
Study of Proposed Mandatory Health Insurance Coverage for Contraceptive Services

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

Report No. 98-7
February 1998

THE AUDITOR
STATE OF HAWAII

Study of Proposed Mandatory Health Insurance Coverage 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. 98-7
February 1998

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. As requested by Senate Concurrent Resolution No. 166, Senate Draft 1 of the 1997 legislative session, this report assesses the impacts of mandated health insurance coverage for contraceptive services as proposed in Senate Bill No. 1061.

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 in the course of this study.

Marion M. Higa
State Auditor

Table of Contents

Chapter 1 Introduction

Background on Mandated Health Insurance	1
Background on Contraceptive Services	3
Existing Mandated Insurance Requirement	3
Current Proposal to Mandate Coverage	4
Mandated Coverage in Other States	5
Federal Initiative for Contraceptive Coverage	6
Objective of the Study	6
Scope and Methodology	6

Chapter 2 Social and Financial Impact of Mandating Health Insurance Coverage for Contraceptive Services

Assessment of S.B. No. 1061	9
Social Impact	11
Financial Impact	15
Conclusions	17

Notes	19
-------------	----

Response of the Affected Agency	21
---------------------------------------	----

Exhibits

Exhibit 2.1	Family Planning Coverage for Women With Medical Insurance	13
-------------	---	----

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 assessment is to provide the Legislature with an independent review of the social and financial consequences of each proposal.

Senate Concurrent Resolution No. 166, Senate Draft 1, of the 1997 legislative session requests the Auditor to assess the social and financial impacts of mandated health insurance coverage for contraceptive services. Senate Bill (S.B.) No. 1061 was introduced in the 1997 legislative session as a vehicle to require health insurance coverage for contraceptive services under all insurance policies.

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. Between 1978 and 1992, the number of mandates grew dramatically from 343 to 950 respectively. Since 1992, the growth of mandated coverage has slowed to about 980 mandates in 1996.

Arguments for and against mandated health insurance

Mandated health insurance may be appropriate in certain circumstances. However, proponents and opponents disagree about several key issues such as whether a particular coverage is necessary, whether it is justified by the demand, and whether it will increase costs. 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 state that premium rates 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 mandating health insurance in Hawaii would affect three main types of private insurance: (1) Blue Cross and Blue Shield plans, (2) health maintenance organizations (HMOs), and (3) commercial insurance plans. Private insurance plans cover approximately 88 percent of Hawaii's civilian population.

The Hawaii Medical Service Association (HMSA) is the Blue Cross and Blue Shield insurer in Hawaii. It offers traditional fee-for-service plans that reimburse physicians and hospitals for services. HMSA also has various HMO plans that offer a package of preventive and treatment services for a fixed fee. With a 1995 membership of 749,600 members, HMSA covers about 69 percent of Hawaii's population.¹

Kaiser Foundation Health Plan is a federally qualified health maintenance organization. In 1995, Kaiser served 186,066 people in Hawaii, or about 17 percent of the population.²

Commercial insurance plans such as University Health Alliance (formerly Hawaii Dental Service Medical) and Straub Care Plus cover most of the remaining privately insured population. Some mainland companies such as Aetna and United Health Care (formerly Travelers) also provide 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 who work at least 20 hours per week. A qualified plan is one with benefits that are equal to, or are medically reasonable substitutes for, the benefits provided by the plan with the largest number of subscribers in Hawaii.³

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. The exemption, however, 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.⁴

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. According to the *American Journal of Public Health*, more than half of all pregnancies in the United States are unintended.⁵ 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 exist, 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 (IUD), diaphragms, cervical caps, implanted time release capsules (Norplant), and injectable contraceptives (Depo-Provera). Among the most effective prescription contraceptives approved by the Food and Drug Administration (FDA) are oral contraceptives, Norplant, Depo-Provera and the IUD. Over-the-counter contraceptives do not require a prescription and are reversible. They include condoms, contraceptive foams, creams, jellies, film, and suppository capsules.

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

Existing Mandated Insurance Requirement

Hawaii's insurance laws do not require health plans to provide contraceptive services. There is, however, a requirement to give employers the option to include contraceptive services and contraceptive prescription drug coverage in the plans they select for their employees. Section 431:10A-116.6, HRS, governing commercial health plans, and Section 432:1-604.5, HRS, governing mutual benefit societies (such as HMSA), require each group health policy, contract, plan, or agreement that provides for payment or reimbursement for 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. Section 432D-23, HRS, governing health maintenance organizations, requires each policy to include the same benefits as provided by commercial health plans.

These statutes define contraceptive services as medical services intended to promote the effective use of prescription contraceptive supplies or devices to prevent unwanted pregnancy. The services are supervised by physicians or delivered by physicians, physician assistants, certified nurse midwives, or nurses. The statutes also require any plans with prescription drug coverage to cover any FDA approved prescriptive contraceptive drug or device. These include IUDs, Norplant, and Depo-Provera, in addition to the Pill. The plans cannot impose any unusual copayment, charge, or waiting requirement.

Employers and insurers in Hawaii have responded to these requirements of the Prepaid Health Care Act in a variety of ways. Not all insurers provide prescription drug plans, but contraceptive services and prescription devices are available nevertheless. HMSA reports that 6,526 out of the 10,073 employers in its medical services Preferred Provider Plan purchase its optional drug plans. But that same plan also includes oral contraceptive coverage within its definition of medical services, and gives employers the option to purchase the full range of contraceptive services coverage to include IUDs, Norplant, and Depo-Provera, again as a medical service. Straub Care Plus, a commercial HMO, includes birth control pills under its medical plan but does not offer a separate prescription drug plan. Employers purchasing Straub Care Plus who seek additional prescription drug coverage must purchase a drug plan from another insurer.

Current Proposal to Mandate Coverage

The current proposal to mandate coverage for contraceptive services is Senate Bill (S.B.) No. 1061. It would require all health maintenance organizations, commercial health insurers, and mutual benefit societies to cease excluding contraceptive services from coverage by repealing the *employer option*. Only those health plans that provide prescription drug coverage would have to cover any FDA approved prescription contraceptive drug or device.

Health maintenance organizations

S.B. No. 1061 would add a new section to Chapter 432D, HRS, requiring HMOs that provide pregnancy-related services to also provide contraceptive services for enrollees or any enrollees' dependents. Coverage for any FDA approved prescription contraceptive drug or device would be required only of HMOs that provide prescription drug coverage. The new section would prohibit plans from imposing any unusual copayment, charge, or waiting requirement for such drugs or devices. The new section retains the current definition of *contraceptive services*.

Commercial health insurance

S.B. No. 1061 removes the *employer option* to provide contraceptive services for each employer health policy, contract, plan or agreement. It amends only subsection (a) of Section 431:10A-116.6, HRS, so that group policies that provide pregnancy-related services would also have to provide contraceptive services for subscribers and subscribers' dependents. There are no changes to subsection (b) that requires policies *with drug plans* to cover all FDA approved prescription contraceptive drugs or devices.

Mutual benefit societies

S.B. No. 1061 removes the *employer option* to provide contraceptive services for each employer health policy, contract, plan or agreement through a mutual benefit society. It amends only subsection (a) of Section 432:1-604.5, HRS, so that group policies providing pregnancy-related services would have to provide contraceptive services for subscribers and subscribers' dependents. There are no changes to subsection (b) which requires policies *with drug plans* to cover all FDA approved prescription contraceptive drugs or devices.

Mandated Coverage in Other States

National organizations, including the Alan Guttmacher Institute and the Blue Cross and Blue Shield Association, report that no state mandates health insurance coverage for contraceptive services. There is a new law in Virginia requiring employer notification and some very limited laws in some other states requiring contraceptive coverage.

As of July 1, 1997, Virginia requires insurers that include coverage for prescription drugs on an outpatient basis to also make available coverage for any prescription contraceptive drug or device approved by the FDA. Like Hawaii's law, the mandate requires insurers to inform employers that such coverage is available. Virginia's law requires insurers to cover any FDA approved contraceptive which includes oral, implant, injectable, IUD and prescription barrier contraceptive methods. However, this law does not require plans to cover prescription contraceptives if it does not otherwise cover prescription drugs.

We also identified limited requirements for mandated coverage for contraceptive services affecting a small number of people in several states. Insurance statutes in Illinois, Indiana, Iowa, and Washington mandate contraceptive coverage for their high risk insurance pools. Administrators in these states explained that such mandates affect a small number of people. High risk insurance pool coverage is limited to people who cannot purchase regular health insurance due to pre-existing conditions or other reasons.

Federal Initiative for Contraceptive Coverage

At the federal level, a bill called the *Equity in Prescription Insurance and Contraceptive Coverage Act*, was introduced in May 1997. This legislation would require health plans that cover prescription drugs to also cover FDA approved prescription contraceptive drugs or devices. In addition, this law would mandate health plans that provide outpatient services to provide outpatient contraceptive services. Supporters of this legislation cite fairness in insurance coverage, greater access to health care for women, and potential economic savings. This law would not mandate contraceptive coverage for everyone in Hawaii. Like S.B. No. 1061, only insurance plans with prescription drug coverage would have to also provide prescription contraceptive drugs or devices approved by the FDA.

Objective of the Study

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

Scope and Methodology

Pursuant to Sections 23-51 and 23-52, HRS, we assessed both the social and financial effects of the proposed coverage.

Scope

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 Hawaii's 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 for 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 insurance coverage would increase or decrease the cost of contraceptive services.
2. Extent to which this proposed 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 insurance premiums or administrative expenses of policyholders.
5. Impact of insurance coverage for contraceptive services on the total cost of health care.

Methodology

We reviewed recent research literature and reports on the social and financial aspects of contraceptive services. We reviewed applicable statutes and proposed legislation. We surveyed and obtained information from commercial insurers, mutual benefit societies, health maintenance organizations, local organizations, employer groups, collective bargaining organizations, professional associations and state agencies. In our survey, we specifically requested information on oral and other contraceptive methods including Depo-Provera, Norplant and IUDs. We did not test the data on coverage and utilization provided by HMSA, Kaiser, and other insurers.

We contacted insurance administrators in other states that have laws mandating aspects of health insurance coverage for contraceptive services. We also contacted national organizations including the National Conference of State Legislatures, the Blue Cross and Blue Shield Association, and the Alan Guttmacher Institute.

Our work was performed from May 1997 to January 1998 in accordance with generally accepted government auditing standards.

Chapter 2

Social and Financial Impact of Mandating Health Insurance Coverage for Contraceptive Services

This chapter summarizes our assessment of the potential social and financial impact of mandating health insurance coverage for contraceptive services. We also discuss information on mandatory coverage of contraceptives other than oral contraceptives and the costs of such services. The chapter begins with an analysis of S.B. No. 1061, the current proposal to mandate contraceptive services.

Assessment of S.B. No. 1061

The intent of S.B. No. 1061 is to require health insurance coverage for contraceptive services for *all* health insurance policies. Although this bill includes the word *options*, the legislation is intended to mandate coverage for contraceptive services and not make coverage optional. We note that the extent of coverage can be limited under the current and proposed laws for contraceptive services for certain kinds of policies.

Supporters of mandated health insurance coverage for contraceptive services seek broad coverage to incorporate *all* Food and Drug Administration (FDA) approved prescription contraceptive drugs and devices. With this in mind, the Legislature asked our review to include, but not be limited to, (1) oral contraceptives (the Pill), (2) intrauterine devices (IUD), (3) injectable contraceptives (Depo-Provera), and (4) implanted contraceptives (Norplant). S.B. No. 1061 would not require that coverage be provided for those four specific contraceptive methods. In order to provide expanded or full coverage for all FDA approved contraceptives, this bill would need to be modified.

Proposed changes for health maintenance organizations

S.B. No. 1061 would establish a new section for contraceptive services under a proposed Section 432D(a), HRS. Health maintenance organization (HMO) plans that provide pregnancy-related services would also have to provide contraceptive services. The current language of S.B. No. 1061 does not ensure coverage for oral, IUD, injectable, and implanted contraceptives. Furthermore, S.B. No. 1061 would not ensure coverage for all FDA approved prescriptive contraceptive drugs or devices. Under Section 432D-23, that cites Section 431:10A-116.6, subsections (a) and (b), only HMO plans that provide prescription drug coverage would be required to provide the full coverage. However, this requirement does not apply to HMO plans that do not provide a prescription drug plan.

Proposed changes for commercial insurance

For commercial health insurance plans, S.B. No. 1061 would not ensure coverage for oral, IUD, injectable, and implanted contraceptives, nor coverage for all FDA approved prescription contraceptive drugs or devices. S.B. No. 1061 would amend only subsection (a) of Section 431:10A-116.6, that would require group policies which provide pregnancy-related services to also provide contraceptive services. In order to provide expanded coverage for oral, IUD, injectable or implanted contraceptives, S.B. No. 1061 must amend Section 431:10A-116.6, subsection (a) to specify coverage for these contraceptives. If full coverage for all FDA approved methods is intended, then Section 431:10A-116.6, subsection (b) must be amended to repeal the employer option of providing prescription drug coverage. As the statute is currently written, employers have the option to provide drug coverage and only policies with prescription drug coverage must also cover any FDA approved prescription contraceptive.

Proposed changes for mutual benefit societies

For mutual benefit society plans, S.B. No. 1061 would not ensure coverage for oral, IUD, injectable, and implanted contraceptives. S.B. No. 1061 would amend Section 432:1-604.5, that requires group policies providing pregnancy-related services to also provide contraceptive services for subscribers and subscribers' dependents. In order to provide expanded coverage for oral, IUD, injectable, and implanted contraceptives, S.B. No. 1061 must amend Section 432:1-604.5, subsection (a) to specify coverage for these contraceptives. If full coverage is desired, then S.B. No. 1061 must amend Section 432:1-604.5 subsection (b), since only policies with prescription drug plans are required to cover all FDA approved contraceptive drugs or devices under the current law.

The extent of coverage can be limited under current and proposed policies

The extent of prescription contraceptive coverage can be limited under both the current and proposed laws, under Section 431:10A-116.6, (a) and (b), for commercial insurance plans, under Section 432:1-604.5, (a) and (b), for mutual benefit societies, and under Section 432D-23, for HMOs. There may be situations in which an employer purchases a medical plan and a prescription drug plan from separate insurers. In such situations, the Department of Commerce and Consumer Affairs confirmed that the separate prescription drug plan insurer would not be required to cover any FDA approved prescription contraceptives. For example, Straub Care Plus sells only medical coverage with no drug plan. Employers seeking prescription drug coverage must purchase a drug plan from another insurer.

Social Impact

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

Contraceptive services are primarily used by sexually active women of childbearing age who do not want to become pregnant. The Department of Health reports that there are approximately 265,000 women of reproductive age (14 to 44) in Hawaii. Of those, the health department estimates that there are 245,000 women with medical insurance. In the department's *1996 Hawaii Behavioral Risk Factor Survey*, 78 percent of sexually active women of childbearing age reported using contraception. This includes sterilization and does not imply that these women are using contraceptives regularly.

Insurers reported that a significant portion of women in childbearing years are using prescription contraceptives. Queen's Health Plans (Queen's) reports that from an employee's standpoint, prescription contraceptives are the most frequently requested prescription medications. The Waianae Coast Comprehensive Medical Center reports 5,664 visits for family planning services in 1997.

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

Currently, coverage of contraceptive services is available and varies across health plans. Oral contraceptives are most commonly covered under most health plans. Insurers report that current coverage for prescription contraceptive services ranges from only oral contraceptives to a range of other FDA approved methods including not only the Pill, but also Depo-Provera, Norplant, and IUD contraceptives. In addition, Kaiser, HMSA and Queen's offer employers the option to purchase drug riders that cover additional contraceptive services. Queen's offers coverage for Norplant and IUDs as a covered medical benefit. It covers oral contraceptives and Depo-Provera under its pharmacy rider. Queen's reports that nearly all employers choose the pharmacy rider, with a few employers specifically declining the option on religious grounds.

The health department reports that approximately 60,000 out of an estimated 265,000 women of reproductive age in Hawaii have coverage for all contraceptive services under health plans that include Kaiser, Queen's Island Care, and some HMSA plans. Approximately 95,000 women covered under most HMSA plans and some smaller insurers have coverage for only oral contraceptives. Under the state's Med-QUEST plan, 40,000 women have coverage for oral contraceptives, Depo-Provera, Norplant, IUD, contraceptive supplies and family planning visits. The health department notes that some smaller and a

few larger companies' health plans still do not offer contraceptive coverage for about 50,000 women of reproductive age. Exhibit 2.1 presents information prepared by the Department of Health on the number of reproductive age women with medical insurance and contraceptive services by insurer.

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

We found limited evidence that persons were unable to obtain necessary contraceptive services because of the lack of coverage. HMSA, Kaiser and Queen's report that contraceptive coverage is available under their plans. Kaiser notes that all of its members have access to contraceptives at minimal cost. It receives very few comments from members who say that they cannot afford the copayment. One union noted that some of its members may prefer a contraceptive method not covered by its plan.

In a recent health department report, *Family Planning in Hawaii*, the department noted that many women would choose another method instead of oral contraceptives for a variety of medical reasons including risk factors, side effects and difficulty in using a daily method. Of women who have private insurance, the health department estimates that 95,000 women with health insurance have coverage for only three types of oral contraceptives. Of those, approximately 5,000 are prohibited from using them for medical reasons.

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

We found little information on whether the lack of contraceptive coverage would result in unreasonable financial hardship. None of the local organizations, insurers, providers or unions had specific information on financial hardship among their members.

According to the health department, oral contraceptives cost between \$20 and \$30 each month. Depo-Provera costs about \$20 per injection or \$80 each year. IUDs cost \$140 for the initial visit. Norplant would cost \$600 for the initial visit. Those who lack coverage may find it more difficult to pay for the more expensive contraceptive options.

One provider noted that the cost of birth control pills is significant for young working people who do not have contraceptive coverage. The health department, two providers and one local organization stated that with limited or no coverage for contraceptive services, some women pay out-of-pocket, obtain services from community health clinics, or cease using contraceptives.

Exhibit 2.1
Family Planning Coverage for Women With Medical Insurance
(Estimated Population is 245,000 Women)

Health Plan	No Contraceptives Covered	Oral Contraceptives	Depo-Provera	IUD, Norplant	Family Planning Visit
Med-QUEST	N/A	40,000	40,000	40,000	40,000
Private Insurance					
HMSA	N/A	90,000 <i>(85,000 with only the Pill)</i>	5,000	5,000	80,000
Kaiser	N/A	35,000	35,000	35,000	35,000
Queen's Island Care	N/A	2,000	2,000	2,000	2,000
Kapiolani	N/A	3,000	3,000	3,000	3,000
Straub	N/A	500	N/A	N/A	500
TriCare Plans <i>(formerly Champus)</i>	N/A	15,000	15,000	15,000	15,000
Other Private Plans	50,000	9,500	N/A	N/A	9,500
Sub-Total for Only Oral Contraceptives <i>(See Italics)</i>		95,000			

Source: 1997 Department of Health Telephone Survey.

5. Level of public demand for health insurance coverage for contraceptive services.

Employers responding to our survey unanimously and strongly oppose any additional mandated health benefits. Responses from other groups indicated that there is no great demand for insurance coverage for contraceptive services. Only one local organization stated that the demand for contraceptive services is extremely great. Another local organization stated that there is no current information available that estimates the number of additional women who would use contraceptive services were they available. One health provider indicated a high demand for services, but one noted that the population they serve are not using contraceptive services. We found virtually no recent local newspaper coverage indicating a strong local demand for health insurance coverage for contraceptive services.

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

Demand for individual or group insurance coverage for contraceptive services is low. HMSA and Kaiser have not received requests from individual policy holders or professional organizations for contraceptive services. However, Queen's reports that the demand for contraceptive coverage is fairly consistent from employers, as employees view this coverage as a *right* rather than a *benefit*. The health department stated that employers tend to be more concerned with premium costs than with services covered.

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

Interest from collective bargaining organizations in negotiating privately for this coverage is very limited. Only two of the six unions we contacted responded to our survey in writing. Both unions reported that demand is very low or non-existent. One union noted that if demand was high, it would have been part of the collectively bargained benefits, noting that it is opposed to increasing health care costs with more state mandates.

Neither Kaiser nor HMSA has received such requests from unions. Queen's stated that contraceptive services are typically an important benefit as part of collectively bargained health benefits.

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

The health department expects that comprehensive family planning coverage will prevent a significant number of unintended pregnancies. Also, insurance coverage would enable more women to receive preventive family planning and health care services, thereby improving women's health status. Kaiser does not expect changes in health status and/or quality of care for its members since it currently covers a full range of contraceptive services, and most at a nominal cost. Straub and local organizations expect mandated coverage to improve health status and quality of care and prevent unwanted pregnancies. However, one local organization noted that insurance coverage alone is not sufficient to assure family planning practices.

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

We found limited information on indirect costs.

Financial Impact

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

Insurers provided limited information on the extent to which costs would increase or decrease under mandated coverage. Kaiser expects the cost of individual contraceptive services to remain the same since it already covers a broad range of contraceptives in its basic medical plan and drug rider. Over 90 percent of Kaiser's members are covered under its drug rider. However, it expects costs on a statewide basis to increase if usage increases. Queen's does not expect any impact since it currently provides full coverage.

2. Extent to which the proposed coverage might increase the use of contraceptive services.

Insurers expect little or no increase in contraceptive use. Kaiser does not expect use to increase since it already provides a broad range of contraceptive services. It added that some members choose not to purchase contraceptives, some lack family planning education, and others lack the motivation to use contraceptives. Straub and one local organization expect contraceptive use would increase with mandated coverage since cost would be less of a factor.

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

Advocates maintain that the cost of unintended pregnancies far exceed the cost of contraceptive services for employers and insurers. The health department estimates that each unintended pregnancy prevented saves the state about \$55,000 in perinatal, infant, child and youth services.

In 1995, the *American Journal of Public Health* evaluated the economic impact of 15 contraceptive methods including oral, injectable, implant, and the IUD. It found that all 15 contraceptives were more effective and less costly than no method. The report projected savings for periods of one through five years based on costs incurred from the time of conception to pregnancy termination, delivery, prenatal care and newborn hospitalization. Over five years, one type of IUD saved \$14,122; implanted (Norplant) saved \$13,813; injected (Depo-Provera) saved \$13,373; and oral contraceptives saved \$12,879. The report concluded that the higher initial expense of some contraceptive methods does not take into account the total cost impact of an unintended pregnancy when using methods such as Norplant or IUD. The journal noted that unintended pregnancy can be the consequence of even the best methods used imperfectly. Whatever method is used correctly and consistently is the most cost-effective.

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

Respondents indicate little or no increase in insurance premiums or administrative expenses. HMSA estimates that coverage for a full range of contraceptives would cost an additional two to four dollars per member per month. Straub Care Plus, a commercial HMO which does not include a drug plan, expects a minimal impact on insurance premiums and administrative expenses. Queen's does not expect any impact since it already provides comprehensive coverage.

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

Straub and the health department expect a reduction in total health care costs under mandated coverage, through fewer abortions, deliveries, and decreased prenatal, newborn and pediatric care. Queen's noted that there would probably be an increase in premiums to employers who may pass any additional costs to employees or reduce other health benefits to save money. Insurers have indicated that employers faced with a mandate to cover contraceptive services may choose to drop prescription drug coverage to save money.

Conclusions

We found little evidence that inadequate health insurance coverage for contraceptive services has resulted in persons lacking these services or causing them financial hardship. Limited coverage, such as only birth control pills, may be a barrier to choosing from a full range of contraceptive services. Demand for full coverage of contraceptive services is primarily from local organizations and providers. There is very little demand for this coverage from unions and employer groups.

The cost of unintended pregnancies exceeds the cost of contraceptive services. Recent research demonstrates the cost effectiveness of contraceptives, even those with a higher initial expense. Insurers indicate that covering contraceptive services would result in little or no increase in insurance premiums or administrative expenses.

Perhaps more importantly, we note that S.B. No. 1061 does not ensure coverage for either specific contraceptive methods or all FDA approved contraceptives in commercial health, mutual benefit, or HMO plans. Expanded coverage for oral, IUD, injectable or implanted contraceptives or full coverage of all FDA approved contraceptives would need to be specified in this bill. Only those plans that provide prescription drug coverage would be required to cover all FDA approved prescription contraceptives. However, prescription drug plans are still an employer's option under Hawaii's Prepaid Health Care Act. Insurers have indicated that employers faced with a mandate to cover contraceptive services may choose to drop their drug plan coverage to save money. The effect would be a loss of contraceptive coverage resulting from the loss of prescription drug coverage.

Notes

Chapter 1

1. Hawaii, Department of Business, Economic Development and Tourism, *Data Book, 1996*, p. 410.
2. Ibid.
3. Section 393-7, HRS.
4. National Governors' Association, *Roadblock to Reform, ERISA Implications for State Health Care Initiatives*, 1994, pp. 6, 46, 49, 50.
5. S. Harlap, K. Kost and J.D. Forrest, *Preventing Pregnancy, Protecting Health: A New Look at Birth Control in the United States*, The Alan Guttmacher Institute, New York, 1991, pp. 19 and 22.

Response of the Affected Agency

Comments on Agency Response

We transmitted a draft of this report to the Department of Health on January 21, 1998. 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 of Health expressed concerns that the evidence of need for this coverage is more apparent than was included. The department stated that providers are demanding these services. It estimates that 16,000 to 20,000 women need contraceptive services, but limited funding allows community health centers to subsidize family planning visits for only 8,000. The department states that privately insured low-income women are competing with uninsured women for these limited resources, and links this to the increasing rate of unintended pregnancies. The health department estimates there are approximately 3,000 low-income, privately insured women visiting community health centers receiving subsidized coverage for contraceptive methods. The department maintains that if all privately insured women had comprehensive coverage for contraceptive methods, then more uninsured women could receive subsidized family planning coverage. The Department of Health agreed with our conclusions regarding cost effectiveness and the minimal increase in insurance premiums and administrative expenses should full coverage be mandated. The department also stated it will seek changes in Senate Bill No. 1061 to address the problems we raised regarding prescription drug plan coverage.

We incorporated some technical and editorial clarifications suggested by the department.

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

January 21, 1998

COPY

The Honorable Lawrence Miike
Director of Health
Department of Health
Kinau Hale
1250 Punchbowl Street
Honolulu, Hawaii 96813

Dear Dr. Miike:

Enclosed for your information are three copies, numbered 6 to 8 of our draft report, *Study of Proposed Mandatory Health Insurance Coverage for Contraceptive Services*. We ask that you telephone us by Friday, January 23, 1998, 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 Friday, January 30, 1998.

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

BENJAMIN J. CAYETANO
GOVERNOR OF HAWAII



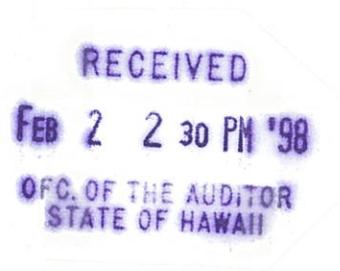
LAWRENCE MIIKE
DIRECTOR OF HEALTH

STATE OF HAWAII
DEPARTMENT OF HEALTH
P. O. BOX 3378
HONOLULU, HAWAII 96801

In reply, please refer to:
File: FHSD/MCHB/F

January 28, 1998

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



Dear Ms. Higa:

In response to your draft report, "Study of Proposed Mandatory Health Insurance Coverage for Contraceptive Services", the following are our comments on your recommendations.

- I. Our main concern is that evidence of need of this coverage is more apparent than was concluded:
 - A. Conclusions (p.17, paragraph 1): Regarding "little evidence" of lack of services/hardship from lack of coverage: it was noted that providers are demanding these services. These are the very people to whom the consumers complain, and who are in a position to keep track of the numbers of insured clients they serve who are not covered for family planning, or whose method of choice is not covered. For example, of the 1,100 FY 1997 visits to Kalihi-Palama Health Center, half were by privately insured, low-income women who paid for their contraceptive method on a sliding fee scale. The working poor affected by this lack of coverage are less likely to make a formal complaint to an anonymous representative of an insurance company, than would be a more affluent, self-confident consumer who would actually be less affected by incomplete coverage.
 - B. Three pieces of information presented on page 11 ("Social Impact") are misleading:

1. Section 1, paragraph 1: After stating the number of women with medical insurance, it should then be noted that 50,000 do not have family planning coverage.
2. Section 1, paragraph 1: The percentage of women in need of family planning services in 1996 is compared with the percent using contraception in 1992. These are two different measures. "In need" means fertile, sexually active, and currently not wanting a pregnancy. The comparable figure for 1992 is 75% -- 3% more than were using contraception.
3. Section 1, paragraph 2: The number of family planning visits at a clinic -- in this case, Waianae Coast Comprehensive Health Center (WCCHC), has no correlation either with insurance coverage or ability to pay out-of-pocket. In fact, 95% of WCCHC's patients have Med-QUEST coverage, a much higher percentage than at other community health centers (CHCs). At other CHCs, the uninsured rate (for all patients) ranges from 20% to 60%.

There are approximately 20,000 uninsured women of reproductive age in Hawaii. It is not known how this group of women fits the 78% "in need" profile; it is safe to say that between 16,000 and 20,000 uninsured women are in need. State and federal (Title X) monies are able to subsidize family planning visits for only 8,000. CHCs provide services for as many other women as possible through other sources of funding (grants, fundraising), and even after these resources are exhausted. Unfortunately, privately insured low-income women whose insurance does not cover family planning, or more than one method, are competing with the uninsured women for these limited resources. Thus, as many as 8,000 uninsured women may still lack services, in addition to those privately insured who can neither access subsidized care or afford out-of-pocket payment.

This competition for increasingly limited resources, especially at the state level, is reflected in the increase in the percentage of unintended pregnancies: in 1992, those who stated their most recent pregnancy had been unintended was 27%; in 1996, it had risen to

38%. Private insurers taking responsibility for comprehensive family planning coverage could make a significant impact on unintendedness. In addition to those whose visits are not covered, there are approximately 3,000 low-income, privately insured women visiting CHCs, who have visit coverage, but not method coverage. On each of these women, an average of \$25 per year is spent on full or partial subsidization of contraceptive methods. If all privately insured women had comprehensive contraceptive coverage, this minimum amount of \$75,000 could fully subsidize both visits and contraceptives for 625 uninsured women currently not able to access services.

- C. Conclusions (p.17, paragraph 1): Regarding little demand by unions and employer groups:
1. The largest private insurer in Hawaii has told us that while union members themselves may value family planning coverage, the unions themselves have not been advocates, since the coverage has not been on the table for negotiation, but provided at no extra cost.
 2. The Department of Health has been sharing information with the Hawaii Employers' Council regarding the cost-effectiveness of such coverage (including increased worker productivity), so it is expected that they will be more supportive, or at least less oppositional, in the 1998 session.

II. Regarding amendments needed: (Assessment of S.B. 1061, pp. 9-10, Conclusions, p.17, paragraph 3)

- A. We will ask that wherever "contraceptive prescription drug coverage" is mentioned, "of all FDA approved methods" be added.
- B. After further study of the bill, we will ask for amended wording to address the problem of coverage being dependent solely on provision of prescription drug plans.

Ms. Marion M. Higa
Page 4
January 28, 1998

Finally, we do appreciate the conclusions regarding the cost-effectiveness of contraceptives, and the minimal increase in insurance premiums or administrative expenses.

Thank you for the thoroughness of your report.

Sincerely,

A handwritten signature in cursive script that reads "Lawrence Mike".

LAWRENCE MIIKE
Director of Health