Foreword

Act 267 of the 1999 Sessions Laws of Hawaii requires the Insurance Commissioner to submit to the Legislature a review and assessment of the contraceptive coverage mandated benefit to the 2001 Legislature. Specifically, the Act requests the Insurance Commissioner provide an assessment to determine whether the cost of health insurance has increased as a result of this Act, including an assessment of the impact of contraceptive coverage on reducing maternity costs, employee turnover, and absenteeism costs around maternity and family-related costs.

The Insurance Division acknowledges the fact that this report has not been submitted on time. However, this review and assessment was not completed prior to the convening of the 2001 Legislature because the data for the calendar year 2000 could not be compiled until early 2001. The 2000 data was necessary to accurately review the contraceptive mandate, since it was the first complete calendar year after the mandate. This allowed us to assess that data against 1998 and 1999 data.

The Insurance Commissioner and the Insurance Division would like to thank all the health plans that provided the data and information to complete this report.

WAYNE METCALF
Insurance Commissioner

Introduction

Since each of the four health plans servicing employer groups in Hawaii differs in membership size and organizational structure this review will focus on the effect, if any, the mandated benefit has had on the health plan and its members, rather than compare the plans.

The Insurance Division surveyed health plans offering coverage to employer groups regarding contraceptive services. Each plan was asked the following questions:

1. How many employers have elected to provide health plans without contraceptive coverage?

2. How many members are covered by plans that exclude coverage for contraceptive services and supplies?

3. How many members are covered by plans that provide coverage for contraceptive services and supplies?

4. Please provide any information you may have from employers regarding the impact of contraceptive coverage on reducing their maternity costs, employee turnover, and maternity and family-related absenteeism.

5. What type of coverage if any, did the plan have for contraceptive services prior to the mandate?

6. How was contraceptive use (as measured in costs) changed as a result of the mandate? Please provide data for 1998, 1999, and 2000 on costs (i.e. eligible charges) for contraceptives.

7. How has the number of pregnancies changed as a result of the mandate? Please define this category as broad as possible and track for 1998, 1999, and 2000?

8. How have maternity related costs (i.e. eligible charges) changed? Please define this category as broad as possible and track for 1998, 1999, and 2000.

Health Plan A

None of the employer groups with Health Plan A have invoked the religious exemption. However, Health Plan A serves five plan sponsors affiliated with religious organizations. These organizations requested that Health Plan A provide them with plan summaries that do not describe contraceptive coverage.

Currently, all Health Plan A members receive contraceptive coverage, as it is included in the basic medical plan purchased by all plan sponsors. This coverage was already provided to Health Plan A's entire membership as part of the base medical plan prior to the mandate. The mandate therefore, resulted in only one minor change for Health Plan A. The legislation required coverage of "all FDA-approved" modes of contraception. As a result, Health Plan A was obliged to move coverage for IUDs and cervical caps from the optional drug plans to the base medical plans. This change granted access to these two modes of contraception to approximately 15% of Health Plan A's membership who did not have drug coverage.

Contraceptive use has changed very little since the mandate was enacted. For the calendar year 2000, Health Plan A physicians wrote only 11 more prescriptions for IUDs or cervical caps than in 1999. In contrast, Health Plan A's membership of women of child-bearing age (10-64 years old) grew by over 2,000.

Since Health Plan A does not process claims for visits, codes indicating the specific services delivered are not readily available. However, for the three-year period 1998 to 2000, Health Plan A provided the following obstetrics data:

MEMBERSHIP – FEMALES OF CHILD BEARING AGE (10-64 years old)

Calendar Year	Members
1998	79,841
1999	79,891
2000	83,057

OBSTETRICS DISCHARGES

Calendar Year	Discharges	Rate/1,000 Female Members
1998	2,866	36/1,000
1999	2,659	33/1,000
2000	2,951	36/1,000

"Female Members" means females of childbearing age.

OB/GYN OFFICE VISITS

Calendar Year	Visits	Rate/1,000 Female Members
1998	115,492	1,244/1,000
1999	111,535	1,198/1,000
2000	111,653	1,156/1000

"Female Members" means females of childbearing age and post-menopausal women.

Health Plan A's data illustrates that the number of obstetric discharges increased while the number of Obstetrics and Gynecology office visits remained constant. Such data does not indicate any adverse impacts as a result of contraceptive coverage. It further correlates with the statement by Health Plan A that since contraceptive coverage was offered prior to the mandate, the mandate has had minimal or no impact on Health Plan A members or employer groups.

Health Plan B

None of Health Plan B's employer groups have elected to invoke the religious exemption. Currently, approximately 26,000 Health Plan B members are covered for contraceptive services. Prior to the mandate, Health Plan B only offered oral contraceptives via prepaid prescription drug riders. The plan did not cover contraceptive devices, such as IUDs, or topical products such as Norplant.

Health Plan B has experienced an increase in costs for contraceptive services and supplies as follows:

Calendar Year	Cost per Member	% Increase
1998	$0.66	
1999	$0.78	18%
2000	$0.82	5%

In terms of pregnancies, the number of pregnancies per 1,000 for 1999 decreased by 2.2% from 1998, and increased by 3.2% in 2000 from 1999. However, Health Plan B states that this has not resulted in any material changes in eligible charges for maternity related services.

Health Plan B is another example of a plan that offered some form of contraceptive coverage to its membership prior to the mandate, and has experienced a trend of increased pregnancies or maternity related services in 2000. We conclude that Health Plan B's results are significant, however, because the cost of contraceptive services has increased. Since many factors affect the cost of a health care service, the mandate itself probably did not contribute significantly to this increase. Therefore, the impact of the mandate on Health Plan B's members and employer groups has been minimal.

Health Plan C

None of Health Plan C's employer groups have elected to invoke the religious exemption. Health Plan C provides contraceptive coverage for approximately 32,000 members. Prior to the mandate, Health Plan C offered contraceptive services as an optional rider. About 29% of Health Plan C's members had coverage for contraceptive services prior to the mandate.

Health Plan C has provided the following data regarding contraceptive use and pregnancies:

CONTRACEPTIVE USE MEASURED IN COSTS

Calendar Year	Cost per Member
1998	$1.03
1999	$1.68
2000	$2.53

PREGNANCIES

Calendar Year	Paid Deliveries/1000 Members
1998	12.81
1999	12.47
2000	12.03

MATERNITY RELATED COSTS

Calendar Year	Cost/1000 Members
1998	$112.29
1999	$98.72
2000	$95.61

Health Plan C also reported an increase in contraceptive costs, a cost per member increase of 146% since 1998. As cost for a specific health care service can be attributed to many factors, it is unlikely that the mandate itself is the cause for this increase. More importantly, the data shows a slight decrease in the number of paid pregnancies from 1998 to 2000 and a noticeable decrease in the maternity related costs for the same period. This suggests that the mandate has had little effect on Health Plan C members or employer groups. However, Health Plan C's membership did increase during this period, and prior to the mandate only 29% of the members were covered for contraceptive services. Therefore, evidence of an impact, if any, may not be apparent for one or two more years.

Health Plan D

Currently, only one Health Plan D employer group has invoked the religious exemption and has elected not to provide contraceptive coverage. This employer group represents 896 Health Plan D members. In contrast, approximately 480,030 Health Plan D members are covered by Health Plan D plans that provide contraceptive coverage.

Prior to the contraceptive services mandate Health Plan D's free choice plans did not cover contraceptive services and supplies. However, additional drug rider coverage including these benefits was available for purchase by employer groups. The majority of these drug riders provided oral contraceptives at special member rates, but were limited to specific brand names. Members paid for the contraceptive prescription in full, but saved on the discounted rate arranged by Health Plan D.

For the three-year period from 1998 to 2000, Health Plan D provided the following data for contraceptive use and pregnancies:

CONTRACEPTIVE USE MEASURED IN COSTS

Calendar Year	Total Eligible Charges	% Change from Prior Year
1998	$1,370,115	
1999	$1,567,168	14.4%
2000	$1,954,807	24.7%

NUMBER OF PREGNANCIES

Calendar Year	15-44 year old Members Identified as Pregnant	% Change from Prior Year	% Female Base Identified as Pregnant
1998	8,617		9.1%
1999	7,891	-9.2%	9.0%
2000	9,942	26.0%	11.5%

MATERNITY RELATED COSTS

Calendar Year	Total Eligible Charges for Maternity	% Change from Prior Year
1998	$21,953,354	
1999	$19,758,912	-11.5%
2000	$19,467,829	-1.5%

Although the cost of contraceptive use increased, there was also an 11.5% increase in the number of members identified as pregnant in 2000. Health Plan D could not identify any data that would provide a reason for the significant increase in pregnancies after the contraceptive mandated was enacted. Furthermore, the average maternity related cost for pregnancies decreased from 1998 to 2000, due to a decreased mix of complicated maternity related cases in 2000.

This increase in pregnancies and decrease in maternity related costs illustrates that Health Plan D's contraceptive coverage appears to have very little or no impact on its members and employer groups.

Conclusion

Given the responses from each of the health plans surveyed we conclude that, Act 267 of the 1999 Session Laws of Hawaii did not appear to have a direct affect on an increase in the cost of health insurance, since a majority of the health plans reporting increases in the number of pregnancies after the mandate was enacted. With some plans even recording a decrease in maternity related costs.

Although the number of pregnancies increased none of the health plans reported that any employers had substantial concerns regarding the impact of contraceptive coverage on their maternity costs, employee turnover, and family related absenteeism. It is also uncertain whether or not the contraceptive coverage mandate had any effect on the increase in pregnancies.

Contraceptive coverage is a new mandated benefit. Further review and assessment in two to three years would be appropriate, and provide more utilization data and cost-benefit trends.