
Study of Proposed Mandatory Health Insurance for Contraceptive Services

A Report to the
Governor
and the
Legislature of
the State of
Hawaii

Submitted by

THE AUDITOR
STATE OF HAWAII

Report No. 93-27
December 1993

Foreword

Sections 23-51 and 23-52, Hawaii Revised Statutes, require the State Auditor to study the social and financial impact of measures that propose to mandate health insurance benefits. The purpose of these studies is to give the Legislature an objective basis for evaluating the merits of the proposals.

As requested by Senate Concurrent Resolution No. 8, Senate Draft 1, House Draft 2 of the Regular Session of 1993, we assessed the social and financial impact of mandating health insurance coverage for contraceptive services. The resolution referred us to House Bill No. 99 of 1993 which would mandate the coverage.

We wish to express our appreciation for the cooperation and assistance of those state agencies, private insurers, and other interested organizations and individuals whom we contacted during the course of the study.

Marion M. Higa
State Auditor

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Chapter 1

Introduction

Sections 23-51 and 23-52, Hawaii Revised Statutes, require the Legislature to pass concurrent resolutions requesting the State Auditor to study the social and financial effects of any proposed legislative measure that would mandate health insurance for specific services, diseases, or providers.

The law stems from legislative concern over the increasing number of these proposals in recent years and their impact on the cost and quality of health care. The purpose of the Auditor's assessment is to provide the Legislature with an independent review of the social and financial consequences of each proposal.

Senate Concurrent Resolution No. 8, Senate Draft 1, House Draft 2 of the Regular Session of 1993 requests the Auditor to assess the social and financial impacts of mandated health insurance coverage for contraceptive services. To guide the assessment, the House Committee on Legislative Management directed the Auditor to refer to House Bill No. 99 of 1993, which would mandate the coverage.¹

Background on Mandated Health Insurance

Since the 1960s, states have enacted a variety of laws mandating the health coverage that insurers must provide. These laws have required insurers to cover specific medical conditions and treatments, particular groups of people, and the services of certain health practitioners. As of 1992, state governments had enacted over 950 mandates, up from 343 in 1978.² However, the growth of mandated coverage appears to be slowing.³

Arguments for and against mandated health insurance

Mandated health insurance may be appropriate in certain circumstances. However, proponents and opponents disagree about key issues: whether a particular coverage is necessary, whether it is justified by the demand, whether it will increase the costs of care and by how much, and whether it will increase premiums. Generally, providers and recipients of medical care support mandated health insurance, and businesses and insurers oppose it.

Proponents say gaps in existing coverage prevent people from obtaining the care they need. They believe the current system is not equitable because it does not cover all providers, medical conditions, or needed treatments and services. Proponents also argue that mandated coverage

could increase competition and the number and variety of treatments available. In some instances, it could also reduce costs by making preventive care, early treatment, or alternate care more available.

Opponents argue that mandated benefits add to the cost of employment and production and reduce other more vital benefits. They create particular hardship for small businesses that are less able to absorb rising premium costs. Opponents also argue that mandates reduce the freedom of employers, employees, and unions to choose the coverage they want. Insurers cite premium rates that may rise beyond what employers and consumers are willing to pay. They see mandates as creating an incentive for employers to adopt self-insurance plans that are exempt from the mandates.

Types of insurance plans affected

Laws to mandate health insurance affect three main types of private insurance: (1) Blue Cross and Blue Shield plans, (2) health maintenance organizations (HMOs), and (3) commercial insurance plans.

The Hawaii Medical Service Association (HMSA), the Blue Cross and Blue Shield insurer in Hawaii, offers traditional fee-for-service plans (sometimes called indemnity plans) that reimburse physicians and hospitals for services. HMSA also operates a managed care system in which beneficiaries may obtain services from a network of designated providers. In addition, HMSA has an HMO plan that offers a package of preventive and treatment services for a fixed fee. With a 1992 membership of 623,074, HMSA covers about 56 percent of Hawaii's civilian population.⁴

Kaiser Foundation Health Plan is a federally qualified health maintenance organization. As of 1993, Kaiser served 189,026 people in Hawaii, or about 16 percent of Hawaii's population.⁵

Commercial insurance plans such as HDS (Hawaii Dental Services) Medical, Island Care, and Straub Plan cover most of the remaining privately insured population. Some mainland insurance companies, such as Travelers and Aetna, also provide health insurance coverage in Hawaii.

Potential legal challenge

Hawaii's Prepaid Health Care Act, enacted in 1974, requires employers to provide a qualified prepaid health care plan to regular employees working at least 20 hours per week. A qualified plan is one with benefits that are equal to, or a medically reasonable substitute for, the benefits provided by the plan with the largest number of subscribers in Hawaii.

The federal courts have ruled that the Prepaid Health Care Act is preempted by the federal Employee Retirement Income Security Act

(ERISA), which has a provision preempting state laws relating to employment benefit plans. A subsequent congressional amendment exempted Hawaii's Prepaid Health Care Act from ERISA but the exemption applied only to the law as it was enacted in 1974. In effect, this has frozen the law at its original provisions since ERISA would preempt any subsequent amendments. It is possible, therefore, that in Hawaii any mandated benefit laws could be viewed, and challenged, as bypassing the limitations placed on the Prepaid Health Care Act.

Federal health reform proposal

Health insurance reform is a pressing national issue. President Clinton recently delivered a proposed national Health Security Act to Congress. The proposed legislation contains a basic package of benefits for all Americans. Significant health insurance reform based on this or other proposals is possible. It is too early to assess the impact of national developments, but they could preempt or otherwise affect states' mandated health insurance laws.

Background on Contraceptive Services

Contraceptive services are designed to prevent unintended pregnancy. They may include education and counseling on the effective use of various contraceptive methods.

One principle of family planning is that people should be able to use the contraceptive methods that best suit their needs and circumstances. A wide variety of methods exists, including periodic abstinence, withdrawal, medicines, devices, and surgical procedures.

Contraceptive methods prescribed by physicians may be irreversible or reversible. Irreversible methods include tubal sterilization for women and vasectomy for men. Reversible methods include oral contraceptives (the Pill), intrauterine devices (IUDs), diaphragms, cervical caps, implanted time release capsules (Norplant), and injectable contraceptives (Depo-Provera).

Those seeking prescribed contraceptive methods visit a medical practitioner who takes their history, conducts a physical examination, orders laboratory tests, and provides health education. Follow-up visits are recommended at intervals that may vary depending on the contraceptive method.

Over-the-counter contraceptives do not require a prescription and are reversible. They include condoms and contraceptive foams, creams, jellies, films, suppository capsules, and sponges. A greater risk of pregnancy exists with these methods than with prescribed contraceptives.

Current Proposal to Mandate Coverage

House Bill No. 99 would amend Section 431:10A-116, HRS, of Hawaii's insurance code to require health insurance policies, contracts, plans, or agreements issued in the state to provide coverage for any service related to contraception procedures which is within the lawful scope of practice of any practitioner licensed to practice medicine. This includes the supplying of any type of contraceptive device.

Insurance companies subject to Chapter 431, Article 10A, HRS (accident and sickness insurance), and Chapter 432, HRS (mutual benefit societies), would be required to include coverage for contraceptive services in their policies. However, policies that provide coverage only for specific diseases or other limited-benefit coverage would be exempt.

The services covered would be subject to any coinsurance provisions in the policies. Insurers may give the services through contracts with providers if the contract is determined to be a cost-effective means of delivering the services without sacrificing their quality and meets the approval of the director of health.

Review of testimony

Testimony was presented on the resolution requesting the study. The Department of Health testified in support of the study because it would serve as a tool for future legislative consideration of mandated health care benefits. The department said that studies in California and elsewhere have shown considerable cost savings potential from ready access to preventive health care services. The HMSA testified that it would be happy to cooperate with the Auditor in the study.

Testifying on an earlier version of the resolution, Hawaii Right to Life testified that the term "birth control" should be removed from the resolution to ensure that abortion is not included.

Related legislation

In Act 365 of the Regular Session of 1993, the Legislature amended Chapter 431 and Chapter 432, HRS, to require each employer group health policy that provides for payment or reimbursement of pregnancy-related services to provide, as an employer option, contraceptive services for the subscriber or any dependent of the subscriber who is covered by the policy.

Act 365 defines contraceptive services as physician-delivered, physician-supervised, physician assistant-delivered, certified nurse midwife-delivered, or nurse-delivered medical services intended to promote the effective use of prescription contraceptive supplies or devices to prevent unwanted pregnancy.

In addition, Act 365 prohibits insurance policies that provide prescription drug coverage from excluding any prescription contraceptive drugs or devices that have been approved by the U.S. Food and Drug Administration, and from imposing any unusual co-payment, charge, or waiting requirement for such drug or device.

Mandated Coverage in Other States

The number of states that have mandated health insurance for contraceptive services is not exactly clear. As of November 1993, the Alan Guttmacher Institute, which specializes in family planning issues, reported that no states mandate contraceptive insurance coverage.⁶ We found that one state, Iowa, requires small businesses to cover prescription birth control pills in their insurance coverage. Norplant and contraceptive devices are excluded.

Objective of the Study

The objective of our study was to describe the social and financial effects of mandating health insurance coverage for contraceptive services.

Scope and Methodology

It is important to note that our study examined the impact of mandated *insurance coverage* for contraceptive services and not the impact of the services themselves.

Our work was significantly limited for two reasons. First, House Bill No. 99 defines contraceptive services generally with little guidance about the types of contraceptive services that will be covered, the extent of the coverage, the target groups that will be covered, limits on utilization, and standards of care. Second, little data are available on the utilization, benefits, and costs of privately insured contraceptive services.

To the extent feasible, however, we considered the following issues set forth by the law:

Social impact

1. Extent to which contraceptive treatment or services are generally utilized by a significant portion of the population.
2. Extent to which insurance coverage for contraceptive services is already generally available.
3. Extent to which the lack of coverage results in persons being unable to obtain necessary treatment.

4. Extent to which the lack of coverage results in unreasonable financial hardship on persons needing treatment.
5. Level of public demand for contraceptive services.
6. Level of public demand for individual or group insurance coverage of contraceptive services.
7. Level of interest of collective bargaining organizations in negotiating privately for this coverage.
8. Impact of providing coverage for contraceptive services on health status, quality of care, practice patterns, provider competition, or related items.
9. Impact of indirect costs upon the costs and benefits of coverage.

Financial impact

1. Extent to which the insurance coverage would increase or decrease the cost of contraceptive services.
2. Extent to which the coverage might increase the use of contraceptive services.
3. Extent to which mandated contraceptive services might serve as an alternative to more expensive treatment or services.
4. Extent to which insurance coverage of contraceptive services might increase or decrease the insurance premiums or the administrative expenses of policyholders.
5. Impact of insurance coverage for contraceptive services on the total cost of health care.

In carrying out the study, we reviewed and analyzed research literature and information obtained through interviews of commercial insurers, mutual benefit societies, health maintenance organizations, employer groups, collective bargaining organizations, professional associations, state agencies, and national experts. We did not test the data on coverage and utilization provided by HMSA, Kaiser, and other insurers. HDS Medical said it could not provide most of the information we requested.

Our work was performed from May 1993 through December 1993 in accordance with generally accepted government auditing standards.

Chapter 2

Social and Financial Impact of Insurance Coverage for Contraceptive Services

This chapter presents our assessment of the potential social and financial impact of mandating health insurance coverage for contraceptive services. The assessment is limited by inadequate data available on the utilization, benefits, and costs of privately insured contraceptive services, and by the lack of specificity in House Bill No. 99 which proposes the coverage.

Social Impact

1. Extent to which contraceptive treatment or services are generally utilized by a significant portion of the population.

Many different practitioners provide a wide range of contraceptive services. Contraceptive services of one kind or another are generally utilized by a significant portion of the population. More than half of American women between the ages of 15 and 44 use a contraceptive method.¹ In 1988 about 40 percent of these women used oral contraceptive pills, the intrauterine device (IUD), or the diaphragm, all of which require a medical prescription.² We could find no data on the number of men who use contraceptive services.

2. Extent to which insurance coverage for contraceptive services is already generally available.

Insurance coverage for contraceptive services is available in Hawaii through the state Medicaid program, the State Health Insurance Program, federally qualified health maintenance organizations (HMOs), and to a lesser extent through mutual insurance companies.

The Kaiser Foundation Health Plan, the largest federally qualified HMO in Hawaii, covers a broad range of family planning services as required by federal HMO laws. Members with a drug rider are covered for oral contraceptives, Norplant, and the diaphragm. The drugs and devices must be purchased at a Kaiser pharmacy. In addition, Kaiser covers tubal sterilization for women and vasectomy for men. Health Plan Hawaii, an HMSA HMO, also covers family planning services.

Fee-for-service plans, such as HMSA's basic group plan, and indemnity plans offered by commercial insurers cover some family planning services. For example, HMSA, the largest mutual insurance company in Hawaii, does not explicitly cover contraceptive services in its basic group plan nor does it cover contraceptive drugs and devices in its drug plan.

But HMSA does pay claims for “office visits,” that could include visits to get a prescription for contraceptives. Moreover, HMSA does cover tubal sterilizations and vasectomies as surgery. Also, HMSA will add family planning services to its coverage at the request of any employer or other group sponsor.

HMSA estimates that 34,000 to 35,000 of its 620,000 beneficiaries are covered for contraceptive drugs (not including contraceptive devices) through its drug plan. Another 80,000 of its beneficiaries who have a special discount under the drug plan can go to a participating pharmacy and get contraceptive drugs from certain manufacturers at a discount.

3. Extent to which the lack of coverage results in persons being unable to obtain necessary treatment.

We found no evidence that persons were unable to obtain necessary contraceptive services because of the lack of coverage. Whether contraceptive services are necessary depends on each individual. Whether the individual has access to the contraceptive service of choice depends also on individual preferences and to some extent on income and insurance coverage. According to one insurer, the average cost of the Pill is \$24 for a one-month cycle. Norplant costs between \$500 and \$600 at insertion. Those who lack coverage may find it more difficult to obtain the more expensive contraceptive options.

Insurers, however, believe that the lack of coverage is not a serious obstacle because publicly sponsored agencies provide these services free or at a very modest charge. They say that coverage may not make a difference in the number of unwanted pregnancies. They see the cost of service as small and predictable. We should also point out that other factors besides insurance coverage—such as knowledge, convenience, and attitudes—influence people’s decision to seek contraceptive services.

4. Extent to which the lack of coverage results in unreasonable financial hardship on persons needing treatment.

The charges for contraceptive services in Hawaii are not likely to lead to financial hardship, but they may be beyond the means of some. It is possible that some women who cannot afford the services will simply forgo them.

Insurers acknowledge that contraceptive services could be a burden to those with limited income. However, they believe that the costs are reasonable and predictable and are appropriately the individual’s responsibility. Further, as noted earlier, publicly sponsored agencies provide these services free or at a modest charge.

5. Level of public demand for contraceptive services.

The level of public demand for services is not clear, but contraceptives are widely used by couples. For example, more than half of American women between the ages of 15 and 44 use a contraceptive method and about 40 percent of these women used oral contraceptives, the IUD, or the diaphragm in 1988. These usage rates suggest that substantial demand exists. On the other hand, HDS Medical reported that its groups are not demanding these services.

6. Level of public demand for individual or group insurance coverage of contraceptive services.

Public demand for optional group insurance coverage of contraceptive services was voiced during the 1993 legislative session by numerous community organizations testifying in support of a bill which became Act 365 of 1993. The act requires employer group health policies, contracts, plans, and agreements that cover pregnancy-related services to provide contraceptive coverage as an employer option. It also requires that policies may not exclude FDA-approved contraceptive drugs and devices in any prescription drug coverage.

Those testifying in favor of the bill included the Hawaii Commission on the Status of Women, the Hawaii Nurses' Association, the Kalihi-Palama Health Clinic, and the National Association of Social Workers, Hawaii Chapter.

HMSA testified that, with rare exceptions, employer groups do not request adding contraceptive services to their group medical or drug plan because of the potential added costs involved. Employers, especially small businesses, are already having difficulty paying for health coverage for their employees.

Most consumers already have a choice, since they can select an HMO plan which provides coverage for contraceptive services.

7. Level of interest of collective bargaining organizations in negotiating privately for this coverage.

One union official reported some interest in negotiating for coverage of contraceptive services. Another did not know the level of interest. A third said that little demand for coverage exists.

8. Impact of providing coverage for contraceptive services on health status, quality of care, practice patterns, provider competition, or related items.

Coverage could reduce the number of unintended pregnancies by making the most effective prescription methods of contraception more widely available and financially accessible. This could reduce morbidity and mortality associated with pregnancy among sexually active women.

However, coverage for contraceptive services could result in increased reliance on prescription drugs that do not protect against sexually transmitted diseases (including the HIV virus), which could increase morbidity and mortality among sexually active women.

Another insurer observed that mandated coverage for contraceptive services could lead to additional providers entering the market.

We could find no information on possible impacts of providing coverage on quality of care or practice patterns.

9. Impact of indirect costs upon the costs and benefits of coverage.

We found no information on indirect costs.

Financial Impact

1. Extent to which the insurance coverage would increase or decrease the cost of contraceptive services.

The impact of insurance coverage on the cost of treatment is unknown. There is not enough experience to determine whether the proposed coverage might increase the cost of contraceptive services. Kaiser has done no cost studies on these services.

One insurer said that it is not certain whether the cost per service would increase. He noted, however, that under mandated coverage contraceptive services formerly provided as part of an “office visit” could get separated out with a separate fee. This could increase costs and the number of providers entering the market.

Insurance coverage could decrease the cost of prescription drugs and devices if a formulary is used to control costs through bulk-purchasing arrangements.

It is possible that insurance coverage would have little impact on the cost of medical visits for contraceptive services because major insurers in Hawaii already cover family planning services or routinely pay claims for office visits that can include family planning services.

2. Extent to which insurance coverage might increase or decrease the use of contraceptive services.

Research on this issue is limited. Again, Kaiser has done no utilization studies because it already provides the services, and there is not enough experience to determine the impacts of utilization.

One insurer said that utilization could increase, including an increase in the use of the more expensive services such as Norplant. There could be a slight increase in the number of medical office visits and use of prescription drugs and devices.

3. Extent to which mandated contraceptive services might serve as an alternative to more expensive treatment or services.

Advocates of mandatory insurance coverage for contraceptive services believe that, in the long run, effective family planning could be a cost-effective tool in controlling health care costs.

The costs of abortions, pre- and post-natal care, and potential neonatal care for unplanned and unwanted infants exceed the cost of providing insurance coverage for contraceptive services. Nationwide in 1988, of the unplanned pregnancies, 43 percent ended in birth, 44 percent in abortion and an estimated 13 percent in miscarriage.³ In 1987, an analysis of federal and state government spending revealed that for every government dollar spent on family planning services, an average of \$4.40 was saved by averting short-term expenditures on medical services, welfare, and nutritional services during the first two years after a birth, or by preventing publicly funded abortions.⁴

In 1989, a study conducted by the Center for Population and Reproductive Health Policy in California found that for every dollar spent by the state in clinic female contraceptive services, there is an expected savings to the state of at least \$12.20.⁵

Some in Hawaii, however, express caution about projected cost savings. One insurer said the evidence is insufficient to show that the women insured by his company would choose abortion if they could not obtain contraceptive services due to lack of coverage.

4. Extent to which insurance coverage for contraceptive services might increase or decrease the insurance premiums or the administrative expenses of policyholders.

One insurer observed that insurance premiums could go up if utilization increases after mandated coverage. Contraceptive services are frequently used, unlike other services such as in-vitro fertilization in which just a few

are performed. Insurers believe that mandated benefits shift the cost of the mandated insurance coverage for contraceptive services from individuals to employers.

Insurance premiums could increase with the addition of coverage for prescription drugs and the administrative costs of processing claims and maintaining drug formularies. However, HMSA reports no dramatic changes in the premiums of drug plans when they began offering this coverage.

The plans that are currently offering contraceptive services should see no change in their premium and administrative expenses.

5. Impact of insurance coverage for contraceptive services on the total cost of health care.

Whether the total cost of health care would increase, decrease, or remain the same if contraceptive services were covered cannot be determined at this time. Increased utilization and fees could drive total costs up. Differences of opinion exist, however, as to whether coverage would increase utilization. Proponents of coverage feel that substantial numbers of people are currently not getting these services, which suggests that utilization would increase. Concerning fees, insurers point out that fees could increase if contraceptive services are broken out as a separate item from office visits and more providers enter the market. On the other hand, increased competition among providers could lower costs.

Assessment of House Bill No. 99

We reviewed the legislation with two questions in mind: (1) will it achieve responsible and humane goals, and (2) will it do so in an economical manner?

Purpose

The measure as currently drafted should encourage the use of contraceptive services among those for whom cost is a barrier by ensuring, with some exceptions, that policies cover the benefit.

Scope

The measure would mandate the coverage both under Chapter 431, HRS, the state Insurance Code, and Chapter 432, HRS, which covers benefit societies such as HMSA. The measure does not specify health maintenance organizations and plans. However, HMOs already cover these services.

The measure describes the coverage only in general and vague terms. The coverage is for “any service related to contraception procedures which is

within the lawful scope of practice of any practitioner licensed to practice medicine in this State, including the supplying of any type of contraceptive device.” It is not clear whether both prescription and nonprescription procedures, both reversible and irreversible methods, and both surgical and nonsurgical procedures are included. Nor is it clear whether other practitioners besides physicians are included. The meaning of “any type of contraceptive device” is not explained.

Contracts with providers

The measure authorizes insurers to provide the services through contracts with providers if the contract is determined to be a cost-effective means of delivering the services without sacrificing quality and meets the approval of the director of health. It is not clear who would make the determination of cost-effectiveness or what criteria would apply. The role of the director of health is not explained.

Conclusions

Because of insufficient data and the vagueness of the legislative proposal, we could not fully assess what the impact of mandated coverage of contraceptive services might be.

We found little evidence that inadequate coverage for contraceptive services has resulted in lack of services or in financial hardship. Inadequate coverage, however, could be a barrier to the contraceptive service of choice. The evidence strongly suggests that mandating coverage for contraceptive services could reduce the cost of health care.

We do not believe that the Legislature should mandate insurance coverage for contraceptive services at this time. It would be best to see what kind of federal health care package will be enacted. The Council of State Governments has also cautioned that “because the cost of health insurance has a significant impact on the health care delivery system in the states, states must evaluate whether certain mandated health benefits...are worth the cost that would be added to the basic health insurance coverage.”⁶

Notes

Chapter 1

1. House Standing Committee Report No. 1636 on Senate Concurrent Resolution No. 8, Senate Draft 1, House Draft 2, Regular Session of 1993.
2. Susan S. Laudicina, *Impact of State Basic Benefit Laws on the Uninsured*, Blue Cross and Blue Shield Association, December 1992, p. 1; Jon R. Gabel and Gail A. Jensen, "The Price of State Mandated Benefits," *Inquiry*, vol. 26, Winter 1989, p. 420.
3. Laudicina, *Impact of State Basic Benefit Laws on the Uninsured*, p. 2.
4. Information provided by HMSA to the Office of the Auditor, November 17, 1993.
5. Letter to Jessica Hashimoto, Analyst, Office of the Auditor, from Francie Boland, Counsel, Kaiser Permanente, November 16, 1993.
6. Telephone interview with Rachel Gold, Senior Public Policy Analyst, Alan Guttmacher Institute, November 9, 1993.

Chapter 2

1. Kathryn Kost et al., "Comparing the Health Risks and Benefits of Contraceptive Choices," *Family Planning Perspectives*, vol. 23, no. 2, March/April 1991, p. 54.
2. "Contraceptive Use," *Facts in Brief*, The Alan Guttmacher Institute, March 15, 1993, p. 1.
3. *Ibid.*, p. 2.
4. Jacqueline D. Forrest and Susheela Singh, "Public-Sector Savings Resulting from Expenditures for Contraceptive Services," *Family Planning Perspectives*, vol. 22, no. 1, January/February 1990, p. 6.

5. Claire D. Brindis and Carol C. Korenbrot, *A Study of the Cost Implications Resulting from the Elimination of the California Office of Family Planning*, Center for Population and Reproductive Health Policy, Institute for Health Policy Studies, University of California, San Francisco, June 1989.
6. *CSG Background*, July 1990, p. 4.

Response of the Affected Agency

Comments on Agency Response

We transmitted a draft of this report to the Department of Health on December 16, 1993. A copy of the transmittal letter to the department is included as Attachment 1. The response from the department is included as Attachment 2.

The department disagrees with our conclusion that the State should wait to see what kind of federal health care package should be enacted. The department suggests this could take four to seven years, and says a strong argument can be made to obtain clear cost savings and health benefits as soon as possible. However, we believe it is prudent to hold off since there is little evidence of lack of service or financial hardship. In addition, federal developments could preempt or otherwise affect Hawaii's mandated health insurance laws.

The department feels that our analysis needed to include the public interest and benefits to the public health by increasing access to contraceptive services. The department does not clarify, however, what it means by "increasing access" nor what information might be available on the social and financial impacts of this "access."

STATE OF HAWAII
OFFICE OF THE AUDITOR
465 S. King Street, Room 500
Honolulu, Hawaii 96813-2917



MARION M. HIGA
State Auditor
(808) 587-0800
FAX: (808) 587-0830

December 16, 1993

COPY

The Honorable John C. Lewin
Director of Health
Department of Health
1250 Punchbowl Street
Honolulu, Hawaii 96813

Dear Dr. Lewin:

Enclosed for your information are three copies, numbered 6 to 8 of our draft report, *Study of Proposed Mandatory Health Insurance for Contraceptive Services*. We ask that you telephone us by Monday, December 20, 1993, on whether or not you intend to comment on our recommendations. If you wish your comments to be included in the report, please submit them no later than Monday, December 27, 1993.

The Governor and presiding officers of the two houses of the Legislature have also been provided copies of this draft report.

Since this report is not in final form and changes may be made to it, access to the report should be restricted to those assisting you in preparing your response. Public release of the report will be made solely by our office and only after the report is published in its final form.

Sincerely,

Marion M. Higa
State Auditor

Enclosures

JOHN WAIHEE
GOVERNOR OF HAWAII



JOHN C. LEWIN, M.D.
DIRECTOR OF HEALTH

STATE OF HAWAII
DEPARTMENT OF HEALTH

P. O. BOX 3378
HONOLULU, HAWAII 96801

In reply, please refer to:
File:

December 27, 1993

Mrs. Marion M. Higa
State Auditor
Office of the Auditor
465 South King Street, Room 500
Honolulu, Hawaii 96813-2917

RECEIVED
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OFFICE OF THE AUDITOR
STATE OF HAWAII

Dear Mrs. Higa:

Subject: Report of the Legislative Auditor
Study of Proposed Mandatory Health Insurance
Coverage of Contraceptive Services

Herewith are our comments on the above study which was requested by the Legislature in its last session.

The legislative proposal for this mandated service (H.B. 99) was supported by the Department of Health; we also supported the resolution(s) for the Legislative Auditor to conduct this study. Our Family Planning Services Section provided a considerable amount of materials to be helpful to the study process.

We appreciate the opportunity to comment on the report.

We feel that the analysis needed to include the public interest and benefits to the public sector and the public health by increasing access to these services. Such services would assist in reducing unwanted, often high risk pregnancies with their high medical and social costs.

We agree with the first conclusion that "... evidence suggests that mandating coverage for contraceptive service could reduce the cost of health care," and suggest that the "vagueness" mentioned can be readily clarified by referring to existing community standards, and analysis of commonly available methods, costs of which are all available.

Mrs. Marion M. Higa
December 27, 1993
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However, we feel that the final conclusion of the report should not depend on waiting four to seven years or more for implementation thru national health care reform. The argument could be made very strongly to obtain the clear cost-savings and health benefits for Hawaii's people and our state health care system as soon as possible.

Thank you again for the opportunity to comment. I hope these points will be helpful as you prepare the final report for the Legislature in the coming session.

Very truly yours,


Dr. JOHN C. LEWIN, M.D.
Director of Health