Hepatitis B	86704, 86705, 86706, 86707, 87340, 87341, 87350, 87515, 87516, 87517, 87912
Hepatitis C	86803, 87520, 87521, 87522
HIV	86701, 86702, 86703
Human papilloma virus	87623, 87624, 87625

- CHBRP estimated annual utilization rates for California Preventive Services and associated office visits and services using Milliman's 2023 Commercial Health Guidelines™.
- Utilization rates were trended at 0.25% from 2021 to 2024.
- CHBRP made specific assumptions regarding the utilization of self-pay STI screenings and home-test STI screenings, as self-pay services are not observable in claims data. These assumptions are summarized in **Table C.2**.

Table C.2: Baseline Assumptions for Self-Pay and Home Test Kits:

Self-pay	
% of OON STI services at a "noncontracting health care facility"	40.00%
% Self-pay / (INN + OON + self-pay) STI services	25.00%
Home test Kit	
% STI tests offered through self-pay	25.0%
% Tests done at home baseline	10.0%
% Tests done not at home baseline	90.0%
% Baseline (at home, self pay) / (total)	7.5%

Methodology and Assumptions for Baseline Cost

- CHBRP calculated the average California commercial cost per service for STI screening and associated office visits and services in Milliman's proprietary 2021 Milliman Consolidated Health Cost Guidelines Sources Database™ (CHSD) for commercial members in California. .
- The average costs per service were trended at 3.5% annually from 2021 to 2024.
- CHBRP estimated average cost for California Preventive Services and associated office visits and services using Milliman's 2023 Commercial Health Guidelines™.

Methodology and Assumptions for Baseline Cost Sharing

- CHBRP calculated the average California commercial cost sharing for STI screening and associated office visits and services in Milliman's proprietary 2021 Milliman Consolidated Health Cost Guidelines Sources Database™ (CHSD) for commercial members in California.
- The average cost-sharing was trended at 3.5% annually from 2021 to 2024, in line with the average cost per service.

[63] CPT copyright 2023 American Medical Association. All rights reserved.

- CHBRP estimated average cost sharing for Federal Preventive Services and associated office visits and services using Milliman's 2023 Commercial Health Guidelines™.

Methodology and Assumptions for Postmandate Utilization

- The survey of commercial plans and insurers indicated that other than pre-authorization requirements for use of out-of-network providers, no utilization management tools are generally employed with respect to STI screenings or California Preventive Services. Thus, no adjustment was made for AB 1645's prohibitions on utilization management.

- AB 1645 mandates certain expansions of coverage for different enrollee groups, including all USPSTF- or CDC-defined high risk enrollees in grandfathered. For STI screenings, CHBRP estimated the share of the population included in various groups identified as being at higher risk for certain STIs, shown in **Table C.3**:

Table C.3: Higher-risk groups identified in CDC recommendations for STI screenings:

Percentage of population who are women < 25 who are sexually active	2.9%
Percentage of women > 25 who are "high risk" for STIs	2.7%
Percentage of population who are women at "high risk" for syphilis (geo/race/ethnicity)	3.0%
Percentage of population who are straight and sexually active	80.9%
Percentage of population who are 15-65 and at "increased risk" for HIV	5.3%
Percentage of population are MSM, HIV+ or trans/g-diverse	5.6%
Percentage of population who are women 21-65	30.3%

- CHBRP assumed that the availability of out-of-network services would increase out-of-network utilization of STI screenings and associated services by 3.0% for impacted populations without current out-of-network benefits. CHBRP further assumed that this 3.0% would be split as 50% from baseline in-network services and 50% new utilization.

- CHBRP assumed that the availability of Community Essential Providers would increase utilization of STI screenings and associated services by 3% for impacted populations without current out-of-network benefits. CHBRP further assumed that this 3.0% would be split as 50% from baseline in-network services and 50% new utilization.

- CHBRP assumed that AB 1645 would result in a shift of 0.6% from self-pay STI screening to out-of-network STI screenings. (CHBRP analysis of AB 2204 (2021)).

- CHBRP assumed that AB 1645 would increase utilization of STI screenings among qualifying enrollees of grandfathered plans by 25% due to cost sharing prohibition. The total impact of this assumption on STI screening utilization across all populations is approximately 0.8%.

- CHBRP used Milliman's 2023 Commercial Health Guidelines™ to estimate the utilization impact of AB 1645's prohibition of office visit and associated services cost sharing for certain populations on California Preventive Services utilization.

Methodology and Assumptions for Postmandate Cost

- CHBRP assumed the average cost per service provided by in-network providers would not change as a result of AB 1645.

- CHBRP that postmandate unit costs for out-of-network providers and home test kits would be the same as for in-network providers.

Methodology and Assumptions for Postmandate Cost Sharing

- AB 1645 prohibits cost sharing for office visits and associated services related to STI screenings and California Preventive Services under certain conditions. CHBRP adjusted post mandate cost sharing to match the requirements of the bill.

Methodology and Assumptions for Offsets/Additional Costs

- CHBRP assumed that additional testing would increase treatment for HIV by 0.2%.
- CHBRP assumed the additional monthly cost of HIV treatment with anti-retroviral therapy is $2,078 per month (trended to 2024).
- CHBRP assumed the additional cost of an 8-week course of treatment for Hepatitis C is $26,445 (trended to 2024).
- Assumed costs of treatment are not offset by rebates offered by drug manufacturers.

Determining Public Demand for the Proposed Mandate

CHBRP reviews public demand for benefits by comparing 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.

Among publicly funded self-insured health insurance policies, the preferred provider organization (PPO) plans offered by CalPERS have the largest number of enrollees. The CalPERS PPOs currently provide benefit coverage similar to what is available through group health insurance plans and policies that would be subject to the mandate.

To further investigate public demand, CHBRP used the bill-specific coverage survey to ask plans and insurers 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. The responses indicated that there were no substantive differences.

Second-Year Impacts on Benefit Coverage, Utilization, and Cost

CHBRP has considered whether continued implementation during the second year of the benefit coverage requirements of AB 1645 would have a substantially different impact on utilization of either the tests, treatments, or services for which coverage was directly addressed, the utilization of any indirectly affected utilization, or both. CHBRP reviewed the literature and consulted content experts about the possibility of varied second-year impacts and determined the second year's impacts of AB 1645 would be substantially the same as the impacts in the first year (see Table 1). Minor changes to utilization and expenditures are due to population changes between the first year postmandate and the second year postmandate.

APPENDIX D SCREENING GUIDELINES

Table D1. Comparison of STI Screening Recommendations Between the USPSTF and the CDC

STI	USPSTF Screening Recommendation	USPSTF Increased Risk	CDC Screening Population	CDC Increased Risk
Chlamydia	Sexually active women <25 (Grade B)	Women age >24 at increased risk (Grade B) • A previous or coexisting STI • A new or more than 1 sex partner • A sex partner having sex with other partners at the same time • A sex partner with an STI • Inconsistent condom use when not in a mutually monogamous relationship • A history of exchanging sex for money or drugs • A history of incarceration • Communities with higher rates of infection	Same as USPSTF	In addition to USPSTF • MSM • MSM on Prep , with HIV infection, or with multiple partners (every 3-6 months) • Transgender and gender diverse: consider screening at rectal site based on behaviors and exposure
Gonorrhea	Sexually active women <25 (Grade B)	Women age >24 at increased risk (Grade B) • A previous or coexisting STI • A new or more than 1 sex partner • A sex partner having sex with other partners at the same time • A sex partner with an STI • Inconsistent condom use when not in a mutually monogamous relationship • A history of exchanging sex for money or drugs • A history of incarceration • Communities with higher rates of infection	Same as USPSTF	In addition to USPSTF • MSM • MSM on Prep , with HIV infection, or with multiple partners (every 3-6 months) • Transgender and gender diverse: consider screening at rectal site based on behaviors and exposure
Syphilis	Screen for syphilis in persons at increased risk for infection; all pregnant women at first prenatal visit. Grade: A	Risk of syphilis is higher (screen 3-6 months): • In men who have sex with men • Persons with HIV or other STIs • Persons who use illicit drugs • Persons with a history of incarceration, sex work, or military service • Communities with higher rates of infection	Same as USPSTF	In addition to USPSTF • Consider screening transgender and gender diverse people at least annually

STI	USPSTF Screening Recommendation	USPSTF Increased Risk	CDC Screening Population	CDC Increased Risk
Hepatitis B	• Adolescents and adults at increased risk for infection (Grade B) • Pregnant persons (Grade A)	• Persons born in countries and regions with a high prevalence of HBV infection (≥2%), such as Asia, Africa, the Pacific Islands, and parts of South America • US-born persons not vaccinated as infants whose parents were born in regions with a very high prevalence of HBV infection (≥8%) • HIV-positive persons • Persons with injection drug use • MSM • Household contacts or sexual partners of persons with HBV infection	Same as USPSTF	In addition to USPSTF • Women with >1 sex partner in the previous 6 months • Evaluation or treatment for an STI
Hepatitis C	• Age 18-79 1 time screening (Grade B)	• Persons with past or current injection drug use	Same as USPSTF	In addition to USPSTF • Annual HCV testing in MSM with HIV infection
HIV	• Age 15-65 **(**Grade A) • All pregnant persons (Grade A)	Younger adolescents and older adults who are at increased risk: • MSM • Injection drug use • Anal intercourse without a condom, • Vaginal intercourse without a condom and with more than 1 partner whose HIV status is unknown, • Exchanging sex for drugs or money (transactional sex), • Having other STIs or a sex partner with an STI • Having a sex partner who is living with HIV or is in a high-risk category. • Persons who request testing for STIs, including HIV, are also considered to be at increased risk.	Same as USPSTF except includes ages 13-64	In addition to USPSTF Recs that HIV screening should be discussed and offered to all transgender persons

STI	USPSTF Screening Recommendation	USPSTF Increased Risk	CDC Screening Population	CDC Increased Risk
Human papillomavirus (HPV)	**(Grade A)** • Age 21-29: every 3 years with cervical cytology • Age 30-65: every 3 years with cervical cytology alone, every 5 years with high-risk HPV (hrHPV) testing or every 5 years with hrHPV in combination with cytology. • Anal cancer screening recommendations are in progress	• None identified	• Same as USPSTF for women or people with a cervix	• Digital anorectal screening is recommended for MSM

Source: USPSTF Recommendations (https://www.uspreventiveservicestaskforce.org/uspstf/recommendation); CDC Recommendation (https://www.cdc.gov/std/treatment-guidelines/screening-recommendations.htm).

Note: Text in red indicates a difference between USPSTF and CDC screening guidelines. Recommendations also align for the following infections: bacterial vaginosis, genital herpes simplex, pediculosis pubis, scabies, trichomoniasis.

Key: CDC = Centers for Disease Control and Prevention; HBV = hepatitis B virus; MSM = men who have sex with men; USPSTF = United States Preventive Services Task Force.

APPENDIX E COST SHARING AND UTILIZATION MANAGEMENT

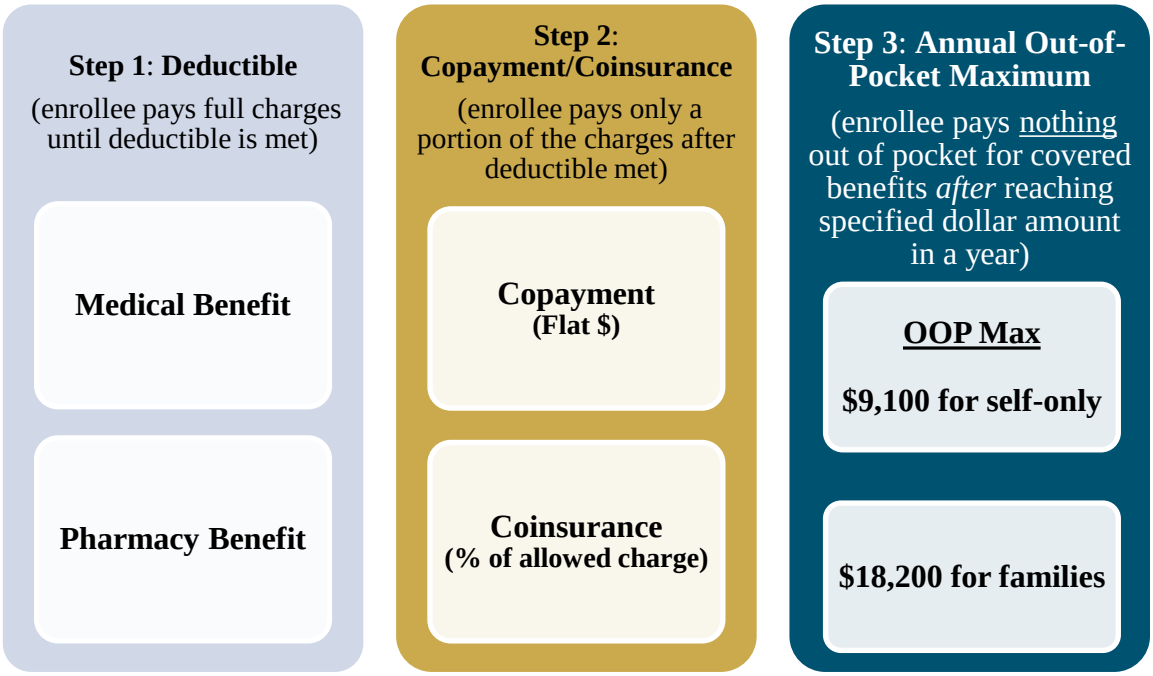
This appendix provides an overview of the cost-sharing and utilization management structures used for health insurance benefits, including prescription drugs.

Cost Sharing

Payment for use of covered health insurance benefits is shared between the payer (e.g., health plan/insurer or employer) and the enrollee. Common cost-sharing mechanisms include copayments, coinsurance, and/or deductibles (but do not include premium expenses[64]). There are a variety of cost-sharing mechanisms that can be applicable to covered benefits (Figure E-1). Some health insurance benefit designs incorporate higher enrollee cost sharing in order to lower premiums. Reductions in allowed copayments, coinsurance, and/or deductibles can shift the cost to premium expenses or to higher cost sharing for other covered benefits.[65]

Annual out-of-pocket maximums for covered benefits limit annual enrollee cost sharing (medical and pharmacy benefits). After an enrollee has reached this limit through payment of coinsurance, copayments, and/or deductibles, insurance pays 100% of the covered services. The enrollee remains responsible for the full cost of any tests, treatments, or services that are not covered benefits.

Figure E-1. Overview of the Intersection of Cost-Sharing Methods Used in Health Insurance



Source: California Health Benefits Review Program, 2023; CMS, 2022.

[64] Premiums are paid by most enrollees, regardless of their use any tests, treatments, or services. Some enrollees may not pay premiums because their employers cover the full premium, they receive premium subsidies through the Covered California, or they receive benefits through Medi-Cal.

[65] Plans and policies sold within Covered California are required by federal law to meet specified actuarial values. The actuarial value is required to fall within specified ranges and dictates the average percent of health care costs a plan or policy covers. If a required reduction in cost sharing impacts the actuarial value, some number of these plans or policies might have to alter other cost-sharing components of the plan and/or premiums in order to keep the overall benefit design within the required actuarial value limits.

Note: Steps 1 and 2 are not mutually exclusive. Under certain circumstances (i.e., preventive screenings or therapies), enrollees may pay coinsurance or copayments prior to their deductible being met; also copayments and coinsurance may be applied against the deductible in some circumstances. The figure assumes that the enrollee is in a plan with a deductible. If no deductible, then enrollee pays a coinsurance and/or a copayment beginning with the first dollar spent (Step 2).

The annual out-of-pocket maximums listed in Step 3 increase each year according to methods detailed in CMS' Notice of Benefit and Payment Parameters (CMS, 2022).

Key: OOP Max = annual out-of-pocket maximum.

High deductible health plans

Both DMHC-regulated plans and CDI-regulated policies may be designated high deductible health plans (HDHPs). [66] HDHPs are a type of health plan with requirements set by federal regulation.[67] As the name implies, these plans include a deductible – but they are not allowed to have separate medical and pharmacy deductibles. For the 2023 plan year, the Internal Revenue Service (IRS) defines an HDHP as any plan with a deductible of at least $1,500 for an individual and $3,000 for a family.[68] Annual out-of-pocket expenses for coverage of in-network tests, treatments, and services, which would result from cost sharing[69] applicable after the deductible is met, are not allowed to be more than $7,500 for an individual and $15,000 for a family.[70]

Health Savings Account qualified HDHPs

To be eligible to establish a Health Savings Account (HSA) for taxable years beginning after December 31, 2003[71] (and so to be eligible to make tax-favored contributions to an HSA), a person must be enrolled in an HSA–qualified HDHP.

In order for a HDHP to be HSA qualified, it must follow specified rules regarding cost sharing and deductibles, as set by the IRS. Generally, an HDHP may not provide benefits for any year until the deductible for that year is satisfied – but federal law provides a safe harbor for the absence of a deductible applicable to preventive care.[72] Therefore an HDHP may cover preventive care benefits without any deductible or with a deductible below the minimum annual deductible – but is not required to do so for a specified list of preventive services. The list of preventive services for which application of a deductible is not required includes treatments for chronic conditions.[73]

Allowed Cost Amounts for Medical Services

Insurers usually negotiate how much they will pay for the costs of covered health care services with health care providers and suppliers (Center on Budget and Policy Priorities, 2022). These negotiated amounts are known as the "allowed cost amount." Health care providers, including hospitals and physicians, participating in a plan's network agree to accept these payment amounts when an enrollee

[66] For enrollment estimates, see CHBRP's resource *Deductibles in State-Regulated Health Insurance*, available at https://chbrp.org/other_publications/index.php.
[67] HealthCare.gov, Glossary: High Deductible Health Plan (HDHP). Available at www.healthcare.gov/glossary/high-deductible-health-plan/#:~:text=For%202019%2C%20the%20IRS%20defines,or%20%2413%2C500%20for%20a%20family. Accessed March 5, 2021.
[68] IRS Revenue Procedure 2022-24, available at www.irs.gov/pub/irs-drop/rp-22-24.pdf
[69] Such as copays and coinsurance applicable to the covered test, treatment, or service.
[70] There is no annual out-of-pocket expenses limit for coverage of out-of-network tests, treatments, and services.
[71] Section 1201 of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003, Pub. L. No. 108-173, added section 223 to the Internal Revenue Code.
[72] For more information on screening services, see Notice 2004-23, 2004-15 I.R.B. 725, available at www.IRS.gov/irb/2004-15_IRB#NOT-2004-23.
For additional guidance on preventive care, see Notice 2004-50, 2004-2 C.B. 196, Q&A 26 and 27, available at www.IRS.gov/irb/2004-33_IRB#NOT-2004-50; and Notice 2013-57, 2013-40 I.R.B. 293, available at IRS.gov/pub/irs-drop/n-13-57.pdf.
[73] For information on preventive care for chronic conditions, see Notice 2019-45, 2019-32 I.R.B. 593, available at www.IRS.gov/pub/irs-drop/n-19-45.pdf.

covered by the plan uses covered services. The cost-sharing charges the enrollee owes (for example, a 20% coinsurance rate) are based on this allowed cost amount. If an enrollee uses a service that is not covered or sees a provider that is not within the insurer's network, the overall charge, including an enrollee's cost sharing, could be higher than the allowed amount.

Utilization Management

Utilization management techniques are used by health plans and insurers to control costs, ensure medication compatibility, and manage safety. Examples include benefit coverage requirements related to prior authorization, step therapy, quantity limits and limits related to the age or sex of the enrollee (such as prescription-only infant formula or prostate cancer screening for men). A brief description of some key utilization management techniques follows.

Prior authorization

Prior authorization – also known as precertification, prior approval, or prospective review – is a utilization management technique commonly used by health insurance carriers to ensure that a given medical intervention meets the insurance plan or policy's criteria for coverage (Newcomer et al., 2017). Prior authorization developed as a tool for insurers to assess the appropriateness of treatment that would result in a hospital admission or a high-cost procedure (Resneck, 2020). The process typically requires providers to establish eligibility and submit documentation demonstrating medical need to the plan/insurer for approval of coverage before either medical services are provided or a prescription is filled in order to qualify for payment. Health plans/insurers may also impose prior authorization requirements on nonpreferred medications in an effort to promote the use of preferred medications that they can procure at lower prices.

Step therapy

Step therapy or "fail-first" protocols may be applied to prescription medications by health plans and insurers to control costs, ensure medication compatibility, and manage safety. Health plans/insurers may use step therapy protocols to apply clinical guidelines established by professional societies and other recognized organizations to treatment plans. They require an enrollee to try and fail one or more medications prior to receiving coverage for the initially prescribed medication. Step therapy protocols usually recommend starting with a medication that is less expensive (generics) and/or has more "post-marketing safety experience" (PBMI, 2015). In addition, they sometimes require starting with a less potent medication or dosage, perhaps with fewer side effects, and graduating to more potent medications as necessary (e.g., from prescription Motrin to OxyContin to treat pain). Generally, more expensive or more potent medications are covered when the patient fails to respond to the step therapy–required medication (PBMI, 2018).

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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 researchers and analysts who are **Task Force 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, **Milliman**, 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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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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