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California Health Benefits Review Program

Analysis of California Senate Bill 245 Abortion Services: Cost Sharing

A Report to the 2021–2022 California State Legislature

March 23, 2021

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 Impacts[1]: 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.

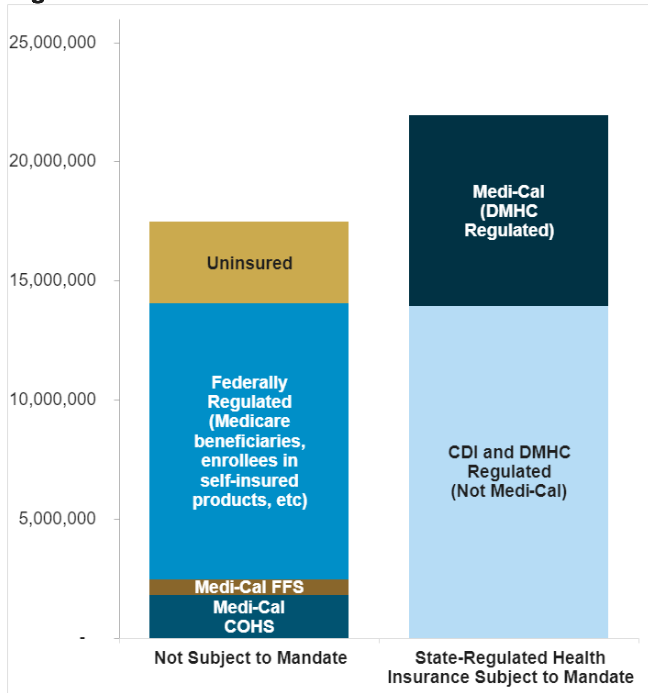
necessary to obtain services, lost wages, and expenses for childcare.

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.

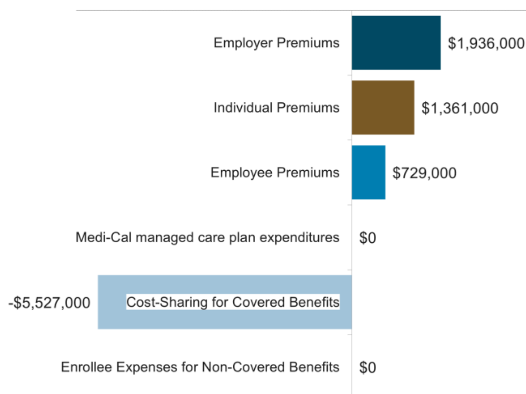
0.0033%. Total premiums for purchasers of individual market health insurance would increase by $1,361,000, or 0.0086%. Changes in premiums as a result of SB 245 would vary by market segment. The greatest change in premiums as a result of SB 245 is for DMHC-regulated individual market plans (0.0085% increase) 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 evidence[5] that utilization management policies affect abortion outcomes.
- Limited evidence[6] 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 evidence[7] 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 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.

[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.

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.

A Report to the California State Legislature

Analysis of California Senate Bill 245
Abortion Services: Cost Sharing

March 23, 2021

California Health Benefits Review Program
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www.chbrp.org

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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.

Table of Contents

Policy Context 1
- Bill-Specific Analysis of SB 245, Abortion Services: Cost Sharing 1
- Analytic Approach and Key Assumptions 1
- Cost Sharing and Utilization Management 2
- Interaction With Existing State and Federal Requirements 4

Background on Abortion Services 8
- Abortion Services 8
- Payment for Abortion Services 12
- Disparities and Social Determinants of Health in Abortion Incidence, Access, and Cost Sharing 13

Medical Effectiveness 16
- Research Approach and Methods 16
- Methodological Considerations 17
- Outcomes Assessed 17
- Study Findings 17
- Summary of Findings 22

Benefit Coverage, Utilization, and Cost Impacts 23
- Baseline and Postmandate Benefit Coverage 24
- Baseline and Postmandate Utilization 24
- Baseline and Postmandate Cost 25
- Baseline and Postmandate Expenditures 26
- Other Considerations for Policymakers 28

Public Health Impacts 33
- Estimated Public Health Outcomes 33
- Impact on Disparities 35

Long-Term Impacts 37
- Long-Term Utilization and Cost Impacts 37
- Long-Term Public Health Impacts 37

Appendix A Text of Bill Analyzed A-1
Appendix B Literature Review Methods B-1
Appendix C Cost Impact Analysis: Data Sources, Caveats, and Assumptions C-1
Appendix D Information Submitted by Outside Parties D-1

References
California Health Benefits Review Program Committees and Staff
Acknowledgments

LIST OF TABLES AND FIGURES

Table 1. SB 245 Impacts on Benefit Coverage, Utilization, and Cost, 2022 xi

Table 2. FDA-Approved Medications Utilized in Two-Drug Regimen for Medication Abortions 10

Table 3. Comparison of Procedural Abortion Services 11

Table 4. Percent of U.S. Women 15–44 Years of Age Who Obtained Abortions in 2018 14

Table 5. Average Enrollee Cost-Sharing Reductions Postmandate 27

Table 6. Baseline Per Member Per Month Premiums and Total Expenditures by Market Segment, California, 2022 29

Table 7. Postmandate Per Member Per Month Premiums and Total Expenditures by Market Segment, California, 2022 31

Figure 1. Overview of the Cost-Sharing Mechanisms Used in Health Insurance 3

Figure 2. Utilization Management Policies on Abortion Outcomes 18

Figure 3. Cost-Sharing Policies as a Barrier to Abortion 20

Figure 4. Cost-Sharing Policies on Maternal Mental Health Outcomes 20

Figure 5. Baseline Utilization Calculations 25

Figure 6. Postmandate Utilization Calculations. 25

Table 1. SB 245 Impacts on Benefit Coverage, Utilization, and Cost, 2022

	Baseline (2022)	Postmandate Year 1 (2022)	Increase/ Decrease	Change Postmandate
Benefit Coverage				
Total enrollees with health insurance subject to state-level benefit mandates (a)	21,945,000	21,945,000	0	0.00%
Total enrollees with health insurance subject to SB245	21,945,000	21,945,000	0	0.00%
Total percentage of enrollees with coverage subject to SB245 (b)	100%	100%	0%	0.00%
Utilization and Cost				
Utilization of abortion services with cost sharing				
Number of users with cost sharing using ANY abortion services (c)	9,652	0	-9,652	-100.00%
Number of users of medication abortion (d)	3,759	0	-3,759	-100.00%
Number of users of procedural abortion (d)	3,516	0	-3,516	-100.00%
Number of users of associated services (e)	5,366	0	-5,366	-100.00%
Utilization of abortion services without cost sharing (f)				
Number of users without cost sharing using ANY abortion services (c)	13,840	23,589	9,748	70.43%
Number of users of medication abortion (d)	7,414	11,210	3,797	51.21%
Number of users of procedural abortion (d)	5,063	8,614	3,551	70.13%
Number of users of associated services (e)	4,429	9,849	5,420	122.37%
Average costs for abortion services per user				
Average costs of ANY abortion service per user	$1,601	$1,601	$0	0.00%
Average cost of medication abortion per user (d)	$741	$741	$0	0.00%
Average cost of procedural abortion per user (d)	$2,763	$2,763	$0	0.00%
Average cost of associated services per user (e)	$574	$574	$0	0.00%
Average out of pocket costs for users with cost sharing				
Average out of pocket costs for users with cost sharing for ANY abortion services	$543	$0	-$543	-100.00%
Average cost share for medication abortion (d)	$306	$0	-$306	-100.00%
Average cost share for procedural abortion (d)	$887	$0	-$887	-100.00%
Average cost share for associated services (e)	$182	$0	-$182	-100.00%

Continued pregnancies resulting from users facing cost-sharing barriers				
Number of continued pregnancies due to cost-sharing barrier	97	0	-97	-100.00%
Average cost of continued pregnancy per user (g)	$25,574	$25,574	$0	0.00%
Expenditures				
Premium (expenditures) by Payer				
Private Employers for group insurance	$55,032,803,000	$55,034,611,000	$1,808,000	0.0033%
CalPERS HMO employer expenditures (h) (i)	$5,765,017,000	$5,765,145,000	$128,000	0.0022%
Medi-Cal Managed Care Plan expenditures	$24,150,529,000	$24,150,529,000	$0	0.0000%
Enrollee premiums (expenditures)				
Enrollees for individually purchased insurance	$15,847,507,000	$15,848,868,000	$1,361,000	0.0086%
Enrollees with group insurance, CalPERS HMOs, Covered California, and Medi-Cal Managed Care (i)	$20,753,446,000	$20,754,175,000	$729,000	0.0035%
Enrollee out-of-pocket expenses				
Cost-sharing for covered benefits (deductibles, copayments, etc.)	$13,168,032,000	$13,162,505,000	-$5,527,000	-0.0420%
Expenses for noncovered benefits (j)	$0	$0	$0	0.00%
Total Expenditures	$134,717,334,000	$134,715,833,000	-$1,501,000	-0.0011%

Source: California Health Benefits Review Program, 2021.

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) SB 245 does not affect coverage for induced abortions. Rather, it impacts cost sharing for plans covering abortion services. This percentage reflects the percentage of DMHC-regulated plans and CDI-regulated policies that are subject to SB 245, and not the percentage of enrollees with coverage or cost sharing for abortion services.

(c) A single enrollee may receive medication abortion services, procedural abortion services, and associated services. Therefore, the number of enrollees using any abortion services is not a summation of the three categories.

(d) Cost of medication and procedural abortion includes any associated services performed on the same day of the abortion.

(e) Associated services includes both pre-abortion and follow-up services.

(f) Postmandate utilization of abortion services without cost sharing aggregates users who had no cost sharing at baseline, users who had cost sharing at baseline who have no cost sharing postmandate, and users who decide to use abortion services due to the elimination of cost sharing. The third category is also represented in the “continued pregnancy” offset section of Table 1, as postmandate, these users choose to no longer continue their pregnancy.

(g) These costs only include labor and delivery for a live birth or medical care for a miscarriage. They do not include prenatal care.

(h) Of the increase in CalPERS employer expenditures, about 54.1%, or $69,000, would be state expenditures for CalPERS members who are state employees or their dependents.

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

(j) 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.

Key: CalPERS = California Public Employees’ Retirement System; CDI = California Department of Insurance; DMHC = Department of Managed Health Care; HMO = Health Maintenance Organizations

POLICY CONTEXT

The California Senate Committee on Health has requested that the California Health Benefits Review Program (CHBRP)[8] conduct an evidence-based assessment of the medical, financial, and public health impacts of SB 245 Abortion Services: Cost Sharing.

Bill-Specific Analysis of SB 245, Abortion Services: Cost Sharing

Bill Language

For plans and policies, including Medi-Cal Managed Care plans, that provide coverage for abortion services, SB 245 would prohibit cost sharing for all abortion services, including follow-up services such as management of side effects and counseling.

SB 245 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.

SB 245 defines abortion services as "any medical treatment intended to induce the termination of a pregnancy except for the purpose of producing a live birth."

The full text of SB 245 can be found in Appendix A.

Relevant Populations

If enacted, SB 245 would apply to the health insurance of approximately 21.9 million enrollees (55.7% of all Californians). This represents 100% of 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 DMHC-regulated plans and CDI-regulated policies, including Medi-Cal Managed Care plans regulated by DMHC.

Although Medi-Cal Managed Care plans are subject to the Health and Safety Code, cost sharing for all Medi-Cal services is determined through the Welfare and Institutions Code (Section 14134). Therefore, Medi-Cal Managed Care plans are not impacted by the cost-sharing–related provisions of SB 245. Furthermore, the Medi-Cal program already covers abortions as a physician service without cost sharing.

Analytic Approach and Key Assumptions

CHBRP uses the following terms throughout the report:

- "Induced abortion" refers to a medical treatment that causes the termination of a pregnancy except for the purpose of producing a live birth. Induced abortions may be performed using medication or by procedure. See the *Background* section for additional information on these techniques.
- "Associated services" refers to any pre-abortion evaluation services and any follow-up care related to abortion services. Pre-abortion evaluation services are classified as abortion services and therefore CHBRP includes them as part of the analysis. Follow-up services are included per

[8] CHBRP's authorizing statute is available at www.chbrp.org/about_chbrp/faqs/index.php.

the explicit mandate under SB 245. Counseling for abortion services may include options counseling as a pre-abortion service, or behavioral health counseling as a follow-up service.

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

CHBRP does not include emergency contraception, such as Plan B, in the analysis. Emergency contraception is not considered an abortifacient, or a drug that can cause an abortion.

CHBRP assumes that abortion services are typically covered under the medical benefit for any induced abortion. However, medication abortions may be covered under the pharmacy benefit by some health plans/insurers.

Because SB 245 defines abortion services as those intended to induce the termination of pregnancy, CHBRP excludes selective reduction, spontaneous miscarriage, ectopic pregnancies, and pregnancy losses after the first trimester/stillbirth. This approach is consistent with definitions used by public health departments (NYC Department of Health, 2021):

- Selective reduction: In multifetal pregnancies, the purpose of a selective reduction is to improve the viability of a fetus and produce a live birth (Rao, 2015).

- Miscarriage (spontaneous abortion): In the United States, miscarriage is defined as fetal loss prior to 20 weeks gestation (CDC, 2020; Harvard Medical School, 2021). Although a dilation and curettage or another procedure may be necessary to complete the process, the loss is considered spontaneous in nature and not induced by a medical procedure or medication.

- Ectopic pregnancies: The fertilized egg is unable to survive in an extrauterine pregnancy, and the growing tissue may cause life-threatening bleeding, if left untreated. Treatment is typically given through an injection of methotrexate or laparoscopic surgery.

- Stillbirth: In the United States, stillbirth is defined as fetal loss after 20 weeks gestation (CDC, 2020). Although a dilation and evacuation or another procedure may be necessary to complete the process, the loss is considered spontaneous in nature and not induced by a medical procedure or medication.

Cost Sharing and Utilization Management

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

Cost Sharing

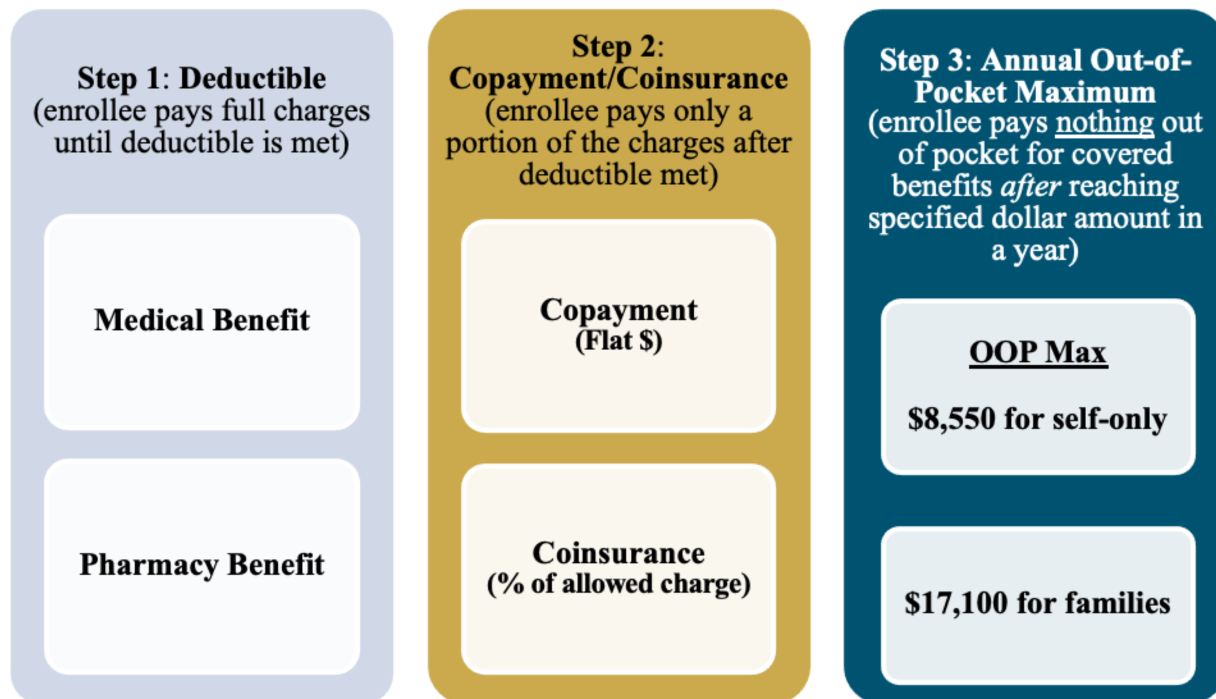
Payment for use of covered benefits is shared between the payer (e.g., health plan/insurer or employer) and the enrollee using the covered test, treatment, or service. Common cost-sharing mechanisms include copayments, coinsurance, and/or deductibles (but do not include premium expenses[9]). There are a variety of cost-sharing mechanisms that can be applicable to covered benefits (Figure 1). Deductibles and copayments/coinsurance 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. Some health insurance benefit designs incorporate higher enrollee cost sharing in order to lower

[9] 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 receive benefits through Medi-Cal.

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.[10]

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 1. Overview of the Cost-Sharing Mechanisms Used in Health Insurance



Source: California Health Benefits Review Program, 2021.

Notes: 1. The annual cost sharing amounts in this figure are the maximum amounts allowed in 2021 for nongrandfathered plans/policies; some nongrandfathered plans/policies may have lower annual cost-sharing limits.

2. 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).

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

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). Utilization management that

[10] 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.

may be used in conjunction with abortion care includes prior authorization. A brief description of this technique is below.

Prior authorization

Prior authorization — also known as precertification, prior approval, or prospective review — is used to enforce clinical guidelines from professional societies and organizations, and the U.S. Food and Drug Administration (FDA) indication for use of specific medications. 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.

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

Coverage and Costs

Under the Reproductive Privacy Act, California law prohibits the State from denying or interfering with a woman's right to choose or obtain an abortion prior to viability of the fetus, or when medically necessary. The state defines viability as the point in a pregnancy when, in the good faith medical judgment of a physician, there is a reasonable likelihood that a fetus will survive outside the uterus without "extraordinary medical measures."

Abortion is considered a basic health care service in California[11] and, therefore, is required to be covered by commercial health insurance plans and policies and CalPERS.[12] 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.

California's Medi-Cal program is 1 of 16 state Medicaid programs that use their own funds to cover abortion services and follow-up services for beneficiaries (Salganicoff et al., 2021). The Medi-Cal program covers abortions as a physician service without cost sharing for all enrollees.

California law prohibits family planning grants distributed by the Department of Health Care Services from funding abortions or associated services, including postabortion examinations.[13]

Utilization Management

Medi-Cal Managed Care plans, providers, independent practice associations, preferred provider groups, and all delegated entities that provide physician services are prohibited from requiring medical justification and/or prior authorization for outpatient abortion services.[14] It should be noted that under Medi-Cal policy,

[11] DMHC letter to health plans dated August 22, 2014.
[12] HSC 1367.006; INS 10112.27.
[13] WIC 14509.
[14] Department of Health Care Services All Plan Letter 15-020.

inpatient hospitalizations for procedural (surgical) abortions do require prior authorization. However, this mandate follows the same criteria as any other medical procedure requiring hospitalization; the purpose of the review is to ensure the number of days of hospital care is appropriate for the diagnosis specified or the operative procedure contemplated in the authorization request.[15] Hospitalizations due to induced abortions are rare (ACOG, 2018). As such, the provisions of SB 245 related to prior authorization will have no effect on Medi-Cal Managed Care beneficiaries.

CHBRP conducted a survey of the largest (by enrollment) providers of health insurance in California to determine current coverage of abortion services and existence of utilization management for commercial enrollees. Responses to this survey represent 92% of commercial enrollees with health insurance that can be subject to state benefit mandates. In their responses, health insurance providers stated they do not require utilization management, including prior authorization, for abortion services, with the exception of one health plan that stated prior authorization and medical necessity review is required for inpatient admissions. As previously discussed, such requirements 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.

Patient Confidentiality

Health plans/insurers are required to honor enrollee requests for confidential communications relating to receipt of sensitive services. Health care providers are authorized by law to make arrangements with a patient for payment of out-of-pocket expenses and communicate that arrangement with the health plan/insurer.[16] As abortion services are sensitive in nature, enrollees may request confidentiality from health plans/insurers so that these procedures are not shown in the explanation of benefits (EOB). Health plans/insurers use EOBs in part to prevent fraud. They are sent to policyholders and typically show the actions taken by any individual covered under the plan/policy and all related costs. Although SB 245 addresses cost sharing, the provisions do not impact existing law related to patient confidentiality for sensitive services. Thus, patient confidentiality is not addressed in this report.

Similar requirements in other states

Three states have passed laws that prohibit commercial health insurance plans from imposing cost sharing for abortion coverage, as of February 2021. Illinois prohibits private health insurance plans from imposing any deductibles, coinsurance, waiting periods, or other cost-sharing limitations that are greater than what is required for other pregnancy-related benefits covered by the policy.[17] Oregon requires private health insurance plans to cover all reproductive health services, including abortion services, with no cost sharing.[18] New York prohibits copayments, coinsurance, or annual deductibles on medically necessary in-network abortion services, with limited exceptions for high deductible health plans.[19]

Massachusetts[20] and New Jersey[21] have recently introduced legislation similar to SB 245.

[15] 22 CCR 51327.
[16] CIV 56.107; INS 791.29.
[17] Illinois Senate Bill 25 of 2019.
[18] Oregon House Bill 3391 of 2017.
[19] New York Codes, Rules and Regulations 11 CRR-NY 52.16.
[20] Massachusetts Senate Bill 605 of 2021.
[21] New Jersey Senate Bill 3030 of 2020.

Federal Policy Landscape

Hyde Amendment

Since 1976, Congress has included a provision in the annual appropriations legislation for the Departments of Labor, Health and Human Services, and Education prohibiting the use of federal funds for most abortions. This provision, the Hyde Amendment, only provides exceptions to this prohibition in cases of rape, incest, or if a woman suffers from a life-threatening physical injury or illness that would place her in danger of death unless an abortion is performed.

Medicaid is a jointly funded program by the federal and state governments. States may choose to pay for abortion services for additional circumstances; however, they must use nonfederal funds to pay for the service. Sixteen states currently have policies that allow for Medicaid funds to be used to pay for abortions that exceed Hyde limitations, including Alaska, California, Connecticut, Hawaii, Illinois, Oregon, Maine, Maryland, Massachusetts, Minnesota, Montana, New Jersey, New Mexico, New York, Washington, and Vermont (Salganicoff et al., 2021).

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 SB 245 may interact with requirements of the ACA as presently exist in federal law, including the requirement for certain health insurance to cover essential health benefits (EHBs).[22,23]

Any changes at the federal level may impact the analysis or implementation of this bill, were it to pass into law. However, CHBRP analyzes bills in the current environment given current law and regulations.

Essential Health Benefits

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

Annual and Lifetime Limits

The ACA prohibits health plans and policies from imposing annual or lifetime limits on EHBs. Annual and lifetime limits are dollar limits on what health plans and policies will spend for an enrollee on covered benefits for 1 year or the entire time of enrollment, respectively. Health plans and policies may still require these limits for any health care services not considered EHBs. Grandfathered individual health insurance policies are exempt from this rule.

Women's Health and Preventive Services

Under the ACA, all non-grandfathered small-group and individual health plans/policies sold on the health insurance marketplace must include certain preventive health care benefits for women without cost sharing, regardless of whether the annual deductible has been met. Services that must be covered for pregnant women, or women who may become pregnant, include contraception, screenings for various

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[22] 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.

[23] 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.

conditions, and counseling for breastfeeding and tobacco use.[24] The U.S. Health Resources and Services Administration does not include abortion services in its list of women's preventive services that require coverage without cost sharing.

[24] More information about these services are included in CHBRP's Resource: Federal Preventive Services Mandates and California Mandates. Available at https://chbrp.org/other_publications/index.php#revize_document_center_rz44.

BACKGROUND ON ABORTION SERVICES

Abortion is the termination of pregnancy by either medication or procedure (Steinauer, 2021). This section defines the different types of abortion services and the disparities in the incidence of abortions associated with cost sharing and utilization management.

Abortion Services

There are two types of abortion services — medication abortions and procedural abortions, the latter of which is sometimes referred to as surgical abortion. Both require associated services such as pre-abortion evaluation services and follow-up care. The method chosen for an abortion is dependent on gestational age, medical condition (comorbidities that favor either medication or procedural abortion), patient preference (socioeconomic or personal choice associated with the side effects of medication or procedural abortions), clinician experience, and availability of the necessary equipment or medications (Steinauer, 2021). Emergency contraception, such as Plan B, are not abortifacients and will not be discussed in this analysis.

Associated Services: Pre-Abortion Evaluation

Provider evaluation (office visit or telemedicine [ACOG, 2020c]) and other clinical services are part of the pre-abortion evaluation for pregnant women[25] seeking abortions. These services and tests are offered to women when indicated based on the women's preferences and medical history. During the initial evaluation, a medical history, physical exam, laboratory and radiology tests, and counseling on abortion methods, including risk, benefits, alternatives, are conducted as relevant to the individual. These laboratory or radiology tests may include pregnancy confirmation and/or dating (urine or serum human chorionic gonadotropin measurement or pelvic ultrasound), hematocrit and hemoglobin levels[26], and Rh(D) status[27]. Discussion about contraception may occur at the initial visit and can typically be started the day of the abortion procedure (Steinauer, 2021).

It is necessary to know the gestational age of the pregnancy to assist providers and pregnant women in choosing the safest and most effective type of abortion. Gestational age may be determined by menstrual dating (if patients have regular menses and are confident of the date of their last period) or pelvic ultrasound examination (if patients are uncertain of dates, have irregular menses, their uterine size is inconsistent with menstrual dating, or uterine size cannot be accurately measured) (Steinauer, 2021).

Note that some associated services may be billed as prenatal services under certain circumstances, such as when women are unsure about whether they will continue the pregnancy or if they decide to have an abortion after initial prenatal services. See the *Benefit Coverage, Utilization, and Cost Impacts* section for further discussion.

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

[26] Hemoglobin levels are checked to ensure that women do not have anemia or hemoglobin below 9.5 g/dl ((normal levels for women are 12 to15.5 g/dl (Mayo Clinic, 2019a).

[27] Approximately 15% of pregnant women are Rh(D)-negative and will require an intramuscular injection of RhoGAM whether the pregnancy is carried to term or terminated. During a pre-abortion office visit, a clinician will give the injection to prevent the women's body from developing Rh antibodies . If women do not receive RhoGAM during their first pregnancy, there is risk to subsequent pregnancies. If the future fetus is Rh(D)-positive, the antibodies from the mother could cross the placenta and damage the fetus's red blood cells causing life-threatening anemia (Mayo Clinic, 2020).

Medication Abortions

There are two FDA-approved medications for use to terminate a pregnancy within the first 70 days of gestation, or first trimester: mifepristone and misoprostol. According to the American College of Obstetricians and Gynecologists (ACOG), the most common medication protocol involves prescribing both medications in sequence: mifepristone is administered first and blocks progesterone to prevent the pregnancy from progressing; misoprostol is administered 24 to 48 hours later and induces cramping and bleeding to empty the uterus, similar to a miscarriage (ACOG, 2020b). In rare instances, if mifepristone is not available, misoprostol alone may be prescribed as an approved alternative to the two-drug regimen (Raymond et al., 2019). There are various ways misoprostol alone may be prescribed for medication abortions. Providers typically prescribe at least one dose with up to five additional doses and different routes (Table 2) (Raymond et al., 2019). In California, both physicians and advanced practice clinicians can prescribe and dispense medication abortion pills.

Second trimester medication abortions are uncommon and usually occur in the hospital setting under the supervision of a provider (ACOG, 2013, 2018). Medication is administered to cause the body to go into labor to pass the pregnancy tissues through the vagina. Methods used for second trimester medication abortions are similar to the first trimester medication abortion regimen and include one or more of the following: mifepristone, misoprostol, osmotic cervical dilators, Foley catheters, and oxytocin. However, evidence suggests the majority of second trimester abortions (95%) performed are dilation and evacuation (D&E) (ACOG, 2013).

Table 2. FDA-Approved Medications Utilized in Two-Drug Regimen for Medication Abortions

FDA-Approved Medications	Intended Use	Route	Time of Administration	Gestational Age	Side Effects	Aftercare
Mifepristone (Mifeprex)	Counters the effect of progesterone	Oral pill	Dispensed in office or prescribed via telemedicine and obtained at clinic; taken in clinic or at home	Within 70 days of gestation (10 weeks)	Nausea, vomiting, vaginal bleeding, pelvic pain	Pain and/or nausea medication
Misoprostol (Cyotec)	Prostaglandin-like drug; causes uterus to contract	Buccal (between cheek and gum) or Vaginally	24–48 hours after mifepristone buccally; or 6 to 72 hours after mifepristone vaginally	Within 70 days of gestation (10 weeks)	Diarrhea, nausea, vomiting	Pain and/or nausea medication

Source: California Health Benefits Review Program, 2021 based on (ACOG, 2020b; Grossman et al., 2011; KFF, 2020).

Women are advised to contact their provider or emergency services if the following occur after administration of misoprostol: heavy bleeding, significant abdominal pain, or fever for more than 4 hours (ACOG, 2020b; WHO, 2018). A follow-up visit may be scheduled to address these adverse side effects or complications, or women may be advised to seek emergency care if necessary. In about 3% to 5% of cases medications are unsuccessful (Gatter et al., 2015), and women may be treated with additional doses of misoprostol. However, depending on the women's preference and/or clinical circumstances, some women may need an additional procedure, such as uterine aspiration or D&E (ACOG, 2020b). See the complications discussion below.

Procedural (Surgical) Abortions

Procedural abortions are medical procedures that occur in a clinic or hospital setting to terminate a pregnancy. They are minor operative procedures that use suction or forceps to remove all of the pregnancy tissue and uterine contents (ACOG, 2018). There are two methods for procedural abortions that may be used in the first trimester of pregnancy: vacuum suction aspiration (suction curettage) and dilation and curettage (D&C). Procedural abortions completed in the second trimester are D&E (Table 3) (ACOG, 2018).

Table 3. Comparison of Procedural Abortion Services

Type of Procedural Abortion	Description of Procedure	Indication	Gestational Age	Recovery	Aftercare
Vacuum suction Aspiration	Suction device inserted through the cervix to remove contents of uterus under local anesthesia	Procedural abortion or failed medication abortion	First trimester (up to 12 weeks)	Observed 1 hour after procedure; cramping 1 to 2 days, bleeding up to 2 weeks	Antibiotics, oral pain medication
Dilation and curettage (D&C)	Cervix dilated and curette inserted to scrape uterine wall; suction device used to remove remaining tissue under light sedation and local or general anesthesia	Procedural abortion or failed vacuum aspiration	First to second trimester (up to 16 weeks)	Observed for several hours after procedure; light cramping and bleeding up to 2 weeks	Antibiotics, oral pain medications
Dilation and evacuation (D&E)	Cervix dilated and removal of the fetal tissue through the vagina using a suction device and/or forceps under light sedation or anesthesia	Abortion in second trimester	Second trimester (After 12 weeks)	Observed for several hours after procedure; light cramping and bleeding up to 2 weeks	Antibiotics, oral pain medications

Source: California Health Benefits Review Program, 2021 based on ACOG, 2018; American Pregnancy Association, 2017; and Jones and Lopez, 2013.

Associated Services: Post-Abortion Aftercare

Follow-up care for medication abortions include a routine clinic visit, telemedicine visit, or phone call with a provider 1 to 4 weeks after the abortion (ACOG, 2020b; Grossman et al., 2004; Steinauer et al., 2021; Upadhyay et al., 2017). At a follow-up visit, an ultrasound may be conducted to confirm completion of the abortion. For women who complete a follow-up phone/telemedicine visit, and symptoms are indicative of a completed abortion, no ultrasound is necessary. A home pregnancy test may be administered 4 weeks after the abortion. If pregnancy symptoms persist for more than a week or menses has not restarted 6 to 8 weeks post-procedure, women should contact their physician (Grossman et al., 2004). If the medication abortion was incomplete, misoprostol may be prescribed, or a procedural abortion may be scheduled (Steinauer et al., 2021).

Follow-up care for procedural abortions does not routinely include an additional office visit unless there are complications or adverse outcomes (Steinauer et al., 2021; Upadhyay et al., 2017). The aftercare associated with procedural abortions include antibiotics, pain medications, and educating patients on the symptoms to monitor for including heavy bleeding, cramping, or fever. If a woman chooses, plans for

contraception can be discussed and begin immediately after the abortion, and behavioral health counseling services may be offered (Steinauer et al., 2021).

Rates of Abortions by Gestational Age

In 2018, 92.2% of all abortions were provided at 13 weeks or less (Kortsmit et al. 2020). The most common abortion method at 13 weeks or less were procedural abortions (52.1%) followed by early medication abortions at 9 weeks or less (38.6%), and medication abortions greater than 9 weeks (1.4%). After 13 weeks, procedural abortions only are done (7.8% of all abortions). Medication abortions and aspiration abortions are both safe and effective methods to end a pregnancy (ACOG, 2020a; Steinauer, 2021).

Abortion-Related Complications

Complications related to abortion services are rare. Although research has shown that abortion past the first trimester is safer than carrying a pregnancy to term with respect to risk of death, studies have shown that abortion complication risk increases with duration of pregnancy (Paul et al., 2009; Zane et al., 2015). The earlier the gestational age, the lower the risk of complications. One study reported that the risk of death associated with abortion rises from 0.3 for every 100,000 abortions at or before 8 weeks to 6.7 per 100,000 abortions at 18 weeks or later (Zane et al., 2015). An analysis conducted with California Medi-Cal data found the rate of complications associated with abortions, from all sources, including emergency departments and abortion facilities, is estimated to be about 2% (5.2% for medication abortions, 1.3% for first-trimester aspiration abortions, and 1.5% for second-trimester or later procedures)(Upadhyay et al., 2015b) The most common complications reported were incomplete or repeat abortions, which were treated with uterine aspiration (Upadhyay et al., 2015b). Major complications, including failed abortion, hemorrhage, infection, and uterine perforation were seen in less than 0.23% of all abortions in the study (Upadhyay et al., 2015b). Other potential complications include injury from the procedure (vaginal or cervical lacerations, uterine, bowel, or bladder injury) (Sajadi-Ernazarova and Martinez, 2020).

Additional associated services may be required in the event of complications (Sajadi-Ernazarova and Martinez, 2020). These services may include physical assessment (vital signs, abdominal exam, pelvic exam, rectal exam), lab tests (complete blood count, metabolic panel, blood type, blood cultures, coagulation studies, blood or urine human chorionic gonadotropin test), imaging studies (x-ray, ultrasound, computed tomography scan), additional procedures (procedural abortion in the case of failed medical abortion, abdominal surgery, stitches, blood transfusions), or medications (antibiotics, medications to stop bleeding) (Sajadi-Ernazarova and Martinez, 2020).

Payment for Abortion Services

In the United States, research shows that for states without restrictive laws on abortion services, 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 (Jones et al., 2018). In California, median abortion costs based on a 2020 survey of 151 clinics are $926 for a medication abortion, $994 for a first trimester procedural abortion and $1,218 for a second trimester procedural abortion.[28] Studies suggest most women with private insurance pay out of pocket for abortion services (Jones et al., 2010, 2013b; Roberts et al., 2014; Van Bebber et al., 2006). In a national survey administered to abortion patients, at least 69% paid out of pocket for abortion care although only 36% reported a lack of health insurance (Jones et al., 2013b). For women with private insurance, reasons for paying out of pocket included “insurance doesn’t pay for abortion” (48.4%), “not sure if insurance covers abortion” (26.2%), “don’t want to use my insurance” (13.1%), and “clinic doesn’t accept my insurance” (10.7%). A total of 18% of patients who had private insurance through a spouse or family member

[28] Advancing New Standards in Reproductive Health (ANDIRH). Abortion Facility Database, University of California, San Francisco. 2021.

reported that they did not utilize insurance because they did not want others to know they had obtained an abortion (Jones et al., 2013b).

When women do not use their insurance coverage for abortion services or cannot afford the out-of-pocket costs associated with abortion services, they may seek abortions at women's health clinics, such as Planned Parenthood, or seek other resources to help pay for abortion services, such as the National Network of Abortion Funds. However, some women may not have access to women's health clinics due to travel and the barriers associated with travel such as cost of travel, lost wages, or expenses for childcare (Jones et al., 2013b; Kiley et al., 2010; Upadhyay et al., 2014). In addition, abortion funds may not provide sufficient resources to cover the full cost of a procedure (Roberts et al., 2014). As such, some women may delay an abortion procedure while they save for its cost (Finer et al., 2006; Roberts et al., 2014). Women may pursue self-managed abortions, which occur when pregnant women terminate their pregnancy independent of the medical care setting (KFF, 2020). The most common method for completing a self-managed abortion is by ordering abortion medication pills (mifepristone–misoprostol combination packs or misoprostol only) online without a prescription. The cost of these medication packs range from $110 to $360 (Murtagh et al., 2018). SB 245 does not apply to self-managed abortions because these medications are not covered by insurance in this circumstance.

Disparities[29] and Social Determinants of Health[30] in Abortion Incidence, Access, and Cost Sharing

Per statute, CHBRP includes discussion of disparities and social determinants of health (SDoH) as it relates to the cost sharing and utilization management associated with abortion care. Disparities are noticeable and preventable differences between groups of people. CHBRP found no data regarding disparities by race/ethnicity and age for abortion services in California and, thus, relies on reports at the national level.

Abortion Incidence

In 2017, an estimated 862,320 abortions were completed in the United States. Within California. 132,680 abortions were completed (Jones et al., 2019). About half of all the abortions completed in California are covered by Medi-Cal (Johns et al., 2017). CHBRP did not find specific incidence rates by demographics for California because there are no published data with these statistics.[31]

Age

In 2018, in the United States, 619,591 abortions were reported to the CDC for women 15 to 44 years of age. Women aged 20 to 29 years accounted for more than half of all abortions (57.7%) (Kortsmit et al., 2020) (Table 4). See the *Public Health Impacts* section for further discussion of disparities related to age, and cost sharing and utilization management for abortion services.

[29] 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.
[30] CHBRP defines social determinants of health as conditions in which people are born, grow, live, work, learn, and age. These social determinants of health (economic factors, social factors, education, physical environment) are shaped by the distribution of money, power, and resources and impacted by policy (adapted from: Healthy People 2020, 2019, CDC, 2014. See CHBRP's SDoH white paper for further information: http://chbrp.com/analysis_methodology/public_health_impact_analysis.php.
[31] California, Maryland, and New Hampshire do not participate in the CDC's voluntary abortion surveillance program, which gathers data to document the number and characteristics of women who obtain abortions and the number of abortion-related deaths in the United States.

Table 4. Percent of U.S. Women 15–44 Years of Age Who Obtained Abortions in 2018

Age, Years	<15	15–19	20–24	25–29	30–34	35–39	40–44
Percent of women who obtained abortions	0.2%	8.8%	28.3%	29.4%	18.8%	10.7%	3.5%

Source: California Health Benefits Review Program, 2021 based on Kortsmit et al., 2020.

Race or Ethnicity

Abortion rates among women of color in the United States are two to three times higher than among White women (Dehlendorf et al., 2013). In 2018, the CDC reported the abortion rate[32] for Black women to be 21.2 abortions per 1,000 Black women, Hispanic women to be 10.9, and other non-Hispanic women to be 11.9 as compared to White women at 6.3 (Kortsmit et al., 2020). These rates reflect systemic barriers that lead to inequalities for women of color relative to White women. The systemic barriers that affect women of color include "decreased access to health care, higher levels of stress, exposure to racial discrimination, and poorer living and working conditions" (Braveman et al., 2011; Dehlendorf et al., 2013; Dominguez et al., 2008; Williams and Mohammed, 2009). All of these systemic barriers impact a women's ability to access contraceptives and prevent unintended pregnancies and may perpetuate higher rates of abortions among women of color (Dehlendorf et al., 2013). Although women of color obtain abortion services at higher rates than White women, disparities exist in access to abortion services at earlier gestational ages for women of color (Jones and Finer, 2012), and delayed abortion services are associated with greater risk than abortions performed earlier (Bartlett et al., 2004; Dehlendorf et al., 2013). SB 245 only addresses disparities associated with cost sharing for abortion services.

Social Determinants of Health

Social determinants of health (SDoH) include factors outside of the traditional medical care system that influence health status and health outcomes (e.g., income, education, geography, etc.). In this section, CHBRP describes income and geography related to costs and cost sharing associated with abortion services.

Income

The financial burden related to abortion care disproportionally affects low-income women due to higher abortion rates among this population and increased barriers to paying for abortion services (Dehlendorf et al., 2013). Research shows that saving money or securing funds to pay for an abortion is a financial barrier to obtaining abortion services (Finer et al., 2006; Foster et al., 2008). In 2014, data[33] from the Guttmacher Institute showed that 19% of women who obtained abortions had private insurance, and among these privately insured women, more than two-thirds reported income below 200% of the Federal Poverty Level. "For poor and low-income women, even meeting a relatively low deductible may be prohibitive" (Jones et al., 2013b). Pregnant women report additional financial barriers to obtaining an abortion, including transportation costs, lost wages, childcare expenses, and cost of bills or rent, food, or utilities (Jones et al., 2013b; Kiley et al., 2010; Upadhyay et al., 2014). These additional financial barriers are not addressed by SB 245 but are important considerations for low-income women seeking abortion

[32] The CDC defines the abortion rate as "Number of abortions obtained by women in a given racial/ethnic group per 1,000 women in that same racial/ethnic group. For the total abortion rate only, abortions for women of unknown race/ethnicity were distributed according to the distribution of abortions among women of known race/ethnicity" (CDC, 2020).
[33] These data were extracted from the 2014 Abortion Patient Survey. The dataset is nationally representative of all individuals obtaining abortions, and not intended to be representative of all people obtaining abortions in California.

care. Research indicates that financial barriers, such as out-of-pocket costs associated with abortion services, for women of low-income status delays their abortion care or prevents them from obtaining abortions at the desired gestational age (Dehlendorf et al., 2013; Roberts et al., 2014). California Medi-Cal plans already provide abortion services with no cost sharing for all enrollees.

Geography

Location of the abortion clinic or provider can have an impact on how far women must travel to obtain abortion services and result in additional costs related to abortion service, separate from the medical services costs, because they must pay for transportation, hotel, or childcare and might experience lost wages from missed days of work (Jones et al., 2013a; Kiley et al., 2010; Upadhyay et al., 2014). In 2008, women reported traveling 30 miles one way for abortion services, and 6% of women reported traveling more than 100 miles for abortion services (Jones and Jerman, 2013). Another study conducted in California reported that 12% of women must travel over 50 miles for abortion services (Johns et al., 2017). According to the Guttmacher Institute, in 2017, although 40% of California counties did not have a clinic that could provide abortions, only 3% of California women resided in those counties (Jones et al., 2019). However, the size of each county must be considered because many counties in California are very large, and women may have to travel long distances even within each county. For women in California who do not live in a county that provides abortion services, they may have to travel outside of their community to receive abortion services and may incur additional costs related to travel for abortion services. SB 245 does not address the location of clinics or providers that offer abortion services nor does it provide coverage for any of these costs.

MEDICAL EFFECTIVENESS

As discussed in the *Policy Context* section, SB 245 prohibits plans and policies from applying a deductible, coinsurance, and other cost-sharing requirements on abortion services. The medical effectiveness review summarizes findings from evidence[34] on the impact of cost sharing and utilization management for abortion services on access to care, utilization of health care services, and health outcomes.

Research Approach and Methods

Studies of effects of cost sharing and/or utilization management for abortion on health outcomes and utilization were sought through searches of relevant databases of peer-reviewed literature listed in Appendix B. The search was limited to abstracts of studies published in English.

Studies of the impact of cost sharing on abortion services were identified through searches of PubMed, Embase, and Business Source Complete. Websites maintained by the following organizations that produce and/or index meta-analyses and systematic reviews were also searched: the Guttmacher Institute and Kaiser Family Foundation.

The search was limited to abstracts of studies published in English.

Because of the limited studies available, the search included studies published from 2010 to present. Of the 109 articles found in the literature review by CHBRP, 9 were reviewed as potentially relevant for inclusion in this report on SB 245, plus an additional 8 were included from CHBRP's 2016 analysis of SB 999, the Content Expert, and snowball searches for a total of 17 studies included in the medical effectiveness review for this report. Only articles that addressed the research questions below were included in this report. The other articles were eliminated because they did not focus on abortion services, were of poor quality, or did not report findings from clinical research studies. 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.[35] Unpublished studies were not reviewed because the results of such studies, if they exist, cannot be obtained within the 60-day timeframe for CHBRP reports.

Key Questions

- What are the effects of utilization management policies (as discussed in the *Policy Context* section) for abortion on utilization and related health outcomes?

- What are the effects of cost sharing for abortion on utilization and related health outcomes?

[34] Much of the discussion in this section is focused on reviews of available literature. However, as noted in the section on Implementing the Hierarchy of Evidence on page 11 of the Medical Effectiveness Analysis and Research Approach document (posted at http://chbrp.com/analysis_methodology/medical_effectiveness_analysis.php), in the absence of fully applicable to the analysis peer-reviewed literature on well-designed randomized controlled trials (RCTs), CHBRP's hierarchy of evidence allows for the inclusion of other evidence.

[35] 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.

Methodological Considerations

Most of the research related to abortion services is not classified as high quality as defined by CHBRP methodology (see Appendix B for description), which limits the potential strength of the conclusions. There are not randomized control trials on abortion because it is not ethical to randomize women who are seeking abortion services into an intervention or placebo group. Most studies on abortion services analyzed for this report use self-reported survey data, and most studies investigating financial barriers to abortion access have been done with an uninsured population. One study compares groups of women in states that fund abortion through Medicaid to women in states that do not fund abortion without studying the individual women who had Medicaid-paid abortions; that is, they used population level data rather than individual data to make conclusions about individual-level outcomes (ecological fallacy).

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. Using this logic model, CHBRP examined literature that studied the impacts of cost sharing and utilization policies on access to abortion services to help answer the key questions proposed earlier in this section.

Most of the studies included in this review are based on data from the Turnaway study at the University of California, San Francisco,[36] a prospective cohort study of 956 women who sought abortions at abortion facilities in the United States. Women were recruited from 2008 to 2010, from 30 abortion facilities in 21 states throughout the United States. They completed telephone interviews 1 week after seeking an abortion, and then semiannually for 5 years. Women were categorized into two groups, those who received abortions because they were under the gestational age limit for abortion, and those who were turned away from abortion because they were just beyond the gestational age limit for abortion. This study documented women's reports of side effects, and physical and mental health outcomes experienced after abortion, or if they were turned away after seeking abortion, ongoing pregnancy and birth.

In addition, CHBRP considered the literature on the health outcomes related to unintended pregnancies, previously examined in CHBRP's analysis of SB 999 on contraceptive coverage (CHBRP, 2016).

Outcomes Assessed

In alignment with the logic model discussed above, this analysis 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.

Study Findings

The following section summarizes CHBRP's findings regarding the strength of evidence on the impact of cost sharing and utilization management for abortion services, as related to the bill language. Thus, it

[36] Advancing New Standards in Reproductive Health (ANDIRH). The Turnaway Study. 2013. University of California, San Francisco. Available at: https://www.ansirh.org/research/ongoing/turnaway-study. Accessed March 2021.

does not review the medical effectiveness of abortion or related abortion services, for which the medical effectiveness has been well documented.

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.

Findings on the Impact of Utilization Management Policies on Abortion Outcomes

CHBRP did not find any studies that examine the impact of utilization management policies such as prior authorization on abortion outcomes.

Summary of findings regarding utilization management policies on abortion outcomes: 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 (Figure 2).

Figure 2. Utilization Management Policies on Abortion Outcomes

NOT EFFECTIVE
INSUFFICIENT EVIDENCE
EFFECTIVE
Clear and Convincing
Preponderance
Limited
Inconclusive
Limited
Preponderance
Clear and Convincing

Findings on the Impact of Cost-Sharing Policies on Abortion Access and Utilization

CHBRP did not find any studies that directly examine the impact of cost sharing on abortion access and utilization. However, it is well established in the literature that persons who face higher cost sharing use fewer services than persons with lower cost sharing (CHBRP, 2020; Effros et al., 2009). Therefore, it stands to reason that, for patients whose insurance coverage has out-of-pocket costs that are close to or

equal to the uninsured cost of an abortion, due to high deductibles, that research findings around cost of abortion for the uninsured would apply to the high deductible insured population as well. Therefore, CHBRP reviewed articles that addressed cost as a barrier to abortion access and utilization. Much of this research has been done in populations without insurance coverage for abortion. CHBRP also reviewed more general research on those attempting to obtain abortions and their outcomes.

Delayed abortion due to cost as a barrier to abortion

An analysis examining payment for abortion based on data from the Turnaway study, a 5-year prospective cohort study previously described, reported cost as a reason for delay in obtaining an abortion (725 subjects) (Roberts et al., 2014). This study reported that more than half of the sample (54%) reported that raising money for an abortion delayed obtaining care. Another survey study in multiple U.S. states (874 subjects) found that on initial attempt to access abortion services, 67% cited cost for the abortion or travel to the abortion as a barrier. For the 283 pregnant women who were unable to obtain an abortion when sought and still attempting to obtain one 4 weeks later, 80% identified cost as a barrier (Upadhyay et al., 2021). Both studies included women with and without insurance coverage for abortion or Medicaid.

Self-managed abortion

CHBRP identified two studies that found women who performed self-managed abortion, that is an abortion done without physician supervision, cited cost as a common reason (Aiken et al., 2020; Ralph et al., 2020). Aiken et al. (2020) used data from U.S. residents requesting early medication abortion from the online abortion telemedicine service Women on Web (WoW). WoW is a nonprofit organization that typically provides abortion medications to women living in countries where safe abortion is not available. This study found that, although women in states with prohibitive abortion laws reported cost as a reason for self-managed abortion significantly more often than women in abortion supportive states, women in both groups frequently cited cost as a reason for self-managed abortion (71.1% versus 62.9%). Ralph et al. (7,022 subjects) found that women attempting a self-managed abortion, defined in this study as doing something “on their own to try to end a pregnancy without medical assistance,” tended to be poor, measured as living below 100% of the federal poverty level (FPL) compared with those at 200% FPL or greater (OR: 3.43) (Ralph et al., 2020).

Maternal mental health outcomes related to cost as a barrier to abortion

CHBRP found one study that compared maternal mental health outcomes in states with Medicaid coverage for abortion to states that do not provide this coverage, so women have to pay out of pocket for abortion services. The study found that women in states without Medicaid coverage for abortion tend to have higher rates of postpartum depression compared to women in states with Medicaid coverage for abortion (Medoff et al., 2014). Analyzing Pregnancy Risk Assessment Monitoring System data in 22 states, the researchers found that, based on symptom questions for postpartum depression, states that prohibit Medicaid funding of abortions have statistically significantly higher rates of women who stated they often or always felt depressed, down, or hopeless (9.3%) or had these symptoms and/or little interest or pleasure in doing things (13.9%) than in those states that fund Medicaid abortions (8.2% and 11.6%, respectively. The study found that states with other restrictive abortion policies (e.g., parental involvement laws, mandatory counseling laws, waiting period laws), compared to states without these restrictive abortion laws, had similar rates of postpartum depression (Medoff et al., 2014). As discussed in the methodology, this research design examines effects at a population level and not individual level. However, it illustrates the potential impacts of cost barriers to abortion.

Summary of findings regarding cost-sharing policies on abortion access and utilization: There is limited evidence that cost-sharing policies reduce access to, and use of, abortion services based on 4 survey studies that assessed out-of-pocket costs on abortion access and utilization (Figure 3). There is insufficient evidence that out-of-pocket costs for abortion affects maternal mental health outcomes based on one ecological study of survey data that compared health outcomes of women in states without Medicaid coverage for abortion compared to states with Medicaid coverage for abortion (Figure 4).

Figure 3. Cost-Sharing Policies as a Barrier to Abortion

Figure 4. Cost-Sharing Policies on Maternal Mental Health Outcomes

Findings on Maternal and Child Health Outcomes Associated With Continued Pregnancy After Not Obtaining Abortion

As discussed in the CHBRP report for SB 999 on contraception prescriptions and the Turnaway study, both unintended pregnancies or pregnancies continued after women were unable to obtain an abortion, and the resultant births are associated with a range of adverse prenatal and postpartum outcomes (CHBRP, 2016), maternal outcomes, and associated child health and development outcomes. CHBRP determined the findings from SB 999 on unintended pregnancies after lack of contraception are relevant to SB 245 as indirect findings on the impact of barriers to abortion. 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. Findings from SB 999 are presented as the outcomes associated with unintended pregnancy. The Turnaway study directly examined the impact of women who desired abortions and were unable to obtain them, thus their pregnancies continued. Findings from the Turnaway study are presented as outcomes associated with continued pregnancy after being unable to obtain an abortion due to gestational age limits. It stands to reason that women who are not able to obtain an abortion for cost-related reasons would have similar outcomes as those turned away for being just past the gestational age limit.

Prenatal, perinatal, and postnatal outcomes associated with unintended pregnancy

For those who choose abortion, SB 245 aims to increase access by decreasing cost as a barrier. As CHBRP was unable to find articles that directly studied cost sharing on prenatal, perinatal, and postnatal outcomes after being unable to obtain a desired abortion, studies that assessed these outcomes for unintended pregnancies were reviewed. Many, but not all, women who choose abortion had unintended (mistimed or undesired) pregnancies. The following studies present evidence on health outcomes for unintended pregnancies without specifically addressing if abortion was sought.

The CHBRP report for SB 999 on contraceptive coverage included four studies that reported on prenatal and postpartum outcomes for unintended pregnancies. One review (Gipson et al., 2008) reported that

women with unintended pregnancies are more likely to delay initiating prenatal care and have fewer prenatal care visits compared to women with intended pregnancies. Another systematic review (15 studies) (Shah et al., 2011) found that the odds of low birth weight and preterm birth were higher among unintended pregnancies compared to intended pregnancies. Additionally, research shows that children born from unintended pregnancies are less likely to be breastfed and if they are breastfed, are more likely to be breastfed for a shorter duration (Cheng et al, 2009; Gipson et al., 2008).

As discussed in the CHBRP report for SB 999, several studies have found that women with unintended pregnancies had an increased risk of postpartum depression as compared to women with intended pregnancies (Cheng et al., 2009; Mercier et al., 2013; Nakka et al., 2006).

Maternal health outcomes after being unable to obtain an abortion

Analysis of survey data from the Turnaway study comparing women who had abortions to women who gave birth after being turned away from an abortion found that although women reported similar rates of side effects and health issues, such as cramping and pain, women who gave birth reported potentially life-threatening complications (6.3%), such as eclampsia and postpartum hemorrhage, whereas those having either first (0.4%) or second (1.1%) trimester abortions did not (Gerdts et al., 2016).

Another analysis surveyed women at baseline and 5 years later to compare the self-reported health of women who had an abortion compared to women who sought an abortion but were turned away due to gestational limits then subsequently gave birth (Ralph et al., 2019;874 subjects). At 5-year follow-up, women who gave birth reported significantly worse health, more chronic headaches or migraines, and more joint pain. Both groups reported similar levels of other types of chronic pain and obesity compared to women who had an abortion.

An analysis from the Turnaway study (956 subjects) (Biggs et al., 2017), found women assessed 1 week after seeking and being denied an abortion more commonly reported anxiety symptoms compared with women who received abortions. However, at 1-year follow-up, these symptoms declined, and both groups showed similar levels of anxiety.

Child outcomes after being unable to obtain an abortion

An analysis from the Turnaway study (348 subjects) (Foster et al., 2019) compared existing children of pregnant women denied an abortion due to gestational age. This study found that existing children of pregnant women denied abortions had significantly lower mean child development scores (4% fewer milestones achieved) and were significantly more likely to live below the Federal Poverty Level than the children of women who received a wanted abortion (OR: 3.74). There were no significant differences in child health outcomes.

Another analysis from the Turnaway study (328 subjects) (Foster et al., 2018) compared children born to women denied an abortion for that pregnancy to children born subsequently to women who previously received an abortion. Researchers reported that poor maternal bonding was significantly more common for children of women denied an abortion compared with subsequent children of women who previously received an abortion (9% versus 3%), children of women denied an abortion lived in households with significantly lower incomes than did subsequent children (101% versus 132% of the Federal Poverty Level), and were significantly more likely to live in households without enough money to pay for basic living expenses (72% versus 55%) This study reported no difference in child health outcomes between groups, and no clear pattern of delayed child development between groups.

Summary of findings regarding unintended pregnancy and/or continued pregnancy after being unable to obtain an abortion on maternal health and child outcomes:

There is limited evidence based on contraception studies as indirect findings on the impact of barriers to abortion that suggest that unintended pregnancy has negative maternal and child health outcomes. There is 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.

There is insufficient evidence that being unable to obtain an abortion has the adverse maternal health outcomes of life-threatening birth complications, chronic joint or headache pain, and worse self-reported health. There is limited evidence based on two analyses within the Turnaway survey study that children in families where women were denied an abortion have lower household income. There is limited evidence based on these same two analyses that children in families where women were denied an abortion do not have worse health outcomes. There is inconclusive evidence based on these two analyses that child development is impacted in families where an abortion is denied.

Summary of Findings

CHBRP found there is:

- Insufficient evidence that utilization management policies affect abortion outcomes.
- Limited evidence that cost-sharing policies affect abortion access and utilization and insufficient evidence that cost sharing for abortion 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 evidence of the impact on child development of children born to women who were denied an abortion.

BENEFIT COVERAGE, UTILIZATION, AND COST IMPACTS

As discussed in the *Policy Context* section, SB 245 would require DMHC-regulated health plans and CDI-regulated health policies that currently offer coverage for induced abortion services to eliminate all cost sharing (i.e., copays, coinsurance, or deductible payments) and prior authorization requirements for abortions and associated services. The removal of enrollee cost-sharing obligations is commonly known as “first dollar coverage,” meaning that an enrollee would not have any out-of-pocket expenses for abortion services if covered by their insurance. SB 245 does not include reductions in other costs commonly associated with accessing abortion services, including transportation to the clinic, any necessary lodging expenses, or reimbursement for time taken off work.

In addition to commercial enrollees, more than 50% of enrollees associated with the California Public Enrollees’ Retirement System (CalPERS) and more than 70% of Medi-Cal beneficiaries are enrolled in DMHC-regulated plans.[37] As noted in the *Policy Context* section, SB 245 would not impact Medi-Cal beneficiaries’ benefit coverage, because these enrollees currently do not have cost sharing or prior authorization requirements for abortion services.

This section reports the potential incremental impacts of SB 245 on estimated baseline benefit coverage, utilization, and overall cost. SB 245 does not affect coverage for induced abortion, but rather impacts cost sharing for existing coverage. In approaching this issue, CHBRP is unable to determine the specifics of cost sharing for each enrollee among DMHC-regulated plans and CDI-regulated policies. However, in CHBRP’s survey of the largest providers of health insurance in California, health plans and policies reported that enrollees who currently have coverage for abortion services also have cost sharing. To estimate the impact of eliminating cost sharing, CHBRP applied an average estimated rate of cost sharing based on existing medical claims data for abortion services (see Appendix C for full details). Additionally, the total number of enrollees who use associated services include women who used pre- and post-abortion care for their induced abortions, as well as those who used pre-abortion care and then did not have the induced abortion. Finally, CHBRP accounted for the fact that an increase in induced abortions resulting from the enactment of SB 245 would decrease the total number of continued pregnancies in the overall population. Although these outcomes potentially could occur outside of the 12 months after enactment,[38] CHBRP is unable to determine the precise timeframe and therefore includes this outcome and its resulting cost offset in the analysis of SB 245 so as to present a more accurate picture of an average year of costs.

CHBRP’s analysis includes the following assumptions:

- As discussed in the *Background on Abortions* and *Medical Effectiveness* sections, enrollees who have induced abortions often do not choose to use their insurance coverage for the abortion, due to numerous factors, including a preference for privacy or a lack of knowledge that their plan or policy covers abortion services (Drey et al., 2006; Jones et al., 2013a, 2019; Jones and Jerman, 2013; Upadhyay, et al., 2014). CHBRP assumes that these reasons would remain if SB 245 were enacted, and therefore, most women who, at baseline, choose to forego using their private insurance for other reasons would continue to do so.

- Some women who faced cost-sharing barriers and did not obtain an abortion at baseline would successfully obtain an induced abortion postmandate due to the removal of cost sharing. CHBRP assumes the increase in use of abortion services would be similar to other intensive medical services when cost sharing is reduced to zero. There are no data in the literature on price elasticity for abortion services. CHBRP therefore assumes that utilization of abortion services will

[37] For more detail, see CHBRP’s *Estimates of Sources of Health Insurance in California for 2021*, a resource available at http://chbrp.org/other_publications/index.php.
[38] CHBRP postmandate analyses focus on the first 12 months after enactment of a benefit mandate and defines long-term impacts as those occurring beyond the first 12 months after implementation.

increase by 1% among enrollees in commercial plans and policies who had cost sharing at baseline (see Appendix C for a full explanation).

- To determine cost offsets from increased utilization of induced abortions, CHBRP assumes that medical costs from continued pregnancies are the same at baseline and postmandate. See *Appendix C* for a full description of the breakdown of offset costs.

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

In response to the COVID-19 pandemic, CHBRP assumes utilization of health care services in 2022 will be roughly equivalent to utilization in 2019,[39] with adjustments made to account for changes in enrollment and population. CHBRP does not make additional assumptions to adjust for changes in utilization due to COVID-19 because recent 2020 claims data indicates utilization in aggregate has mostly returned to pre-pandemic levels. However, CHBRP acknowledges utilization has not rebounded for some services and for some groups of enrollees (i.e., visits for younger children had not returned to pre-pandemic baseline as of October 2020) (Mehrotra et al., 2020). Additionally, there are additional unknown factors that may impact utilization as a result of COVID-19, such as the potential impacts of deferred care and long-term impacts from COVID-19 infections.

Baseline and Postmandate Benefit Coverage

SB 245 would apply to 100% of the 21,945,000 enrollees in commercial, CalPERS, and Medi-Cal DMHC-regulated plans and CDI-regulated policies would be subject to SB 245 (Table 1).

CHBRP estimates at baseline there are 23,492 enrollees who have induced abortions and use associated services in DMHC-regulated plans and CDI-regulated policies (Table 1). Of these, 9,652 enrollees (41%) have cost sharing, which represents the enrollees in privately funded DMHC-regulated plans and CDI-regulated policies, along with CalPERS HMOs. Postmandate, 100% of enrollees with coverage for abortion would have $0 cost sharing for abortion services, including associated medical care.

Baseline and Postmandate Utilization

Using relevant codes from the International Classification of Diseases, 10th Revision, Clinical Modification (ICD-10-CM), CHBRP extracted data from Milliman's 2019 Consolidated Health Cost Guidelines™ Sources Database Plus (CHSD+) to develop baseline estimates of utilization of induced abortion (both medication abortion and procedural abortion), and associated services (See Appendix C for full list of codes). CHBRP calculated utilization rates for enrollees whose claims for induced abortion services included cost sharing (Table 1).

At baseline, a total of 23,492 enrollees had any use of abortion services, including associated services. As detailed in the *Background* section, it is sometimes medically necessary for a woman to have both a medication and a procedural abortion. Additionally, nearly all women who used associated services did so in relation to an induced abortion that occurred, but there is some proportion of women who have pre-abortion services and then do not have an abortion procedure. Many women who have a medication or procedural abortion require no associated services beyond the day of the procedure. Therefore, due to the overlapping populations of enrollees, the utilization estimates of number of services do not add to the number of total enrollees who used abortion services.

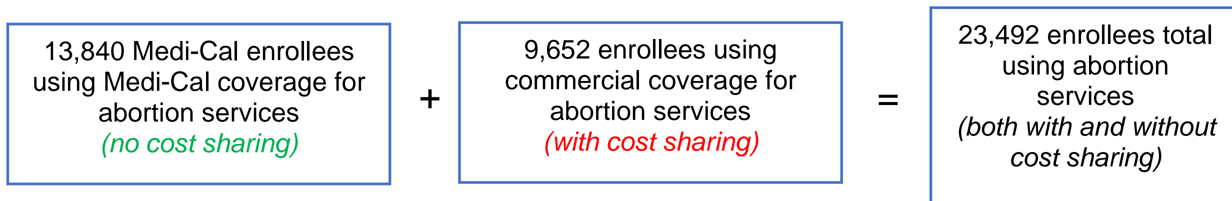
Additionally, CHBRP is aware that the number of enrollees who have induced abortions using their DMHC- or CDI-regulated coverage does not sum up to the overall number of induced abortions in

[39] CHBRP uses Milliman's 2019 Consolidated Health Cost Guidelines Sources Database Plus (CHSD+) to estimate utilization in 2022.

California, as detailed in the *Background* section. Combining the CHBRP Cost and Coverage Model's estimate of enrollees who use their insurance coverage for an induced abortion with the total estimated number of induced abortions in California, CHBRP finds that an estimated 18% of enrollees who have induced abortions use their insurance coverage at baseline.

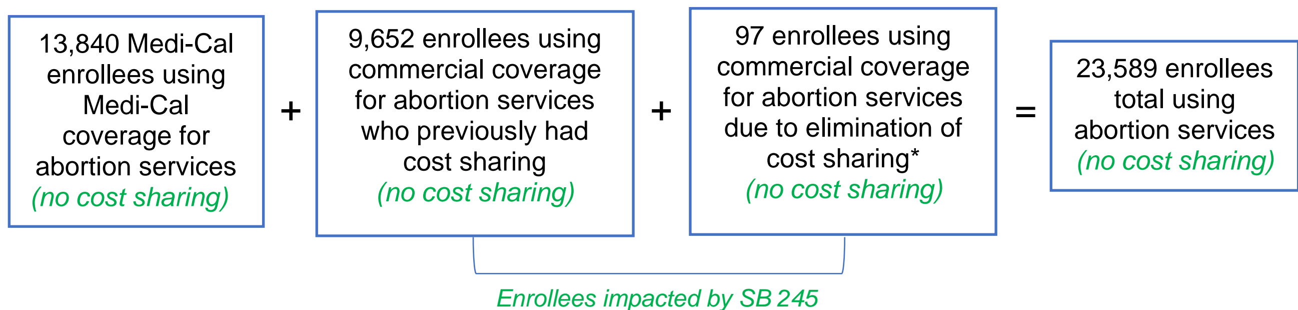
Of the total 23,492 enrollees in DMHC-regulated plans or CDI-regulated policies who used abortion services under their insurance coverage at baseline, 13,840 enrollees had no cost sharing and 9,652 had any cost sharing (Figure 5). CHBRP estimates that at baseline, 7,414 enrollees have medication abortions with no cost sharing, and 3,759 enrollees have a medication abortion with cost sharing (Table 1). Among enrollees having a procedural abortion, 5,063 have no cost sharing and 3,516 have cost sharing. Finally, among enrollees who use associated services at baseline, 4,429 have no cost sharing and 5,366 have cost sharing.

Figure 5. Baseline Utilization Calculations



Postmandate, there would be an overall increase in utilization due to the elimination of cost sharing for abortion services. To estimate changes in utilization postmandate, CHBRP applied an estimate of price elasticity of demand (see the full explanation in Appendix C). This estimated 1% increase in utilization combined with the reduction of cost sharing to zero for all enrollees results in a total of 23,589 enrollees who have any induced abortion or associated services (Figure 6).

Figure 6. Postmandate Utilization Calculations.



**This population represents the estimated 1% increase postmandate from baseline who no longer continuing pregnancies due to enactment of SB 245.*

Postmandate, by service, this results in an estimated 11,210 enrollees who have medication abortions, 8,614 who have procedural abortions, and 9,849 who have associated services (Table 1).

Baseline and Postmandate Cost

At baseline, according to the Milliman claims database, medication abortion has an average total cost of $741, and procedural abortion has an average total cost of $2,763 (Table 1); these totals include any costs from associated services performed on the same day of the abortion. Associated services have an

average total cost of $574. Baseline cost sharing for medication abortion is, on average, $306 for enrollees with cost sharing. For procedural abortion, cost sharing averages $887, and associated services have, on average, $182 in additional cost sharing (Table 1). These do not reflect average total costs per enrollee, which would depend on the amount and type of services used. Enrollees may need to obtain multiple services for various reasons, including medical necessity. For example, as described in the *Background* section, if a medication abortion is incomplete, a woman may need to obtain a procedural abortion. Postmandate, average cost sharing for medication abortion, procedural abortion, and associated services will become $0 (Table 1).

Because SB 245 only impacts cost sharing for induced abortions, CHBRP estimates that the number of abortions newly paid for by DMHC-regulated plans and CDI-regulated policies will not be of a large enough magnitude to affect total per-unit costs for either medication or procedural abortion, or for the related associated services. Therefore, CHBRP estimates that the average total per-unit costs will remain the same postmandate.

Baseline and Postmandate Expenditures

Table 6 and Table 7 present baseline and postmandate expenditures by market segment for DMHC-regulated plans and CDI-regulated policies according to the CHBRP Cost and Coverage Model. 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).

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 (see *Enrollee Expenses* section below) adjusted by a $4,026,000 increase in total health insurance premiums paid by employers and enrollees.

Premiums

CHBRP estimates that the mandate would increase premiums by about $4,026,000 due to increased costs assumed by insurance carriers. Total premiums for private employers purchasing group health insurance would increase by $1,808,000, or 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. Note that such changes are related to the number of enrollees with health insurance that would be subject to SB 245 (Table 1, Table 6, and Table 7). The greatest change in premiums as a result of SB 245 is for commercial individual plans in the DMHC-regulated market (0.0085% increase) and for the individual plans in the CDI-regulated market (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 HMO plans, there is an estimated increase of 0.0022% in premiums.

Enrollee Expenses

SB 245–related changes in cost sharing for covered benefits and out-of-pocket expenses for noncovered benefits would vary by market segment. Note that such changes are related to the number of enrollees with health insurance that would be subject to SB 245 expected to use induced abortion services during the year after enactment (Table 1, Table 6, and Table 7).

It is possible that some enrollees incurred expenses related to induced abortion services for which coverage was denied, but CHBRP cannot estimate the frequency with which such situations occur and therefore cannot offer a calculation of impact. CHBRP also cannot estimate impacts on enrollees who choose to use abortion services outside of their insurance coverage, and who therefore pay the total cost out-of-pocket.

The decreases in enrollee expenditures for covered benefits in commercial plans range from $0.0242 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 (Table 7). These decreases in cost sharing for covered benefits PMPM would result in an overall reduction in total costs of $5,527,000 postmandate.

Average enrollee expenses per user

With the elimination of cost sharing, CHBRP estimates that 9,748 enrollees in DMHC-regulated large group plans and CDI-regulated large-group policies who use abortion services would experience an average decrease in costs of $429 postmandate (Table 5). Among enrollees in small-group DMHC-regulated plans or CDI-regulated policies, cost-sharing decreases will average $721 per user. Enrollees who use abortion services who have individual DMHC-regulated plans or CDI-regulated policies will have an average reduction in cost sharing by $825. Finally, CalPERS enrollees will have an average decrease of $426 in cost sharing per user. Medi-Cal enrollees will not see a reduction in cost sharing postmandate, because they already have $0 cost sharing at baseline.

Table 5. Average Enrollee Cost-Sharing Reductions Postmandate

	Large Group	Small Group	Individual	CalPERS HMO	Medi-Cal HMO *
Average reduction in cost sharing	−$429	−$721	−$825	−$426	$0

Source: California Health Benefits Review Program, 2021.

Notes: Average enrollee out-of-pocket expenses include expenses for both covered and noncovered benefits. Out-of-pocket expenses only reflect those related to abortion services and not pregnancy offsets.

* Benefit coverage for Medi-Cal beneficiaries does not generally include any cost sharing.

It should be noted Table 5 that shows the per-user annual impact in the form of cost-sharing savings for users facing cost sharing at baseline. These numbers reflect population averages and will vary significantly for individual members. Sources of variation include the specific services utilized by the enrollee and the cost sharing and utilization management protocols applicable to their specific DMHC-regulated plan or CDI-regulated policy.

Potential Cost Offsets or Savings in the First 12 Months After Enactment

CHBRP assumes that women who have induced abortions, if they had continued their pregnancies, would have had similar medical outcomes for the pregnancies as the general population of pregnant women. Although these outcomes would have potentially occurred outside of the 12 months after the first year of enactment of SB 245, CHBRP includes them in Table 1 and the analysis so as to present a more accurate picture of an average year of costs. See Appendix C for a full discussion of the methods used in these cost offset estimates.

According to the CHBRP Cost and Coverage Model, there are an estimated 97 women who would choose to have an induced abortion with the elimination of cost sharing postmandate. These pregnancy outcomes at baseline result in an average of $25,574 per pregnancy, accounting for labor and delivery charges and medical costs associated with stillbirths or 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 from the enactment of SB 245 (Table 1).

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 (Table 1, Table 6, and Table 7), CHBRP would expect no measurable change in the number of uninsured persons due to the enactment of SB 245.

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 SB 245.

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

Because enrollees in Medi-Cal already have abortion services coverage without cost sharing, there is no expected cost shifting to occur from public programs into the privately insured market nor would these public programs incur a cost as a result of SB 245. CHBRP is also aware that clinics and foundations exist that can assist women financially to access abortion services through either sliding scale fees based on income or direct funds to cover out-of-pocket costs; however, CHBRP is unable to quantify how many enrollees may use these services.

Table 6. Baseline Per Member Per Month Premiums and Total Expenditures by Market Segment, California, 2022

	DMHC-Regulated						CDI-Regulated			
	Commercial Plans (by Market) (a)			Publicly Funded Plans			Commercial Plans (by Market) (a)			
	Large Group	*Small Group*	*Individual*	*CalPERS HMOs (b)*	*MCMC (Under 65) (c)*	*MCMC (65+) (c)*	*Large Group*	*Small Group*	*Individual*	**TOTAL**
Enrollee Counts										
Total enrollees in plans/policies subject to state mandates (d)	8,405,000	2,086,000	1,989,000	889,000	7,218,000	787,000	384,000	43,000	144,000	21,945,000
Total enrollees in plans/policies subject to SB245	8,405,000	2,086,000	1,989,000	889,000	7,218,000	787,000	384,000	43,000	144,000	21,945,000
Premium Costs										
Average portion of premium paid by employer	$426.28	$374.49	$0.00	$540.40	$226.61	$478.87	$530.80	$421.81	$0.00	$84,948,349,000
Average portion of premium paid by enrollee	$141.02	$180.89	$624.47	$96.86	$0.00	$0.00	$186.55	$212.07	$545.57	$36,600,954,000
Total Premium	**$567.30**	**$555.38**	**$624.47**	**$637.27**	**$226.61**	**$478.87**	**$717.35**	**$633.88**	**$545.57**	**$121,549,303,000**
Enrollee Expenses										
Cost-sharing for covered benefits (deductibles, copays, etc.)	$43.61	$121.70	$173.51	$50.75	$0.00	$0.00	$134.75	$197.13	$184.11	$13,168,032,000
Expenses for noncovered benefits (e)	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0
Total Expenditures	**$610.91**	**$677.07**	**$797.97**	**$688.02**	**$226.61**	**$478.87**	**$852.10**	**$831.01**	**$729.68**	**$134,717,335,000**

Source: California Health Benefits Review Program, 2021.

Notes: (a) Includes enrollees with grandfathered and nongrandfathered health insurance acquired outside or through Covered California (the state's health insurance marketplace).

(b) Approximately 54.1% of CalPERS enrollees in DMHC-regulated plans are state retirees, state employees, or their dependents.

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

(d) 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.

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

(f) Includes only Medi-Cal beneficiaries enrolled in DMHC-regulated plans.

Key: CalPERS HMOs = California Public Employees' Retirement System Health Maintenance Organizations; CDI = California Department of Insurance; COHS = County Organized Health Systems; DMHC = Department of Managed Health Care; MCMC = Medi-Cal Managed Care.

Table 7. Postmandate Per Member Per Month Premiums and Total Expenditures by Market Segment, California, 2022

	DMHC-Regulated						CDI-Regulated			
	Commercial Plans (by Market) (a)			Publicly Funded Plans			Commercial Plans (by Market) (a)			
	Large Group	*Small Group*	*Individual*	*CalPERS HMOs (b)*	*MCMC (Under 65) (c)*	*MCMC (65+) (c)*	*Large Group*	*Small Group*	*Individual*	**TOTAL**
Enrollee Counts										
Total enrollees in plans/policies subject to state mandates (d)	8,405,000	2,086,000	1,989,000	889,000	7,218,000	787,000	384,000	43,000	144,000	21,945,000
Total enrollees in plans/policies subject to SB245	8,405,000	2,086,000	1,989,000	889,000	7,218,000	787,000	384,000	43,000	144,000	21,945,000
Premium Costs										
Average portion of premium paid by employer	$0.0101	$0.0269	$0.0000	$0.0121	$0.0000	$0.0000	$0.0218	$0.0356	$0.0000	$1,937,000
Average portion of premium paid by enrollee	$0.0033	$0.0130	$0.0529	$0.0022	$0.0000	$0.0000	$0.0077	$0.0179	$0.0567	$2,089,000
Total Premium	$0.0134	$0.0400	$0.0529	$0.0142	$0.0000	$0.0000	$0.0294	$0.0535	$0.0567	**$4,026,000**
Enrollee Expenses										
Cost-sharing for covered benefits (deductibles, copays, etc.)	-$0.0242	-$0.0456	-$0.0574	-$0.0249	$0.0000	$0.0000	-$0.0379	-$0.0566	-$0.0594	-$5,527,000
Expenses for noncovered benefits (e)	$0.0000	$0.0000	$0.0000	$0.0000	$0.0000	$0.0000	$0.0000	$0.0000	$0.0000	$0
Total Expenditures	-$0.0108	-$0.0056	-$0.0045	-$0.0107	$0.0000	$0.0000	-$0.0085	-$0.0031	-$0.0028	**-$1,501,000**
Postmandate Percent Change										
Percent change insured premiums	0.0024%	0.0072%	0.0085%	0.0022%	0.0000%	0.0000%	0.0041%	0.0084%	0.0104%	0.0033%
Percent Change total expenditures	-0.0018%	-0.0008%	-0.0006%	-0.0016%	0.0000%	0.0000%	-0.0010%	-0.0004%	-0.0004%	-0.0011%

Source: California Health Benefits Review Program, 2021.

Notes: (a) Includes enrollees with grandfathered and nongrandfathered health insurance acquired outside or through Covered California (the state's health insurance marketplace).

(b) Approximately 54.1% of CalPERS enrollees in DMHC-regulated plans are state retirees, state employees, or their dependents.

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

(d) 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.

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

(f) Includes only Medi-Cal beneficiaries enrolled in DMHC-regulated plans.

Key: CalPERS HMOs = California Public Employees' Retirement System Health Maintenance Organizations; CDI = California Department of Insurance; COHS = County Organized Health Systems; DMHC = Department of Managed Health Care; MCMC = Medi-Cal Managed Care

PUBLIC HEALTH IMPACTS

As discussed in the *Policy Context* section, SB 245 would prohibit plans and policies from imposing cost sharing for all covered abortion and follow-up services, including management of side effects and counseling. Additionally, SB 245 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.

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[40] of SB 245 on eliminating cost sharing and utilization management for abortions and associated services for women with coverage through DMHC-regulated plans or CDI-regulated policies.

Estimated Public Health Outcomes

The analysis discussed in the *Medical Effectiveness* section used indirect evidence to estimate the impact of cost or cost sharing 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 an abortion. CHBRP found there is:

- Limited evidence that cost-sharing policies affect abortion access and utilization and insufficient evidence that cost sharing for abortion 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 evidence of the impact on child development of children born to women who were denied an abortion.

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.

As presented in the *Benefit Coverage, Utilization, and Cost Impacts* section, CHBRP estimates that marginal postmandate impact of SB 245 would be an additional estimated 9,748 women receiving abortion services with zero cost sharing. This 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.

Barriers to Abortion Services

There are significant barriers that may prevent or delay women from obtaining abortions. These barriers include financial barriers (out-of-pocket costs, costs for travel and time off work) (Finer et al., 2006; Foster et al., 2018), distance and time to clinics or providers that perform abortion services (transportation,

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

childcare, accommodations, work schedule), limited clinic options (limited options close to home especially for procedures for second trimester abortions, unavailable appointment times), navigating the system (logistics in securing an appointment, lack of information about resources or referrals, multiple visits needed for the procedure, delay of care), and desire to maintain privacy (seek out new doctor, avoid using insurance) (Jerman et al., 2017; Jones et al, 2013b; Kiley et al., 2010; Upadhyay et al., 2014). SB 245 specifically addresses the financial barrier related to out-of-pocket costs associated with abortion services and would eliminate cost sharing and utilization management for abortions already covered by commercial insurance.

Psychological Outcomes

There are short-term psychological harms associated with not being able to access abortion services. Research demonstrates that rates of self-esteem and life satisfaction are lowest the week after being denied an abortion (Biggs et al, 2017). However, between 6 months to 1 year, the impact of being denied an abortion decreases.

An analysis from the Turnaway study (Biggs et al., 2014) found women assessed 1 week after seeking and being denied an abortion more commonly reported lower self-esteem and lower life satisfaction compared with women who received abortions. However, at 1-year follow-up, these symptoms declined, and both groups showed similar levels of self-esteem and life satisfaction scores (Biggs et al., 2014). Another study (McCarthy et al., 2020) found women denied a wanted abortion were less optimistic about their long-term futures than women who received a wanted abortion. Women denied an abortion had lower odds of setting an aspiring 5-year life plan and goals than women who had an abortion. However, at 5 year follow-up, there were no differences by group in achieving 5-year life plans or goals among those who had them (McCarthy et al., 2020).

As previously discussed, SB 245 may increase access to abortion services for women with commercial insurance by reducing the financial burden associated with cost sharing. However, there are other barriers to seeking abortion services such as distance from clinic, limited clinic options, or navigating the system that may prevent women from obtaining abortion services. Women may also seek abortion services without the use of insurance due to concerns of confidentiality or stigma associated with abortions.

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 that most people are not prepared to experience. Therefore, SB 245 may also provide a financial benefit for the approximately 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.

Impact on Disparities[41]

Insurance benefit mandates that bring more state-regulated plans and policies to parity may change an existing disparity. As described in the *Background* section, disparities in access to/utilization of abortion and associated services exist by race/ethnicity, age, and income. Within the first 12 months postmandate, CHBRP estimates SB 245 would not change disparities related to race/ethnicity, age, and income.

Impact on Racial or Ethnic Disparities

CHBRP found no studies that discuss the impact of cost sharing on racial/ethnic disparities related to abortion services. However, research indicates that women of color report higher rates of abortion in the United States than White women. This is an underlying public health issue related to the need for increasing access to contraceptive use, reducing unintended pregnancies, and improving women's health outcomes for women of color (Dehlendorf et al., 2013).

People of color — Latinos, Black, Asians, and others — represent a larger portion of Medi-Cal enrollees in DMHC-regulated plans (around 80%) and a smaller portion of commercial enrollees (55%). However, although these racial/ethnic groups are overrepresented in the Medi-Cal population relative to their share of California's population, there are more people of color among commercial enrollees (around 8 million) than there are among Medi-Cal beneficiaries enrolled in DMHC-regulated plans (around 5 million). There may be a subset of women of color within the commercially insured population that have not utilized abortions and associated services because they could not afford the out-of-pocket costs. However, there is insufficient evidence to determine whether racial/ethnic disparities exist among commercially insured women seeking abortions and associated services and whether SB 245 would impact racial/ethnic disparities related to eliminating cost sharing and utilization management for women of color within the insured population.

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.

Impact on Income

Research shows that low-income women utilize abortion services at higher rates than higher-income women (Jones et al., 2010, 2013b). These women are disproportionality impacted by the financial burden related to abortion care and associated services. SB 245 would bring parity for abortion services between Medi-Cal beneficiaries enrolled in DMHC-regulated plans and enrollees in CDI-regulated policies and DMHC-regulated plans by removing cost sharing for covered abortions for those with commercial insurance.

In the United States, the majority of women with commercial insurance pay out of pocket for abortion services (Jones et al., 2010). As presented in the *Benefit Coverage, Utilization, and Cost Impacts* section, the estimated average out-of-pocket cost sharing for any abortion service is $543. The average cost is $306 for medication abortions, $887 for procedural abortions, and $182 for associated services (Table 1). Incurring one large health care–associated payment can be especially burdensome, and most adults are not prepared to experience a financial disruption of $400 or greater (Chen et al., 2021; Federal Reserve, 2020). Additionally, many women report delaying abortion services in order to save money or find financial assistance from outside sources (partners, family members, abortion funds) to pay for abortions

[41] For details about CHBRP's methodological approach to analyzing disparities, see the Benefit Mandate Structure and Unequal Racial/Ethnic Health Impacts document here: http://chbrp.com/analysis_methodology/public_health_impact_analysis.php.

and associated services (Finer et al., 2006; Foster et al., 2008). SB 245 may have an impact for women with commercial insurance by eliminating the large financial burden related to high out-of-pocket costs so that they may utilize abortion services.

Regardless of income or insurance status, there is a group of pregnant women who do not use commercial insurance for abortion services even when they have access to coverage, which may be related to concerns about stigma, confidentiality (such as to prevent a spouse or parent insurance policyholder from seeing a bill), or lack of knowledge about insurance coverage (Jones et al., 2013b; Roberts et al., 2014).

There is evidence of disparities in the United States related to income among women who seek abortions and associated services; however, CHBRP 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.

Impact on Age

In the United States, both pregnancy and abortion rates among women aged 15 to 17 years old have declined. In 2017, the California adolescent pregnancy rate was 13 pregnancies per 1,000 women 15 to 17 years of age, and the abortion rate was 5 abortions per 1,000 women 15 to 17 years of age (Maddow-Zimet and Kost, 2021). California provides publicly funded family planning services through the Family Planning, Access, Care, and Treatment (PACT) program, and evidence shows that Family PACT has helped reduce unintended pregnancies among adolescents. Adolescents seeking abortion services may face barriers to access disproportionately compared to adult women seeking abortion services (Dragoman and Davis, 2008). Adolescents experience barriers to abortion such as distance to abortion clinics and cost, and tend to access services later, which delays their abortion care and can lead to gestational limits for abortion (Davis and Beasley, 2009). They may not know how to access the appropriate resources or have the financial means to pay out of pocket for the abortion services. In California, adolescents can obtain abortions without consent or notification of their parents (Ralph and Brindis, 2008). Adolescents who seek abortions may choose to not use their parent's insurance in order to maintain privacy and keep the abortion confidential. They may seek services through women's health clinics, abortion funds, or self-managed abortion options that require cash payment. Adolescent parenthood is associated with negative outcomes such as educational underachievement, poverty, welfare dependence, domestic violence, and poor social relationships (Fergusson et al, 2007). SB 245 would eliminate cost sharing related to abortion services for adolescents who are willing to use their parent's commercial insurance coverage or have their own commercial insurance.

Although there is evidence of disparities in the United States related to age among women who seek abortions and associated services, CHBRP found insufficient evidence of reduction in age 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 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

In this section, CHBRP estimates the long-term impact of SB 245, 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 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.

Cost Impacts

CHBRP estimates 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.

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 on social determinants of health.

As previously discussed, one study from the Turnaway project assessed women's mental health outcomes 5 years after receiving or being denied an abortion (Biggs et al., 2017). The study concluded that women who received an abortion reported similar or better mental health outcomes compared to the women who did not receive an abortion (Biggs et al., 2017). Additional studies from the Turnaway project found that women who receive abortions are more likely to report aspirational 1-year plans (Upadhyay et al., 2015a) and aspirational 5-year plans (McCarthy et al., 2020) as compared to women who were denied abortion services. The 5-year aspirational plans were focused on employment, finances, education, relationship status, child-related plans, living situation, and emotions. Among women who set aspirational 5-year plans, the women who were denied abortions were just as likely to achieve their plans as women who obtained abortions (McCarthy et al., 2020). These studies suggest there may be a positive impact on the long-term mental health outcomes and aspirational life-planning goals for women who obtain wanted abortions as compared to women who are unable to obtain wanted abortions.

Impacts on Disparities and the Social Determinants of Health[42]

In the case of SB 245, CHBRP estimates utilization of abortion services would remain similar to utilization rates during the first 12 months postmandate. 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 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.

[42] For more information about SDoH, see CHBRP's publication Incorporating Relevant Social Determinants of Health Into CHBRP Benefit Mandate Analyses at http://chbrp.com/analysis_methodology/public_health_impact_analysis.php.

APPENDIX A TEXT OF BILL ANALYZED

On January 22, 2021, the California Senate Committee on Health requested that CHBRP analyze SB 245.

SENATE BILL **NO. 245**

Introduced by Senator Gonzalez
(Principal coauthor: Senator Leyva)
(Principal coauthor: Assembly Member Kamlager)
(Coauthor: Senator Durazo)
(Coauthors: Assembly Members Bauer-Kahan, Boerner Horvath, Burke, Calderon, Cervantes, Friedman, and Cristina Garcia)

January 22, 2021

An act to add Section 1367.251 to the Health and Safety Code, and to add Section 10123.1961 to the Insurance Code, relating to health care coverage.

LEGISLATIVE COUNSEL'S DIGEST

SB 245, as introduced, Gonzalez. Health care coverage: abortion services: cost sharing.

Existing law, the Reproductive Privacy Act, prohibits the state from denying or interfering with a person's right to choose or obtain an abortion prior to viability of the fetus, or when the abortion is necessary to protect the life or health of the person. The act defines "abortion" as a medical treatment intended to induce the termination of a pregnancy except for the purpose of producing a live birth.

Existing law also establishes the Medi-Cal program, which is administered by the State Department of Health Care Services, under which qualified low-income individuals receive health care services through, among other things, managed care plans licensed under the act that contract with the State Department of Health Care Services.

Existing law, the Knox-Keene Health Care Service Plan Act of 1975, requires the Department of Managed Health Care to license and regulate health care service plans and makes a willful violation of the act a crime. Existing law also requires the Department of Insurance to regulate

health insurers. Existing law requires group and individual health care service plan contracts and disability insurance policies to cover contraceptives, without cost sharing, as specified.

This bill would prohibit a health care service plan or an individual or group policy of disability insurance that is issued, amended, renewed, or delivered on or after January 1, 2022, from imposing a deductible, coinsurance, copayment, or any other cost-sharing requirement on coverage for all abortion services, as specified, and additionally would prohibit cost sharing from being imposed on a Medi-Cal beneficiary for those services. The bill would apply the same benefits with respect to an enrollee's or insured's covered spouse and covered nonspouse dependents. The bill would not require an individual or group health care service plan contract or disability insurance policy to cover an experimental or investigational treatment.

Because a violation of the bill 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 1367.251 is added to the Health and Safety Code, to read:**

1367.251. (a) (1) A health care service plan, except for a specialized health care service plan contract, that is issued, amended, renewed, or delivered on or after January 1, 2022, shall not impose a deductible, coinsurance, copayment, or any other cost-sharing requirement on coverage for all abortion services, including followup services including, but not limited to, management of side effects and counseling. Cost sharing shall not be imposed on a Medi-Cal beneficiary.

(2) Except as otherwise authorized by this section, a health care service plan shall not impose any restriction or delay, including prior authorization and annual or lifetime limit, on the coverage for abortion services.

(3) Benefits for an enrollee under this subdivision shall be the same for an enrollee's covered spouse and covered nonspouse dependents.

(4) For purposes of paragraphs (2) and (3) and subdivision (b), "health care service plan" includes Medi-Cal managed care plans that contract with the State Department of Health Care Services pursuant to Chapter 7 (commencing with Section 14000) and Chapter 8 (commencing with Section 14200) of Part 3 of Division 9 of the Welfare and Institutions Code, risk-bearing

organizations pursuant to this chapter and any other participating provider acting pursuant to a subcontract with a managed care plan.

(b) This section does not deny or restrict in any way the department's authority to ensure plan compliance with this chapter when a health care service plan provides coverage for abortion services.

(c) This section does not require an individual or group health care service plan contract to cover an experimental or investigational treatment.

(d) For purposes of this section, “abortion” means any medical treatment intended to induce the termination of a pregnancy except for the purpose of producing a live birth.

SEC. 2. Section 10123.1961 is added to the Insurance Code, to read:

10123.1961. (a) (1) A group or individual policy of disability insurance, except for a specialized health insurance policy, that is issued, amended, renewed, or delivered on or after January 1, 2022, shall not impose a deductible, coinsurance, copayment, or other cost-sharing requirement on coverage for all abortion services, including followup services including, but not limited to, management of side effects and counseling.

(2) Except as otherwise authorized by this section, an insurer shall not impose any restrictions or delays, including prior authorization and annual or lifetime limit, on the coverage for abortion services.

(3) Coverage with respect to an insured under this subdivision shall be the same for an insured's covered spouse and covered nonspouse dependents.

(b) This section does not deny or restrict in any way the department's authority to ensure an insurer’s compliance with this chapter when the insurer provides coverage for abortion services.

(c) This section does not require an individual or group disability insurance policy to cover an experimental or investigational treatment.

(d) For purposes of this section, “abortion” means any medical treatment intended to induce the termination of a pregnancy except for the purpose of producing a live birth.

SEC. 3. 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 cost sharing and utilization management on abortion outcomes including access to care, health services utilization, and health outcomes were identified through searches of PubMed, Embase, and Business Source Complete. Websites maintained by the following organizations were also searched: The Guttmacher Institute and Kaiser Family Foundation. The search was limited to abstracts of studies published in English and studies in the United States. The search was limited to studies published from 2000 to present. The literature on the medical effectiveness of cost sharing policies on abortion did not include any randomized controlled trials. The majority of the papers returned were case reports or survey data.

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 106 articles, of which 38 were reviewed for inclusion in this report. A total of 16 studies were included in the medical effectiveness review for SB 245.

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*.[43] 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

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

- *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.

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 (* indicates truncation of word stem)

Abortion

Abortion, Induced

Abortion, Spontaneous

Abortion, Therapeutic

Age Factors

Coinsurance

Cost Sharing

Deductible*

Deductibles and Coinsurance

Economic Factors

Economic Status

Economics

Educational Status

Ethnicity

Ethnology

Health Expenditures

Income

Induced Abortion

Insurance Coverage

Medicaid

Poverty

Prior Authorization

Race Factors

Racism

Social Class

Social Factors

Socioeconomic Factors

Socioeconomics

United States

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.[44] 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.[45]

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 abortion services and existence of cost sharing for commercial enrollees was determined by a survey of the largest (by enrollment) providers of health insurance in California. Responses to this survey represent 92% of commercial, enrollees with health insurance that can be subject to state benefit mandates. In addition, CalPERS, DHCS, and the four largest (by enrollment) DMHC-regulated plans enrolling Medi-Cal beneficiaries were queried regarding related benefit coverage.

Analysis-Specific Caveats and Assumptions

Identification of Induced Abortions and Associated Services

CHBRP examined Milliman's proprietary 2019 Consolidated Health Cost Guidelines™ Sources Database Plus (CHSD+) for enrollees with an induced abortion diagnosis or abortion-related procedure codes in California's commercial and Medi-Cal markets. The 2019 CHSD+ contains proprietary historical claims experience from several of Milliman's Health Cost Guideline (HCG) data contributors. The database contains annual enrollment and paid medical and pharmacy claims for over 72 million commercially insured individuals covered by the benefit plans of large employers, health plans, and governmental and public organizations nationwide. Medicaid members were also included in the database.

The analysis of California's 2019 CHSD+ claims data for induced abortion services required categorizing claims to estimate annual utilization rates and costs per service. Abortions were classified as either a medication abortion or procedural abortion based on Current Procedural Terminology (CPT) or Healthcare Common Procedure Coding System (HCPCS) codes, and all abortion associated services were identified using diagnosis codes. Any associated service rendered on the same day as a medication or procedural abortion were included in the cost of the abortion. Other pre-abortion or follow up services not performed on same day are included under associated services. Patients who used pre-abortion services for elective abortions, but ultimately did not pursue an abortion are included in associated service user count.

Content expert input and guidance from recent research formed the basis for CHBRP's methodology on how to group claims codes into abortion treatment categories.46 In this analysis, only in-network claims were considered.

CHBRP completed the following steps to identify enrollees who used abortion services:

[44] 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.
[45] See method documents posted at http://chbrp.com/analysis_methodology/cost_impact_analysis.php; in particular, see *2021 Cost Analyses: Data Sources, Caveats, and Assumptions*.
[46] Personal communication with Dr. Ushma Upadhyay, February 2021.

- First, users receiving a medication or procedural abortion were identified. Claims were subset to only include members with the following HCPCS codes: S0199, S0190, S0191, 59840, 59841, 59850, 59851, 59852, 59855, 59856, 59857, S2260, S2265, S2266, or S2267.
- Potential users were then limited to those with one of the following ICD-10 diagnosis codes:
  - Elective abortions: Z332, Z640, Z3009, Z30430, or O0480.
  - Therapeutic abortions: O351XX0, O359XX0, O358XX0, O350XX0, or Q897.
  - Any potential user without one of these diagnoses were not included in the analysis.
- For enrollees identified as having an elective abortion, claims occurring no more than 14 days before the abortion date with any of the following ICD 10 diagnosis codes were labeled as an associated service to reflect any pre-abortion services.
  - Diagnosis codes: Z332, Z640, Z3009, or Z30430.
- For enrollees identified as having an elective or therapeutic abortion, claims occurring subsequent to their abortion with any of the following ICD 10 diagnosis codes were labeled as an associated service to reflect any follow-up services performed as result of the abortion.
  - Diagnosis codes: Z332, Z640, Z3009, Z30430, O351XX0, O359XX0, O358XX0, Q897, O045, O046, O047, O0480, O0481, O0482, O0483, O0484, O0485, O0486, O0487, O0488, O0489, O070, O071, O072, O0730, O0731, O0732, O0733, O0734, O0735, O0736, O0737, O0738, O0739, or O074.
  - MSDRG codes: 769, 776.
- Separately, all enrollees with either ICD-10 diagnosis code Z332 or Z640 were identified. Those not previously identified as having had either a medication or procedural abortion were categorized as having only received an abortion associated service. An enrollee may have received an associated service but did not go on to receive an induced abortion.

Baseline Utilization — Induced Abortions

- Percent (%) of people with cost sharing – CHBRP is unable to determine the particular distribution of cost sharing among DMHC-regulated plans and CDI-regulated policies, and therefore assumed the empirical cost sharing shown in the Milliman CHSD+ reflects those in DMHC-regulated large group nongrandfathered plans. CHBRP applied the average empirical cost sharing shown in the Consolidated Health Cost Guidelines™ Sources Database Plus (CHSD+) to DMHC-regulated large group nongrandfathered plans. For enrollees in other plan types, cost sharing was estimated by applying a relative value of the plans' average actuarial value to the DMHC-regulated large-group nongrandfathered plans' actuarial value. CHBRP assumed all abortion services users in commercial plans have cost sharing to estimate the upper range of the impact from the elimination of cost sharing.[47] In addition, an average for all abortion-related associated services are included in the SB 245 Cost and Coverage Model as seen in the Milliman health claims dataset (see *Background on Abortions* for a discussion on associated services). The responses to the survey of the largest (by enrollment) health insurance providers suggested

[47] This approach may slightly overestimate the impact of SB 245, because some enrollees in commercial plans may have already met their annual deductible or otherwise have no cost sharing for their abortion services. CHBRP is unable to determine how many enrollees would be in that situation annually.

that enrollees in commercial plans who have coverage for abortion services at baseline have cost sharing for abortion services that is the same as major medical services. All commercial and CalPERS enrollees were assumed to be subject to cost sharing while no Medi-Cal enrollees were assumed to be subject to cost sharing.

- Percent (%) of enrollees using services – The proportion of enrollees using services was assumed to be similar to the proportion of commercial or Medi-Cal members in California identified in the 2019 CHSD+ database found to have received an induced abortion or associated service by age category.
- Utilization data from the 2019 CHSD+ was trended forward three years to reflect the 2022 baseline. The utilization trend was based on data from the Milliman Health Cost Guidelines (HCG) outpatient and professional trends. Procedural induced abortions were trended by 1% per year and medication induced abortions and all associated services were trended by 1.5% per year.

Postmandate Utilization — Induced Abortions

- Percent (%) of people with cost sharing – If passed, SB 245 would eliminate all cost sharing for all plans that cover induced abortions. CHBRP assumed no cost sharing in the postmandate period.
- Percent (%) of enrollees using services – For enrollees subject to cost sharing at baseline, CHBRP used Milliman HCGs adjusted for elasticity of demand for abortion services to estimate an induced utilization factor of 1%. This reflects additional abortions performed with elimination of cost sharing. This factor was only applied to people who are subject to cost sharing at baseline.

Baseline Cost — Induced Abortions

- Using the methodology outlined in the Identification of Induced Abortions and Associated Services section, the California average cost per identified user was calculated for commercial and Medi-Cal enrollees using trended 2019 CHSD+ cost data.
- Cost data from the 2019 CHSD+ was trended forward three years to reflect the 2022 baseline. The cost trend was based on data from the Milliman HCGs outpatient and professional trends. Procedurally induced abortions were trended by 7% per year and medication induced abortions and all associated services were trended by 4.5% per year.

Postmandate Cost – Induced Abortions

- Postmandate costs of induced abortions and associated services are assumed to be the same as in the baseline scenario.

Pregnancy Offsets

- In the baseline scenario, we assume that 1% of enrollees subject to cost sharing decide to not seek an induced abortion due to the cost sharing barrier. Instead, these enrollees would continue with their pregnancy, resulting in a live birth, a miscarriage, or a stillbirth.
- Live births include vaginal and C-section deliveries, which include the professional and facility costs. The cost and frequency of this pregnancy outcome are determined using the following MSDRG codes:

- Births: 765, 766, 767, 768, 774, 775, 783, 784, 785, 786, 787, 788, 796, 797, 798, 805, 806

- Miscarriages and stillbirth cost and frequency are determined using data from the 2019 CHSD+ matching the following ICD-10 diagnosis codes:
  - Miscarriages: O021, O030, O031, O032, O0330, O0331, O0332, O0333, O0334, O0335, O0336, O0337, O0338, O0339, O034, O035, O036, O037, O0380, O0381, O0382, O0383, O0384, O0385, O0386, O0387, O0388, O0389, or O039.
  - Stillbirths: Z377, Z371, P95, Z374, or Z373.
- To determine the cost of pregnancies for women who avoided an induced abortion due to cost sharing, the costs of live births and miscarriages were blended based on their respective prevalence. For women who know they are pregnant, we assumed 15% of pregnancies end in miscarriage and 85% end in a live birth (Mayo Clinic, 2019b), similar to the general population of pregnant women. CHBRP is aware that this represents a higher-end estimate of miscarriages, as many miscarriages occur prior to when an induced abortion would take place. This assumption slightly reduces the average medical cost offsets since a live birth has higher associated costs than a miscarriage.
- Cost and utilization data were trended forward three years from 2019 to the 2022 baseline scenario using outpatient and professional trends from the HCGs. Total allowed costs for live births are trended at 7% per year and total allowed costs for miscarriages and stillbirths are trended at 8% per year.

Determining Public Demand for the Proposed Mandate

CHBRP reviews public demand for benefits relevant to a proposed mandate in two ways. CHBRP:

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

On the basis of conversations with the largest collective bargaining agents in California, CHBRP concluded that in general, unions negotiate for broader contract provisions such as coverage for dependents, premiums, deductibles, and broad coinsurance levels.

Among publicly funded self-insured health insurance policies, the preferred provider organization (PPO) plans offered by CalPERS currently have the largest number of enrollees. 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 carriers who act as third-party administrators for (non-CalPERS) self-insured group health insurance programs whether the relevant benefit coverage differed from what is offered in group market plans or policies that would be subject to the mandate. 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 SB 245 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 SB 245 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 INFORMATION SUBMITTED BY OUTSIDE PARTIES

In accordance with the California Health Benefits Review Program (CHBRP) policy to analyze information submitted by outside parties during the first 2 weeks of the CHBRP review, the following parties chose to submit information.

The following information was submitted by Senator Levya's office, ACCESS Reproductive Justice, Black Women for Wellness Action Project, NARAL Pro-Choice California, National Health Law Program, and Planned Parenthood Affiliates of California in February 2021.

- Aztlan EA Foster DG Upadhyay UD. Subsequent unintended pregnancy among us women who receive or are denied a wanted abortion. *Journal of Midwifery & Women's Health*. 2018;63(1):45-52.
- Biggs MA, Upadhyay UD, McCulloch CE, Foster DG. Women's mental health and well-being 5 years after receiving or being denied an abortion: a prospective, longitudinal cohort study. *JAMA Psychiatry.* 2017;74(2):169-178.
- Cartwright AF, Karunaratne M, Barr-Walker J, Johns NE, Upadhyay UD. Identifying national availability of abortion care and distance from major US cities: systematic online search. *Journal of Medical Internet Research*. 2018;20(5):e186.
- Dennis A, Blanchard K. Abortion providers' experiences with Medicaid abortion coverage policies: a qualitative multistate study. *Health Services Research*. 2013:48(1):236-252.
- Dennis A, Manski R, Blanchard K. Does Medicaid coverage matter? A qualitative multi-state study of abortion affordability for low-income women. *Journal of Health Care for the Poor and Underserved*. 2014;25:1571-1585.
- Foster DG, Biggs MA, Raifman S, Gipson J, Kimport K, Rocca CH. Comparison of health, development, maternal bonding, and poverty among children born after denial of abortion vs after pregnancies subsequent to an abortion. *JAMA Pediatrics*. 2018;172(11):1053-1060.
- Foster DG, Raifman SE, Gipson JD, Rocca CH, Biggs MA. Effects of carrying an unwanted pregnancy to term on women's existing children. *Journal of Pediatrics*. 2019;205:183-189.e181.
- Harris LF, Roberts SCM, Biggs MA, Rocca CH, Foster DG. Perceived stress and emotional social support among women who are denied or receive abortions in the United States: a prospective cohort study. *BMC Women's Health*. 2014;14:76.
- Johns NE, Foster DG, Upadhyay UD. Distance traveled for Medicaid-covered abortion care in California. *BMC Health Services Research*. 2017;17(1):287.
- Jones RK, Upadhyay UD, Weitz TA. At what cost? Payment for abortion care by U.S. women. *Women's Health Issues.* 2013;23(3):e173-e178.
- McCarthy MA, Upadhyay U, Ralph L, et al. The effect of receiving versus being denied an abortion on making and achieving aspirational 5-year life plans. *BMJ Sexual & Reproductive Health.* 2020;46:177-183.
- Roberts SC, Gould H, Kimport K, Weitz TA, Foster DG. Out-of-pocket costs and insurance coverage for abortion in the United States. *Women's Health Issues*. 2014;24(2):e211-e218.

- Roberts SCM, Johns NE, Williams V, Wingo E, Upadhyay UD. Estimating the proportion of Medicaid-eligible pregnant women in Louisiana who do not get abortions when Medicaid does not cover abortion. *BMC Women's Health*. 2019;19(1):78.
- Upadhyay UD, Aztlan-James EA, Rocca CH, Foster DG. Intended pregnancy after receiving vs. being denied a wanted abortion. *Contraception*. 2019;99(1):42-47.
- Upadhyay UD, Biggs MA, Foster DG. The effect of abortion on having and achieving aspirational one-year plans. *BMC Women's Health.* 2015;15:102.
- Upadhyay UD, Johns NE, Meckstroth KR, Kerns J. Distance traveled for an abortion and source of care after abortion. *Obstetrics and Gynecology*. 2017;130(3):616-624.
- Zuniga C, Thompson T-A, Blanchard K. Abortion as a catastrophic health expenditure in the United States. *Women's Health Issues*. 2020;30(6):416-425.

Submitted information is available upon request. For information on the processes for submitting information to CHBRP for review and consideration please visit: www.chbrp.org/requests.html.

REFERENCES

Aiken ARA, Broussard K, Johnson DM, Padron E. Motivations and experiences of people seeking medication abortion online in the United States. *Perspectives of Sexual and Reproductive Health.* 2018;50(4):157-163.

Aiken ARA, Starling JE, van der Wal A, et al. Demand for self-managed medication abortion through an online telemedicine service in the United States. *American Journal of Public Health*. 2020;110(1):90-97.

American College of Obstetricians and Gynecologists (ACOG). Induced Abortion. 2018. Available at: www.acog.org/womens-health/faqs/induced-abortion. Accessed February 26, 2021.

American College of Obstetricians and Gynecologists (ACOG). Medication abortion up to 70 days of gestation. ACOG Practice Bulletin No. 225. *Obstetrics and Gynecology.* 2020b;136(4):225-236.

American College of Obstetricians and Gynecologists (ACOG). ACOG Practice Bulletin No. 135: second-trimester abortion. *Obstetrics and Gynecology.* 2013;121(6):1394-1406.

American Pregnancy Association. D&C Procedure After a Miscarriage. 2017. Available at: https://americanpregnancy.org/healthy-pregnancy/pregnancy-complications/d-and-c-procedure-after-miscarriage-837/. Accessed February 26, 2021.

Bartlett LA, Berg CJ, Shulman HB. Risk factors for legal induced abortion-related mortality in the United States. *Obstetrics and Gynecology*. 2004;103(4):729-737.

Biggs MA, Upadhyay UD, McCulloch CE, Foster DG. Women's mental health and well-being 5 years after receiving or being denied an abortion: a prospective, longitudinal cohort study. *JAMA Psychiatry.* 2017;74(2):169-178.

Biggs MA, Upadhyay UD, Steinberg JR, Foster DG. Does abortion reduce self-esteem and life satisfaction? *Quality of Life Research*. 2014;23(9):2505-2513.

Board of Governors of the Federal Reserve (Federal Reserve). *Report on the Economic Well-Being of U.S. Households in 2019.* Washington, DC: Board of Governors of the Federal Reserve; 2020.

Braveman PA, Egerter SA, Mockenhaupt RE. Broadening the focus: the need to address the social determinants of health. *American Journal of Preventive Medicine.* 2011;40(Suppl 1):S4-S18.

California Department of Health Care Services (CDHCS). *Medi-Cal Funded Induced Abortions, 2010.* Sacramento, CA: California Department of Health Care Services; 2011.

California Health Benefits Review Program (CHBRP). *Analysis of California Senate Bill (SB) 999: Contraceptives: Annual Supply.* Revised 2016. Available at: www.chbrp.org. Accessed March 2021.

California Health Benefits Review Program (CHBRP). *Analysis of California Assembly Bill (AB) 2203: Insulin Cost-Sharing Cap*. 2020. Available at: www.chbrp.org. Accessed March 2021.

Centers for Disease Control and Prevention (CDC). National and state-specific pregnancy rates among adolescents--United States, 1995-1997. *MMWR: Morbidity and Mortality Weekly Report.* 2000;49:605-611.

Centers for Disease Control and Prevention (CDC). NCHHSTP Social Determinants of Health: Frequently Asked Questions. March 10, 2014. Available at: www.cdc.gov/nchhstp/socialdeterminants/faq.html. Accessed August 27, 2015.

Centers for Disease Control and Prevention (CDC). Pregnancy and Infant Loss. 2020. Available at: www.cdc.gov/ncbddd/stillbirth/features/pregnancy-infant-loss.html#:~:text=Both%20miscarriage%20and%20stillbirth%20describe,weeks%20of%20pregnancy%20and%20later. Accessed February 2021.

Chen S, Shafer PR, Dusetzina SB, Horny M. Annual out-of-pocket spending clusters within short time intervals: implications for health care affordability. *Health Affairs (Millwood).* 2021;40(2):274-280.

Cheng D, Schwarz EB, Douglas E, Horon I. Unintended pregnancy and associated maternal preconception, prenatal and postpartum behaviors. *Contraception.* 2009;79(3):194-198.

Davis AR, Beasley AD. Abortion in adolescents: epidemiology, confidentiality, and methods. *Current Opinion in Obstetrics & Gynecology.* 2009;21(5):390-395.

Dehlendorf C, Harris LH, Weitz TA. Disparities in abortion rates: a public health approach. *American Journal of Public Health.* 2013;103(10):1772-1779.

Dominquez TP, Dunkel-Schetter C, Glynn LM, Hobel C, Sandman CA. Racial differences in birth outcomes: the role of general, pregnancy, and racism stress. *Health Psychology.* 2008;27(2):194-203.

Dragoman M, Davis A. Abortion care for adolescents. *Clinical Obstetrics and Gynecology.* 2008;51(2):281-289.

Drey EA, Foster DG, Jackson RA, Lee SJ, Cardenas LH, Darney PD. Risk factors associated with presenting for abortion in the second trimester. *Obstetrics and Gynecology.* 2006;107(1):128-135.

Effros R. Increase Cost-Participation by Employees (e.g., Through High-Deductible Health Plans). Technical Report TR-562/4-HLTH. Santa Monica, CA: RAND Corporation; 2009. Available at: www.rand.org/pubs/technical_reports/TR562z4.html. Accessed March 2021.

Fergusson DM, Boden JM, Horwood LJ. Abortion among young women and subsequent life outcomes. *Perspectives on Sexual and Reproductive Health.* 2007;39:6-12.

Finer LB, Frohwirth LF, Dauphinee LA, Singh S, Moore AM. Timing of steps and reasons for delays in obtaining abortions in the United States. *Conception.* 2006;74(4):334-344.

Foster DG, Jackson RA, Cosby K, Weitz TA, Darney PD, Drey EA. Predictors of delay in each step leading to an abortion. *Conception.* 2008;77(4):289-293.

Foster DG, Biggs MA, Raifman S, Gipson J, Kimport K, Rocca CH. Comparison of health, development, maternal bonding, and poverty among children born after denial of abortion vs after pregnancies subsequent to an abortion. JAMA Pediatrics. 2018;172(11):1053-1060.

Foster DG, Raifman SE, Gipson JD, Rocca CH, Biggs MA. Effects of carrying an unwanted pregnancy to term on women's existing children. *Journal of Pediatrics.* 2019;205:183-189.e181.

Gatter M, Cleland K, Nucatola DL. Efficacy and safety of medical abortion using mifepristone and buccal misoprostol through 63 days. *Contraception.* 2015;91(4):269-273.

Gerdts C, Dobkin L, Foster DG, Schwarz EB. Side effects, physical health consequences, and mortality associated with abortion and birth after an unwanted pregnancy. *Women's Health Issues.* 2016;26:55-59.

Gipson JD, Koenig MA, Hindin MJ. The effects of unintended pregnancy on infant, child, and parental health: a review of the literature. *Studies in Family Planning*. 2008;39:18-38.

Grossman D, Ellerston C, Grimes DA, Walker D. Routine follow-up visits after first-trimester induced abortion. *Obstetrics and Gynecology.* 2004;103(4):738-745.

Grossman, D, Grindlay K, Buchacker T, Lane K, Blanchard K. Effectiveness and Acceptability of Medical Abortion Provided Through Telemedicine. *Obstetrics & Gynecology*. 2011;118(2):296-30.

Harvard Medical School. Miscarriage: What Is It? 2021; Available at: www.health.harvard.edu/a_to_z/miscarriage-a-to-z. Accessed February 2021.

Ireland LD, Gatter M, Chen AY. Medical compared with surgical abortion for effective pregnancy termination in the first trimester. *Obstetrics and Gynecology.* 2015;126(1):22-28.

Jerman J, Frohwirth L, Kavanaugh ML, Blades N. Barriers to abortion care and their consequences for patients traveling for services: qualitative findings from two states. *Perspectives on Sexual and Reproductive Health.* 2017;49(2):95-102.

Johns NE, Foster DG, Upadhyay UD. Distance traveled for Medicaid-covered abortion care in California. *BMC Health Services Research.* 2017;17:287.

Jones RK, Finer LB. Who has second-trimester abortions in the United States? *Contraception.* 2012;85(6):544-551.

Jones RK, Finer LB, Singh S. *Characteristics of US Abortion Patients, 2008.* New York, NY: Guttmacher Institute; 2010.

Jones RK, Frohwirth L, Moore AM. More than poverty: disruptive events among women having abortions in the USA. *Journal of Family Planning and Reproductive Health Care.* 2013a;39(1):36-43.

Jones RK, Ingerick M, Jerman J. Differences in abortion service delivery in hostile, middle-ground, and supportive states in 2014. *Women's Health Issues.* 2018;28(3):212-218.

Jones RK, Jerman J. How far did US women travel for abortion services in 2008? *Journal of Women's Health (Larchmt).* 2013;22(8):706-713.

Jones RK, Jerman J. Population group abortion rates and lifetime incidence of abortion: United States, 2008-2014. *American Journal of Public Health.* 2017;107(12):1904-1909.

Jones RE, Lopez KH. *Human Reproductive Biology*. 4th ed. Cambridge, MA: Academic Press; 2013.

Jones RK, Upadhyay UD, Weitz TA. At what cost? Payment for abortion care by U.S. women. *Women's Health Issues.* 2013b;23(3):e173-e178.

Jones RK, Witwer E, Jerman J. *Abortion Incidence and Service Availability in the United States, 2017.* 2019. Available at: www.guttmacher.org/report/abortion-incidence-service-availability-us-2017. Accessed March 2021.

Kaiser Family Foundation (KFF). The Availability and Use of Medication Abortion. 2020; Available at: www.kff.org/womens-health-policy/fact-sheet/the-availability-and-use-of-medication-abortion/. Accessed February 26, 2021.

Kiley JW, Yee LM, Niemi CM, Feinglass JM, Simon MA. Delays in request for pregnancy termination: comparison of patients in the first and second trimesters. *Conception.* 2010;81(5):446-451.

Kortsmit K, Jatlaoui TC, Mandel MG, et al. Abortion surveillance—United States, 2018. *Morbidity and Mortality Weekly Report: Surveillance Summaries.* 2020;69(7):1-29.

Maddow-Zimet I, Kost K. Pregnancies, births and abortions in the United States, 1973-2017: national and state trends by age. 2021. Available at: www.guttmacher.org/report/pregnancies-births-abortions-in-united-states-1973-2017. Accessed March 2021.

Mayo Clinic Staff. Hemoglobin Test. 2019a. Available at: www.mayoclinic.org/tests-procedures/hemoglobin-test/about/pac-20385075. Accessed February 26, 2021.

Mayo Clinic Staff. Miscarriage: Symptoms and Causes. 2019b. Available at: www.mayoclinic.org/diseases-conditions/pregnancy-loss-miscarriage/symptoms-causes/syc-20354298. Accessed March 2021.

Mayo Clinic Staff. Rh Factor Blood Test. 2020. Available at: www.mayoclinic.org/tests-procedures/rh-factor/about/pac-20394960. Accessed February 26, 2021.

McCarthy MA, Upadhyay UD, Ralph L, Biggs MA, Foster DG. The effect of receiving versus being denied an abortion on making and achieving aspirational 5-year life plans. *BMJ Sexual & Reproductive Health.* 2020;46:177-183.

Medoff MH. The relationship between restrictive state abortion laws and postpartum depression. *Social Work in Public Health*. 2014;29(5):481-490.

Mehrotra A, Chernew M, Linetsky D, Hatch H, Cutler D, Schneider EC. The Impact of the COVID-19 Pandemic on Outpatient Care: Visits Return to Prepandemic Levels, but Not for All Providers and Patients. 2020. Commonwealth Fund website. Available at: www.commonwealthfund.org/publications/2020/oct/impact-covid-19-pandemic-outpatient-care-visits-return-prepandemic-levels. Accessed December 15, 2020.

Mercier RJ, Garrett J, Thorp J, Siega-Riz AM. Pregnancy intention and postpartum depression: secondary data analysis from a prospective cohort. *BJOG*. 2013;3(9):1116-1122.

Murtagh C, Wells E, Raymond EG, Coeytaux F, Winikoff B. Exploring the feasibility of obtaining mifepristone and misoprostol from the internet. *Contraception.* 2018;97(4):287-291.

Nakka JEM, Nakase G, Mirembe F. Postpartum major depression at six weeks in primary health care: prevalence and associated factors. *African Health Sciences*. 2006;3(4):207-214.

New York City Department of Health and Mental Hygiene Health (NYC Department of Health). ICD-10 Codes to Be Submitted as Spontaneous Terminations of Pregnancy. Available at: www1.nyc.gov/assets/doh/downloads/pdf/vr/vr-icd10-codes-update.pdf. Accessed February 2021.

Office of Disease Prevention and Health Promotion. Healthy People 2020: Social Determinants of Health. 2019. Available at: www.healthypeople.gov/2020/topics-objectives/topic/social-determinants-of-health. Accessed August 29, 2019.

Paul M, Lichtenberg SE, Borgatta L, Grimes DA, Stubblefield PG, Creinin MD, eds. *Management of Unintended and Abnormal Pregnancy: Comprehensive Abortion Care*. Chichester, UK: Wiley-Blackwell; 2009.

Rahorst L. A Brief History of RhD Determination and RhIG Administration. 2019. National Center for Blood Group Genomics. Available at: www.bloodgroupgenomics.org/blog-blood-experts/articles/brief-history-rhd-determination-rhig-administration/. Accessed February 26, 2021.

Ralph L, Brindis C. *Adolescents & Parental Notification for Abortion: What Can California Learn From the Experience of Other States?* San Francisco, CA: Bixby Center for Global Reproductive Health, University of California, San Francisco; 2008.

Ralph L, Foster DG, Raifman S, et al. Prevalence of self-managed abortion among women of reproductive age in the United States. *JAMA Network Open.* 2020;3(12):e2029245.

Ralph LJ, Schwarz EB, Grossman D, Foster DG. Self-reported physical health of women who did and did not terminate pregnancy after seeking abortion services: a cohort study. *Annals of Internal Medicine*. 2019;171:238-247.

Rao R. Selective reduction: "a soft cover for hard choices" or another name for abortion? *Journal of Law, Medicine & Ethics.* 2015;43(2):196-205.

Raymond EG, Harrison MS, Weaver MA. Efficacy of misoprostol alone for first-trimester medical abortion: a systematic review. *Obstetrics and Gynecology.* 2019;133(1):137-147.

Roberts SCM, Gould H, Kimport K, Weitz TA, Foster DG. Out-of-pocket costs and insurance coverage for abortion in the United States. *Women's Health Issues.* 2014;24(2):e211-e218.

Robson SC, Kelly T, Howel D, et al. Randomised preference trial of medical versus surgical termination of pregnancy less than 14 weeks' gestation (TOPS). *Health Technology Assessment.* 2009;13(53):1-124.

Sajadi-Ernazarova KR, Martinez CL. Abortion complications. In: *StatPearls [Internet].* Treasure Island, FL: StatPearls Publishing; 2020.

Salganicoff A, Sobel L, Ramaswamy A. *The Hyde Amendment and Coverage for Abortion Services*. Oakland, CA: Kaiser Family Foundation; 2021.

Shah PS, Balkhair T, Ohlsson A, Beyene J, Scott F, Frick C. Intention to become pregnant and low birth weight and preterm birth: a systematic review. *Maternal and Child Health Journal*. 2011;15(2):205-216.

Steinauer J. Overview of pregnancy termination. In: Barbieri RL, Chakrabarti A, eds. *UpToDate.* 2021. Available at: https://www.uptodate.com/contents/overview-of-pregnancy-termination. Accessed March 2021.

Upadhyay UD, Biggs MA, Foster DG. The effects of abortion on having and achieving aspirational one-year plans. *BMC Women's Health.* 2015a;15:102.

Upadhyay UD, Desai S, Zlidar V, et al. Incidence of emergency department visits and complications after abortion. *Obstetrics and Gynecology.* 2015b;125(1):175-183.

Upadhyay UD, Johns NE, Meckstroth KR, Kerns J. Distance traveled for an abortion and source of care after abortion. *Obstetrics and Gynecology*. 2017;130(3):616-624.

Upadhyay UD, McCook AA, Bennett AH, Cartwright AF, Roberts SCM. State abortion policies and Medicaid coverage for abortion are associated with pregnancy outcomes among individuals seeking abortion recruited using Google Ads: a national cohort study. *Social Science & Medicine.* 2021;274:113747.

Upadhyay UD, Weitz TA, Jones RK, Bara RE, Foster DG. Denial of abortion because of provider gestational age limits in the United States. *American Journal of Public Health.* 2014;104(9):1687-1694.

Van Bebber SL, Phillips KA, Weitz TA, Gould H, Stewart F. Patient costs for medication abortion: results from a study of five clinical practices. *Women's Health Issues.* 2006;16(1):4-13.

Williams DR, Mohammed SA. Discrimination and racial disparities in health: evidence and needed research. *Journal of Behavioral Medicine*. 2009;32(1):20-47.

World Health Organization (WHO). Medical Management of Abortion. Geneva, Switzerland: World Health Organization; 2018. Available at: https://apps.who.int/iris/bitstream/handle/10665/278968/9789241550406-eng.pdf. Accessed March 2021.

Zane S, Creanga AA, Berg CJ, et al. Abortion-related mortality in the United States: 1998–2010. *Obstetrics and Gynecology*. 2015;126(2):258-265.

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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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