

Key Findings

Analysis of California Senate Bill 245 Abortion Services: Cost Sharing

Summary to the 2021–2022 California State Legislature, March 23, 2021



SUMMARY

The version of California Senate Bill (SB) 245 analyzed by CHBRP would prohibit cost sharing for all abortion services, including follow-up services such as management of side effects and counseling. It also prohibits health plans and policies from imposing any restrictions or delays on abortion services, including prior authorization, and prohibits annual or lifetime limits on any covered abortion services.

In 2022, 100% of the 21.9 million Californians enrolled in state-regulated health insurance would have insurance subject to SB 245.

Benefit Coverage: At baseline, CHBRP estimates there are 23,492 enrollees who would have induced abortions and use associated services. Of these, 9,652 enrollees (41%) have cost sharing. Postmandate, 100% of enrollees with coverage for abortion would have \$0 cost sharing for abortion services, including associated medical services.

Medical Effectiveness: There is insufficient evidence that utilization management policies affect abortion outcomes. There is limited evidence that cost-sharing policies reduce access to, and use of, abortion services and insufficient evidence that cost sharing for abortion services affects maternal health outcomes.

Cost and Health Impacts¹: In 2022, CHBRP estimates SB 245 would result in an increase of 9,748 women utilizing abortion services with zero cost sharing. This estimate includes the population of women who shift from having cost-sharing payments for abortion services at baseline and an estimated additional 97 women who would be new users of abortion services due to the elimination of cost sharing. This would result in a decrease of \$1,501,000 (0.0011%) in annual expenditures (includes likely reduction in health care costs

associated with continued pregnancies due to increased utilization of abortion services, as well as applicable reductions in benefit-related expenses for enrollees).

SB 245 may reduce the negative health outcomes associated with being unable to access an abortion for the additional 97 women who would be new users of abortion services. Furthermore, the average out-of-pocket cost for any abortion service is estimated to be \$543, which has been shown to be a financial barrier. Therefore, SB 245 may also provide a financial benefit for enrollees that experience an elimination of cost sharing for covered abortion services.

CONTEXT

Abortion is the termination of pregnancy by either medication or procedure. There are two types of abortion methods — medication abortions and procedural (surgical) abortions. Both require associated services such as pre-abortion evaluation services and follow-up care.

Abortion is considered a basic health care service in California and, therefore, is required to be covered by commercial health insurance plans and policies, the California Public Employees' Retirement System (CalPERS), and Medi-Cal. Medically necessary, follow-up services to abortions that constitute basic health care services must also be covered. However, the state does not mandate which types of abortion methods (i.e., procedural or medication) must be covered nor does it mandate cost-sharing requirements specific to these services.

In the United States, the average out-of-pocket cost paid for a medication abortion ranges from \$300 to \$1,500 and for a procedural abortion from \$295 to \$1,600, depending on insurance coverage and geographic location.² Studies show that saving money or securing funds to pay for an abortion is a financial barrier to obtaining abortion services. Other identified barriers to use of abortion services include the cost of travel

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

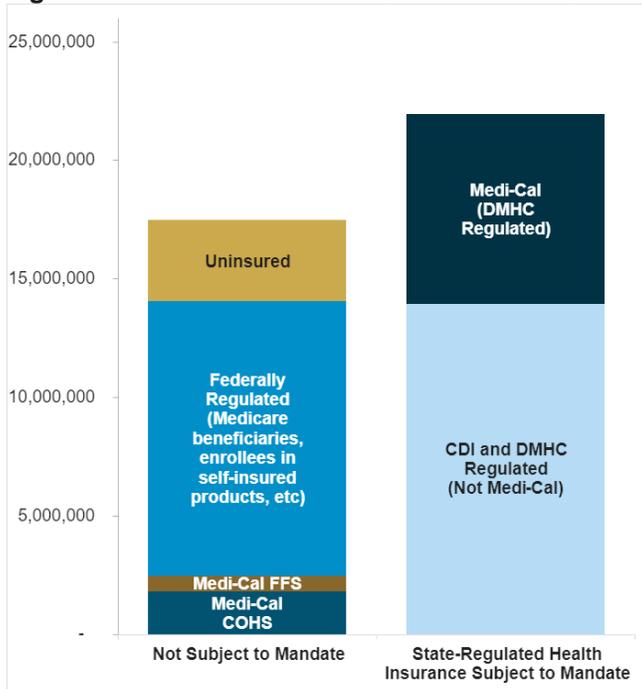
necessary to obtain services, lost wages, and expenses for childcare.

BILL SUMMARY

As introduced, SB 245 would prohibit cost sharing for all abortion services, including follow-up services such as management of side effects and counseling. It also prohibits state-regulated health plans and policies (including CalPERS and Medi-Cal) from imposing any restrictions or delays on abortion services, including prior authorization, and prohibits annual or lifetime limits on any covered abortion services.

Figure A notes how many Californians have health insurance that would be subject to SB 245.

Figure A. Health Insurance in California and SB 245



Source: California Health Benefits Review Program, 2021.

IMPACTS

Benefit Coverage, Utilization, and Cost

Benefit Coverage

CHBRP estimates at baseline there are 23,492 users of any abortion services, including medication and procedural abortions and associated services, enrolled in plans regulated by the California Department of Managed Health Care (DMHC) and policies regulated by the California Department of Insurance (CDI). Of this

population, 9,652 users of any abortion services have cost sharing. Postmandate, 100% of users of abortion services with cost sharing at baseline will have zero cost sharing.

Medi-Cal Managed Care plans are prohibited from requiring medical justification and/or prior authorization for outpatient abortion services. Based on a CHBRP survey of health insurance providers in California, state-regulated health plans and policies do not require utilization management, including prior authorization, for abortion services, except for one health plan that stated prior authorization and medical necessity review is required for inpatient admissions. Medi-Cal policy also requires prior authorization for inpatient hospitalizations for procedural abortions. However, such requirements for inpatient admissions are typical for medical procedures and are related to the provision of hospital care and are not specific to abortion services. As such, CHBRP anticipates the provisions of SB 245 related to prior authorization and other restrictions or delays will have no impact on commercial enrollees.

Utilization

CHBRP estimates that, postmandate, a 1% increase in utilization would occur resulting in an additional 97 women obtaining abortions with zero cost sharing.

Expenditures

At baseline, average out-of-pocket costs for enrollees who use any abortion services and have cost sharing is \$543. The average cost share is \$306 for a medication abortion, \$887 for a procedural abortion, and \$182 for associated services.³ These do not reflect average total costs per enrollee for services, which would depend on the amount and type of services used. Postmandate, enrollees with coverage with cost sharing for abortion services at baseline would have \$0 cost sharing for abortion services, including associated medical care.

SB 245 would decrease total net annual expenditures by \$1,501,000, or 0.0011%, for enrollees with DMHC-regulated plans and CDI-regulated policies. This is due to a \$5,527,000 decrease in enrollee cost sharing for covered benefits adjusted by a \$4,026,000 increase in total health insurance premiums paid by employers and enrollees.

Total premiums for private employers purchasing group health insurance would increase by \$1,808,000, or

³ The cost of medication and procedural abortion includes any associated services performed on the same day of the abortion. Associated services includes both pre-abortion and follow-up services.

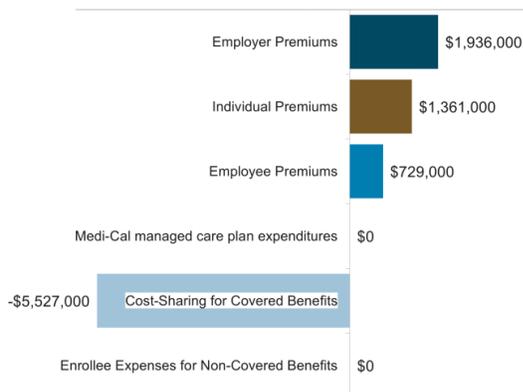
0.0033%. Total premiums for purchasers of individual market health insurance would increase by \$1,361,000, or 0.0086%. Changes in premiums as a result of SB 245 would vary by market segment. The greatest change in premiums as a result of SB 245 is for DMHC-regulated individual market plans (0.0085% increase) and for CDI-regulated individual market policies (0.0104% increase).

Among publicly funded DMHC-regulated health plans, there is no impact on Medi-Cal premiums because no enrollees have cost sharing for induced abortion services or related associated care. Among CalPERS health maintenance organization (HMO) plans, there is an estimated increase of \$128,000, or 0.0022%, in premiums.

The decreases in enrollee expenditures for covered benefits in commercial plans range from \$0.0242 per member per month (PMPM) among enrollees in DMHC-regulated large-group plans to \$0.0594 PMPM among enrollees in CDI-regulated individual policies. Among publicly funded plans, there is no impact for Medi-Cal enrollees; however, CalPERS enrollees will have a decrease in enrollee expenditures of \$0.0249 PMPM.

CHBRP assumes that women who have induced abortions, if they had continued their pregnancies, would have had the same proportion of live births and miscarriages as the overall population of pregnant women. CHBRP estimates there are an additional 97 women who would choose to have an induced abortion as a result of the elimination of cost sharing postmandate. The per-unit cost of continuing a pregnancy averages \$25,574, accounting for labor and delivery charges and medical costs associated with miscarriages. CHBRP does not include prenatal care in these average costs. The discontinuation of these 97 pregnancies postmandate leads to an estimated cost offset of \$2,455,000.

Figure B. Expenditure Impacts of SB 245



Source: California Health Benefits Review Program, 2021.

Note: Employer premiums include private employers and CalPERS HMO employers.

Medi-Cal

Medi-Cal covers abortions as a physician service without cost sharing. Medi-Cal policy prohibits requiring medical justification and/or prior authorization for outpatient abortion services. Inpatient hospitalizations for procedural abortions do require prior authorization; however, this mandate follows the same criteria as any other medical procedure requiring hospitalization. As such, no impact on this population by SB 245 is projected.

CalPERS

For CalPERS HMO enrollees, there is an estimated increase of \$128,000, or 0.0022%, in premiums due to the elimination of enrollee cost sharing under SB 245.

Number of Uninsured in California

Because the change in average premiums does not exceed 1% for any market segment, no measurable impact is projected on the number of uninsured persons due to the enactment of SB 245.

Medical Effectiveness

CHBRP developed a logic model to determine the potential impacts of cost sharing policies on utilization of abortions services and their related health outcomes as follows. The model is based on the idea that the elimination of cost sharing and utilization management policies, as proposed under SB 245, would reduce the barriers that cost and delays related to cost and utilization management can present in obtaining an abortion. As such, enactment of SB 245 would lead to increased access to timely abortion services, and therefore an increase in abortions completed when chosen. Consequently, SB 245 would decrease unintended pregnancies, which are associated with poor pregnancy and maternal health outcomes.⁴ In alignment with this logic model, CHBRP looked at the evidence of the impact of cost sharing and utilization management policies on abortion outcomes, including: abortion access, utilization of abortion services, abortion complications, prenatal care, maternal health outcomes, maternal mental health outcomes, birth outcomes, infant morbidity and mortality, child health status, and breastfeeding after being unable to obtain abortion.

⁴ Because many women who seek abortions do so for unintended pregnancies, it stands to reason that outcomes associated with unintended pregnancy can apply to women who sought abortion but were unable to obtain an abortion due to a cost or other barrier

CHBRP found there is:

- Insufficient evidence⁵ that utilization management policies affect abortion outcomes.
- Limited evidence⁶ that cost-sharing policies reduce access to, and use of, abortion services and insufficient evidence that cost sharing for abortion services affects maternal health outcomes.
- Limited evidence to suggest that unintended pregnancy leads to a decrease in prenatal care and breastfeeding and an increase in postpartum depression and low birth weight or preterm births.
- Insufficient evidence that unintended pregnancies impact maternal health outcomes.
- Limited evidence that not obtaining a chosen abortion may have socioeconomic consequences for their children and that there is no impact on child health outcomes.
- Inconclusive evidence⁷ of the impact on child development of children born to women who were denied an abortion.

Public Health

In the first year postmandate, CHBRP projects that the removal of cost sharing for abortion services, as proposed under SB 245, would enable an additional 97 women, for whom the baseline cost-sharing requirements would have otherwise prevented them from accessing these services, to obtain an abortion. For those women, SB 245 may reduce the negative health outcomes associated with being unable to access an abortion. CHBRP estimates the average out-of-pocket cost for any abortion service is \$543, which has been shown to be a financial barrier. Therefore, SB 245 may also provide a financial benefit for the approximately

⁵ 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.

⁶ Limited evidence indicates that the studies have limited generalizability to the population of interest and/or the studies have a fatal flaw in research design or implementation.

⁷ 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.

9,650 commercially-insured women who had cost sharing for covered abortions at baseline. These estimates are supported by limited evidence that cost-sharing policies reduce access to, and use of, abortion services.

CHBRP did not identify any studies that assessed utilization management among those with insurance coverage for abortion; therefore, there is insufficient evidence that utilization management policies affect abortion outcomes.

Although there is evidence of disparities in the United States related to racial/ethnic disparities in the rates of abortions, CHBRP found insufficient evidence of reduction in racial/ethnic disparities due to eliminating cost sharing and utilization management among women with commercial insurance. Please note that the absence of evidence is not “evidence of no effect.” It is possible that an impact — desirable or undesirable — could result, but current evidence is insufficient to inform an estimate.

CHBRP also found insufficient evidence of reduction in income-related disparities due to eliminating cost sharing among women with commercial insurance. Despite the lack of evidence that eliminating cost sharing results in increased utilization of abortions and associated services, SB 245 may have an impact for a subset of women with commercial insurance who are unable to pay the full or unmet deductibles and copayments or coinsurance for abortion services.

CHBRP found insufficient evidence of reduction in age related disparities due to eliminating cost sharing among women with commercial insurance. However, SB 245 may have an impact for adolescents who are willing to use their parent’s commercial insurance coverage or have their own commercial insurance and who are unable to pay the full or unmet deductibles and copayments or coinsurance for abortion services.

Long-Term Impacts

CHBRP estimates annual utilization of induced abortion services after the initial 12 months from the enactment of SB 245 would likely stay similar to utilization estimates during the first 12 months postmandate. Utilization changes may occur if new abortion medications or procedures change the landscape for enrollees; however, CHBRP is unable to predict these types of changes. Similarly, health care utilization due to improved reproductive health services may change in the long term.

CHBRP estimates of cost after the initial 12 months from the enactment of SB 245 are likely to remain similar in the subsequent years. Any savings resulting from a decrease in the outcomes from continuing a pregnancy would also lead to reductions in any subsequent health care needed from those outcomes; however, that cannot be quantified.

The long-term impact of SB 245 on potential disparities related to abortions and associated services among women with commercial insurance is unknown. However, SB 245 may have an impact on social determinants of health (SDoH) by eliminating the cost barrier associated with obtaining an abortion and improving the long-term mental health outcomes and aspirational goals of women who obtained abortion services.

Essential Health Benefits and the Affordable Care Act

SB 245 would not require coverage for a new state benefit mandate and instead modifies cost-sharing terms and conditions of an already covered benefit. Therefore, SB 245 appears not to exceed the definition of EHBs in California.