Study of Proposed Mandatory Health Insurance Coverage for Various Sexual and Reproductive Health Care Services

A Report to the Governor
and the Legislature of
the State of Hawai‘i

Report No. 23-10
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OFFICE OF THE AUDITOR
STATE OF HAWAI‘I

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Constitutional Mandate

Pursuant to Article VII, Section 10 of the Hawaiʻi State Constitution, the Office of the Auditor shall conduct post-audits of the transactions, accounts, programs and performance of all departments, offices and agencies of the State and its political subdivisions.

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To improve government through independent and objective analyses.

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We report our findings and make recommendations to the Governor and the Legislature to help them make informed decisions.

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Foreword

We assessed the social and financial impacts of mandating insurance coverage for sexual and reproductive health care services as proposed in House Bill No. 1179 (2023 Regular Session), pursuant to Sections 23-51 and 23-52, Hawai‘i Revised Statutes (HRS). Section 23-51, HRS, requires passage of a concurrent resolution requesting an impact assessment by the Auditor before any legislative measure mandating health insurance coverage for a specific health service, disease, or provider can be considered. The 2023 Legislature requested this assessment through Senate Concurrent Resolution No. 18, Senate Draft 1, House Draft 1.

We wish to express our appreciation for the cooperation and assistance extended to us by the State's health plan providers as well as other organizations and individuals we contacted during the course of our work.

Leslie H. Kondo
State Auditor

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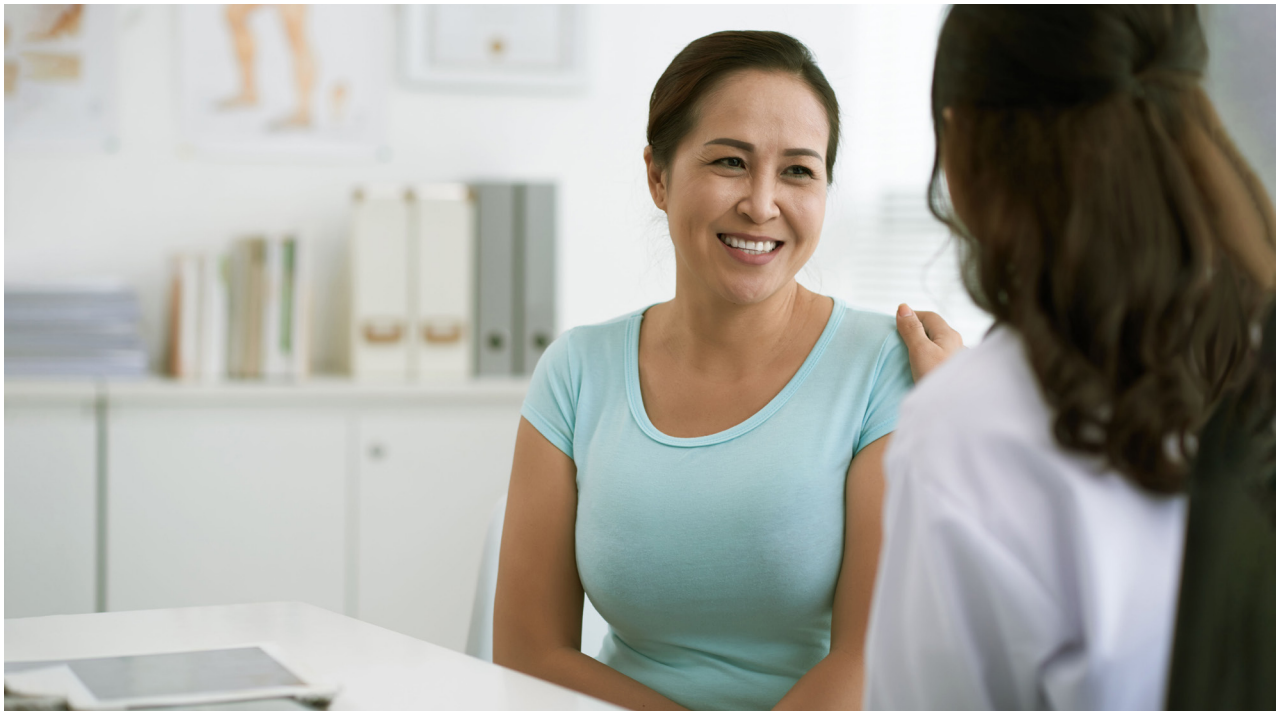

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Introduction

Senate Concurrent Resolution No. 18, Senate Draft 1, House Draft 1

We assessed the social and financial effects of mandating health insurance coverage for various sexual and reproductive health care services proposed in House Bill No. 1179 (HB 1179), introduced in the Regular Session of 2023, in accordance with Sections 23-51 and 23-52, Hawai‘i Revised Statutes (HRS). The 2023 Legislature requested this assessment through Senate Concurrent Resolution No. 18, Senate Draft 1, House Draft 1 (SCR 18, SD 1, HD 1).

House Bill No. 1179

HB 1179 requires certain insurance policies to provide coverage for various sexual and reproductive health care services. As we detail in this report, we found there will be little-to-no social or financial impact should HB 1179 be enacted into law, as nearly all of the services, drugs, devices, products, and procedures that would be mandated are, except for a relatively small number of "grandfathered" plans, currently

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covered by Hawai‘i health insurance plans, including those plans available under the Patient Protection and Affordable Care Act, also known as the Affordable Care Act (ACA). As discussed below, mandating insurance coverage for sexual and reproductive health care services described in HB 1179, with limited exceptions, does not expand coverage currently provided to insureds.

Objectives of the Study

In accordance with Section 23-52, HRS, and pursuant to SCR 18, SD 1, HD 1, the objectives of this study are to assess the social and financial aspects of requiring health insurers, mutual benefit societies, and health maintenance organizations to provide coverage for the sexual and reproductive health care services, drugs, devices, products, and procedures[1] proposed in HB 1179.

Scope and Methodology

We surveyed major health insurance providers for information necessary to complete our assessment. We also independently researched certain aspects of the ACA and Hawai‘i’s Prepaid Health Care Act, Chapter 393, HRS. We conducted this assessment from May 2023 through September 2023 in accordance with Sections 23-51 and 23-52, HRS.

Proposed Mandatory Health Insurance Coverage for Sexual and Reproductive Health Care

HB 1179 proposes to amend the Hawai‘i Insurance Code to mandate insurance coverage for certain sexual and reproductive health care services.

According to the bill, the Legislature is concerned about the federal government’s attempts to restrict and repeal the ACA and to limit access to sexual and reproductive health care. The Legislature found “access to sexual and reproductive health is critical for the health and economic security of all people in Hawaii” and determined “it is vital to preserve certain aspects of the Patient Protection and Affordable Care Act and ensure access to health care for residents of Hawaii.” The bill is intended “to ensure comprehensive coverage

[1] For sake of simplicity, we refer to the services, drugs, devices, products, and procedures listed in HB 1179, collectively, as “sexual and reproductive health care services.”

for sexual and reproductive health care services, including family planning and abortion, for all people in Hawaii."

Specifically, HB 1179 requires individual and group health insurance policies as well as medical service plan contracts to provide coverage "for the policyholder or any dependent of the policyholder who is covered by the policy"[2] for sexual and reproductive health care services listed in the bill. Specifically, the services include:

- Well-woman preventive care visit annually for women to obtain the recommended preventive services that are age and developmentally appropriate, including preconception care and services necessary for prenatal care.
- Counseling for sexually transmitted infections, including human immunodeficiency virus and acquired immune deficiency syndrome.
- Screening for chlamydia; gonorrhea; hepatitis B; hepatitis C; human immunodeficiency virus and acquired immune deficiency syndrome; human papillomavirus; syphilis; anemia; urinary tract infection; pregnancy; Rh incompatibility; gestational diabetes; osteoporosis; breast cancer; and cervical cancer.
- Screening to determine whether counseling and testing related to the BRCA1 or BRCA2 genetic mutation is indicated and genetic counseling and testing related to the BRCA1 or BRCA2 genetic mutation, if indicated.
- Screening and appropriate counseling or interventions for:

  (A) Substance abuse, including tobacco and electronic smoking devices, and alcohol; and

  (B) Domestic and interpersonal violence.
- Screening and appropriate counseling or interventions for mental health screening and counseling, including depression.
- Folic acid supplements.
- Abortion.
- Breastfeeding comprehensive support, counseling and supplies.
- Breast cancer chemoprevention counseling.
- Any contraceptive supplies, as specified in section 431:10A-116.6 [HRS].

[2] The portion of the bill relating to medical service plan contracts refers to "subscriber or member or any dependent of the subscriber or member who is covered by the plan contract." HMSA defines "dependent" to include the policyholder's spouse and/or eligible children.

- Voluntary sterilization, as a single claim or combined with the following other claims for covered services provided on the same day:

  (A) Patient education and counseling on contraception and sterilization; and

  (B) Services related to sterilization or the administration and monitoring of contraceptive supplies, including:

    (i) Management of side effects;

    (ii) Counseling for continued adherence to a prescribed regimen;

    (iii) Device insertion and removal; and

    (iv) Provision of alternative contraceptive supplies deemed medically appropriate in the judgment of the insured's health care provider.

- Pre-exposure prophylaxis, post-exposure prophylaxis, and human papillomavirus vaccination.

- Any additional preventive services for women that must be covered without cost sharing under Title 42 United States Code (USC) Section 300gg-13, as identified by the United States Preventive Services Task Force or the Health Resources and Services Administration of the United States Department of Health and Human Services, as of January 1, 2019.

HB 1179 also prohibits insurers from imposing any cost-sharing requirements, including copayments, coinsurance, or deductibles on an insured with respect to the proposed coverage for sexual and reproductive health care services[3] and requires providers to be reimbursed for providing the services without any deductions for copayments or other cost-sharing amounts.

[3] HB 1179 allows cost-sharing if necessary for eligibility for a health savings account pursuant to 26 USC Section 223. That provision permits taxpayers to deduct amounts from federal income tax returns for contributions to a health savings account (HSA). An HSA is an account created by a taxpayer to pay or reimburse medical expenses such as deductibles, co-payments, and coinsurance. 26 USC Section 223 requires that taxpayers seeking to deduct amounts paid into HSAs must be insured under a high deductible health plan (HDHP). To be considered an HSA-qualified HDHP, a health plan must have a deductible above a certain minimum threshold and must limit total annual out-of-pocket expenditures for covered benefits to no more than a certain maximum threshold. This office cannot assess the impact of HB 1179 on an individual under an HSA-qualified HDHP and suggests that such an analysis may be better undertaken by the Hawai'i Insurance Commissioner or Hawai'i Department of Taxation.

Health Insurance In Hawai‘i

The vast majority of Hawai‘i residents (in 2016, almost 93 percent) are covered by health insurance issued through their employer or under a government program such as Medicaid. A significant majority of Hawai‘i’s 1,440,196 residents as of 2022 are insured under a health insurance policy, mutual benefit society plan, or by a health maintenance organization. As part of this study, we surveyed nine health insurance providers in Hawai‘i. The five health insurance companies that responded have a combined total of approximately 1,183,000 members and/or subscribers as of 2022.

Underpinning the significant number of residents with employer-based coverage is Hawai‘i’s Prepaid Health Care Act. The Prepaid Health Care Act, passed in 1974, requires virtually every employer with at least one permanent full-time employee to purchase employee health insurance coverage.

The Patient Protection and Affordable Care Act

The ACA was enacted in March 2010 with the primary goals of making affordable health insurance available to more people, expanding the Medicaid Program, and supporting innovative medical care delivery methods designed to lower the costs of health care generally. It requires all non-exempted U.S. citizens, U.S. nationals, permanent residents, and lawful resident aliens to have an acceptable level of health insurance.

The ACA established “insurance marketplaces” where individuals and small employers can shop for private health insurance. Those plans must include coverage for ten broad categories of “essential health benefits,” along with certain preventive services.

The essential health benefits categories include:

- Ambulatory patient services;
- Emergency services;
- Hospitalization;
- Pregnancy, maternity, and newborn care;
- Mental health and substance use disorder services including behavioral health treatment;
- Prescription drugs;
- Rehabilitative and habilitative services and devices;
- Laboratory services;

- Preventive and wellness services and chronic disease management; and
- Pediatric services, including oral and vision care.

All marketplace health plans must also cover the following list of preventive services for women without charging a copayment or coinsurance:

- Breastfeeding support and counseling from trained providers and access to breastfeeding supplies, for pregnant and nursing women;
- Birth control (not applicable to health plans sponsored by certain exempt "religious employers");
- Folic acid supplements for women who may become pregnant;
- Gestational diabetes screening for women 24 weeks pregnant (or later) and those at high risk of developing gestational diabetes;
- Gonorrhea screening for all women at higher risk;
- Hepatitis B screening, for pregnant women at their first prenatal visit;
- Maternal depression screenings for mothers at well-baby visits;
- Preeclampsia prevention and screening for pregnant woman with high blood pressure;
- Rh incompatibility screening for all pregnant woman and follow-up testing for women at higher risk;
- Syphilis screening;
- Expanded tobacco intervention and counseling for pregnant tobacco users;
- Urinary tract or other infection screening;
- Bone density screening for all women over age 65 or women age 64 and younger who have gone through menopause;
- Breast cancer genetic test counseling (BRCA) for women at higher risk;
- Breast cancer mammography screening every two years for women 50 and over and as recommended by a provider for women 40 to 49 or women at higher risk for breast cancer;
- Breast cancer chemoprevention counseling for woman at higher risk;

- Cervical cancer screening – PAP test/PAP smear for women aged 21 to 65;
- Chlamydia infection screening for younger women and other women at higher risk;
- Diabetes screening for women with a history of gestational diabetes who are not currently pregnant and who have not been diagnosed with type 2 diabetes before;
- Domestic and interpersonal violence screening and counseling for all women;
- Gonorrhea screening for all women at higher risk;
- HIV screening and counseling for everyone age 15 to 65 and other ages at increased risk;
- PrEP (pre-exposure prophylaxis) HIV prevention medication for HIV-negative women at high risk for getting HIV through sex or injection drug use;
- Sexually transmitted infections counseling for sexually active women;
- Tobacco use screening and interventions;
- Urinary incontinence screening for women yearly; and
- Well-women visits to get recommended services for all women.

Less than 22,500 residents (or less than 2 percent of Hawai‘i’s population) were enrolled in health insurance plans purchased through Hawai‘i’s ACA marketplace in 2022.

The Hawai‘i Medical Service Association (HMSA) Preferred Provider Plan 2010 is Hawai‘i’s benchmark plan and serves as the standard for the essential health benefits coverage within the State. Hawai‘i health insurers use this plan as a guide for creating their own essential health benefit coverage. If the benchmark plan covers a particular service, then all policies sold through the marketplace must also cover that service.[4]

The benchmark plan includes coverage for the categories of essential health benefits described in the ACA as well as other services, some of which are mandated by Hawai‘i law. More specifically, HMSA represents that its benchmark plan includes coverage for *all* of the sexual and reproductive health care services listed in HB 1179.

[4] HMSA’s benchmark plan provides coverage for individuals, as well as individuals and their dependents (the member’s spouse and/or eligible child(ren)).

The Current State of Insurance Coverage of Sexual and Reproductive Health Care in Hawai‘i

We surveyed nine health insurance providers that belong to the Hawai‘i Association of Health Plans (HAHP), a statewide organization that unifies Hawai‘i’s state-licensed health insurance providers, to determine the social and financial impact of covering the sexual and reproductive health care services described in HB 1179.[5] The vast majority of Hawai‘i residents receive their health coverage through a health insurance provider associated with one of these HAHP organizations. We found that health insurance plans offered in Hawai‘i, including those offered through the marketplace under the ACA, currently provide coverage for the services proposed by HB 1179.

Hawai‘i Health Plan Provider Name	Number of members/ subscribers (2022)	Does the health insurance provider provide coverage for sexual and reproductive health services as described in the bill?
Hawai‘i Medical Service Association (HMSA)	779,833	yes
Kaiser Permanente (Kaiser)	253,293 members	yes
Hawai‘i Medical Assurance Association (HMAA)	37,849	yes
‘Ohana Health Plan	54,434	yes
United Health Alliance (UHA)	57,673 members	yes

Source: Office of the Auditor

[5] MDX was sent a survey but did not provide data in its response. MDX represented that it was a third-party administrator for UnitedHealthcare and Humana and that benefit structures are established by these two entities. Humana was surveyed but declined to respond as the company has never been an active participant in the group/individual health insurance market in Hawai‘i and could not provide meaningful responses. UnitedHealthcare was sent a survey but declined to participate as it provides Medicaid coverage under a contract with the State of Hawai‘i and did not feel that its responses would apply to this office’s assessment. AlohaCare was sent a survey but did not respond.

Health Insurance Policies in Hawai‘i Currently Provide Coverage That Would Be Mandated by House Bill No. 1179

Social and Financial Impact of House Bill No. 1179

While we assess below each of the social and financial impacts listed in Section 23-52, HRS, we note that those impacts, if any, are likely negligible because, as reported above, the sexual and reproductive health care services for which the bill would mandate health insurance coverage are already covered by policies issued in the State of Hawai‘i.[6] And, because the benchmark policy for the plans offered under the ACA in the Hawai‘i marketplace is the HMSA Preferred Provider Plan 2010, which HMSA represents includes coverage for the services identified in HB 1179, individual and small group health insurance plans purchased in Hawai‘i under the requirements of the ACA also include coverage for those sexual and reproductive health care services. Accordingly, mandating that health insurers include coverage for the sexual and reproductive health care services listed in HB 1179 does not change the status quo and likely will not result in any significant social or financial impact, which the providers who responded to our survey confirmed.

We note, however, that some plans require cost-sharing by their members in the form of copayments or deductibles for certain treatments, such as family planning and abortion care. HB 1179 would prohibit an insurer from imposing any cost-sharing requirements with respect to coverage for the sexual and reproductive health care services, including copayments, coinsurance, or deductibles. While eliminating the cost-sharing that the policies currently may require adds costs that insurers must bear, we believe that those costs are relatively insignificant to insurers' total costs and any financial impact, if any, will likewise be immaterial.

1) Social Impact

A. The extent to which the treatment or service is generally utilized by a significant portion of the population:

The health insurance providers disclosed that the treatment and services described in HB 1179 are commonly utilized by their members.

[6] Similarly, some health insurance providers have "grandfathered" plans purchased on or before March 23, 2010 that are not subject to certain requirements under the ACA, such as coverage for pre-existing conditions and free preventive care. Such policies do not cover all treatments or services required under the ACA or may provide such treatments or services with a member's copayment.

The health insurance providers have a combined membership of 1,154,322.

HMSA stated that almost 23 percent of female commercial plan members age 18 or older used annual well-woman visit coverage. Another health insurance provider reported that close to 23 percent of its members utilize sexual and reproductive health services listed in HB 1179.

B. The extent to which such insurance coverage is already generally available:

The plan providers reported that the services listed in HB 1179 are generally covered. HMSA noted that such treatment and services are covered under all new HMSA plans, while some "grandfathered," pre-March 23, 2010 plans did not include such coverage. However, such grandfathered HMSA plans constitute less than 10 percent of HMSA's plans.

C. If coverage is not generally available, the extent to which the lack of coverage results in persons being unable to obtain necessary health care treatment:

Health insurance providers stated that the sexual and reproductive health care services listed in HB 1179 are currently available under their plans.

D. If the coverage is not generally available, the extent to which the lack of coverage results in unreasonable financial hardship on those persons needing treatment:

Health insurance providers reported that this impact was either unknown or did not apply, as the coverage is generally available. However, as discussed above, some health insurance providers have issued pre-March 23, 2010 "grandfathered" plans that do not cover all of the treatment or services described in HB 1179. For individuals insured under such policies, the financial impact is unknown.

E. The level of public demand for the treatment or service:

The health insurance providers reported that the level of public demand for the treatment or services was reflected in the utilization rates of such coverage by their members. HMSA reported that the level of demand varies from service to service, but that the usage for the annual well-woman visit for women ages 18 and older enrolled in one commercial health plan averaged close to 23 percent.

F. The level of public demand for individual or group insurance coverage of the treatment or service:

The public demand for coverage for sexual and reproductive health care services described in the bill is unclear; however, plans offered by those responding to the survey currently include coverage for sexual and reproductive health care services described in the bill, except in "grandfathered" plans. "Grandfathered" plans purchased on or before March 23, 2010 are not subject to certain requirements under the ACA and, therefore, do not currently provide coverage for certain of the services, such as preventive care. HMSA described the membership in such "grandfathered" plans as less than 10% of their total membership. In 2023, HMSA's total membership is 785,073. The level of demand for insurance coverage for such treatment or service among members under such "grandfathered" plans is unclear.

G. The level of interest of collective bargaining organizations in negotiating privately for inclusion of this coverage in group contracts:

HMSA reported that union members covered under "grandfathered" plans have asked why certain screenings are not covered under their plans, but that there have not been many requests to add such benefits to grandfathered plans.

H. The impact of mandating insurance coverage for the treatment or service (such as morbidity, mortality, quality of care, change in practice patterns, provider competition, or related items):

The plan providers uniformly described the impact of mandating the services described in HB 1179 as minimal.

I. The impact of any other indirect costs upon the costs and benefits of coverage as may be directed by the legislature or deemed necessary by the Auditor in order to carry out the intent of this section:

Most plan providers described the impact of any other indirect costs upon the costs and benefits of coverage as minimal although they did not quantify the impact. As discussed above, the "grandfathered" plans either do not cover the services described in HB 1179 or require copayment. Under Section 1311(d)(3)(B) of the ACA, if a state mandates that plans sold in the marketplace offer benefits in addition to essential health benefits, the state is responsible for defraying the cost of such benefits. The impact of any defrayment, however, is unknown.

2) Financial Impact

A. The extent to which insurance coverage of the kind proposed would increase or decrease the cost of the treatment or service:

Two health insurance providers reported that any increase in the cost of services described in HB 1179 would be minimal. However, the plan providers did not explain why even minimal increases in the cost of the service would occur since the treatment or services described in HB 1179 are currently included in almost all plans.

One plan provider with over 250,000 members in the State of Hawai‘i, reported that all services are currently covered, with a few requiring applicable cost sharing, but that the removal of cost sharing would result in an increase of approximately $0.25 per member, per month.

B. The extent to which the proposed coverage might increase the use of the treatment or service:

The plan providers generally anticipated the likely increase of the use of the service, if mandated, as minimal. One plan provider, whose plans require cost-sharing for certain family planning services, stated that removing copayment requirements may increase the usage of such services. HMSA predicted that utilization of those treatments and services would increase by those members covered under pre-March 23, 2010 “grandfathered” plans if these treatments and services are added to those plans.

C. The extent to which the mandated treatment or service might serve as an alternative for more expensive treatment or service:

Three plan providers stated that making these services mandatory would have no impact or a minimal impact on the extent to which those services would serve as an alternative for more expensive treatments since the services are currently covered under their plans.

D. The extent to which insurance coverage of the health care service or provider can be reasonably expected to increase or decrease the insurance premium and administrative expenses of policyholders:

Four plan providers stated that the likely increase of insurance premiums and administrative expenses of policyholders would be minimal, as the services are currently covered. Two plan providers cited the removal of cost-sharing in current plans as the reason for possible increases in insurance premiums and administrative expenses. One plan estimated that removal of cost sharing would result in an increase of approximately $0.25 per member, per month.

E. The impact of this coverage on the total cost of health care:

The impact on the total cost of health care would be minimal on the insurers and patients because benefits currently exist. Two health plans stated that coverage for abortion care may be subject to cost sharing by the State of Hawai‘i, should the services described in HB 1179 be mandated. This is because federal funds, with some exceptions, cannot be used to pay for certain sexual and reproductive health care services such as abortion services, which then requires the State to defray the cost of those services (as well as others that are outside of the essential health benefits).

Conclusion

Pursuant to Section 23-52, HRS, we have assessed the social and financial effects of mandating health insurance coverage for various sexual and reproductive health care services, as provided in HB 1179. We conclude the coverage that HB 1179 seeks to mandate is, with few exceptions or limitations, currently provided by Hawai‘i’s plan providers and that the likely social and financial impacts on those covered under plans and on the cost of health care in general would be minimal.