

# A Plan for Action

*Based on The Hawai'i Uninsured Project Policy Summit 2001*



Striving to Make Health Care  
Available for All People in Hawai'i

Sponsored by: State Coverage Initiative program of The Robert Wood Johnson Foundation  
Hawai'i Community Foundation • HMSA Foundation

# THE HAWAI'I UNINSURED PROJECT

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January 2002

Dear Friends of The Hawai'i Uninsured Project:

We are very pleased to present "A Plan for Action: Striving to Make Health Care Available for All People in Hawai'i." This three-part report is the product of a diverse collaboration that cares deeply about the health and well-being of Hawai'i.

The first part contains a report on the Project and a plan for the year ahead. We would especially like to call your attention to pages 7 through 11. There you will find the specific steps that have been derived from two years of community listening, stakeholder meetings and expert analysis.

Part two is a report on the Policy Summit held on November 29, 2001. This section contains all the participant recommendations that went into the creation of the plan. Also take a moment to read the tremendously insightful comments from our panel of experts on pages 17 through 28. We believe their wisdom will be very valuable as we continue on our path toward healthcare for all.

The third part is an updated version of the reference materials provided to summit participants. It is based on the research conducted by the Project in 2001. Anyone who may be thinking of strategies to expand health insurance coverage and health care access should become familiar with these materials. We believe it is the best available compilation of information for Hawai'i.

The Hawai'i Uninsured Project is on a calculated and purposeful course toward a healthier Hawai'i. We have been able to accomplish every step along the way thus far and we plan on maintaining that record. However, the next phase is particularly ambitious, complex and important. As in the past, we will need your continuing attention, input, support and leadership. If you are not already a partner, please consider joining by contacting Piilani Pang, Project Specialist.

Mahalo

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STATE COVERAGE  
INITIATIVES

*A National Initiative of The Robert Wood Johnson Foundation*

January 31, 2002

Dear Friends of the Hawaii Uninsured Project:

Having worked with the Hawaii Uninsured Project (HUP) over the past 15 months, we would like to express our commendation of your team's work on an important health care issue in Hawaii.

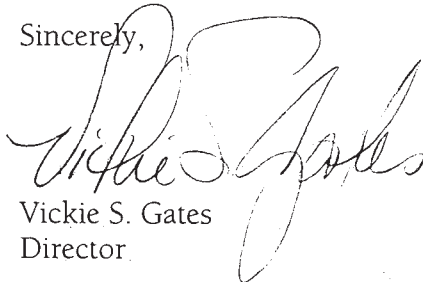
The *State Coverage Initiatives* (SCI) program, an initiative of the Robert Wood Johnson Foundation, is proud to be a sponsor of the Hawaii Uninsured Project. Through a policy planning grant to the Hawaii State Department of Health for \$149,900, SCI is pleased to support: the collection and analysis of qualitative and quantitative data; generating support among the public and all stakeholders; and a strategy conference to prioritize options for coverage expansion.

Working with you and your staff, and having attended two summits sponsored by HUP, we are continually impressed with the collaboration between the HMSA Foundation, the Department of Health and other state agencies. In addition, your team clearly has been effective in securing the commitment of all stakeholders to solving the growing problem of the uninsured in Hawaii.

Although some may think that Hawaii's situation is unique due to its geographic isolation from the "mainland," in fact, all states face the similar challenges of rising health care costs, struggling local economy, and access to care issues. We believe that as Hawaii can learn from the other states, so too can states learn from your state's experience with the Prepaid Health Care Act, efforts to control costs, and strategies to cover your diverse population base. For this reason, the Hawaii Uninsured Project is an important endeavor in understanding where the state is on coverage matters and developing strategies for maintaining existing programs and potentially expanding them when the opportunity arises.

We wish you continued success in your efforts and look forward to working with you and your team over the coming years.

Sincerely,



Vickie S. Gates  
Director



Jeremy J. Alberga  
Senior Associate



# **A Plan for Action**

Striving to Make Health Care Available for All People in Hawai'i

January 2002

Produced and distributed by:



Sponsored by:

State Coverage Initiative program of The Robert Wood Johnson Foundation  
Hawai'i Community Foundation ♦ HMSA Foundation

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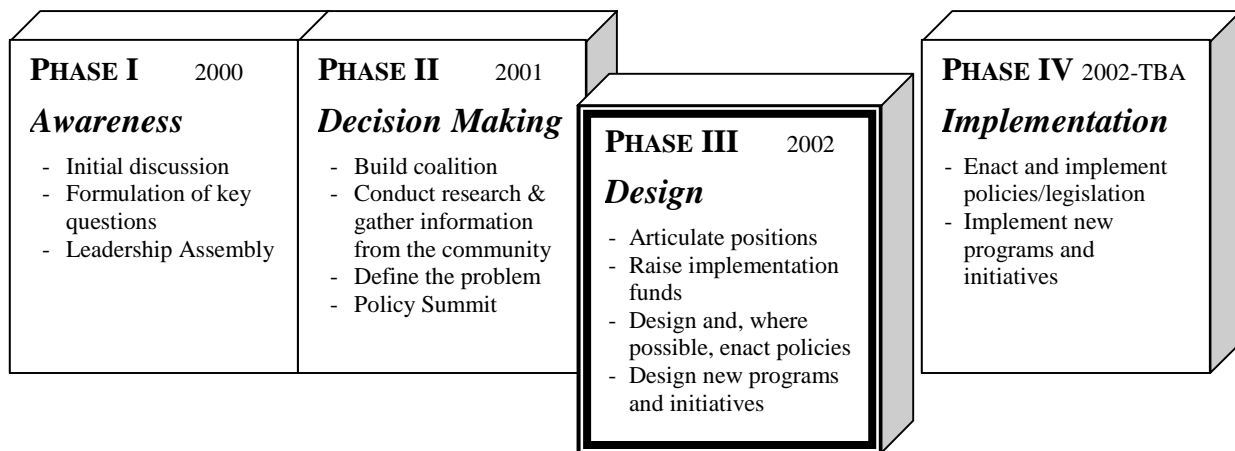
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# THE CALL FOR ACTION

## ► About The Hawai‘i Uninsured Project

The Hawai‘i Uninsured Project was initiated by a group of local health care leaders in 2000 as a response to the steadily rising number of people in Hawai‘i who lack health insurance. The HMSA Foundation provided the initial funding and staffing for the project.

The goal of the project is to dramatically reduce the number of uninsured people in Hawai‘i. From January through June 2002, the project is in Phase III.



## ► Guiding Principles

**Inclusion** – Everyone is needed at the table: community groups, health plans, health centers, hospitals, researchers, big and small businesses, labor unions, legislators, state and federal agencies, physicians, nurses, foundations, uninsured people and anyone with a stake in this issue.

**Community Input and Education** – We actively seek and share information with the people of Hawai‘i. It is our responsibility to create and maintain a high level of awareness and comprehension so that the public is a full participant in policy formation.

**Action** – This is not “another study that sits on the shelf.” Commitments are being made, resources are being found, and public/private policy changes are the only acceptable outcomes.

**Listening and Respect** – We acknowledge all stakeholders and the conviction with which they hold their views. Obviously, the issues are complex and many people have only vague or partial pictures of solutions. No one person or group can unilaterally solve the problem.

**Reason** – We seek a common base of knowledge through careful review of what we know from Hawai‘i and elsewhere. We will discuss, debate, decide and, in the end, act.

## ► People

With this call to action, a coalition was born with the broadest possible representation. The project is still growing today as other concerned individuals and organizations sign on as partners or join the hundreds of others participating in the project.

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### Financial Support

Hawai'i Community Foundation

HMSA Foundation

The Robert Wood Johnson Foundation

### Partners (as of print date)

#### Federal, State & Local Govt

Centers for Medicare & Medicaid Svcs  
Mayor's Office, County of Hawai'i  
Office of the Lt. Governor  
Representative Bertha F.K. Leong  
Representative Brian Schatz  
Senator Bob Nakata  
Senator David M. Matsuura  
State Comm on the Status of Women  
State Dept of Business & Econ. Dev.  
State Dept of Hawaiian Home Lands  
State Dept of Health  
Chronic Disease Management  
Community Health Division  
Developmental Disabilities Division  
Executive Office on Aging  
Family Health Services Division  
Office of Environmental Quality  
Office of Planning, Policy & Prog.  
State Dept of Human Services  
State Dept of Labor & Industrial Rel.  
State Dept of Public Safety  
State Office of Children & Families  
State Office of Community Services  
State Office of Information Practices

#### Business & Employment

Ashford & Wriston  
Dik & Assoc. Direct Marketing, Inc.  
Hawai'i Air Ambulance  
Hawai'i Business Roundtable  
Hawai'i Government Employees Assn.  
J.W. Loo & Associates  
Milici Valenti Ng Pack  
Screen Actors Guild  
Software Pharmacy Hawai'i

#### Health Care Providers

Aloha Medical Mission  
Bay Clinic, Inc.  
Community Clinic of Maui  
Hamakua Health Center  
Hana Community Health Center  
Hawai'i Dental Association  
Hawai'i Health Systems Corporation  
Hawai'i Family Dental Centers  
Hawai'i Medical Association  
Hawai'i Primary Care Association  
Healthcare Association of Hawai'i  
Ho'ola Lahui Hawai'i  
Kalihi-Palama Health Center  
Kapi'olani Health  
Kuakini Medical Center  
Moloka'i General Hospital  
St. Francis Healthcare System of Hawai'i  
Wahiawa General Hospital  
Wai'anae Coast Comp. Health Center  
Waikiki Health Center

#### Academia & Research

Acad. for Hlth Svcs Research & Hlth Policy  
Hawai'i Area Health Education Center  
Hawai'i Health Information Corporation  
Pac. Basin Rehab Research & Trng Ctr  
SMS Research & Marketing Services  
University of Hawai'i  
Center on the Family  
College of Business Administration  
College of Social Sciences  
Department of Economics  
Social Science Research Institute  
School of Nursing & Dental Hygiene

#### Community Investment

Aloha United Way  
Hawai'i Community Foundation  
HMSA Foundation  
The Robert Wood Johnson Foundation

#### Health Plans

AlohaCare  
Hawaii Medical Service Association  
Kaiser Permanente  
University Health Alliance

#### Community Organizations

American Heart Association of Hawai'i  
America's Promise Hawai'i  
Catholic Charities  
Child & Family Services  
Good Beginnings Alliance  
Hale Na'au Pono  
Hawai'i Community Services Council  
Hawai'i Covering Kids  
Hawai'i Institute for Public Affairs  
Hawai'i Justice Foundation  
Hawai'i Kids Count  
Hawai'i Kids Watch  
Healthy Mothers, Healthy Babies  
Helping Hands Hawai'i  
Institute for Human Services  
Kahi Mohala Behavioral Health  
Ke Ala Pono  
Ke Alaula  
Ke Ola Mamo  
March of Dimes Hawai'i Chapter  
Mental Health Association in Hawai'i  
Na Loio - Immigrant Rights  
NAMI O'ahu  
National Association of Social Workers  
National Kidney Foundation of Hawai'i  
Office for Social Ministry  
Pacific Gateway Center  
Papa Ola Lokahi  
Queen Lili'uokalani Children's Center  
Susannah Wesley Community Center  
TJ Mahoney & Associates  
The Legal Aid Society of Hawai'i

# THE CASE FOR ACTION

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## ► **FACT – Being uninsured harms individuals**

In a March 2001 study by the American College of Physicians-American Society of Internal Medicine (ACP-ASIM), it was found that uninsured Americans experience **reduced access to care** and have **poorer medical outcomes**. People without health insurance:

- Are less likely to have a regular source of care
- Are less likely to use preventive services
- Are more likely to delay seeking care
- Are more likely to report they have not received needed care
- Experience a generally higher mortality and a specifically higher in-hospital mortality
- Are up to three times more likely than privately insured individuals to experience adverse health outcomes
- Are up to four times as likely as insured patients to require both avoidable hospitalizations and emergency hospital care

The ACP-ASIM said it most succinctly: “**Uninsured Americans tend to live sicker and die earlier than insured Americans.**”

## ► **FACT – A large uninsured population harms society**

A substantial uninsured population reduces overall productivity in the workforce, costing employers and putting a drag on the economy. Also, **health care costs increase** because when the uninsured do get care, it is often in the most inefficient ways, creating a strain on hospitals. Providers, health plans, employers, the insured and taxpayers all bear the burden of these social costs.

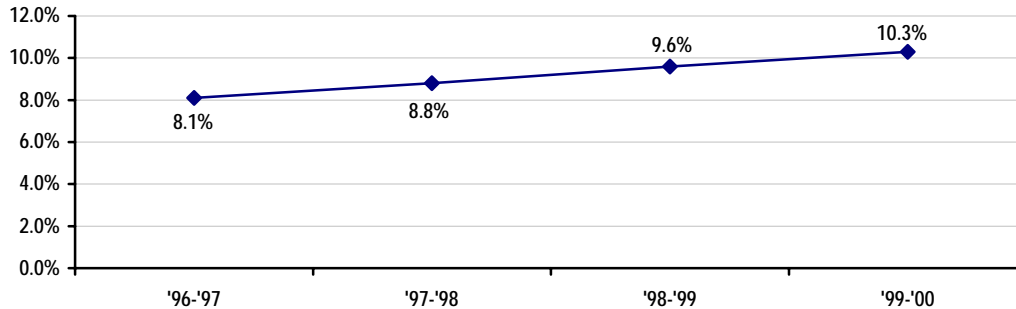
Furthermore, the tragic events of September 11, 2001 remind us that **we are all vulnerable of becoming uninsured** whenever a job is lost or work hours are reduced. Even temporary loss of coverage can lead to financial ruin if a catastrophic illness occurs.

## ► **FACT – The number of uninsured people is growing**

One commonly used measurement of uninsured numbers is the Current Population Survey conducted by the U.S. Census Bureau. According to their figures, the number of uninsured people in Hawai‘i has been **rising over the last five years**. This number is not easy to measure. People come in and out of insurance with new jobs and changing family circumstances. Some uninsured people are difficult to identify or survey because of socio-economic barriers. However,



one thing is clear—where at one time we had the lowest uninsured rate in the country (by some estimates, less than 5% uninsured) Hawai‘i can no longer claim to have solved the uninsured problem.



Two-Year Moving Averages of the Percentage of Uninsured People in Hawai‘i

Source: U.S. Census Bureau, Current Population Reports, *Health Insurance Coverage 1998* (October 1999) for '96-'97 figures, *Health Insurance Coverage 1999* (September 2000) for '97-'98 figures, *Health Insurance Coverage 2000* (September 2001) for '98-'99 and '99-'00 figures.

### ► **FACT – There is something we can do**

The individual and social costs of a large uninsured population have warranted the attention of the entire nation. The call for innovative and politically courageous solutions has made the uninsured issue a **national focal point** for groups like The Kaiser Family Foundation, The Robert Wood Johnson Foundation, The Commonwealth Fund, Children’s Defense Fund, Health Insurance Association of America, National Association of Public Hospitals and Health Systems, W.K. Kellogg Foundation, National Governors Association, numerous federal and state government agencies and many others.

This is a time of opportunity for Hawai‘i as national resources are being made available for new policy directions. Other states are already demonstrating that political and administrative challenges can be successfully overcome with **creativity** and **determination**.

### ► **THEREFORE – Hawai‘i must act**

The logic is clear—the problem is serious and solutions exist. Therefore, **no matter how politically challenging or administratively complex**, we must begin the process of forging a strategy for Hawai‘i. The Hawai‘i Uninsured Project is firmly committed to creating an environment where this process can move forward and to finding sufficient resources to see it through.

# THE FORMULA FOR ACTION

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In the past, Hawai‘i has seen honest efforts to address the uninsured issue, which have not resulted in significant societal change. Why not? Perhaps there was a lack of community support or political will or supportive research or leadership. Or perhaps past efforts simply lacked the resources and accountability to put plans into action.

We believe The Hawai‘i Uninsured Project is different. It is committed to following a formula for wise public action. Though it may seem elementary, having these four features is clearly more easily said than done. Hawai‘i’s own experience with controversial issues—the Felix consent decree, prison construction, traffic safety, legalized gambling—demonstrate the challenges of making good policy in a dynamic environment. With these ingredients, we hope to prove that, even in challenging times, Hawai‘i can come together to solve even its toughest problems.

## **1. A Clear Problem and an Ambitious Vision**

An evolving understanding of the actual problem and its importance is critical to shaping the vision. All members of society deserve and should expect that community leaders articulate a clear and inspiring vision that directs and defines our efforts to improve.

## **2. Action As Soon As Possible**

Every day that the difficulties of Hawai‘i’s uninsured people are not addressed, thousands face a deterioration of their health, well being and security. The problem of the uninsured creates a continuous flow of unnecessary pain, family suffering and financial ruin. Meanwhile, the costs of these problems permeate through our economy in a downward spiral.

Time is of the essence and we must do something now. We must change rules, pass laws, update policies, redirect money and do whatever else is prudent and necessary. The public demands it and our sense of humanity demands it.

## **3. Action Based on Expert Analysis and Broad Human Experience**

At the same time, important public policy issues should be based on the most expert, fact-based analysis available and with the greatest possible involvement of those stakeholders who will benefit from and those who will implement these policies. Some ideas will work and some won’t. In most cases, we need not resort to trial-and-error to make this distinction.

Our decision-makers need the data, research capacity, ideas and broad opinions that are prerequisites to adequately answer some of the most difficult questions. Without these, no broad vision of healthcare in Hawai‘i can be widely pursued. Important public actions ought to be firmly based in sound knowledge, empirical evidence and human experiences. The perceptions of our communities indicate a belief that decisions are too often based on political whim, the loud voice of a very few, restless habits or unconfirmed hearsay.

This concept of widely supported and calculated action takes time. How can one do this and still maintain a commitment to immediate action?

#### **4. Outstanding Leadership**

The only way to successfully navigate the conundrum of numbers 2 and 3 is through courageous, visionary and purposeful leadership. It is leadership that does not pit interests against each other, waiting for a “winner” to emerge. Nor does this leadership merely defer to “experts” without consulting the people and communities who will be affected. Toward this end, The Hawai‘i Uninsured Project is optimistic that elected and appointed officials, in particular, will exert such leadership and will welcome the similar leadership that exists in our own communities.

The Hawai‘i Uninsured Project is simply a vehicle that hopes to enable this leadership to flourish. The project will seek out the money and staff resources to continue fueling research, outreach, dialogue and action. The project itself does not wield any authority to make the necessary policy changes and long-term financial commitments.

That is why everyone who wields any authority is called upon to shoulder the corresponding responsibility that will be required to implement these plans. This will take compromise, cooperation and courage. This is the most difficult and in the end, most essential part of any positive social change.

# THE PLAN FOR ACTION

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This plan creates actionable items from common themes gleaned from the Leadership Assembly on the Uninsured, the Policy Summit, community outreach activities, key leader meetings and research done by The Hawai‘i Uninsured Project (HUP) in the last two years. It is not the viewpoint of any individual, but rather it is a compilation, analysis and condensation of literally hundreds of opinions, comments, stories and reports.

## ► The Problem

**Too Many Without Insurance:** Too many people in Hawai‘i who want or need health insurance cannot obtain it. These people fall in the gaps among employer-based coverage and government-sponsored coverage—they include part-time workers, sole proprietors, immigrants, dependents of the working poor, state emergency hires and others. Also, many people find the process of obtaining insurance confusing, frustrating, intimidating and impersonal. Having a large uninsured population has destructive health effects and negative economic impacts on individuals and on society.

**Employed But Uninsured:** Hawai‘i’s Prepaid Health Care Act (PHCA) provides a solid foundation for providing health coverage to all—its continued existence is critical to preventing an even greater uninsured crisis. At the same time, many working people fall outside the protection of the PHCA as it is currently written. However, updating and amending the PHCA requires tremendous diligence and integrity. Because of Hawai‘i’s unique Employee Retirement Income Security Act (ERISA) waiver, changing the PHCA literally requires an Act of Congress so as not to jeopardize its existence. Furthermore, many stakeholders including employers, consumers and the health care industry have strong and legitimate economic and social concerns about the terms of the PHCA. These views will be difficult to balance.

**Government Insurance Inaccessible:** Many uninsured people do not meet the eligibility requirements of government programs like QUEST. Others who are eligible are not enrolled because they find the application process inaccessible. At the same time, government offices have stagnant or declining resources to deal with a growing demand for services. Substantial federal matching funds are available for expanding programs, but unlike many other states, Hawai‘i has not found ways to access all of these resources.

**Beyond Insurance / Accessing Health Care:** The truly important social outcome we must seek is quality health care access for all. Health insurance is one critical means to that end. However, there are many other barriers to health care that are being addressed by a “safety net” of health care providers, community members, service organizations, government agencies and others who provide care, outreach, enrollment services, education and more. These services will always be needed and are particularly critical as our uninsured population grows. Unfortunately, Hawai‘i’s safety net is precariously lacking in resources.

## ► A Vision

Hawai‘i will once again **lead the nation** by having a cost-effective and coherent system that makes **quality health care available for all**.

**Employment-based** insurance, anchored in the Prepaid Health Care Act, will be bolstered to make health insurance accessible to most working people and their dependents. The law will be designed so that the distribution of costs will be both fair and efficient. All others including the unemployed, the underemployed and their dependents will be able to find coverage through efficient and easily accessible **government sponsored** programs that make maximum use of federal funds. A well-resourced, high-quality **safety net** will ensure that anyone who is still uninsured, in transition, or otherwise having difficulty, can access the health care that they need.

## ► Toward the Vision – Action Steps and Rationale

Action ideas that meet the following two criteria should be implemented as soon as possible. If the criteria have not yet been met, immediate action should be taken to meet those criteria.

- 1) Extensive public and stakeholder support.
- 2) High probability that the action will address the problem based on available data, expert analysis and/or similar experiences elsewhere.

### Employer-Based Insurance

**Now** – HUP to conduct a study/dialogue on the Prepaid Health Care Act involving all key stakeholders and enlisting the guidance of Hawai‘i’s Congressional delegation.

- *This discussion has not yet occurred and legitimate interests exist on many sides (business, labor, government, health care, etc). The act is also complex and unique—much of the population and many public leaders are not yet familiar with it.*
- *Significant empirical questions of health and economics exist regarding cost sharing, defined benefits, premium subsidies and tax incentives, competition in the health insurance market, who should be covered, who should provide coverage, and more.*
- *Premature tinkering that leads to an outright repeal or federal preemption of the act would likely have a disastrous impact on health care coverage.*

**Now** – State to end practice of using “emergency hire” designation to avoid provision of health insurance to certain long-term workers.

- *Detrimental to the health of those workers; appearance of a double standard in light of the state’s mandate for all other employers.*

**2003** – State, if supported by findings of the HUP study/dialogue, draft and pass legislation amending the Prepaid Health Care Act. Obtain an ERISA waiver to allow this law to avoid federal preemption.

- *With some creative thinking and adherence to its basic principles, the Act has the potential to cover many more working people in a more fair and efficient manner.*

## Government Insurance

**Now** – State to expand government insurance eligibility and operational capacity to ensure that all children are covered.

- *Substantial federal match via CHIP is possible; children are particularly devastated by the effects of uninsurance; state Medicaid staff currently stretched to limits of capacity.*

**Now** – State to expand QUEST to pregnant immigrants barred from federal programs.

- *Although there is no federal match it is likely to be more cost-effective than leaving pregnant women and their unborn children uninsured.*

**Now** – State to provide matching funds to access TANF “Delinking” funds to increase outreach, education and enrollment.

- *Could help improve government program accessibility and help relieve severe resource constraints that are hampering Medicaid staff; large federal match.*

**Now** – State to address administrative coordination and process issues that lead to non-enrollment of eligible people in need of services. These include application process barriers, language barriers, and understaffed and underresourced Medicaid offices.

- *Frustration is rampant among community, service organizations and state workers.*

**Now** – HUP to organize comprehensive analysis of Medicaid/QUEST scenarios

- *Instead of continued tinkering, a full analysis could provide needed guidance for lingering questions of appropriate eligibility criteria, enrollment procedures, reimbursement, benefit structures, maximization of federal dollars, etc.*

**2003 and beyond** – State, based on recommendations from the process above, draft and pass legislation on government-sponsored insurance to compliment employer-based coverage and take maximum advantage of federal matching funds. Obtain necessary federal waivers to implement these changes.

- *In conjunction with the Prepaid Health Care Act, a well designed Medicaid/QUEST program could lead to cost-savings and coverage for virtually everyone in Hawai‘i.*

## Safety Net

**Now** – Various stakeholders to begin coordinating points of information for people seeking insurance and health care.

- *Near consensus from the community that this is a problem.*

**Now** – State and private funders to identify and commit funding and other resources to sustain and build the capacity of the safety net.

- *Preexisting unmet needs exacerbated by events of September 11; safety net provides critical “last chance” services.*

**Now** – Various stakeholders including the state, to address deficiencies in dental health, mental health, transportation to care, rural health, chronic disease and other major points of inadequate health care access. Solutions may or may not be insurance based.

- *Near consensus from stakeholders that these are much more than “special interests” but in reality are serious public health problems.*

**2003 and beyond** – All stakeholders, after changes to the Prepaid Health Care Act and Medicaid/QUEST have been determined, identify any gap groups which are still uninsured. Design and implement public, private, or collaborative programs to cover these groups.

- *Action is informed by other processes outlined above; purchasing co-ops, high-risk pools, and other ideas merit consideration.*

### **The Hawai‘i Uninsured Project – Specific Actions**

**Now** – Continue to monitor and disseminate information on other efforts in Hawai‘i and elsewhere.

**Now** – Continue to provide access to local and national experts.

**Now** – Continue statewide community outreach, public relations, key leader meetings and media appearances to provide consumer education and to raise awareness and participation in the issue.

**Now** – Continue to develop implementation plan and proposal for a three-year \$1.5 million Robert Wood Johnson Foundation demonstration grant.

**Now** – Develop a proposal for a \$1.3 million HRSA grant in conjunction with the University of Hawai‘i, other researchers and the state. The purpose is to conduct much of the needed research that could include economic modeling, community specific research and consumer focus groups.

# POLICY SUMMIT – OVERVIEW

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*November 29, 2001, Hawai‘i Convention Center  
Conducted by the Hawai‘i Institute for Public Affairs*

## ► **Background on Summit Convener**

The Hawai‘i Institute for Public Affairs (HIPA) is a nonprofit, nonpartisan and independent research and educational organization whose mission is to provide research, analysis and recommendations on public policy issues facing Hawai‘i and the global community, and to provide opportunities for individuals to develop as productive leaders and citizens in society. As part of its organizational capabilities, HIPA provides a neutral forum to brainstorm ideas and resolve complex issues. HIPA facilitators and mediators provide an environment to resolve disputes between agencies, organizations, communities, and the public and private sectors.

HIPA was asked by The Hawai‘i Uninsured Project (HUP) to serve as a neutral convener in the development of policy recommendations to reduce the number of uninsured people in Hawai‘i. Recognizing that there are many competing interests in dealing with health insurance coverage, HIPA was ideally positioned to convene key leaders for a reasoned, facilitated discourse.

HIPA designed and implemented all aspects of the summit, including sending invitations, designing the panel discussions, coordinating the research and policy presentation, registration and event coordination.

It was imperative that key leaders from all groups be represented at the policy summit. A guiding principle of the project is to reach out to communities, special interests, individuals and organizations that need to be “at the table” in order to have the broadest possible discourse.

## ► **Designing the Policy Summit**

HIPA convened a summit work group to solicit feedback from key leaders in business, labor, government and the community. Participants included: Rich Meiers (Healthcare Association of Hawai‘i), Dr. Virginia Pressler (State Department of Health), Na‘unanikināu Kamali‘i (Papa Ola Lokahi), Tony Saguibo (Laborers International Union), Louise Liu (Office of Congressman Neil Abercrombie), Dr. Peter Adler and William Kaneko (Hawai‘i Institute for Public Affairs), Andrew Aoki and Piilani Pang (HMSA Foundation). A planning meeting was held on August 23, 2001 to better understand past efforts in reducing the number of uninsured, and to develop an effective process that would ensure that policy recommendations would actually be acted upon.

Major efforts in the past decade that sought to reduce the number of uninsured people did not lead to significant policy changes. One reason, their efforts stopped short of implementation because of an inability to convince the State Legislature to enact laws and increase fiscal resources to expand health insurance coverage. It therefore became crucial that HIPA work to broaden the base of support for HUP and to ensure key leader participation.



The summit planning group helped HIPA determine the desired summit outcomes:

- To understand Hawai‘i’s uninsured issue, and its impact on society
- To develop and prioritize policy recommendations and strategies
- To build inspiration and political will to solve the problems

## ► **Efforts to Build Support**

The uninsured problem in Hawai‘i is a hidden one. It has not been a priority amongst the general public and community leaders. Although about 120,000 people in Hawai‘i are without health insurance, there is a lack of public awareness and political will to adequately create change. One of the key elements to ensure that policy recommendations will be acted upon is to elevate the uninsured issue to the forefront of the public policy agenda. Media, public relations, community outreach and key leader meetings became an essential component of the conference and continue to be an overall HUP strategy.

To increase the awareness of the uninsured problem, and thus enhance participation for the summit, the HUP Partners Program was launched to enlist key organizations and leaders that would provide a base of support.

Meetings were held where HUP staff provided an in depth overview of the project and solicited support and participation. Some of the meetings that were held include: U.S. Representative Neil Abercrombie, Guy Fujimura (International Longshoreman Workers Union), Russell Okata (Hawai‘i Government Employees Association), Jim Tollefson (Chamber of Commerce of Hawai‘i), Carl Takamura (Hawai‘i Business Roundtable), Pat McManaman (Na Loio), Sr. Ernest Chung (Catholic Charities), Murray Towill (Hawai‘i Hotel Association), Irving Lauber (Aloha United Way), Rochelle Lee Gregson (Hawai‘i Community Foundation), State Senator David Matsuura, and many others.

## ► **The Policy Summit**

Approximately 160 participants representing virtually every key constituent group attended the November 29 summit. Key organizations representing labor, health plans, governmental agencies, business organizations, academia, health providers and clinics, and uninsured people were present.

There were three major components of the summit: 1) Presentation of research, data and policies on the uninsured; 2) Commentary from national experts on the uninsured issue; and 3) Development of policy recommendations to reduce the number of uninsured in Hawai‘i.

In the opening session, Malaya Rogers, a health policy analyst, and Dr. Susan Forbes, President of the Hawai‘i Health Information Corporation, presented a fact-based understanding of the uninsured problem in Hawai‘i and the nation. Linda Colburn, a community facilitator, provided a summary of qualitative evidence that she gathered from the community. The presentation provided baseline information that would enhance the level of decision-making to follow in the afternoon session.

Also, a panel of experts was assembled to provide conference participants with a national overview of programs and policies that are in place in other states. The proceedings of the summit, including excerpts from their remarks, are contained in this report.

# INFORMATIONAL BRIEFING

## *Edited Transcripts from the Policy Summit*

### ► **Data Collection and Summary**

**Susan Forbes, DrPH**, President, *Hawai'i Health Information Corporation*

We started this effort more than a year ago with the thought that there were multiple instruments used to collect information on the uninsured and none of them were perfect. After the last summit, we decided that there was more work to do in digging down into the data that already existed. The point with the information is not, “Is it exactly right?” It is “What kind of picture do we create and how can we support action?” We don’t want to get stuck in the data. We want to move forward. And that has really been the effort this past year.

Certainly there are several survey data sources: CPS data, the Census Bureau, Behavioral Risk Factor Surveillance System (BRFSS) data collected by the CDC, and the Hawai'i Health Survey through the Department of Health. There is also utilization data from hospitals. The Hawai'i Employers Council provided some benefits data. And there is program data, such as that from the Department of Health and the Hawai'i Primary Care Association. A lot of what I'm going to bring up as percentages here come from the Hawai'i Health Survey.

Some of the key findings:

40% of the uninsured, about 47,000 people live on the neighbor islands.

26% of the uninsured, or about 30,000 work part-time or cannot afford premiums.

21% of uninsured adults are unmarried males under the age of 29. They are three times more likely to be uninsured than all other adults and may be in the group that says “no need, I'm healthy!” They are also in the group that is in motorcycle accidents and things like that.

19% of the self-employed are uninsured.

We have several myths related to the uninsured, and some of them were myths that I held firm before starting this process. One is that there are very few people in Hawai'i that are uninsured. We homed in on a range, 9% to 11% of the population is uninsured. So we are talking about close to 120,000 people who don't have health insurance in this state. There are multiple sources of data that are pointing to a similar number.

The second myth is that those who are uninsured are usually poor and unemployed. That's not quite true. 43% of the uninsured are adults at 100% to 300% of the federal poverty level. They are certainly not rich, but they're also not technically poor. 24% of the uninsured exceed 300% of the federal poverty level.

There is a third myth is that most people without health insurance choose to be uninsured. This is absolutely not true. There are a few people that don't want any of you to know about them, and they don't believe in doctors or don't like doctors, they don't like health plans, or they have a religious reason for not wanting to be involved with health insurance. But this group is a very small portion of the population.

A fourth myth is that the problems don't affect those who are insured. They do. Uncompensated care—bad debt and charity care faced by hospitals—is substantial. We're talking about nearly 93 million dollars in this next year. It threatens the viability of the institutions that we rely on for care.

The final myth is that a person's health does not suffer as a result of being uninsured. We have plenty of national research that shows that if people don't have health insurance they are less likely to go to the doctor for health maintenance, or they may delay going to the doctor when they are sick. So, at the point when they are really, really sick, they may end up in the hospital. What we also see from the survey research is that the uninsured are twice as likely to smoke. Smoking has huge consequences. The uninsured are also more likely to be depressed, downhearted, and blue; and, I am probably getting you depressed with this, but it's true.

## ► **Public Policy Models and Strategies**

**Malaya Rogers, MPP, MPH, Researcher, *The Hawai'i Uninsured Project***

My task today is to try to convey some of the enthusiasm that I got doing this research on what some of the strategies were to address the uninsured in other states. I am going to try and convince you that there are solutions out there. The problems are multiple. The solutions are multiple. Maybe the solutions are complicated and sometimes expensive but, nonetheless, other states have demonstrated some solutions.

There is no one solution. States use a variety of methods that are appropriate to their situation, and the result is a patchwork of strategies. Hawai'i can respond to the problem in a variety of ways. We can choose strategies that build on our strengths and that can address our weaknesses; we can put our own patchwork of solutions that best reflect our capabilities, our values and our desires for the state.

Over the past three months, I looked for state strategies that were feasible, that were properly targeted to reach the uninsured, that appeared to affect large numbers of the uninsured and that seemed adequately funded. And I also looked for those strategies that had potential for Hawai'i. My work shouldn't be considered definitive analysis of all of the strategies. I think that would be impossible to do because states are doing so many different things.

I organized the research into five broad categories of strategies. The first is expanding federally-funded health insurance programs. Many of you already know that there are federally-funded programs available to the state—the largest example being Medicaid and SCHIP. Hawai'i hasn't used its full share of these funds. There is one estimate that said in the year 2002, Hawai'i is estimated to use only 11% of its SCHIP allotment. Hawai'i could expand existing federal programs by raising income levels, by disregarding assets and earnings to make more people eligible, by extending eligibility beyond current levels to cover more of certain categories such as parents or children, and changing benefits and cost-sharing arrangements so that more people could be insured.

The second category is state-only programs. There are many states with programs that don't have the benefit of federal dollars but have the flexibility for the state to respond to important issues in the community. For example, we could decide to cover immigrants in a way that is state-run, state-designed, and state-financed.

The third category is to build on employer-based coverage. The majority of the insured, both in Hawai'i and nationally, get their insurance through their employer. In Hawai'i, 83% of the population have employer-sponsored insurance. One strategy is to build on this base and allow more employers to offer health insurance to their employees and to enable more employees to take advantage of the insurance that is offered by their employers.

The fourth area is to reform the health insurance market. Federal and state laws govern how health insurance is marketed and sold to employer groups and individuals, and certain characteristics of the market make it difficult for some people to get insurance. Reforming the current laws by creating new mechanisms or venues for purchasing insurance, or changing restrictions on how insurance is sold, may make health insurance more affordable and more available to more people.

The fifth area is shoring up and expanding the safety net. The uninsured obtain direct care from community health centers, hospitals, and physicians who often provide this care without compensation. Charity care is limited and expensive, and it must be bolstered with additional financing and support in order to continue.

These five broad, strategic areas are not mutually exclusive, and many states are putting together their own patchwork strategy. One group in Colorado has proposed a plan that involves three different approaches: expanding existing private health insurance and public coverage programs, establishing a prescription assistance program, and establishing a voluntary universal health insurance program.

National surveys indicate that the general population believes that more people should be insured, even if it meant additional government spending. I think most of us in this room believe that we can change the lives of many by creating opportunities to obtain health insurance. We have the desire and the capability to make a difference and create a better system for Hawai'i.

There's no doubt that this is a very complicated problem. There is a lot more work that needs to be done, and this is, indeed, a process that is not going to be solved overnight. What is needed is a commitment of time and energy to address this problem.

## ► **Statewide Community Forums and Feedback**

**Linda Colburn**, Community Facilitator, *The Hawai'i Uninsured Project*

We set about the task of convening discussion groups across the state that would, basically, pose the general question: "Have you or do you know someone that has been uninsured, and can you tell us what that's been like for you or those other people?" We intentionally sought to meet with diverse groups—state program staff, practitioners, consumers. We met with people who didn't have something better to do but were in the vicinity. We had some urban and some rural discussions. Comments were transcribed and are being reviewed and will continue to yield useful information as we go forward. We created a web site to gather and disseminate more information. We also developed a survey, which could be distributed more broadly in the community for those who might not be able to attend the discussions.

Perhaps the best way for you to get a sense of it is to have one story shared with you directly. We have an individual who flew over on the first flight from Moloka'i this morning in order to be here. Her name is Linda Johnston. Linda is a self-employed artist and has resided on the Island of Moloka'i for 11 years, and she has agreed to share with you some of the things that she shared with us.

### **One Person's Story**

My name is Linda and I'm uninsured. I used to have health insurance under my ex-husband's plan, up until about five years ago, and I always thought I could easily get health insurance. I became self-employed about three years ago and realized that it would be a good idea to have health insurance. Otherwise, if something happens to me, I'm in deep trouble.

So I started to explore. Being self-employed, I'm very determined and diligent. Well, the result here was severe disappointment and frustration, because I had trouble even finding insurers that carried anything that would apply to me as a sole proprietor. I did find one that offered an individual plan but they don't cover Moloka'i. I discovered two that would consider carrying me, but I was told that, as a sole proprietor, I would have to be underwritten. The people on the phone with those two companies were very encouraging, very helpful, very informative. They sent me the forms, which were very complex. I was asked to, at my own expense (which I calculated to be \$300), provide copies of my medical records outlining my present health status as well as all labs, x-ray reports, diagnostic test results, any surgical pathological reports, and all progress chart therapy notes for the last five years. Your doctor's

report must include specific diagnoses, dates, and types or treatment rendered as well as prognosis or status of treatment rendered. Also, there was no guarantee that I would get health insurance after that, and I would also be subject to a telephone interview.

What I thought was going to be easy because of Hawai'i's, perhaps, past reputation of being an excellent state for health care, proved to be very, very difficult. Being very busy as a sole proprietor makes it even worse.

When I submitted whatever I could, I was rejected. I was in shock. I wrote a lengthy letter describing my general health, which has been extremely good, and I got a letter back saying they rejected me again. The reason was because I didn't have a HIPAA certificate (whatever that is). I didn't have previous coverage, so I couldn't get health coverage.

I then found out about QUEST. So I called a couple of numbers (because there are several listed in the directory) and I found it impossible to find out what the qualifications were to get QUEST.

One company told me, "Well you can get a job and if you work over 20 hours a week, they would automatically have to cover you." Well that would mean giving up my 80 hour a week business.

I don't have health insurance. I'm uninsured, and I would ask you to please include me in your prayers that nothing happens to me until I can get it. Thank you.

I think you can appreciate some of the ironies in her story. If an articulate, well-educated, professional person has encountered these kinds of difficulties and felt discouraged, I don't think it takes a tremendous amount of imagination to appreciate how difficult it might be for someone who may be non-English-speaking, perhaps unschooled and unfamiliar with the systems.

We came across many examples of things that don't work as well as they could and the way they're supposed to. Clearly there are times when caseloads or lack of training for line staff limit their ability to share accurate information or comprehensive information to people who are seeking legitimate answers to their questions. There are a few wrinkles that we found that were kind of unique to the islands. One, for example, is the local practice of hanai, or adopting youngsters. Care responsibilities for those children can be complicated when you are trying to explain that to a system that doesn't recognize a non-legally determined relationship. There are some issues that pertain to what are called "kuleana lands" that are handed down from generation to generation to Hawaiian families; and, if a person has an undivided interest, that land value may make them ineligible for certain kinds of coverage.

After hearing so many compelling stories, one thing that struck me is worth mentioning to you—a lot of people were grateful that they were asked. A lot of people just appreciated that there was recognition that it's an issue and they appreciated the opportunity to say what their needs were. Talking to the community revealed things that would not require comprehensive revamping of the system but simple things that we could do within our current operating strategies. Just doing some things better and a little bit more effectively. The last thing I would leave you with is that there is an extraordinary resilience out there in the communities, which have varying economic and socioeconomic profiles. On the neighbor islands, in particular, there's a kind of resilience and perseverance and creativity and flexibility that is really quite heart-rending. And, that has worked well for communities that have bent the rules or have circumnavigated the systems in their own ways in those smaller areas, but it's become increasingly difficult for them to do so, as the overall economic conditions in the state have remained stagnant. So, there's a lot of wherewithal out there and desire to take care of the families, but it's just getting harder and harder to do that as the resources available to folks are continuing to contract.

# LESSONS LEARNED

## *Edited Transcripts from the Policy Summit*

### ► Across the United States

**Jeremy Alberga, MA**, Associate, *Academy for Health Services Research & Health Policy*

I'm here to talk to you about the 30,000 foot view of what's going on in the other 49 states and the District of Columbia. As I understand it, your state is facing some serious economic difficulties. After the first couple of minutes of my talk, you will not feel as bad because you're in good, or for that matter, bad company.

There are still 15% uninsured in this country—about 38 million people. About 10 years ago, there were a lot less people but there were still 15% uninsured. So, in spite of all of our incremental efforts over the past decade, we're still at 15% uninsured.

After several years of budget and revenue growth in the states, 44 states are now facing massive budget shortfalls. These, of course, are exacerbated by the tragic events of September 11. As a result, states are being asked to bear the brunt of increased homeland security costs and increased caseloads in their public programs for those who are losing their employment. The states that have been particularly hit are those that depend on tourism and those that depend on the airline industry.

The National Association of Budget Officers has found 44 states below forecasted levels for their budgets this summer—before September 11. They were forecasting that state revenue growth would be about 2% per year. With everything that is going on, states are looking at about a 15-billion-dollar shortfall next year.

States have a couple of options when faced with a budget shortfall. They can increase their revenue collection. For example, they can increase taxes—not exactly a popular move right now. States are also thinking about turning to the federal government to increase their match for public programs. There is something called the Federal Matching Assistance Percentage (FMAP). Basically, the federal government pays a certain share of each program. For example, on Medicaid, the federal government might pay \$0.55 on the dollar and your state will pick up \$0.45. States are also looking to do two other things, 1) tap into rainy day funds and 2) tap into tobacco settlement funds.

The other thing states can do is decrease expenditures. For example, looking at hiring freezes and convening special legislative sessions to cut budgets. What exactly should get cut and what is getting cut?

Well, I'll tell you that some of the biggest culprits out there are public programs, like the Medicaid program. The Medicaid program tends to be about 15% of the state's expenditures. So, out of every dollar that the state spends, about \$0.15 of that is on the Medicaid, QUEST, SCHIP programs.

Now, as I mentioned, state expenditures are growing about 2% a year. The Congressional Budget Office has said that over the next couple of years, Medicaid budgets will grow about 9% a year. 2% and 9%; it doesn't jive, does it? So, to answer the question about why are costs so high, I'm going to give you three particular reasons, specifically with regard to public programs. But, I can tell you that these three things are also driving costs in employer-based insurance.

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**State expenditures are growing about 2% a year... over the next couple of years, Medicaid budgets will grow about 9% a year**

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The first is healthcare cost inflation. Increasing technology, aging population, the cost of pharmaceutical drugs are three that are really driving healthcare cost inflation.

The second is marketplace changes. The managed-care revolution is coming to an end. The managed-care savings that everyone was so excited about have been bled dry, and it is no longer the be-all end-all of saving the healthcare system. There are also workforce issues, nursing shortages and increasing provider rates. With managed care bottoming out, providers, hospitals, and doctors are saying, “I’m not going to take this reimbursement. 65% of what I normally get paid at commercial rate is not acceptable.” This is also driving up costs.

The third impact on costs is increasing program enrollment. For example, all of the Medicaid, SCHIP and other expansions over the last decade combined with the fact that as people lose their jobs they are going to increasingly come on to public programs, drive up costs.

How are states dealing with these high costs? Some are rolling back eligibility. States like Florida are covering pregnant women at 150% of the federal poverty level, instead of covering at 185% as they once did. The second thing states are doing is lessening benefits. There is new federal flexibility from the Bush Administration called HIFA (Health Insurance Flexibility and Accountability Initiative) that is allowing states to use some of their leftover SCHIP dollars to decrease benefits for optional populations. These are the non-categorical eligibles or expansion populations, like the QUEST population. States are also looking to limit pharmaceutical costs. They are using formularies and new purchasing schemes, to try to decrease the costs of drugs. States are also increasing disease management programs and care coordination programs. They are monitoring people with diabetes trying to take care before it gets really expensive. And, finally, states are increasing their fraud and abuse monitoring.

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**Rolling back public programs has significant consequences. When you decrease a public program that receives federal dollars by one state dollar, you lose up to three dollars**

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Unfortunately, rolling back public programs has significant consequences. I mentioned the FMAP. When you decrease a public program that receives federal dollars by one state dollar, you lose up to three dollars of federal funding. So, if you decrease QUEST by a million dollars, you will potentially lose three million dollars in federal financing. That has a real downstream impact. Why is that? Well, if you don’t cover those people, where are you going to see them? All you people out there who are safety net providers—you’re going to see them. Providers—you’re going to see them. Eventually, it’s that thing called cross-subsidization and cost-shift. Someone has to pay for it, and it could end up back on the state’s back or it could end up on the provider’s back. In any case, you’re losing that federal match.

There is also a really difficult trade-off with cutting back public programs. There are a lot of people right now who really need public programs. People are losing their jobs and they are falling back on Medicaid and other public programs to give them insurance.

That’s the end of my grim talk. There are some optimistic points I want to make. I think we are at “a teachable moment.” First of all, both federal and state governments are recognizing that this is a real problem. Secondly, that the public—which is what really counts—is starting to realize “Wow, my drugs are really expensive. Wow, it’s really getting expensive for me to cover my family premium. Wow, I’m really close to losing my health insurance.”

Here are a few of the things that states are doing without that much money. First, states are maintaining and enhancing existing public and private programs. States are, what we call at the State Coverage Initiatives Program, “tinkering around the edges”. They are finding rural populations and groups that need to be approached in a culturally sensitive way to market to them properly. They are not expanding coverage, but rather enrolling those who are eligible but not enrolled. You have spent 30% of your SCHIP dollars. There is a lot of money left out there to not only enroll those people who are eligible now, but also to educate people about their options in the private market. The lady who spoke an hour ago was

saying “This is confusing, I don’t understand it, no one’s helping me.” A lot of states are thinking about public offices that will educate people about their options in the private market.

Secondly, states are leveraging community resources to support the safety net. There are providers who are willing to say, “Well, instead of getting nothing, I’ll take 50% of what I’m normally paid. It’s better than nothing.”

Thirdly, states are taking advantage of federal flexibility. They are using their unused SCHIP dollars to adjust existing programs. They are creating more affordable packages for people by decreasing benefits and offering a preventative care benefit. The new administration has two former governors, George Bush and Tommy Thompson (the U.S. Health and Human Services secretary), who are trying to help states be creative and innovative with public programs. In Hawai‘i, you might have an island with a particular problem. Will the federal government allow the State of Hawai‘i to go to Moloka‘i and say, “We’re going to target the problem in Moloka‘i, because this is a particular problem in that community”?

Finally, states are looking at insurance market reforms—pooling workers into state employee pools, reinsurance strategies, pooling self-employed workers and the young invincibles (19- to 25-year-olds). A couple of states are thinking about allowing these people to stay on their parents’ plan. So there are a lot of things states can do right now without necessarily spending a lot of additional state dollars.

## ► The Colorado Experience

**Barbara Yondorf, Yondorf & Associates, Denver, Colorado**

I’m a private health policy consultant with my own business. I am self-employed and lucky to live in a state which has guarantee issue for business groups of one. Anyone who can’t get insurance in either the individual or the group market always has a fallback of a high-risk pool.

Colorado formed something called the Colorado Coalition for the Medically Underserved about two years ago. This is a group of people, much like yourselves, who said we have to do something about the uninsured. Although government participates in the process, it is run independently as a nonprofit venture. The coalition has more than 150 organizations. It has legislators, business, consumers and providers—all the usual suspects. And we’ve made a very concerted effort, much like yours, to have a deliberative process for figuring out what we want to do in Colorado. Colorado’s uninsurance rate is in the 12% to 15% area, so we’re better than the average state in America. What’s interesting, though, is in our state the problem of the uninsured is probably more of a public sector problem. Although we don’t have an employer mandate, we actually have about the same percentage of our population covered by private insurance as you do. And, let me just say, the very best way to solve the problem of the uninsured is to have a booming economy and no unemployment. That’s more effective than anything else that we can talk about today, and Colorado has been blessed for the past two years with effectively a booming economy and relatively low unemployment. We have 4.3 million people and about 500,000 uninsured.

So, what was our process? The coalition formed and said we want a community-based process. One of the first things we did was a detailed analysis of affordability of coverage. How much does it cost, what are the options, what does a family’s budget look like at different income levels, and at what point could you say that really a person is self-insured? There are people, who make \$100,000 a year and don’t have insurance coverage, and we in Colorado don’t worry about them. So, we did a whole analysis that showed, of course, that the biggest problem people had was affordability of coverage. The vast majority of people who have insurance coverage (like 95%) have it either because they have a substantial employer or government

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**The vast majority of people who have insurance coverage (like 95%) have it either because they have a substantial employer or government subsidy**

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subsidy. There are very few people out there who say, “Yep, I can afford this \$250 a month premium for myself alone or \$750 for a family.”

We then looked at the options and I did a piece for Colorado called “Five Options”. We held community meetings all over the state, with fairly good turnout and spent a lot of time educating the public, getting their input, asking them what they thought about the options, and soliciting community values. We did a detailed examination of that and I was hired to help write a plan based on the feedback. We then developed a policy framework and took it back to the community and said, “This is what we heard you say; was this right?” We’re just finishing up that round and it looks like in the community meetings we are getting 75% of people saying unreservedly we support your policy framework.

We found somewhat surprising support for a single payer system, but we also found a bunch of people who said “over my dead body.” We said, “It’s doable, it probably wouldn’t cost more than we’re spending now in healthcare, and all you would have to do is raise the Colorado income tax by 300%.” We didn’t think it was viable. They said that we don’t want an individual mandate; we don’t want an employer mandate; we are concerned about the safety net; we want you to build on existing public and private programs.

The three basic elements of what we’re doing are expand existing public and private programs, build on what we’ve got, give people choice. We heard this over and over and over again, so we are going to try and build a model that says, “You can either join the expanded Medicaid program *or* get a voucher to buy coverage on your own *or* get a tax credit to help pay for coverage; and, we’re not going to make the decision for you; as long as it’s cost neutral, you can do any one of those.”

And the final piece is what we call a voluntary universal health coverage proposal—trying to do something for the third of the population who actually look like they want to move to Canada. To try and do a program that people could move into and once they’re in this purchasing pool, they can stay in it forever, and the purchasing pool will worry about whether their subsidy comes from their employer if they’re employed, from Medicaid if they become eligible, SCHIP if they become eligible for SCHIP. If they change employers and their new employer doesn’t participate in the pool, we would seek a federal waiver to ask that new employer to have to still contribute to it.

## ► The Oregon Experience

**John Santa, MD, Office of Health Plan and Research, Salem, Oregon**

It’s a privilege to be here for a couple of reasons. As you’ll hear, we’re in the midst of very intense work with all of our stakeholders over waiver issues. We’re down the track and it’s a very complex process. It’s

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**I would die to be in a state that has an employer mandate and a no-risk exemption. You have some enormous advantages here, and you have an obligation to move that ball forward, just like we did**

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wonderful to be someplace where I can actually talk more about what’s actually going on and how I actually feel. It’s also a privilege to be in another state that, I believe, has an obligation. Because of what Oregon’s done over the last 20 years and because of who our governor is, many feel that we have an obligation to push forward and to test various decision-makers. So do you. I would die to be in a state that has an employer mandate and a no-risk exemption. You are also in a state, like ours, that is still predominantly nonprofit when it comes to your insurance industry and your hospital industry. You have some enormous advantages here, and you have an obligation to move that ball forward, just like we did.

Oregon’s situation shares many of the features you’ve heard earlier; our rate of uninsurance, after a decade of success, has risen; we’re probably around 12% (better than average but we’re not very happy

given the obligation we feel). Our economy is in recession. We have the highest unemployment rates in the country. Our political landscape is uncertain because we have one more year of a very charismatic and innovative leader who will be leaving state government. And, we have term limit and redistricting issues that make it very difficult for the state to imagine the legislature continuing to play a leadership role. Everything that we're doing was passed in the last hour of our legislative session. So things are very, very tough even in a state which you might think is a health-policy Disneyland.

The coalition, which has been built over the last 20 years, is very fragile. Concerns have emerged among advocacy organizations and hospitals. You are very fortunate this morning to have an uninsured person actually talk to you. We had two hours of testimony on our proposal. Advocates filled a bus with individuals from the coast all testifying how concerned they were as people who had benefits—that they might lose them. There was not an uninsured person among them. As a person relatively new to state government but not new to healthcare issues, it has been a surprise to me how little traction uninsured people really have, how little representation they really have. We all need to do some soul-searching about whether we really represent the people who have nothing, or do we really represent people who have something?

I think our approach can be summarized in a very few words, and this really is our Governor's philosophy: We believe resources are limited. They are limited for us as individuals; they are limited for our families; they are limited in our communities; they are limited in our state; they are limited in our country. Resources are limited. Therefore, we believe everybody needs to be in the tent. Until everybody is in the tent, it's going to be difficult—if not impossible—to solve the problems we have, and the first priority should be to get everybody something. We think this should be done in an explicit public decision-making process. When the rubber hits the road, many of you represent organizations where your power and your influence is far more substantial in the corridors of the legislature, in the corridors outside of meetings like this, and it's interesting to see how that process happens. That's not what we mean by a public explicit decision-making process.

Finally, we believe the most significant barrier to success is often the federal government. It's a privilege for somebody from one odd state to be in another odd state. The federal government should be more flexible with us odd states. That's why your ERISA exemption is so extraordinary.

Essentially, we're testing those principals I just articulated. We're proposing that we reduce benefits for a portion of our Medicaid population and use those resources to expand. Even in an era of budget cutting, we believe that we should still try and get more people in the tent. We can do that if the federal government will be flexible (which they're indicating they will be). But, as you can imagine, a variety of very strong emotions come into play with that kind of a strategy.

That's where Oregon's at.

## ► The California Experience

**Tomiko Conner, MPP, MPH, *Community Voices Project, Oakland, California***

I work at the Community Voices Project in Oakland. We are a project of two community health centers, Asian Health Services and La Clinica De La Raza, which are the major health providers for the immigrant communities in the Bay Area, and also are also the leading advocates for immigrant communities statewide. The county of Alameda, both in population and in our demographics, are much more similar to Hawai'i than probably the rest of California.

California has an uninsurance rate of about 25%. It's a state of 33 million, and counter to what was said—that if you have high employment and a booming economy you're going to have good insurance rates—that does not ever hold true in California because of the way that our employment market is set up and

because we do not have an employer-based mandate. About 60% of the state is covered by employer-based coverage. Immigrant populations participate primarily in service and agricultural sectors that do not provide health insurance. And that becomes a systemic problem for the way that California deals with the uninsured.

In Alameda County, we do a little bit better. We're a population of 1.44 million. Our uninsurance rate is 16%, which is better than the rest of the state, but it's still a huge issue. When you disaggregate the data, we're looking at a rate of about 8% for Caucasians. But, if you look at the Latino population, particularly Mexican-Americans, new Mexican immigrants, and also in the Central American community, you are looking at rates of 45% to 50%.

The Community Voices Project is actually part of a larger collaborative, and that is what you're beginning to build here. Community Voices is a five-year project funded by the Kellogg Foundation. It is one of 13 sites nationwide. We work collaboratively with the Communities in Charge Project, which is another RWJ-sponsored initiative. I think that the successes in Alameda County addressing the issues of the uninsured really come out of a collaborative engagement. This collaboration not only includes community-based providers but also key county governmental officials, as well as the private and public sector.

I have highlighted that we work on issues around immigrants. That raises issues of cultural competence. Many people who work in a community-based setting recognize that just talking about insurance and giving somebody an insurance card is only the first step. You need to talk about issues of access and people's willingness to enter a system and their ability to work within the system and get the care that they need once they're in it. So, we work on those issues simultaneously—working on expanding eligibility *and* maximizing enrollment for programs that people are already eligible for but don't engage in (often because of issues of culture, language, and other access issues).

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**Many people who work in a community-based setting recognize that just talking about insurance and giving somebody an insurance card is really only the first step**

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In Alameda County we have developed two insurance products. One is called Family Care. It builds on our state Medicaid program and our State Child Health Insurance Program. We have tried to influence both the federal government and the state government to expand eligibility. But because there was such resistance following welfare reform in 1996, the county began to take on the issue itself and tried to create coverage for people who were otherwise ineligible for publicly funded programs. We took it from the perspective of the family unit. You'll have people living within a household who have varied documentation status. For example, the parents could be undocumented but the children are citizens. So when people interface with the public system, they may be putting themselves at risk. Their children may be eligible but they may not be willing to jeopardize their family's ability to stay in the United States. So the county and the Alameda Alliance for Health (our nonprofit managed care provider in the county) created a seamless system in which, if you were eligible for and willing to be in Medicaid or SCHIP, then you would be enrolled. But, if not, you can still enroll in a subsidized product that allows the whole family to participate in the health coverage. It does not discriminate based upon immigration status. Because the access points are through the community health centers who have the relationships, there is a trust that you're not going to be taken advantage of.

The other product, derived from this collaboration between a public provider and the county system, is group care. We are beginning to work on the issue that 53% of the people who are uninsured in the county are adults with nondependent minor children, meaning that they don't have an access point through a SCHIP or through Medicaid. We've begun to devise strategies that incorporate small business. We began with the in-home health supportive services folks and, working with their labor unions, have worked with the Alameda Alliance to create a health insurance product. So, that's how we're beginning to try to incrementally increase options.

## ► Questions and Answers

**Peter Adler, PhD, Moderator, *Hawai'i Institute for Public Affairs***

**Dr. Adler: What are some low-leverage strategies? What are ones where we might invest 80% of our time, energy and resources to produce a very low return rate?**

Dr. Santa: In our state, an employer mandate was “no way.” We actually did look at an individual mandate, but backed off because of the dollars; it would have cost four to five hundred million dollars to do it. At a minimum, states should be maximizing their SCHIP dollars because the match is so good and because of the new flexibility. Our Medicaid director put it like this: the Clinton administration—lots of money but no flexibility; Bush administration—no money but lots of flexibility. If you have SCHIP money left in your allotment, they’re going to let you spend it much more flexibly. Everybody should be doing that. No one quite knows how to leverage employer dollars as efficiently as possible but, if we can figure out how to do it, it should result in insuring a large number of people less expensively.

Ms. Yondorf: Let me just give you highlights of the study that Trish Reilly and I did a couple of years ago called “Lessons From Twenty-Five Years of Healthcare Reform.” I guess there are very few things that don’t work *at all*, but they can be extremely expensive for not getting a whole lot of bang for your buck.

Purchasing cooperatives were held out as something that would be fabulous; all purchasers would get together, exercise their purchasing clout and make a difference in the marketplace. That does not appear to have borne a lot of fruit. It may have other advantages like giving members of the group choice of insurance plans, but it doesn’t seem to have done much, probably nothing, as a strategy for the uninsured.

High-risk pools do a really good job for the handful of people who can’t get coverage otherwise, so it may be something that you want to do in your state; but, based on the numbers in other states, if you set up a high-risk pool, I’m guessing, at most, you’d have five or six hundred people in it.

There’s a continuing debate about medical savings accounts, but on the whole, there’s no convincing evidence that they’ve done anything about the uninsured.

Small group health insurance reforms appear, at best, to have had a marginally positive impact on uninsurance rates. The good news is, if they’ve benefited anyone, they’ve benefited the very sickest. If you do healthcare reform and you brought in 10,000 people who don’t need coverage, I don’t know exactly what you’ve done. And so, again, in Colorado and a handful of other states, we go down to business groups of one. So, the self-employed do have guaranteed-issue product. And on the margin, I think that’s helped but, again, these are not significant numbers.

Tax incentives, are really expensive and we just haven’t seen much evidence that those work. So, unless you have a *huge* tax subsidy, it’s not tax incentives. In Oregon it’s looking like under their Family Health Insurance Assistance Program (FHIAP), if you subsidize 70% to 95% of the premium, you probably can bring people in. But states that gave \$25 a month or \$50 a month in a tax credit or incentive (whether to the employee or the employer) haven’t made a significant impact.

One final footnote: It’s an interesting dilemma that we all have. When we count the uninsured, we’re also counting people who may be making good use of the safety net. In pockets of the community, the safety net may actually be serving people relatively well. We’re still counting

those people as uninsured when, in many respects, that may be one of the best options for those people. It's where they get their regular source of care. It's a trusted source of care. It's not a bunch of government bureaucracy. So, as you think about reform and you think about the safety net, if your goal is insurance coverage, they're not effective. But, if your goal is care, that may be one of the most effective things that you can do for some of the other populations where we're just wasting a lot of money marketing insurance to them when insurance is not something they're going to go for.

Ms. Conner: I just would add on to that. Part of our focus has been getting people who are already eligible for programs actually enrolled in programs. And that means that you have to take on assistance issues, not just the eligibility issues. So, we have a problem in Alameda County in that our health services agency does not administer enrollment into our Medicaid program. That's done by the welfare system, and that creates a huge barrier, because of welfare-stigma issues and because of how poorly our system is set up. So, we're trying to get on-site enrollment within the health centers where people are already being seen so they can be enrolled into programs that they are already eligible for, and they will have a greater willingness to actually participate in a public program because they are being enrolled by an entity that they have a certain amount of trust in.

Mr. Alberga: One thing that hasn't worked is the bare-bones plan. A lot of states have tried these plans where you slim down the benefits to just a preventative plan or just a catastrophic plan. They don't sell well.

Buy-in state employee pools tend to get a lot of pushback from the unions within the state employee plan. The unions think that a sicker risk is going to come in and drive up costs. In fact, state employees tend to be older in a lot of states, and bringing in these "young invincibles," might not be a bad idea, but it hasn't been accepted in very many states.

Finally, I want to put my colleague John Santa on the spot again. The Oregon FHIAP works very well, but it is a state-only program and right now a lot of states are saying, "We just can't afford to do that." I think Oregon is now saying to the federal government, "Hey, can you help us out with this?"

Dr. Santa: Actually, I sit on the board of the Public Employees Benefits Board (PEBB) for state employees in Oregon. We buy coverage for 100,000 people. Years ago, the legislature allowed certain groups to elect to come into PEBB and get coverage, including foster parents. We are opposed to anyone coming in to PEBB, and the unions are opposed because foster parents (only 10% of whom enroll in PEBB) have a loss ratio of 400%. So, we are subsidizing foster parents implicitly rather than explicitly, and we might be interested in groups coming into PEBB just like they come into insurers.

FHIAP is state funded. Our legislature has clearly said, "You guys have got to get matched for FHIAP or you're out of here." They've also said it's got to be more oriented to employer coverage than individual coverage. This is a program that subsidizes 4,000 people on a first-come, first-served basis. We just figured this out: about 30% of our inquiries come from people who have access to employer-based coverage but aren't taking it up. The other 70% can get individual insurance more quickly, get into the queue and get covered. This year we are going to stop that. We are going to give preference to people with employer-based coverage, and we're scrambling to try to figure out how to get matched, how to bring more people in, how to make that program more oriented to groups.

The third thing is we do have a high-risk pool. Very successful. We cover about 7,500 people. There are some controversies around it. Our enrollment has recently gone up because the insurer rejection rate for individual insurance went from 15% to 30%. It's a good mechanism,

because we fund it through premiums that people pay, and about 40% of the costs are an insurer assessment based on their market share. So, essentially, the insurers are paying the price if they reject more people. It's worked well for us.

**Dr. Adler:** **How do you get to the political will, how do you get enough consensus that you can move forward?**

Ms. Conner: The collaborative that we work in is rooted around the community-based health centers. Often community-based health folks are the people with contacts and information but they're not the ones with resources. Therefore, you lack the ability to get local or state government to move in a particular way. So, for me to say, "Get some money from national funders so that you have resources" is easier said than done. But being able to articulate what your needs are and putting community-based health centers and community-based efforts at the core of those initiatives is really very important.

We have a collaborative that works in the county, but we don't always have consensus. And, I think that in the regularized sort of process, you have to tactically find things that you can actually work on. We've taken advantage of the fact that we have the support of leadership who have been in the county for 25-30 years and who have been the leaders of our community health centers. That's where you find a lot of continuity—in the community centers.

Dr. Santa: I think, in our case, you really had to be prepared for the 20-year commitment. It's really nice to have some charismatic leadership. I think it's very important to spend as much time as you can getting folks to buy off on high-level commitments and principles. Avoid getting to specific solutions too soon, because specific solutions are where the money is. A principle is "everybody should be in the tent."

You can keep going back to your principles. The most important thing, though, is whatever you do there are going to be some winners and losers. One mistake we made was we didn't react quickly enough to the losers and re-equilibrate.

**Dr. Adler:** **For the sake of candor in our forum today, who are the losers?**

Dr. Santa: In our case, the doctors have really been committed to this process. With managed care and with a variety of other things, overall, they were the losers. Hospitals have done well. The advocates actually have done well. It's very difficult to get the advocates and the hospitals to re-equilibrate.

Ms. Yondorf: It's really important, then, when you design something, you try to have something for everyone. I certainly don't disagree that there are winners and losers, but try not to have a unilateral plan or approach where there are *clear* losers. In Colorado, there's a constituency group out there who already has coverage; they just don't have prescription drug coverage. They're loud and they're going to every meeting just to discover whether or not you did something for them for prescription drug coverage. And we said, "Yeah, absolutely, we'll do something for you for prescription drug coverage." I told you before that the literature pretty much shows that tax credits are not very effective unless they are huge. You know what? We've got tax credits in our proposal, because a significant minority of the people said "We love tax credits; we think tax credits sound great!" And we thought, well, you know what, they are either going to work or they are not going to work, and if we can structure them properly so we are not wasting a lot of money on people who already had coverage, then let's just let the marketplace work it out.

And a final thing I'd just say is planning is good but you have also got to do something. One of the things I keep harping on as a consultant to the coalition is that we have these big plans, but you've got to do something now. You've got to do something *this* session. You've got to do

something concrete, even if it's small, that moves it forward, that you can say to people, "We are doing something; we are moving in the right direction."

Mr. Alberga: What you also need is to have some good quantitative and qualitative data available. Quantitative data is fantastic but every single legislator will tell you what really hit them hard when they had a proposal shown to them—it was the personal story we heard today. This woman is a hardworking individual who is not poor and trying to do the right thing. We need to do something about this. So, the first point is good data, both quantitative and qualitative, and that exactly is what The Hawai'i Uninsured Project is doing.

Secondly, I want to pick on the insurers in terms of consensus building. You can't do anything without them. Barbara mentioned the Health Insurance Purchasing Cooperatives (HIPC). I can name you half a dozen states where HIPCs collapsed because the insurance companies were not at the table. I don't know how many of them are in the room right now, but they have to be at the table because they are the ones that are going to be selling and providing the product.

**Audience: In the care programs at the community health center, how do you deal with catastrophic illness?**

Dr. Santa: We actually have a waiver—a small one, just for four or five million dollars—at CMS asking that they allow us to provide safety net services to children who are presumptively eligible for SCHIP and to directly reimburse safety net organizations who are more accountable and organized. They are able to generate a bill, tell us the service they've provided for primary, and if they are organized, secondary services. This gives you a more manageable way to deal with presumptive eligibility. We don't have the money to declare all children presumptively eligible. We are trying to define a middle ground and get that match and get more flexibility around SCHIP money.

**Audience: I have two questions. Barbara, can you elaborate on long-term universal health insurance and what that is all about? The second is for Jeremy. Can a single-payer plan work at a state level without adverse selection?**

Ms. Yondorf: There's a significant group of people that would like something that looks like a single payer system. It can take two commonly discussed forms. One is a single payer and single delivery system, and the other looks like the federal employee health benefit plan where everyone has coverage but the private sector is still involved.

What we're trying to set up would look like a purchasing pool and you'd get in initially through employment. So far, looks just like any other health insurance purchasing cooperative. The difference is if you lose your job, you can continue your coverage and stay in the pool and the pool will administer COBRA for you. If your income falls to a level where you would be eligible for Medicaid or the Children's Health Insurance Plan or some other subsidized coverage, we'd get a waiver to allow you to continue in the plan that you're on, in the pool, with Medicaid paying into it. So, you've been in the pool, you've been in Kaiser, or whatever, and you want to stay on that, you get to stay on that plan. Now you get a new job and you're in the middle of some care (or your kids are); you don't really want to change plans and doctors. Your employer offers a plan but it's a different plan. The new employer does not have to join the purchasing cooperative, but what we'd like to do is get a waiver of ERISA to say the employer does have to make the same contribution that he or she would otherwise be making to your coverage for you to stay in PRO Colorado (it's Personal Responsibility Option for Colorado).

Over time, if this works, more and more people will join it and will want to be in it, and that we will, in a voluntary sense, start moving towards that sort of system.

Mr. Alberga: Vermont has just finished a massive analysis available on the web. The Lewin Group did an analysis of what it would cost Vermont to do a single payer system. They would fund a single payer system three ways: an employer payroll tax of 5.8%, an employee tax of 2.9% and funds from discontinued federal and state public programs. This would cost 2.2 billion dollars a year. There were some savings involved, but let me just point out two massive problems. The first, is getting a lot of federal waivers for the feds to give the state a bunch of money so they can use it on a single payer; that would be difficult. Secondly, politically speaking it would be extremely difficult, even in a state like Vermont, to get that passed.

**Audience: Should we target one particular group because it covers a lot of people or a particular group because it tends to be the highest risk and they tend to need the most help as soon as possible?**

Dr. Santa: Our experience is get your stakeholders and get your principles. Make an assessment of the politics in the state. For example, in our particular state, it's very difficult to do anything around undocumented workers or immigrants. Our legislature is focused on citizens. That's the hardest. When you assess that and try to get a sense of which of those subsets stakeholders will rally around, you usually end up with a subset of those populations and go forward.

**Audience: What is the potential for family care coverage to change the number of people that are insured?**

Ms. Conner: In Alameda County they opened the door to enrollment and originally capped it at 2,000. Enrollment began in July of 2000. They hit the 2,000 mark within three months and lifted the cap because we were anticipating that some of those parents would begin to be covered under the state waiver, which we're still waiting for over 14 months. We now have close to 5,000 people. The demand is clearly there, in terms of people wanting to have access to a product that doesn't look at immigration status but also is an affordable product. It's open to people under 300% of the federal poverty level. We have concerns now on how we are going to continue to subsidize it, given that the state waiver went through but the governor has basically said that the expansion wouldn't happen until July 2003. So, the county would be forced to continue to cover the costs in that program.

**Dr. Adler: I want to ask each of you for a final walk-away thought that you'd like to leave with our group?**

Mr. Alberga: I would just urge the group to continue to look at options that worked and, as importantly, that didn't work, around the country and to take advantage of the opportunities that are on the table now. Secondly, continue to take advantage of the support that is out there to help you, and that includes The Robert Wood Johnson Foundation. We continue to look forward to helping you out. The Kellogg Foundation and the federal government have significant funds to continue research and analysis. So, you are not alone, and I think that this is going to be a really interesting process.

Ms. Yondorf: In Colorado, what we're talking about sounds like an oxymoron but is "major incremental reform." Look at this huge turnout. I don't think you turned out to tinker at the margins, did you? To just do little stuff? But the other extreme—we had a vision called Colorado Care and we put a lot of time and effort into it. It was a major systems reform. Of course it was rational. Of course it was what the system should look like. It threatened way too many people, so we also spent too much time on that. So, we're trying to do something that's important, that's significant, but not take on the whole system.

I really applaud what you're doing. I think the turnout today is great. I'm one of those feisty women that Dave Barry, the humorist, talked about, and—you know what he said, don't you? "The problem with women is when given the choice between catching a fly or saving a baby,



the woman will make the choice without even asking how many men are on base.” And, in terms of my commitment to the uninsured, and I’m sure yours, I think we’re all going to save the baby.

Ms. Conner: I think that there’s a lot of work to be done on the margins, and when you do a lot of that work, it can be built into something quite large. When you have a group of people who have been fundamentally disenfranchised by how the federal government has decided to administer our health services programs, to say that you’re going to continue to work on the issue of the uninsured without dealing front and center with the issues of how we work with our immigrant communities means that you’re not dealing with the issue of the uninsured. You are only working on the margins when you don’t take on that issue.

Dr. Santa: Well, I’m mainly impressed because the environment here is different and much more potentially fertile because you have an employer mandate—that ERISA exemption. What is very difficult in small increments for us could be major incremental change here, because you have a very unique environment, and I would urge you to look at those solutions. I’ll just end by saying the same thing the senate president said to a smaller but somewhat similar group in Oregon a couple of years ago (and realize this is a Republican legislator). He said, “I look around the room. I see everybody here, and I can tell you with absolute certainty, if you can agree what you want to do, we’ll do it. You agree on what you want to do and bring it to us, it’ll get done.” The challenge is to agree on what you want done.

# RECOMMENDATIONS – TOP PRIORITIES

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The afternoon session of the summit was devoted to developing recommendations. Participants were asked to select a policy area in which they had experience, expertise or interest. Professional facilitators conducted the sessions with the goal of brainstorming ideas and prioritizing policy recommendations to be acted upon by The Hawai'i Uninsured Project. In selecting the top policy recommendations, the following criteria were used:

1. Achievable within three years
2. Applicable and achievable in Hawai'i
3. Capable of generating political will and public support
4. Will lead to significant impact on reducing the number of uninsured

## ► Expanding Federal Programs

- Standardize eligibility criteria for QUEST, financial and food stamp welfare programs
- Expand outreach and enrollment for SCHIP
- Develop community specific strategies based on disadvantaged data (quantitative/qualitative)
- Work with CMS to maximize SCHIP match, leverage employer-sponsored coverage, increase flexibility for match

## ► State-Only Initiatives

- Undertake a systematic re-examination of Hawai'i's Prepaid Health Care Act and make appropriate recommendations for changes in coverages and thresholds
- Focus on health care access as opposed to insurance by revitalizing Hawai'i's community health centers. Use those as key points of access for those in need of medical and health assistance and coverage help
- Undertake a highly organized outreach program to help locate those who need help and are unable or afraid to access it. For example, undertake an outreach program in emergency rooms

## ▶ **Employer-Based Coverage**

- Go back to Prepaid Health Care Act basic package
- Require employers to pay for part-time workers (pro-rata share)
- Allow for increase employee payment co-pay, premiums and extra coverage

## ▶ **Health Insurance Reform**

- Support creation of task force to study Prepaid Health Care Act to expand coverage
- Redefine the risk pool(s) to ensure that uninsured are included in the pool(s)
- Endorse purchasing cooperatives and facilitate their formation
- Increase competitiveness in the insurance industry

## ▶ **Expanding the Safety Net**

- Secure the safety net with “fast” money with an executive budget
- Find a creative way for health coverage for emergency hire workers
- Create big pool for small businesses
- Get consumers more involved in demanding health care

# RECOMMENDATIONS – DETAIL

“❖” indicates priority recommendation

## ► Expanding Federal Programs

**Miki Lee**, Facilitator; **Jennifer Creedman**, Recorder

### Greater Education & Outreach

#### ❖ **Expand outreach and enrollment for SCHIP**

- Central repository of information requested by potential recipients of services. Ability to route information to appropriate state agencies to decrease duplication
- Statewide toll free # for programs and website
- Make 40-year olds attend benefits workshops so they can plan for insurance needs. PartB Medicare, etc.
- Outreach: Finders fee to individuals and organizations for every child identified that is eligible and actually enrolls in SCHIP, particularly teenagers
- Better coordination and education at state entry points to look at various options for people accessing services and streamlining the process
- Cross-match children in DOE/DOH/DHS to do outreach; more targeted approach

### Eligibility

#### ❖ **Standardize eligibility criteria for QUEST, financial and food stamp welfare programs**

- Increase kid eligibility to 300%
- Increase eligibility payment for women—presumptive eligibility
- Immigrant pregnant women / immigrant adults
- Focus on healing families; multiple eligibility; sliding price scale
- Maximize state and employer approved dollars in SCHIP and Medicaid flexibility on benefits and eligibility
- Increase all eligibility to 300%

### Money/State Match

#### ❖ **Work with CMS to maximize SCHIP match, leverage employer-sponsored coverage, increase flexibility**

#### ❖ **Develop community specific strategies based on disadvantaged data (quantitative/qualitative)**

- Watch other state proposals; creative ways to get match
- Allow states to partner with private organizations to meet match requirement
- More grant \$\$\$
- Ask federal government to allow merge of Medicare and Medicaid funding streams
- Consider match ability of any assessment/tax-related to health care
- Leverage county, city and community sources of funds to match
- Subsidized premiums or program combined with existing federal/state programs to address family needs in a particularly community. Community may be geographically or ethnically, etc. defined

### Other

- State/Federal policy maker—collaboration
- Dental coverage
- Reduce # or make it difficult to sue health care providers

## ► State-Only Initiatives

**Peter Adler, Facilitator; Kanani Akina Lee, Recorder**

As a precursor to organizing long-term initiatives, or in tandem with them, the group urges HUP, HIPA, and other partners to continue to do rigorous policy analysis which looks at specific populations or demographic groups in Hawai'i. This further policy research must be the basis for additional actions and has been sorely missing.

- ✧ **Undertake a systematic re-examination of Hawai'i's Prepaid Health Care Act and make appropriate recommendations for changes in coverages and thresholds**
- ✧ **Focus on health care access as opposed to insurance by revitalizing Hawai'i's community health centers. Use those as key points of access for those in need of medical and health assistance and coverage help**
- ✧ **Undertake a highly organized outreach program to help locate those who need help and are unable or afraid to access it. For example, undertake an outreach program in emergency rooms**
- Voluntary Universal Health System
- Reduce Requirements for Health Insurance Coverage (ie: lessen hours for employer required coverage from 20 hrs to 10 hrs.)
- Limited Universal Healthcare for children and pregnant mothers
- 1996 Welfare Reform for Immigrants (ie: income qualified)
- Retroactive coverage for qualified QUEST/Medicaid recipients (ie: Wai'anae Coast Comprehensive Health Center per Rich Bettini's examples of people that qualify for coverage but too much red tape)
- Insure State Emergency Hires
- Insurance Utilization Usage Reform in relation to premiums (no incentives)
- Identify uninsured and reduce red tape—need to create or streamline tracking system (ie: Medical eligibility)
- Focus on Healthcare access as well as insurability
- Identify 38000 unemployed and uninsured—What's the impact?
- Create a high-risk pool (ie: self-employed group)
- Community-based information referral service (ie: assist in eligibility criteria)
- Set up Bounty Fund (ie: Washington Model)
- Tax incentives for employers
- Outreach program needed in Emergency Rooms
- Develop a program/plan to combine DOH and DHS re: health insurance
- Improve access to healthcare—need to press candidates
- Provide everyone by law a \$1000 tax credit for healthcare
- Increase Poverty Level Guidelines to 300%
- Prevention
- Qualify by Income threshold rather than using poverty guidelines
- Expand eligibility for Public Employee Healthcare Fund
- Long-term care program
- Create educational campaign on impact of uninsured
- Identify Uninsured and Why? (ie: part-timers, immigrants, potential QUEST eligible)
- Community-based data by utilizing community outreach workers

## ► Employer-Based Coverage

Robert Fazzi, Facilitator; Meryam Leong, Recorder

- ◇ **Go back to basic Prepaid Health Care Act package**
- ◇ **Allow for increase employee payment co-pay, premiums and extra coverage**
- ◇ **Require employers to pay for part-time employees (pro-rating)**
  - Allow employers to offer health insurance to part-time employees who work less than 20 hours a week; allows employers to extend COBRA benefits
  - Voluntary Universal Purchasing Cooperative
  - Extend coverage that parents pay for their children
  - Provide incentives to employers—tax benefits
  - Have a standard plan (for appropriate situation)
  - If possible to change PHCA, have a multiple plan
  - Everyone has to play by the same rules (referring to PHCA)
  - Create a pool where everyone is contributing (employer mandate, individual mandate) and government pays a certain level under economic conditions
  - Redesign the benefits package to incentivize the most appropriate cost effective care
  - Amend the Health Trust Fund Law to allow the union to compete to offer plans
  - Encourage more competition by allowing more health plans
  - Regulate health plans; requires more reporting
  - Set a buying pool for prescription drugs
  - Look at health care delivery
  - Premium assistance program—provide match/subsidies to employers providing coverage
  - 100 - 170% federal poverty level, uninsured for 6 months
  - Allow small business groups to buy into the health fund
  - Allow small employers to have an association for purchasing health care
  - Allow higher employee co-payments
  - Employers to educate their employees i.e., why they are covering employees; employee productivity
  - Mandated community rating
  - Provide a catastrophic wrap around by the state. Employers provide all basic coverage Health plan, employer, and state collaboration

## ► Health Insurance Reform

**Sharon Miyashiro, Facilitator; Colin Hayashida, Recorder**

**Goal:** All people able to get insurance on equitable terms regardless of employment

### **Interests**

- ◇ **Endorsing purchasing cooperatives and facilitate their formation**
- ◇ **Increase competitiveness in the insurance industry**
  - Access
  - Sole Proprietors
  - Prepaid Health Care Act
  - Adequate insurance coverage for people
  - Define the problem
  - Broad coverage, including cancer
  - Insurance part of the care for healthcare for all
  - Define the market
  - Individual coverage
  - Management or coverage of chronic diseases of illnesses
  - Discrimination Coverage Availability
  - Open the market to other insurance plans

### **Chronic Conditions**

- ◇ **Redefine the risk pool(s) to ensure that uninsured are included in the pool(s)**
  - High-risk pools
  - Individuals buy supplemental insurance

### **Prepaid Health Care Act**

- ◇ **Support creation of task force to study Prepaid Health Care Act to expand coverage**
  - Redefine the employer
  - Community Risk Pool—single risk pool for Hawai‘i
  - What do we want to cover and how are we going to pay for it
  - Pre-paid health care cap on employee contribution
  - Self employed risk pools—establish community rated purchasing coop
  - Goal: All people able to get insurance on equitable terms regardless of employment
  - Look at other states

## ► Expanding the Safety Net

Joe Lapilio, Facilitator; Stephen Jiang, Recorder

### Access for All

- ◇ **Find a creative way for health coverage for emergency hire workers**
  - Outreach to constituents that are excluded from the Prepaid Health Care Act
  - Increasing outreach to those who are eligible and enrolling them for services
  - Centralize and fund language banks for the state
  - Examine, analyze and change the government structure which are barriers to people accessing services because of the bureaucracy
  - Provide more programs and coverage for people with alcohol and substance abuse problems
  - Health care for all
  - Increase QUEST coverage for dental services -- more than pulling teeth
  - Expand coverage for “alternative care” eg., acupuncture
  - Eliminate undocumented as a criteria for medical care
  - Create access to address life threatening medical emergencies
  - Expand comprehensive health care to not just medical care, but also dental, behavioral health, optometry, nutrition
  - Revamp eligibility barrier to qualify for QUEST medical coverage
  - Explicitly fund services for undocumented immigrants
  - Expand safety net and health center capability to enroll people in public insurance

### Funding

- ◇ **Secure the safety net with “fast” money with an executive budget**
  - Fund and expand community health center resources to help the consumers get appropriate health care insurance
  - Governmental facilitated community sponsored underwriting with CHC services and other safety net services
  - Support existing safety net programs financially
  - Subsidies for specialty referrals (oral surgeries, surgeons, ophthalmology, etc.)
  - Create catastrophic and specialty care -- state supported
  - More money for good chronic disease management
  - Give us the money! Minimum of hassle

### Economics

- ◇ **Big pool for small businesses**
  - Part-time coverage through tax credits to employers
  - Small employers and shifting workforce to part-time
  - Health care providers play a greater role in economic development, job training, education and vocational rehabilitation
  - Medical destination: a world class center for open heart, brain surgery servicing the Pacific Rim
  - Put tennis court lights on timers; turn off some street lights and building store lights
  - Focus on one or two medical specialty from the variety that can be marketed in Asian to fill tourism gap



## **Education**

- More focus at UH on health economics
- Collaborative effort between non-profit agencies and community health centers to join forces to focus on preventative health/screening to foster education and public awareness
- Community involvement and identify needs

## **Information**

- Centralized clearinghouse of all health related resources
- All data is political. More “key” data
- Insurance commission health care division as central point of information (website) for how to get insurance and/or care

## **Human Resources**

- Recruit and retrain unemployed service workers to fill mental health and health worker shortages (short & long-term)
- Focus on volunteer and university resources on improving administration and other systems of the safety net
- Train unemployed to volunteer and give them medical care in payment. Barter system.
- Promoted and increase volunteerism through recruitment, communication and motivation to help a community in crisis
- Focus, energize service learning -- health professionals in communities of need (MUA, MUP)
- Provide affordable insurance capability for retired medical personnel and dental
- Increase health care workforce by identifying retired people in community

## **Reflection**

- Communication of investment aspects and economics of investing in people
- Assurance (providers) v. Insurance (individual)

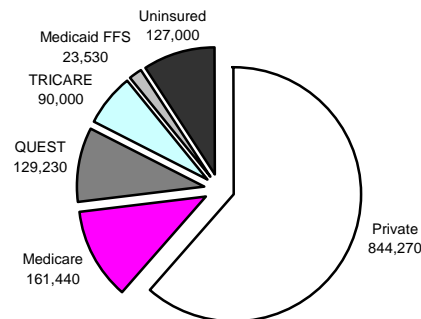
## **Prevention**

- Fluoridation
- Focus more on prevention and on youth to prevent future chronic disease e.g., smoking cessation, fluoridation, drug prevention, etc.

## **Politics/Government Reform**

- ❖ **Get consumer more involved in demanding health care**
- Strengthen school health so they become providers of higher levels of prevention, including oral health
- Allowing qualified licensed dentists from out-of-state to provide volunteer services to safety-net clinics
- Assure uninsured and their advocacy agencies at the decision-making table
- Get the State of Hawai‘i to advertise a RFP from other HMDs
- Get Hawai‘i Community Services Council to provide affordable lobbyist training to health service nonprofits.

# THE INSURED



1999 Number of Covered Lives in Hawai'i

Source: Hawai'i Health Information Corporation

Private insurance and government-sponsored insurance are two primary sources of coverage. Private insurance is purchased either through one's employment or, less commonly, by an individual person. Government insurance is provided for people who meet certain criteria. There are also some time-limited transitional options for people who have lost their insurance.

## ► Private Insurance

### Employer-Based

Hawai'i's Prepaid Health Care Act requires most employers to provide health insurance to their employees. Most people in Hawai'i and the U.S. obtain coverage through their employer. However, Hawai'i's law is unique in the nation because it requires coverage. The employer must cover a portion of the employee's individual premium such that the employee's share is no more than 1.5% of her/his annual wages.

- Only required for employees who regularly work 20 hours per week or more.
- The state and federal government and many sole proprietors are exempt as "employers".
- "Seasonal employees" are not covered by the act.
- Employers are free to do more than what is required. For example, employers often make coverage available for spouses and dependents.

### Individually Purchased

Consumers can buy private insurance coverage by paying the full premium for an individual plan. However, for most people, it is cost prohibitive. People who might nevertheless opt for an individual plan are those who expect to have a high utilization of health services, those who are very risk averse, or those who are wealthy.

Insurers may set up plans for special circumstances. For example, HMSA's Children's Plan is an individual plan providing medical care to children ages thirty-one days through eighteen years who are Hawai'i residents and currently uninsured. It gives children basic health care benefits such as preventive services, immunizations, and doctor visits for a monthly fee. This plan is meant to cover those not reached by QUEST.

## ► **Government-Sponsored Insurance Programs**

### **QUEST**

The QUEST program provides health coverage through managed care plans for eligible lower income Hawai'i residents. Federal matching funds (currently 56.34%) are available to help cover eligible people.

- To be eligible, one must meet the following requirements: be a Hawai'i resident; be a U.S. citizen or qualified alien; have a Social Security number; not be certified blind or disabled; not be age 65 or over; not be living in a public institution; not be eligible for health insurance from employer (except for TANF and General Assistance recipients).
- AND one must meet an INCOME TEST: income not more than 100% of the current Federal Poverty Level (FPL). Note: Pregnant women qualify at 185% and children qualify at 200%.
- AND one must meet an ASSET TEST: assets not exceeding \$2,000 for a household of one; \$3,000 for a household of two; \$250 for each additional person. Note: Asset limits do not apply to children or to pregnant women for the duration of the pregnancy and 60 days following the baby's birth.
- Until very recently, there was a cap of 125,000 people who could be enrolled in QUEST at any given time. People in mandatory eligibility groups (i.e., pregnant women, children and youth, and persons who apply within 45 days of losing employer-sponsored health insurance) were exempt from this cap. Since the events of September 11, the Department of Human Services temporarily lifted the cap.
- Hawai'i's implementation of the State Children's Health Insurance Program (SCHIP) allows children and youth ages 0 through 18 years old to be eligible up to 200% FPL to enroll in QUEST. A different pool of federal funds pays for 69.44% of the program with the rest covered by state funds.
- QUEST provides a standard benefit package which emphasizes preventive care for adults and children and requires that health plans provide Early and Periodic Screening, Diagnostic and Treatment services for all individuals up to age 21 (as long as they are enrolled before age 19).

### **Medicaid Fee For Service (FFS)**

Medicaid is an entitlement program financed by both the state and federal government (through the Social Security Administration). The state operates and administers the program and the federal government matches the states' contribution on certain minimal levels of available coverage. Though the federal guidelines are broad, the states determine the benefits covered, program eligibility, rates of payment for providers and methods of administering the program.

The states may institute additional services beyond those allowed by federal guidelines, but at their own expense. The program covers certain low-income individuals over age 65 (they are “dual eligible” for Medicaid and Medicare) and the certified blind or disabled.

Med-QUEST also provides health insurance for immigrant children and youth that is 100% state funded. It uses the same Med-QUEST application form to cover individuals under age 19 in the QUEST and Medicaid FFS programs. It covers legal immigrants, including those who have been in the United States less than five years, and citizens of the Marshall Islands, Federated States of Micronesia, or Palau.

## **Medicare**

Medicare has two separate but coordinated programs: Part A covers hospital insurance and Part B is supplementary medical insurance that covers doctor visits. It is for:

- People aged 65 and older
- Persons eligible for social security disability payments for two years or longer
- Certain workers and their dependents who need kidney transplants or dialysis

## **TRICARE**

TRICARE is a voluntary HMO option for veterans and active duty dependents.

- TRICARE Prime charges an annual enrollment fee (except for active duty members and their families, who may enroll free) and enrolls for a continuous period of time.
- TRICARE Extra does not require enrollment or paying an annual fee. There is an annual deductible for outpatient care that must be paid.
- TRICARE Standard is the former CHAMPUS program with a new name. It pays a share of the cost of covered health care services obtained from an authorized non-network civilian health care provider.

## **► Transitional Coverage**

### **Consolidated Omnibus Budget Reconciliation Act (COBRA)**

COBRA is a federal law that gives some employees and their dependents the option to continue health insurance if it ends for certain reasons. In companies with at least 20 employees, workers who lose their benefits may be eligible to purchase group health insurance for up to 18 months. Medical benefits are the same as the ones offered by the employer. Most people find the cost of COBRA too high, yet it is still typically less expensive than what could be purchased through an individual plan.

### **QUEST-Net**

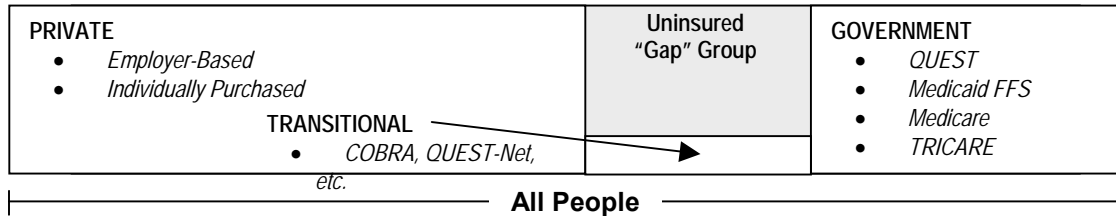
QUEST-Net is a limited benefit transition program for those who have fallen out of Medicaid or QUEST due to increasing income or assets. It is modeled after the State Health Insurance Program that was phased out when QUEST began. It is available for up to twelve months. A

person must already be enrolled in one of those programs and have a monthly income below 300% FPL to be eligible. The monthly fee is \$61.80.

### **Special Programs Related to September 11, 2001**

- HMSA and Kaiser have setup programs to help members retain their coverage if they lost their jobs as a result of September 11 events.
- The state is providing COBRA assistance to certain affected workers as a result of a law passed in a special session of the legislature.
- 9-11 Net is a program similar to QUEST Net with a limited benefit package and low cost. It will be made available to people who lost their job as a result of the events of September 11 and was also created in the special session.




# THE UNINSURED














In the 1980s the number of uninsured people in Hawai‘i was estimated to be about 5% of the population. Today, that number has grown to 10%.

- 50% of those who are uninsured have incomes under 200% FPL. This is equivalent to \$19,800 per year for a single person and \$40,608 per year for a family of four.
- 82% of uninsured working age adults are employed at least part-time; 7% are employed full-time, all year (Kaiser Family Foundation, 2001).
- Neighbor Islands have higher uninsured rates than Oahu. 40% of Hawai‘i’s uninsured population resides on the Neighbor Islands (Hawai‘i Health Survey, 2000).
- When asked, “Why did you stop being covered by health insurance?” respondents to the Hawai‘i Health Survey cited: “Lost job or changed employer” (31.8%), “Couldn’t afford to pay premiums” (19.0%).
- 3% of the uninsured surveyed are likely to remain uninsured because they don’t believe in doctors, hospitals or they see no need for health insurance.

People without health insurance comprise a diverse and often invisible group. There is no outward label that indicates one’s status as “uninsured.” Also, health insurance status can change as many regularly enter and exit the ranks of the uninsured. Consequently, the uninsured population is difficult to count, measure and correctly identify. As The Hawai‘i Uninsured Project attempts to get a firmer grip on these data questions, we do know these possible identities of the uninsured:

 <p><b>Dependents of FT workers</b></p>	<p>The PHCA requires employers to cover employees and sets a maximum amount that the employee can be made to contribute to the premium. Employers need not offer coverage to spouses or dependents, and while many do, the premiums for such coverage are often much higher than individual plans. Lower-wage workers may choose not to pay to cover their dependents.</p>
 <p><b>PT Workers &amp; dependents</b></p>	<p>The PHCA requires employers to cover employees who work 20 or more hours per week. Because of the additional cost of this benefit, many businesses set up jobs that regularly require just under 20 hours per week. Many workers cannot get coverage even if they have multiple part-time jobs with different employers that add up to full time hours.</p>
 <p><b>Self-employed &amp; dependents</b></p>	<p>Many of the self-employed in Hawai‘i are not “employers” covered by PHCA and thus cannot access the group rates available to all other employers (including employers of one). Since they most likely don’t qualify for government programs, their only option is to purchase costly individual plans or to be uninsured.</p>

 <b>Other non-PHCA covered workers &amp; dependents</b>	<p>Emergency hires, seasonal employees, temporary hires, contract workers, and other terms are often associated with workers who are not covered by the PHCA.</p>
 <b>Undocumented workers</b>	<p>While probably not a huge number of people, workers paid “under the table” or workers in businesses that are in violation of PHCA still either consume health services or face dire health outcomes.</p>
 <b>Unemployed</b>	<p>People who are temporarily or chronically unemployed and who do not currently qualify for government insurance are usually uninsured. COBRA is a temporary solution, but is unaffordable to most.</p>
 <b>Program eligible but not enrolled</b>	<p>Many uninsured people could actually be enrolled in an existing government program but are not for some reason. Reasons include lack of awareness, lack of desire to enroll, inaccessible and complicated application forms, extensive document verification and language or cultural barriers</p>
 <b>Program ineligible too much income</b>	<p>Medicaid/QUEST has different income requirements for different groups of people. Some people are ineligible and hence, uninsured, because their income is above the guidelines.</p>
 <b>Program ineligible too many assets</b>	<p>Medicaid/QUEST has an asset requirement for adults that is difficult for some to overcome without gutting savings or hard assets. Some fail this test because of property holdings jointly held by multiple family members and passed down over generations.</p>
 <b>Immigrants</b>	<p>When federal welfare reform occurred, legal immigrants entering the U.S. on or after August 22, 1996 were made ineligible for most federal assistance programs. Immigrants can get “emergency” services as defined by the Department of Human Services. Immigrant children can get QUEST or Medicaid FFS under the Immigrant Children’s Program. Pregnant immigrant women are not covered. It is believed that many immigrants who have been in the United States more than five years and who are eligible for public health insurance might not enroll either because they believe they are not eligible or for other reasons.</p>
 <b>Early retirees</b>	<p>People who leave the workforce before age 65 are not yet eligible for Medicare and may not have coverage from their former employer. Those retiring voluntarily may have the means to purchase coverage on their own, but those forced to retire early because of a health condition may be at least temporarily uninsured until they are able to be certified disabled.</p>
 <b>Voluntary Uninsured</b>	<p>Some people may be uninsured even though they could obtain insurance from some source. Because one is not compelled to be insured, some may opt out because of a personal belief or because they would rather assume the whole risk through “self insurance” or because they believe they are not at-risk. Depending on risk profiles, these decisions can be correct or they can be very costly to individuals and care providers.</p>
 <b>Uninsurable</b>	<p>It is believed that some portion of the uninsured would not get insurance under any circumstance. This may be because of a severe impairment, total inaccessibility, a severe health condition or other reasons. For these people, a strong safety net may be the only alternative.</p>
 <b>Important Related Factors</b>	<p>The following characteristics may be important factors in the likelihood of being uninsured. This may be primarily because of positive correlation with economic disadvantage and other barriers that lead to lack of insurance: rural communities, Neighbor Islands, ethnicity, mental illness, disability, homelessness, previous health condition, language, age, gender, industry.</p>

# VOICES FROM THE COMMUNITY

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The Hawai'i Uninsured Project asked communities throughout the state for their views on the uninsured issue. Through community meetings, individual talk-story sessions, scheduled events, surveying and small group talks, we have begun capturing the views of health care providers, employers, government workers, people afraid of becoming uninsured and people who are uninsured. The various methods of education and listening to communities will continue through 2002. The following recounts some of the oft-mentioned barriers to obtaining health insurance as identified by people in our communities:

## ► Medicaid/QUEST Eligibility & Enrollment

- Because I have family land (multiple families with an undivided interest) I am ineligible. Government required that families liquidate land. Land is all we have for our descendants. QUEST made me provide proof that all other stakeholders were unwilling to sell so I had to retain a lawyer and track down all family members.
- Asset test penalizes me for having savings to cover other necessities
- Forms require data that some are unable to provide.
- People need more help to understand system or understand the concept of health insurance
- Son's medical coverage from Dad's insurance lost when Dad changed jobs. Over financial eligibility by a few hundred dollars. Contemplating asking boss for pay cut.
- Questions too complicated and too personal
- Some unclear how to reinstate or maintain their coverage.

## ► Private Insurance

- Can't get more than 19.5 hours per week
- Sign up process is complicated for small businesses
- Self-employed need to have "1 employee" (Department of Labor number, etc)
- COBRA is just too expensive. Not worth the cost. Rather just risk a health problem.
- Individual plans are too expensive
- Producing records to apply is cumbersome and at times costly
- Employee has to pay \$400 per paycheck to cover their family. By working fewer hours she might qualify for QUEST. There are built in disincentives to work. It is better to be home



without money to qualify for coverage so kids have food, mother, care and insurance (kids not currently qualified for SCHIP).

- Co-payments are additional unknown costs
- Hanai children aren't covered as dependents
- Fear – don't trust health care providers/insurance.
- Alienation from Western health system
- Difficult for an early retiree to get affordable coverage
- Kids coming out of school, no job, no coverage.

# EFFORTS TO EXPAND COVERAGE IN HAWAI‘I

Over the years, Hawai‘i has had many discussions and taken many steps to address the issue of expanding health insurance coverage. The following describes some of the efforts in recent years. Past efforts provide instruction in the design of the overall strategy to come from this Policy Summit. Many of the participants and leaders of these past efforts are leaders and partners of The Hawai‘i Uninsured Project.

## ▶ 1974 – The Prepaid Health Care Act (PHCA)

The anchor of health insurance coverage in Hawai‘i is this act which is unique in the U.S. It required employers to cover most employees, it defined a minimum benefit package, and it set a maximum amount that an employee could be made to contribute toward premiums.

## ▶ 1983 – ERISA Exemption

In 1977, Standard Oil Company of California filed suit against the State of Hawai‘i claiming that the federal Employee Retirement Income Security Act of 1974 (ERISA) prohibited state regulation of self-insured employers. Hawai‘i lost the case in 1977, lost again on appeal in 1980 and failed to get the U.S. Supreme Court to hear the case in 1981. With the PHCA deemed unlawful by the courts, the only hope for its survival was in the hands of Hawai‘i’s Congressional Delegation. After tremendous effort on their part, an exemption to ERISA was granted to Hawai‘i in 1983. This kept the PHCA as the law of Hawai‘i. Importantly, language in the federal law specifically prohibited any change to the PHCA after 1974 (except changes that might improve “effective administration”). This meant that the significant terms of the PHCA were frozen in 1974 including the 20 hour per week classification for covered employees and the maximum 1.5% of annual wages contribution by employees (at the time, for minimum wage workers, this amounted to about 70% of the premium for a common plan). (Source: Emily Friedman, *The Aloha Way*, 1993)

## ▶ 1989 – State Health Insurance Program (SHIP)

In response to increasing numbers of uninsured people, the legislature called for a Department of Health study on the uninsured in 1986. SHIP was conceived as a solution for coverage of the “gap group” and it became law on June 26, 1989. It provided limited coverage for those not eligible for Medicaid because of excess earnings and allowed people to pay prorated premiums based on their incomes. Some believe that the combination of SHIP, Medicaid and PHCA produced as close to complete insurance coverage as possible. The benefits of the health insurance were minimal but could be expanded in case of need. The program was phased out when QUEST, Hawai‘i’s Section 1115 waiver program, was implemented in 1994.

## ▶ 1990 – Governor’s Blue Ribbon Panel on Health Care

A Blue Ribbon Panel representing a broad spectrum of Hawai‘i was convened to look at the financial and economic dynamics of the health care industry. The panel affirmed its commitment to universal access. Given that vision, the group focused its efforts on ways to contain costs.

Recommendations were made in five major issue areas: Administrative Costs, Medical Malpractice, Human Resources, Consumer Expectations and Cost Shifting.

### ► **1994 – QUEST**

In 1994, Hawai‘i implemented the QUEST program, a statewide Section 1115 program which created a public purchasing pool that arranges for health care through capitated managed care plans. The QUEST program originally expanded the Medicaid income eligibility limits to 300% of the Federal Poverty Level (FPL) for pregnant women, children, and non-disabled adults. Incrementally, the State scaled back eligibility levels for QUEST and created a safety-net program, entitled QUEST-Net. Under the QUEST-Net program, monthly premiums were imposed on those enrolled. The adults received a reduced benefit package while children continued to receive the full Medicaid benefit package. In February 1996, the State implemented an enrollment cap for the QUEST program. This cap limited enrollment to 125,000. The cap was applied to the State Health Insurance Program (SHIP) and General Assistance (GA) populations who were above the Temporary Assistance for Needy Families (TANF) level of assistance (approximately 54% FPL). In April 1996, the State implemented an amendment to reinstate the asset test, originally eliminated for QUEST beneficiaries. On January 1, 1998 income eligibility for expansion eligibles was reduced from 300% to 100% FPL. Current law eligibles continue to be covered up to 100% FPL while other categories have increased FPLs: pregnant women and infants ages 0 to 1 years old up to 185% and children ages 1 to 6 years old up to 133%.

### ► **1995 – Vision 2000: Health Care Congress**

Vision 2000 was a community-wide effort and follow up to the Governor’s Blue Ribbon Panel on Health Care. On September 8, 1995 over 300 individuals convened to discuss the five major implementation areas identified by the Panel as well as implementation issues. Perhaps the most significant outcome of this process was the formation of the Hawai‘i Health Council. The council was to investigate and implement the various recommendations of the Congress and address other issues concerning Hawai‘i’s health system.

### ► **1998 – Ka ‘Uhane Lōkahi**

A summit on Native Hawaiian health and wellness was held in March 1998. Over 600 attended this discussion of a wide range of issues including questions of health insurance. On this topic, the main recommendation by participants was outside of the insurance box and reflective of a total health perspective: that Native Hawaiian individuals make it a point to take care of their own health first and foremost.

### ► **1999 – State Children’s Health Insurance Program (SCHIP)**

The SCHIP law appropriated \$24 billion over five years to help states expand health insurance to children whose families earn too much for traditional Medicaid, yet not enough to afford private health insurance. States have three options for devising a plan to cover uninsured children: designing a new children's health insurance program; expanding current Medicaid programs; or a combination of both. Hawai‘i's initial SCHIP plan, a Medicaid expansion, was approved by the U.S. Department of Health and Human Services on January 19, 1999. The state's original plan extended eligibility to children ages 1 to 6 years old in families with income between 133% and 185% of the federal poverty level. An amendment approved on September 22, 2000 increased

the income eligibility level for children below age 19 in families with income levels up to 200% FPL. All states with SCHIP plans receive federal matching funds only for actual expenditures to insure children, however up to 10% of the funds can be used for administration and outreach. Hawai'i was the 50th state or territory to receive approval of its SCHIP plan since the program's inception in October 1997.

### ▶ **1999 – Hawai'i Covering Kids**

Hawai'i Covering Kids is a three-year project, funded by The Robert Wood Johnson Foundation, that launched in June 1999 to create a seamless health insurance enrollment process for children and youth eligible for QUEST and Medicaid Fee-for-Service. These health insurance programs were expanded to include SCHIP and the Immigrant Children's Program effective July 1, 2000.

A state coalition advises the initiative and task forces meet bimonthly to plan and implement the program in the areas of evaluation, identification and outreach, media and public information, process simplification, and training and public education. Pilot projects are in the Kalihi-Palama area of Honolulu and on the Island of Hawai'i. A third pilot project, funded by the Bureau of Primary Health Care, is on Maui.

### ▶ **1999 – Health Futures Task Force**

By order of the Legislature, a task force was formed to look into the QUEST program and the Hawai'i Public Employees' Health Fund. While there was no unanimous agreement on recommendations, the Task Force felt that three ideas were worth further investigation. 1) Improving QUEST looking at improving quality of care and cost savings; 2) Moving QUEST toward becoming a part of a joint purchasing alliance; 3) Making QUEST a direct purchaser of services. The report was left in the hands of the Legislature and administration for follow up.

### ▶ **2000 to present – The Hawai'i Uninsured Project**

On November 28, 2000 the Leadership Assembly for the Uninsured was designed to be a catalyst for thinking and talking about the uninsured issue in Hawai'i. Led by volunteer facilitators from our local community, participants discussed possible solutions. Each group looked at the problem from a particular vantage point: the government perspective, the private insurance perspective, the data perspective, the Prepaid Health Care Act perspective, and the safety net perspective. Comments and recommendations from participants led directly to the creation of a much broader and ambitious multi-phase plan including the 2001 Policy Summit.

# EFFORTS IN OTHER STATES

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Many coverage options are being explored across the United States. A few states have been recognized for their dramatic efforts to reduce the number of uninsured people. Some are listed here as examples of well-resourced model projects that Hawai'i may choose to emulate.

## ► State Coverage Initiative

State Coverage Initiatives is a program sponsored by The Robert Wood Johnson Foundation aimed at improving the practical capabilities of state governments to:

- Plan, execute, and sustain health care coverage expansions to the previously uninsured
- Plan, execute, and sustain mechanisms to improve the availability or affordability of health care coverage or access
- Overcome intervening obstacles to design, implement, and sustain coverage expansions to improve the availability or affordability of coverage

In 2001, four states were chosen to receive large demonstration grants to fund their initiatives. Descriptions of these state projects appear below. In 2002, four more states will be selected to be demonstration sites. The Hawai'i Uninsured Project in conjunction with the State of Hawai'i, expects to apply to be one of those states.

### **Arkansas**

The Arkansas Center for Health Improvement, in partnership with the College of Public Health at the University of Arkansas for Medical Sciences was awarded \$1.5 million to fund a two-pronged coverage expansion strategy. The public-sector prong will expand coverage to adults aged 19 to 64 up to 100% of the federal poverty level and to pregnant women up to 200% of the federal poverty level. The private-sector prong will include: creating a community-based health insurance purchasing pool to support small employers; allowing communities to self-insure a limited benefits package based on a sliding income scale; and allowing carriers to offer health plans without state-mandated benefits. The state also plans to partner with employers to develop a premium-assistance program that will expand coverage to low-wage workers.

### **New Mexico**

The state of New Mexico's Human Services Department, in partnership with the New Mexico Hospitals and Health Systems Association was awarded \$1.5 million to implement an innovative model that combines an employer buy-in program with a purchasing pool. The project will expand coverage to adults up to 200% of the federal poverty level.

Under New Mexico's model, the state, rather than employers, purchase commercial insurance on behalf of employees; employers and employees would help pay for the plan, with employee contributions based on a sliding income scale. This approach would allow the state to pool purchasing for enrollees, so that it can leverage federal dollars to provide both private and public coverage. The state would offer a similar benefits package directly to individuals with incomes

below 100% of poverty (both employed and unemployed), who would face little or no cost-sharing. The grant funds will be used to help coordinate and refine the buy-in program.

## **Oregon**

The Office for Oregon Health Plan Policy and Research was awarded \$1.5 million to help the state expand its innovative Oregon Health Plan (OHP) to cover 42,000 more Oregonians. The funds will be used to support three policy initiatives. The first is the creation of a new benefits package within the OHP to help the state fund its proposed expansion. The second focus of the grant will be for the state to gain federal matching funds for its employer buy-in program, the Family Health Insurance Assistance Program, which is currently financed with state funds only. The third initiative will be to gain federal agency approval to allow families to be covered under a single health insurance policy, even when parents and children are eligible for different programs.

## **Rhode Island**

The Rhode Island Department of Human Services received a demonstration grant of \$859,546. Using these funds, the state hopes to cut its uninsurance rate in half, from 6.9% to 3.5%. A key focus of the grant project will be to evaluate and enhance RItE Share, Rhode Island's newly implemented employer buy-in program. Through RItE Share, the state is partnering with employers to close the "uninsurance gap" between the private and public sectors.

Specific grant activities include: developing and implementing strategies to maximize employer and employee participation and retention in RItE Share; evaluating whether there are differences in quality and provider access between RItE Share and the state's Medicaid program; estimating the cost savings from RItE Share (to finance additional expansions); and examining coverage options for disabled individuals and uninsured populations not eligible for public assistance. Rhode Island hopes to be a model for other states that would like to minimize the administrative obstacles that buy-in programs often create for employers.

## **► HRSA Grants**

Health Resources and Services Administration's State Planning Grants were awarded to eleven states in September 2000 and an additional nine states in February 2001. The states were awarded one-year federal grants totaling \$13.6 million to develop plans for providing their uninsured citizens access to affordable health insurance.

### **2000 HRSA Grantees:**

**Arkansas** Department of Health, **Delaware** Health Care Commission, State of **Illinois**, **Iowa** Department of Health, **Kansas** Insurance Department, **Massachusetts** Division of Medical Assistance, **Minnesota** Department of Health, **New Hampshire** Department of Health and Human Services, Office for **Oregon** Health Plan Policy and Research, **Vermont** Agency of Human Services, **Wisconsin** Department of Health and Family Services

### **2001 HRSA Grantees:**

**Arizona** Health Care Cost Containment System, **California** Health and Human Services Agency, State of **Colorado**, **Connecticut** Office of Health Care Access, **Idaho** Department of Commerce, **South Dakota** Department of Health, **Texas** Department of Insurance, **Utah** Department of Health, **Washington** Office of Financial Management

# OPTIONS FOR HAWAI‘I

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In reviewing the options available to Hawai‘i, we looked to a number of sources including comments from last year’s Leadership Assembly, past efforts and reports in Hawai‘i, and a collection of initiatives from across the country.

The options are grouped into five major categories. The categories represent broad areas within which common sets of stakeholders and common implementation issues will be critical in making change happen. The options presented were chosen for their potential impact. Most of them also have parallels in other jurisdictions.

This list is by no means exhaustive and the information on each option is by no means complete, but we believe it is a good place to start. We encourage you to contribute other options and creative ideas for analysis and discussion. In some cases, the data is incomplete because it is not available or there was not sufficient time to do proper analysis. We need your knowledge and experience to supplement the information that appears in this report and to inform each other of the feasibility of different options.

The options described in this report are as follows:

## **1. Expand Existing Federal Health Insurance Programs**

- 1.1 Simplify Enrollment and Expand Outreach
- 1.2 Expand Eligibility

## **2. Develop State-Only Programs**

- 2.1 Tax Incentives
- 2.2 Direct Coverage Program
- 2.3 State-Only Buy-In Program

## **3. Build on Employer-Based Coverage**

- 3.1 Employer and Employee Tax Incentives
- 3.2 Premium Assistance/Employer Buy-In Program

## **4. Reform Health Insurance Market**

- 4.1 Change Hawai‘i Prepaid Health Care Act
- 4.2 High-Risk Insurance Pools
- 4.3 Establish Purchasing Cooperatives
- 4.4 Medical Savings Accounts
- 4.5 Scaled-Down or Basic-Benefit Policies

## **5. Support Safety Net**

- 5.1 Support Safety Net Providers
- 5.2 Expand Safety Net Providers

# ***1. Expand Existing Federal Health Insurance Programs***

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Since the 1960s, states and the federal government have worked together to provide health insurance to low-income families under the Medicaid program. Before the 1990s, Medicaid eligibility was tied to other federal programs such as Aid to Families with Dependent Children (AFDC). In 1996, welfare reform “delinked” these programs and created a new eligibility category for Medicaid based on state AFDC eligibility standards. Today, states vary widely on who is eligible for Medicaid. States may apply for waivers under Section 1115 or 1931 of the Social Security Act to change the way Medicaid operates in their state.

## **▶ 1.1 Simplify Enrollment and Expand Outreach**

Many people fail to participate in public programs because they do not know about them or because enrollment procedures are too complicated. Coverage through public health insurance programs is typically neither automatic nor easy. Some ideas to remedy the situation include:

- Work with employers to encourage qualifying beneficiaries to sign up for health insurance
- Mandate employers to provide information about existing health insurance programs
- New purchasing pools could provide information and simplified enrollment procedures for qualifying beneficiaries
- Reach out to past participants
- Restore presumptive QUEST eligibility for pregnant women and children zero to five

### **Section 1115 and Section 1931 Waivers**

Federal law allows for flexibility in state design of Medicaid and SCHIP programs. Section 1115 allows states to change provisions of their Medicaid or SCHIP program, including; eligibility requirements, the scope of services available; the freedom to choose a provider; a provider’s choice to participate in a plan; the method of reimbursing providers; and the statewide application of the program. Section 1931 allows states to expand Medicaid eligibility to more low-income families using these three mechanisms: (1) income disregards; (2) asset disregards; (3) increasing income and asset limits by as much as the increase in inflation since July 1996.

Hawai‘i is one of 13 states that have used such flexibility to expand eligibility under Medicaid. Hawai‘i is in its eighth year of QUEST—an 1115 demonstration project.

### **Health Insurance Flexibility and Accountability (HIFA)**

A new initiative called the HIFA demonstration initiative announced earlier this year offers states even greater authority in the operations of their Medicaid programs, including the ability to change Medicaid benefits, implement and/or increase cost-sharing to families, and cap enrollment in the program. It is meant to encourage innovation and give states programmatic flexibility to increase the number of individuals with health insurance coverage within current level Medicaid and SCHIP resources.



## ► 1.2 Expand Eligibility

### **Medicaid/QUEST**

Pregnant women up to 185% FPL are eligible for QUEST. Adults must be at or below 100% FPL. Other states have expanded eligibility far beyond Hawai'i's 100% level. Massachusetts' 1115 waiver, MassHealth, covers children, families and persons with disabilities at or below 150% FPL. Minnesota's 1115 waiver covers parents and children under age 19 up to 275% FPL and Missouri covers some adults up to 300% FPL. New Mexico covers all Medicaid eligible children in families at 186%-235% FPL. Rhode Island covers children up to age 18 at or below 250% poverty. Vermont covers all uninsured at or below 150% of poverty and uninsured children between 225% and 300% FPL.

### **State Children's Health Insurance Program (SCHIP)**

Hawai'i's SCHIP program, an expansion of QUEST and Medicaid Fee For Service, currently covers children ages 0-19 up to 200% FPL. However, 15 states have expanded coverage beyond the 200% FPL limit. For example, Maryland covers children up to 300% FPL, California, 250% FPL and Georgia, 235% FPL.

### **Asset and Income Disregards**

States may use Section 1931 to extend eligibility to more low-income families using any of these three mechanisms: 1) income disregards; 2) asset disregards; and 3) increasing income and asset limits by as much as the increase in inflation since July 1996. Thirty states currently utilize Section 1931 to disregard earnings and enable more people to qualify for Medicaid under current eligibility requirements.

Of particular interest in Hawai'i has been the issue of Hawaiian homestead land ownership. If you are an adult and you own property (including Hawaiian homestead land) the value of that land is used to calculate eligibility for Medicaid. As a result, homesteaders may be determined ineligible. The State had attempted to address this in the 2001 Congress through the "Akaka Bill." However, the State could also request that such assets be disregarded under Section 1931.

### **Extend SCHIP Eligibility Beyond Current Categories**

Current Medicaid and SCHIP 1115 waivers as well as the new HIFA waivers allow states to establish demonstration programs in which they change provisions of the program, including: eligibility requirements and the scope of services. Four states (Minnesota, New Jersey, Rhode Island, and Wisconsin) have used SCHIP Section 1115 waivers to expand SCHIP eligibility to parents up to 200% FPL and pregnant women up to 250% poverty level.

### **Full-Cost Buy-in Option**

It is possible to allow families or individuals to buy into the SCHIP program: Four states, Connecticut, Florida, New York and North Carolina allow higher income families up to 300% FPL to purchase coverage for their children through SCHIP at the full premium price with no state subsidy.

# 1. Expand Existing Federal Health Insurance Programs

## OPTION 1.1

### *Simplify Enrollment and Expand Outreach*

*Many Hawai'i residents are eligible for Medicaid and QUEST but not enrolled. Some are not enrolled because they are not aware that they are eligible or they do not understand the application process. This strategy is focused on finding, educating and enrolling those individuals.*

#### **Target Group(s)**

- Low-income individuals and families eligible for Medicaid and QUEST programs

#### **Key stakeholders in strategy**

- Hawai'i State Department of Human Services
- Community health centers and hospitals
- Employers and human resource departments
- Schools and other community organizations
- Legislature and other public/private funders

#### **How the program might work**

The Department of Human Services (DHS) and other appropriate state agencies and community-based organizations would cooperate to conduct outreach activities designed to find individuals eligible but not enrolled in Hawai'i's federally-funded health insurance programs. DHS would simplify enrollment procedures to make it easier for eligible individuals to enroll in programs. Some of the strategies which may be implemented include:

- Expand electronic application capabilities
- Create and print more user-friendly brochures
- Train workers to improve customer service skills

- Annual conference for community-based organizations, agencies, and outstationed eligibility workers to get Medicaid updates, networks, etc.
- Quarterly training sessions for agencies involved in application assistance and for outstationed workers to learn and improve skills
- Collaborate with community to design and implement statewide public information campaign, including outreach materials
- Translate "Hawai'i's Medicaid programs" and "How to Complete the Med-QUEST application"
- Create and produce outreach toolkits for community organizations, businesses, faith based groups, media, unions, state agencies, and healthcare providers
- Additional eligibility workers at DHS to process applications
- Upgrade Med-Quest computer systems
- Record telephone information in major languages
- Require employers with low-income employees to provide information on available health coverage programs
- Restore presumptive eligibility to pregnant women and young children
- Work with employers to encourage qualifying beneficiaries to sign up for health insurance

#### **Program cost/potential financing**

- Medicaid federal administrative match (56.34%)
- Hawai'i's share of \$500 million federal "delinking" fund
- SCHIP federal administrative match (69.44%)
- Public and private grants

**17,600**

Adults who are uninsured and at or below 100% Federal Poverty Level

Source: Hawai'i Health Survey 2000, Dept. of Health, analysis by SMS

**16,000**

Children 0-19 who are at or below 200% of Federal Poverty Level

Source: U.S. Census Bureau, Low Income Uninsured Children by State, 1998-2000, [www.census.gov](http://www.census.gov)

**UNKNOWN**

Number of pregnant women who are uninsured and at or below 185% of Federal Poverty Level

**800**

Approximate number of families coming off of TANF on December 1, 2001

### Related experiences

- **Hawai'i Covering Kids** is currently working collaboratively with state agencies and community organizations on some of these initiatives.
- **Santa Clara County, California** intends to expand outreach programs through schools, clinics, faith based organizations and others and simplify the application process to enroll 100% of uninsured children up to 300% FPL.
- **Colorado** has trained county eligibility technicians on the Section 1931 eligibility category and helped to cover the costs of making eligibility determinations under this category. Colorado also has catalyzed local outreach activities. Last March, the state invited each county to submit a plan describing how it would undertake outreach and enrollment efforts. Plans from 30 counties subsequently received funds for an array of activities including the establishment of 25 new outstation sites at federally qualified health centers, hospitals, and some community-based sites such as schools. In addition, the counties have developed informational brochures and produced public service announcements. Plans include conducting outreach and enrollment activities at special community events. The state tapped into the \$500 million TANF delinking fund.
- **Indiana** provided grants directly to community groups that represent African American and Hispanic families to enable them to do targeted outreach in their communities. The state has also paid for a broad-based media campaign, including billboards and print advertising, to encourage families to sign up for health insurance coverage. The state tapped into the \$500 million TANF delinking fund.
- **Wisconsin** through its Department of Health and Family Services, trained public health agencies, tribal health agencies and community-based organizations on Medicaid eligibility and developed demonstration projects in eight counties. Through the demonstration projects, county workers are able to take full Medicaid applications at a wide range of community sites, including health clinics, food pantries, schools, hospitals and others. The state also increased the capacity of the state's customer assistance telephone line and financed a public information campaign. The state tapped into the \$500 million TANF delinking fund.

### Major Pros and Cons

- PRO – Takes advantage of available federal dollars
- PRO – Takes care of the most vulnerable population
- PRO – Builds and promotes community-based solutions
- CON – Will require state matching funds
- CON – Limited administrative systems to work with expanded population.
- CON – Welfare stigma of government sponsored program

### Resources and Contacts

- Peter Long, "A First Glance at the Children's Health Initiative in Santa Clara County, California," Kaiser Commission on Medicaid and the Uninsured. (August 2001). [www.kff.org](http://www.kff.org)
- Donna Cohen Ross and Jocelyn Guyer, "How are states using their share of the \$500 million fund?" Center on Budget and Policy Priorities (October, 1999). [www.cbpp.org](http://www.cbpp.org)

# 1. Expand Existing Federal Health Insurance Programs

## OPTION 1.2

## Expand Eligibility

*Many low-income individuals are not currently eligible for assistance through Hawai'i's federal insurance programs (QUEST, Medicaid), although federal matching dollars would be available to them if eligibility were expanded. A variety of expansions are possible under current laws and regulations.*

### Target Group(s)

- Low to moderate-income individuals
- Parents of SCHIP-eligible children
- Others currently ineligible for Medicaid or QUEST

### Key stakeholders in strategy

- Department of Human Services
- Legislature
- U.S. Department of Health and Human Services

### How the program might work

A Medicaid waiver could be obtained which might adopt one or more of the following strategies:

- Expand existing programs (Medicaid, QUEST) for low to moderate-income uninsured people. The income thresholds would be raised, perhaps to 250% or 300% FPL, certain categories of individuals would be included (e.g., parents of SCHIP eligible children, childless adults)
- Asset tests could be loosened to allow more people to qualify for coverage under the state's existing income limit.
- Use HIFA waiver to cover virtually all demographic groups under 200% of the poverty line by changing benefits or altering cost sharing arrangements.

Medicaid laws allow states flexibility in determining eligibility either by raising income thresholds or revising formulas used to determine eligibility. Section 1931 allows greater flexibility to extend eligibility to more low-income families by using any of these three mechanisms: 1) income disregards; 2) asset disregards, 3) increasing income and asset limits by as much as the increase in inflation since July 1996. SCHIP and Medicaid rules allow states to extend coverage to families. The new Health Insurance Flexibility and Accountability (HIFA) demonstration provides states even broader latitude to cover populations up to 200 percent of the federal poverty level.

### Program cost/potential financing

- Federal funds (SCHIP, Medicaid)
- State matching funds

### Related experiences

- **Minnesota's** MinnesotaCare covers parents and children under age 19 up to 275% FPL.
- **Missouri** covers some adults up to 300% FPL.
- **Rhode Island's** RItE Care covers children up to age 18 up to 250% FPL. Parents of RItE Care eligible children are covered to 185%.
- **Vermont** covers all uninsured up to 150% FPL and uninsured children up to 300% FPL.
- **North Carolina** and **Wyoming** have used Section 1931 to ease the asset test for families seeking Medicaid Coverage. For example, North Carolina disregards the first \$2000 of otherwise countable resources when evaluating whether a family's assets fall below the resource standard of \$1000. In effect, this raises the asset limit to \$3000.
- **New Jersey's** NJ Family Care Program uses an SCHIP 1115 waiver to cover 117,000 parents (100-

50,440

Adults who are uninsured and at 100%-300% Federal Poverty Level

Source: Hawai'i Health Survey 2000, Dept. of Health, analysis by SMS

5,890

Children 0-17 who are uninsured at 200%-300% of Federal Poverty Level

Sources: Hawai'i Health Survey 2000, Dept. of Health, analysis by SMS; U.S. Census Bureau, American Fact Finder, Table QT-01, factfinder.census.gov

9,480

Low-income parents who are uninsured.

Hawai'i is the only state where low-income parents have a lower rate of uninsurance than low-income children

Source: Lambrew, Jeanne M., *Health Insurance: A Family Affair: A National Profile and State-by-State Analysis of Uninsured Parents and Their Children*, The Commonwealth Fund, May 2001

185% FPL), pregnant women (185-250% FPL) and until recently, single adults and childless couples up to 200% FPL.

- **Wisconsin's** BadgerCare programs uses SCHIP funds to cover parents 100-185% FPL.
- **New York's** SCHIP program covers children up to 250% FPL and its Family Health Plus program covers parents up to 150% FPL.

### **Major Pros and Cons**

PRO – Medicaid expansions have proven to be an effective method for improving insurance rates

PRO – Builds on existing administrative systems

PRO – Using Section 1931 authority is a state option and does not require a federal waiver

PRO – Covering parents will help make leaving welfare and entering low-wage job market a more viable option

CON – Would require state match

CON – Taxes an already over-burdened and challenged administrative system

### **Resources and Contacts**

- State Coverage Initiatives Website, [www.statecoverage.net](http://www.statecoverage.net)
- Birnbaum, Michael, “Expanding Coverage to Parents through Medicaid Section 1931” State Coverage Initiatives Issue Brief. (May 2000)
- Center on Budget and Policy Priorities, “Expanding Medicaid Coverage to Low-Income Parents Reduces Number of Uninsured Children, New Research Finds” (September, 2000) [www.cbpp.org](http://www.cbpp.org)
- Jeanne M. Lambrew, “Health Insurance: A Family Affair” The Commonwealth Fund. (May 2001).
- Vernon Smith, Eileen Ellis, Christina Chang, “Eliminating the Medicaid Asset Test for Families: A Review of State Experiences.” Kaiser Family Foundation. [www.kff.org/content/2001/2239/2239.pdf](http://www.kff.org/content/2001/2239/2239.pdf)
- Health Insurance Flexibility and Accountability (HIFA) Demonstration Initiative. [www.hcfa.gov/medicaid/hifademo.htm](http://www.hcfa.gov/medicaid/hifademo.htm)

## ***2. Develop State-Only Programs***

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States may choose to develop programs that are state designed, state run and state financed. Several states have developed state programs to cover specific populations such as children or childcare workers. State-run programs offer flexibility to address specific needs without the requirements and restrictions that come with federal funding. Strategies include tax incentives, direct coverage, and buy-in programs.

### **▶ 2.1 Tax Incentives**

State-only tax incentives are also used by states to make private health insurance more affordable. Fifteen states provide tax relief, either through tax deductions or tax credits, to an employer or individual who purchases health insurance for themselves, their family or their employees. Many of these tax incentive programs target the small-business employees, self-employed or dependents of employees with health coverage.

### **▶ 2.2 Direct Coverage Program**

The ultimate in flexibility is realized when a state sets up a direct coverage program. States may target specific groups in their populations and provide health services or health insurance. On its face, this option also appears to be the most expensive from a state resources perspective. Still it may be the most efficient way to reach certain uninsured groups.

### **▶ 2.3 State-Only Buy-in Program**

Currently, six states provide direct, major medical health insurance coverage or premium assistance for private insurance coverage through programs that are state designed and state funded. These programs provide care through a specially designed insurance program, or by allowing eligible individuals to obtain insurance through an existing state program. The cost of the buy-in might be below the premium cost or at full-cost. For example, Illinois operates KidCare, an employer buy-in program for children between 133% and 185% FPL. Another option under consideration by some states is to allow eligible low-income working people to buy into the state employees plan at a price below the full premium cost. Delaware is considering this option for uninsured adults and children of uninsured adults above 200% FPL.

## 2. Develop State-Only Programs

### OPTION 2.1

### Tax Incentives

*States can offer tax incentives to make health insurance more affordable and encourage individuals and families to purchase coverage.*

#### Target Group(s)

- Uninsured or potentially uninsured workers and families ineligible for federal health insurance programs

#### Key stakeholders in strategy

- Department of Taxation
- Department of Human Services
- Employers
- State and local lawmakers

#### How the program might work

The state would provide a refundable tax credit or tax deduction for eligible uninsured people (perhaps 200-300% FPL) and their families to help cover the cost of purchasing health insurance.

#### Program cost/potential financing

- State funds

#### Related experiences

15 states provide state-only tax relief, either through tax deductions or credits, to an employer or individual who purchases health insurance for themselves, their family, or their employees.

- **California, Georgia, Idaho, Illinois, New Jersey and Wisconsin** allow self-employed, spouse and dependents to deduct 100% of premium expenditures.

- **Colorado and Iowa** allow individuals, spouses, and dependents to deduct 100% of premium expenditures.
- **Delaware** allows self-employed individuals to deduct 100% of premium expenditures.
- **Kansas and Maine** allow small employers a credit of varying amount per eligible employee.

#### Major Pros and Cons

PRO – Builds on the existing tax system

PRO – Choice of plan is up to individual

CON – New administrative mechanisms would need to be established: systems for determining eligibility, timing for tax deduction/tax credit, reconciliation

CON – Does not work as well for those without steady employment

CON – Assistance would have to be large to have substantial impact

#### Resources and Contacts

- [www.statecoverage.net](http://www.statecoverage.net)
- Glied, Sherry, Challenges and Options for Increasing the Number of Americans with Health Insurance (December 2000). From A Report Series from the Commonwealth Fund Task Force on the Future of Health Insurance.
- Yondorf, Barbara “Five Approaches to Achieving Health Insurance Coverage for All Coloradans” (July 2000) p. 25-29.
- Riley, Trish & Barbara Yondorf, Flood Tide Forum, “Access for the Uninsured: Lessons from 25 Years of State Initiatives.” National Academy for State Health Policy (January 2000).

#### UNKNOWN

Uninsured people living in families where the head of household is unemployed

**60%**

Percentage of uninsured people who live in households where there is at least one full-time job

Source: Hawai'i Health Survey 2000, Dept. of Health, analysis by SMS

## 2. Develop State-Only Programs

### OPTION 2.2

### *Direct Coverage Program*

*Some families and many individuals are ineligible for federally-funded programs and do not have access to or cannot afford to purchase health insurance. States can establish, operate and fund their own insurance programs that reflect the specific needs and opportunities for their populations.*

#### Target Group(s)

- Working poor or near poor
- Part-time or temporary workers
- Immigrants not eligible for federal programs
- Students, homemakers, dependents and spouses of workers whose employers do not extend coverage
- Any others ineligible for federally-funded programs and without access to health insurance

#### Key stakeholders in strategy

- Department of Human Services
- Private health plans
- Health care providers
- Legislature and other public/private funders

#### How the program might work

Establish a coverage program to directly pay for a limited set of benefits for low to moderate income adults and children who do not qualify for QUEST

or Medicaid. For example, the old State Health Insurance Program (SHIP) covered individuals at 100-200% FPL. The program may also target specific categories of uninsured such as children, immigrants, or childcare workers.

#### Program cost/potential financing

- Existing state funds
- New state funds such as a tobacco tax
- Private funds

#### Related experiences

- **The Hawai'i Immigrant Health Initiative** is a state program that started in the Fall of 1998 to provide free or low-cost health care to legal resident immigrants. Federal law has prohibited immigrants who arrived after Aug. 22, 1996 from receiving federally-funded health care benefits. Legal immigrants who would otherwise be eligible for Medicaid or QUEST can receive a maximum of \$2,100 in health care services.
- **Massachusetts** developed the Children's Medical Security Plan, a health insurance program that provides children and adolescents with access to primary care and preventive services. Any child age 18 or younger who lives in Massachusetts, is currently uninsured and is not eligible for the state's Medicaid or SCHIP program is eligible. In 1997, 31,000 children were enrolled.
- **Minnesota's** MinnesotaCare provides direct coverage for adults 21 and over up to 175% FPL.

**50,440**

Adults who are uninsured and at 100%-300% Federal Poverty Level

Source: Hawai'i Health Survey 2000, Dept. of Health, analysis by SMS

**37,440**

People who are uninsured due to unemployment

Source: Hawai'i Health Survey 2000, Dept. of Health, analysis by SMS

**9,100**

Children who are uninsured and above 200% Federal Poverty Level

Source: Hawai'i Health Survey 2000, Dept. of Health, analysis by SMS

**8,110**

Stated that they were no longer insured because their employer stopped offering coverage, or their employment was cut back to part-time

Source: Hawai'i Health Survey 2000, Dept. of Health, analysis by SMS

**9,460**

Uninsured immigrants

Nearly 14% of immigrants who entered between 1990 and 2000

Source: Hawai'i Health Survey 2000, Dept. of Health, analysis by SMS; American FactFinder, US Census, Table QT-02, 2000, factfinder.census.gov



- **Washington's** Basic Health Plan is a state sponsored health insurance program that provides coverage to uninsured individuals who are not eligible for Medicaid (Basic Health Plan Plus). The Basic Health Plan is underwritten by 8 private health insurance plans. Premiums vary based on family income.
- **Alaska** established The Chronic and Acute Medical Assistance Program, which is a 100% state funded medical assistance program that pays for a very limited amount of health care services for very low income adults and children who do not qualify for Medicaid. Covered services include limited inpatient hospital stays and prescription drugs for individuals with certain chronic illnesses.

**Major Pros and Cons**

- PRO – Flexible and free from the often cumbersome mandates of federal programs
- PRO – The only clear way to address populations that are prohibited from receiving federally subsidized insurance (namely immigrants)
- CON – Expensive for state governments (these programs receive no federal funding)
- CON – Can be resource-intensive to administer

**Resources and Contacts**

- [www.statecoverage.net](http://www.statecoverage.net)
- [www.state.ma.us.dph](http://www.state.ma.us.dph)
- [www.wa.gov/hca/basichealth.htm](http://www.wa.gov/hca/basichealth.htm)
- [www.hss.state.ak.us/dma/cama.htm](http://www.hss.state.ak.us/dma/cama.htm)
- [www.dhs.state.mn.us/hlthcare/asstprog/mncare/default.htm](http://www.dhs.state.mn.us/hlthcare/asstprog/mncare/default.htm)

## 2. Develop State-Only Programs

### OPTION 2.3

### State-Only Buy-In Program

*Some families and many individuals are ineligible for federally-funded programs and do not have access to or cannot afford to purchase health insurance. States can establish programs into which qualified individuals can enter by paying a fair share of the cost.*

#### Target Group(s)

- Working poor or near poor
- Part-time or temporary workers
- Immigrants not eligible for federal programs
- Students, homemakers, dependents and spouses of workers whose employers do not extend coverage
- Any others ineligible for federally-funded programs and without access to health insurance

#### Key stakeholders in strategy

- Department of Human Services
- Health plans
- Employers
- Legislature

#### How the program might work

Subsidize low to moderate-income individuals without access to affordable private health insurance to buy into programs like QUEST. Another option is to allow low-income uninsured

employees to buy into the state employee health plan.

#### Program cost/potential financing

- State funds
- Premiums paid by individuals

#### Related experiences

- **Hawai'i's** SHIP has been phased out with the onset of QUEST. However, similar programs—QUEST Net and 9-11 Net—give people an opportunity to buy into limited benefit plans.
- **Rhode Island's** RItE Care for Home-Based Child Care Providers offers eligible home-based child care providers and their dependent children to enroll in the state's insurance program RItE Care. Current enrollment is approximately 300.
- **Illinois's** KidCare Rebate program is a state-only program available to those with family income 133%-185% FPL whose children are insured. KidCare Rebate reimburses part of the cost for private health insurance for children.
- **Oregon's** Family Health Insurance Assistance Program (FHIAP) provides a subsidy for eligible families without access to private health insurance to purchase coverage from one of the insurance companies approved by FHIAP.
- **Colorado** studied the feasibility of an employer buy-in and decided against it because of predicted low enrollment and high administrative costs. Instead, they will pursue grant funding to market

**37,440**

People who are uninsured due to unemployment

Source: Hawai'i Health Survey 2000, Dept. of Health, analysis by SMS

**110,000**

Part-time employees in 1998

Source: The State of Hawai'i Data Book 2000, Tables 12.17 and 12.18, [www.hawaii.gov/dbedt/](http://www.hawaii.gov/dbedt/)

**8,110**

Stated that they were no longer insured because their employer stopped offering coverage, or their employment was cut back to part-time

Source: Hawai'i Health Survey 2000, Dept. of Health, analysis by SMS

**7,820**

Uninsured people said that they lost insurance as a result of spouse's job change or job loss

Source: Hawai'i Health Survey 2000, Dept. of Health, analysis by SMS

**1,576**

State government workers classified as "emergency hires" in 2001

Source: State Department of Human Resources

existing programs to eligible families at their workplace.

- **Delaware** is considering allowing eligible low-income working people to buy-into the state employees plan at a price below the full premium cost. The cost to the enrollee would be based on income and the state would finance the option through a larger appropriation to fund the state employees' plan. Low-income people enrolled would be eligible for the same covered benefits and the same choice of health plans as are offered to state employees.

### **Major Pros and Cons**

PRO – Can take advantage of existing administration of programs

PRO – Flexibility to address needs of those not eligible for federal programs

PRO – Low-cost limited benefit plans might be more in line with segments of consumer demand

PRO – Cost sharing with health care consumer

CON – Introduces possibility of crowd out (people dropping existing coverage for state subsidized coverage)

CON – Research shows that subsidies must be substantial to encourage people to enroll

CON – QUEST Net enrollment thus far has been limited

CON – Welfare stigma

### **Resources and Contacts**

- [www.ipgb.state.or.us](http://www.ipgb.state.or.us)
- [www.kidcareillinois.com](http://www.kidcareillinois.com)
- [www.statecoverage.net/statereports/de2.pdf](http://www.statecoverage.net/statereports/de2.pdf) (Delaware)
- [www.dhs.state.ri.us/index.htm](http://www.dhs.state.ri.us/index.htm)

### ***3. Build on Employer-Based Coverage***

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Many states seek to leverage private funding for health insurance through innovative public-private sector partnerships, predominately with employers. This politically attractive strategy enables states to maximize the number covered with limited state funds, deter crowd-out (when private coverage is dropped for public coverage), improve continuity of coverage, support the participation of low-income residents in employee coverage programs, keep families in a single insurance plan, and make private insurance available to those reluctant to participate in public insurance programs.

There are two basic approaches to this strategy: 1) Increase employer offer rates through direct (tax credit) or indirect subsidies (assistance directed to health plans serving small group market – states reduce plans’ financial risk through reinsurance or other mechanisms); or, 2) Increase employee take-up rates through premium subsidies through Medicaid, SCHIP and state-only programs.

A state will offer a tax credit or direct subsidy to employers to entice them to offer health insurance to their employees. This type of program is often targeted to small businesses with less than 50 employees. In Massachusetts, the state will pay employer subsidies of up to \$1,000 per year for each eligible employee (an employee making less than 200% FPL) provided that the benefits package is comparable to a benchmark standard and the employer contributes at least 50% of the premium. In Kansas, the State provides a tax credit of \$35 per employee per month to any small business (2-50 employees) that has not contributed to health insurance for the past two years. In Hawai‘i, a subsidy could be designed to encourage an employer’s expanded coverage to part-time or contract employees and their dependents.

On the other side of the coin, states can provide premium assistance to low-income employees to encourage them to fully participate in employer-sponsored health coverage. Many of these premium subsidy programs are possible under federally sponsored health insurance plans Medicaid and SCHIP. Seven states have approved state plan amendments to use SCHIP funds to provide premium assistance for enrollment in group health insurance coverage. A state may also elect to use state funds only to reach a more targeted audience. Some states consider premium assistance programs too administratively complex and not attractive enough to the target audience to be successful. Nonetheless, premium subsidies provide an opportunity to reduce premium costs facing employers and encourage participation, to reduce state program costs by partnering with employees, and improve coverage continuity for the entire family.

Assistance to employers can also take the form of a tax incentive for employers or employees to encourage the provision of private coverage through the workplace.

## 3. Build on Employer-Based Coverage

### OPTION 3.1

### *Employer and Employee Tax Incentives*

*Many of the uninsured in Hawai'i are low-income families with at least one member in the workforce. These families are too poor to afford the employer-based coverage that is offered to them. Or, they may work for an employer that does not offer employer-based coverage or does not extend employer-based coverage to spouses and dependents. This strategy is designed to encourage employers to offer health insurance and encourage employees to take advantage of employer-based health insurance available to them.*

#### **Target Group(s)**

- Low to moderate income working individuals and their families
- Part-time workers
- Employees of small businesses

#### **Key stakeholders in strategy**

- Legislature
- Employers and business groups
- Department of Taxation
- Labor unions and individuals

#### **How the program might work**

Build on existing base of employer-sponsored health insurance by improving employer offer rate and employee take up rate. Employers will be encouraged through direct or indirect subsidy to offer health coverage beyond the requirements of the Prepaid Health Care Act. For example, Employers might be eligible for a refundable tax credit to cover a portion of their cost of covering dependents. Employees would be eligible for a refundable tax credit to cover a portion of their health coverage costs. Coverage could also be increased if the state were required to offer coverage to emergency hires and temporary contract workers.

#### **Program cost/potential financing**

- State funds
- Private sector funds

#### **Related experiences**

15 states provide state-only tax relief, either through tax deductions or credits, to an employer or individual who purchases health insurance for themselves, their family, or their employees.

- The **Massachusetts** Insurance Partnership provides tax credits for small employers (under 20 employees) of low-income workers up to 200% FPL to offer group coverage. Massachusetts also offers employers currently not providing health plans incentive payments equaling \$1,000 for family coverage, \$800 for dual coverage, and \$400 for one adult if they begin offering a plan.
- The **Kansas** Tax Credit for Newly Insured is a tax credit of \$33 per employee per month open to any small 2-50 employer group that has not contributed to health insurance for the past two years. In two years, the program involved 123 groups.

#### **Major Pros and Cons**

PRO – Takes advantage of private dollars already available to go toward premium payments

PRO – Enables parents and children to have the same coverage

PRO – People often prefer private coverage to public coverage

CON – State will have to finance

CON – Administrative burden on tax department

CON – Employers may not be interested in participating if doing so means the imposition of any additional administrative burdens

#### **Resources and Contacts**

- [www.statecoverage.net](http://www.statecoverage.net)
- [www.state.ma.us/dph](http://www.state.ma.us/dph)

**94%**

Employers offer coverage for full-time employee dependents

Source: Hawai'i Employers Council, Employee Benefit Plans in Hawai'i, 1999, with permission

**85%**

Employers offer coverage for part-time employee dependents

Source: Hawai'i Employers Council, Employee Benefit Plans in Hawai'i, 1999, with permission

## 3. Build on Employer-Based Coverage

### OPTION 3.2

### *Premium Assistance/Employer Buy-In Program*

*Some families and many individuals are ineligible for federally-funded programs and have access to employer-based or individual products but cannot afford to purchase health insurance. The SCHIP program allows for states to use federal matching funds to pay for part or all of the premium payments for eligible children and/or their families with access to private health insurance. States may also use their own funds to establish premium assistance programs for individuals not eligible for federal funding.*

#### **Target Group(s)**

- Low to moderate-income adults and children with access to employer-based coverage.

#### **Key stakeholders in strategy**

- Department of Human Services
- Employers

#### **How the program might work**

This state-run, state-financed program would help those individuals take advantage of private insurance by helping them to pay all or part of the premiums for coverage. Payments may be made to the employee, the employer or directly to the health insurance carrier. In order to use federal funds for this program, the employer must offer a benefits package comparable to the state Medicaid program. If the employer does not offer such a package, it may still be possible to draw down federal funds by developing a “wrap around” relationship between the private and public sector – the private sector offers the basic package and the state offers the other services, making the total package comprehensive while still building on employer-based coverage.

#### **Program cost/potential financing**

- Cost share with families/individuals (sliding fee scale based on income)
- Cost share with employers/private sector. 50% contribution.
- Existing state funds
- New state funds such as a tobacco tax

#### **Related experiences**

- **Oregon’s** Family Health Insurance Assistance Program helps qualified Oregonians purchase insurance through their employer or through the individual market. Eligible individuals are Oregon residents at or below 170% FPL with investments and savings less than \$10,000, and uninsured for the past six months. Some participants are paid directly, in other cases, the program pays the insurance carrier directly. More than 5,000 lives are covered through this approach.
- **Maryland’s** Children’s Health Program provides premium assistance to families with income between 200%-300% FPL.
- **Virginia’s** Family Access to Medical Insurance Security Plan provides premium assistance for eligible children up to 200% FPL who have access to health insurance coverage through their parents’ employer.
- **Wisconsin’s** BadgerCare Program will pay premiums to enroll families into their employer-sponsored health insurance. To qualify for the Health Insurance Premium Purchasing Program, the employer must pay at least 60% but less than 80% of a family premium. In addition, the cost of the family premium, plus wraparound services equal to BadgerCare coverage, must be cost-effective compared to BadgerCare HMO coverage for the family.

**9,480**

Low-income parents who are uninsured.

Hawai’i is the only state where low-income parents have a lower rate of uninsurance than low-income children

Source: Lambrew, Jeanne M., *Health Insurance: A Family Affair: A National Profile and State-by-State Analysis of Uninsured Parents and Their Children*, The Commonwealth Fund, May 2001

**UNKNOWN**

Uninsured people living in families where the head of household is unemployed

**60%**

Percentage of uninsured people who live in households where there is at least one full-time job

Source: Hawai’i Health Survey 2000, Dept. of Health, analysis by SMS

### **Major Pros and Cons**

PRO – Takes advantage of private dollars already available to go toward premium payments

PRO – Could enable parents and children to have the same coverage

PRO – People prefer private coverage to public coverage

PRO – Helps maintain insurance coverage for people coming off welfare programs

CON – Administrative burden

CON – Potentially low enrollment

CON – Assistance will have to be large to have substantial impact

CON – Employers may not be interested in participating if doing so means the imposition of any additional administrative burdens.

### **Resources and Contacts**

- [www.statecoverage.net](http://www.statecoverage.net)
- Alberga, Jeremy, “Wisconsin’s BadgerCare Program Offers Innovative Approach for Family Coverage.” State coverage Initiatives Case Study (January 2001).
- [www.ipgb.state.or.us](http://www.ipgb.state.or.us)
- [www.dhmh.state.md.us/healthchoice/html/fact.htm](http://www.dhmh.state.md.us/healthchoice/html/fact.htm)
- [www.cns.state.va.us/dmas/child\\_health/FAMIS/FAMIS.htm](http://www.cns.state.va.us/dmas/child_health/FAMIS/FAMIS.htm)
- [www.dhfs.state.wi.us/badgercare/index.htm](http://www.dhfs.state.wi.us/badgercare/index.htm)

## ***4. Reform Health Insurance Market***

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Another approach to improving health care coverage is to enact market reforms that would enhance the availability of health insurance coverage to targeted groups regardless of their health status or claims experience and improve the overall fairness and efficiency of small group and individual health insurance markets. Throughout the 1990s, states across the country enacted a number of small group and individual health market reforms. They were passed in response to complaints from small employers and individuals about their inability to get and keep affordable health insurance.

Because of the Prepaid Health Care Act (PHCA), Hawai‘i’s health insurance market developed somewhat differently than markets in other states. The combination of the federal HIPAA regulations, unique standardized plans and voluntary community rating, reforming the health insurance market is a less likely strategy for Hawai‘i. However, some of the market reforms that Hawai‘i could consider include: changing the PHCA, establishing purchasing pools, creating high-risk insurance pools, allowing medical savings accounts, and authorizing limited benefit plans.

### **▶ 4.1 Change Hawai‘i Prepaid Health Care Act**

The PHCA requires most employers to provide health insurance to employees working more than 20 hours per week. Hawai‘i obtained a waiver from the federal Employee Retirement Income and Security Act (ERISA), which prohibits state regulation of self-insured employers, for the state’s employer health insurance mandate. The waiver restricts changes to the act. However, some argue that the current market circumstances warrant looking into the possibility of changes that would improve the PHCA’s effectiveness in insuring employees.

### **▶ 4.2 High-Risk Insurance Pool**

Twenty-nine states operate a high-risk pool to cover residents whose medical costs preclude them from obtaining coverage at affordable prices in the private market. A high-risk pool is typically a state-created, non-profit association that offers comprehensive health insurance benefits to individuals with pre-existing health problems; people who have been denied coverage in the private market due to a chronic illness or condition; people who have found they can only access restricted coverage; or people who have found coverage that costs more than what is available from the pool. Funding for the pool is subsidized through assessments on insurers or through government revenues.

### **▶ 4.3 Establish Purchasing Cooperatives**

A health insurance purchasing cooperative or purchasing alliance would enable small employers and individuals to band together to purchase coverage and achieve the same health insurance purchasing clout as large employers. Some states have considered providing public reinsurance for such purchasing alliances; the state would cover costs above a certain amount, thereby lowering the overall premium of available plans.



## ▶ 4.4 Medical Savings Accounts

Medical Savings Account (MSA) plans combine a high deductible health insurance policy that covers catastrophic medical expenses with a tax-free personal savings account to cover a portion of out-of-pocket health care expenses. Money deposited in an MSA may be used to pay for medical expenses not covered by the plan either because the deductible has not been met or because the medical expense is not covered by the plan (e.g., vision care, dental care). Funds withdrawn from an MSA for these purposes are not subject to income taxation.

Proponents of MSAs argue that they would lower the price of insurance coverage and create incentives for individuals to be more cost conscious in their utilization of health services. In 1996, Congress passed a law allowing for a pilot MSA program. Prior to the passage of this law 20 states had enacted some form of MSA legislation. According to the Internal Revenue Service, as of June 1998, 54,702 taxpayers (including 17,688 who had no health insurance prior to opening an account) had established MSA accounts.

## ▶ 4.5 Scaled-Down or Basic-Benefit Policies

Some states have tried to encourage more small employers to offer, and more employees to sign up for, health insurance by allowing insurers to sell certain policies that are exempt from some or all of a state's insurance benefit mandates (e.g., mental health, substance abuse). The purpose of allowing insurers to sell policies that are exempt from state benefit mandates is to reduce the cost of insurance and thus encourage more people to buy coverage. A number of states passed laws in the late 1980s and early 1990s authorizing "bare-bones" policies to small employers (usually firms with 25 or fewer employees). Some reports show that basic-benefit packages are not popular and furthermore, do not reduce premium costs.

## OPTION 4.1

### *Change Hawai‘i Prepaid Health Care Act*

*The Prepaid Health Care Act of 1974 (PHCA) requires most employers to provide health insurance to employees working more than half-time, making Hawai‘i the only state with such a requirement. Hawai‘i obtained a waiver from the federal Employee Retirement Income and Security Act (ERISA), which prohibits state regulation of self-insured employers, for the state’s employer health insurance mandate. However, that waiver restricts changes to the act and many believe that it is too difficult to change the act to reflect current circumstances.*

#### Target Group(s)

- Uninsured residents who are employed

#### Key stakeholders in strategy

- Employers of all sizes
- Employee groups, labor unions
- State government
- Hawai‘i Congressional Delegation
- Health plans

#### How the program might work

Specifically, proponents from a variety of perspectives argue for the following diverse changes:

- Eliminate the state government’s exemption from the provisions of the PHCA
- Include sole proprietors as “employers”

- Lower minimum hours to qualify for coverage
- Change mix of defined benefits
- Require family coverage under the act (PHCA does not require employers to extend coverage to spouses or dependents)
- Raise maximum employee contribution

#### Program cost/potential financing

- Employers
- Employees
- State via tax subsidies for employers and/or employees

#### Related experiences

These issues have been discussed at length at other times and venues. The overarching issue is fear that any change would threaten the ERISA exemption and Hawai‘i could lose the PHCA altogether.

#### Major Pros and Cons

PRO – Clear potential to reach “gap group”

PRO – Relatively easy to administer

PRO – Builds on Hawai‘i’s ability to cover individuals through employer-based coverage

PRO – May improve workforce quality by creating disincentive to create inefficient part-time jobs

PRO – An alternative cost-sharing could strengthen business and economy

CON – Any attempted change in the PHCA may jeopardize Hawai‘i’s ERISA exemption

CON – Politically challenging

**8,110**

Do not have insurance because they are part-time (less than 20 hours per week)

Source: Hawai‘i Health Survey 2000, Dept. of Health, analysis by SMS

**84%**

Of the insured population (around 888,870) are insured through their employment

Source: Hawai‘i Health Survey 2000, Dept. of Health, analysis by SMS

**94%**

Employers offer coverage for full-time employee dependents

Source: Hawai‘i Employers Council, Employee Benefit Plans in Hawai‘i, 1999, with permission

**85%**

Employers offer coverage for part-time employee dependents

Source: Hawai‘i Employers Council, Employee Benefit Plans in Hawai‘i, 1999, with permission

### OPTION 4.2

### High-Risk Insurance Pools

*People with chronic health conditions often have difficulty obtaining insurance. This is generally not a problem for persons with access to employer-sponsored health insurance. However, those without access to employer-sponsored health insurance cannot obtain coverage in the individual insurance market because of high premiums, deductibles, and co-payments.*

#### Target Group(s)

- People with chronic health conditions who are unable to obtain affordable private health insurance.

#### Key stakeholders in strategy

- Insurance Commissioner
- Legislature

#### How the program might work

Create a high-risk pool to cover Hawai'i residents whose medical costs preclude them from obtaining coverage at affordable prices in the private market. Subsidies may or may not be offered to eligible participants.

#### Program cost/potential financing

- Premiums are generally 125-200% of the cost of comparable private coverage
- Deductibles are typically \$500 to \$1,000 but can be as high as \$10,000 (Alaska, Arkansas, and Florida)
- Most states cap patient out-of-pocket expenses at \$2,000 to \$2,500 per year, but a few cap them at \$10,000 while others have no limits at all
- State or private funds would be necessary if subsidies are to be provided

#### Related experiences

29 states operate a high-risk pool to cover residents whose medical costs preclude them from obtaining

coverage at affordable prices in the private market. But enrollment is very limited and these pools cover only about 113,000 people.

- **Minnesota** has the largest program with 25,892 enrollees in 1999.
- The **Texas** Health Insurance Risk Pool is a health insurance program created by the Texas Legislature to provide health insurance to Texas residents who either 1) cannot obtain adequate health insurance coverage as a result of their medical conditions; or 2) are considered "Federally Eligible Individuals" as defined by HIPAA. The pool was created in 1989 and funded in 1997 with an appropriation of \$500,000. Premium rates are limited to no more than 200% of the standard premium rate.
- The **Wisconsin** Health Insurance Risk Sharing Plan offers health insurance to Wisconsin residents who, due to their medical conditions, are unable to find adequate health insurance coverage in the private market. Two plans are available to eligible persons under the program's major medical policy. The program is administered by the Wisconsin Department of Health and Family Services.

#### Major Pros and Cons

- PRO – Help for otherwise uninsurable people
- PRO – Costs are less than what they might otherwise be with no pooling
- CON – Limited enrollment
- CON – Waiting periods from six to 12 months
- CON – High premiums, deductibles and copayments

#### Resources and Contacts

- State Coverage Initiatives, [www.statecoverage.net](http://www.statecoverage.net)  
State Coverage Matrix
- Achman, Lori and Deborah Chollet, Insuring the Uninsurable: An Overview of State High-Risk Health Insurance Pools, Mathematica Policy Research, Inc. (August 2001).
- [www.txhealthpool.com](http://www.txhealthpool.com)
- [www.dhfs.state.wi.us/hirsp/index.htm](http://www.dhfs.state.wi.us/hirsp/index.htm)

22,340

Uninsured cite inability to afford insurance premiums as main reason for being uninsured

Source: Hawai'i Health Survey 2000, Dept. of Health, analysis by SMS

1,370

Uninsured reported that they were refused coverage

Source: Hawai'i Health Survey 2000, Dept. of Health, analysis by SMS

## 4. Reform Health Insurance Market

### OPTION 4.3

### *Establish Purchasing Cooperatives*

*Certain characteristics of the health care market make it difficult for segments of the population to obtain insurance. Workers who fall outside of the Prepaid Health Care Act requirements often find it difficult to purchase affordable health insurance. A health insurance purchasing cooperative (also known as a purchasing alliance) shops for, selects, and monitors the quality of care and service provided by health insurance plans that it makes available to its members.*

#### **Target Group(s)**

- Low income workers
- Individuals (self-employed, independent contractors, freelancers)
- Part-time workers (temps, emergency hires)
- Small business employers and employees

#### **Key stakeholders in strategy**

- Legislature
- New entity, i.e. a non-profit agency
- Health plans
- Employers

#### **How the program might work**

A law authorizing health insurance purchasing cooperatives would have to be passed. This would enable small employers and certain individuals to band together to purchase coverage and achieve the same health insurance purchasing clout as large employers. The law should take one of three approaches – either it would call for the establishment of a single purchasing cooperative, allow for regional alliances or authorize the creation of competing groups. The state would consider public reinsurance of the plans offered by the cooperative in order to reduce the overall premium cost.

#### **Program cost/potential financing**

- State funds
- Private funds
- Start-up costs of cooperative

#### **Related experiences**

By the end of 1998, 28 states had enacted laws authorizing health care purchasing cooperatives.

- **California** established the Health Insurance Plan of California. By June, 1999, the program was

**50,440**

Adults who are uninsured and at 100%-300% Federal Poverty Level. Not clear what portion of these are employed

Source: Hawai'i Health Survey 2000, Dept. of Health, analysis by SMS

**22,340**

Uninsured cite inability to afford insurance premiums as main reason for being uninsured

Source: Hawai'i Health Survey 2000, Dept. of Health, analysis by SMS

**133,430**

Self-employed workers in 1999 (19.2% of civilian workforce)

Source: The State of Hawai'i Data Book 2000, Table 12.17, [www.hawaii.gov/dbedt/](http://www.hawaii.gov/dbedt/)

**8,110**

Do not have insurance because they are part-time (less than 20 hours per week)

Source: Hawai'i Health Survey 2000, Dept. of Health, analysis by SMS

**4<sup>th</sup> in the nation**

Hawai'i ranks for most people holding multiple jobs in civilian workforce (9.8%)

Source: The State of Hawai'i Data Book 2000, Table 12.20, [www.hawaii.gov/dbedt/](http://www.hawaii.gov/dbedt/)

**73%**

Of the 29,569 businesses in Hawai'i in 1999 (excludes government and self-employed workers) employ fewer than 10 employees and 52% employ four or fewer employees

Source: The State of Hawai'i Data Book 2000, Tables 15.15 and 115.17, [www.hawaii.gov/dbedt/](http://www.hawaii.gov/dbedt/)

**1,576**

State government workers classified as "emergency hires" in 2001

Source: State Department of Human Resources

providing coverage for about 8,200 employer groups, nearly 84,000 employees and more than 144,000 enrollees.

- **Arizona:** The Healthcare Group of Arizona makes prepaid coverage from three HMOs available to businesses with two to 50 employees and the self-employed; more than 11,600 people are enrolled.
- The **New Mexico** Health Insurance Alliance offers a basic insurance package to small businesses, the self-employed, and those who lose group coverage; it covers 8,500 lives in 1,800 firms and 1,900 individual policies.

### Major Pros and Cons

PRO – Cooperatives could keep down insurance rates by negotiating lower rates on behalf of their small employer members and encouraging insurers who contracted with them to compete on the basis of efficiency, quality and service

PRO – Increase health plan choice and limit disruptions in patient-provider relationships by giving alliance members a wide choice of plans and allowing individual employees to select whichever plan they wanted

PRO – Reduce access inequities by requiring cooperatives to be open to all eligible small employers

PRO – Reduce high administrative costs for small employers through economies of scale realized by banding together into a single purchasing, bargaining and consumer education unit

CON – Adverse selection is possible in purchasing pools

CON – Cooperatives have increased plan choice for employees of small firms but it is not clear that they have been able to achieve sustained health insurance premium savings for their members

### Resources and Contacts

- Commonwealth Fund, Expanding Employment Based Health Coverage: Lessons from Six State and Local Programs (February, 2001) [www.cmwf.org](http://www.cmwf.org)
- Commonwealth Fund, State and Local Initiatives to Enhance Health Coverage for the Working Uninsured (November, 2000). [www.cmwf.org](http://www.cmwf.org)
- Riley & Yondorf, Access for the Uninsured: Lessons from 25 Years of State Initiatives, Flood Tide Forum, National Academy for State Health Policy. (January 2000): pgs 26-28.

### OPTION 4.4

### *Medical Savings Accounts*

*A medical savings account (MSA) is an account in which individuals can accumulate contributions to pay for medical care or insurance. Under certain circumstances, contributions to these accounts are tax deductible. MSAs have been raised as a possible way to lower costs and allow individual choice.*

#### **Target Group(s)**

- Moderate-income insured and uninsured population
- Self-employed and small businesses

#### **Key stakeholders in strategy**

- Business groups
- Employee groups
- Health care providers and educators
- Health plans
- Financial institutions
- Legislature

#### **How the program might work**

A law allowing the practice would have to be passed. Holders of MSAs would need a high deductible health insurance policy that covers catastrophic medical expenses. They would also setup a tax-free personal savings account to cover a portion of out-of-pocket health care expenses. Money deposited in an MSA may be used to pay for medical expenses not covered by the plan either because the deductible has not been met or because the medical expense is not covered by the plan (e.g., vision care, dental care). Funds withdrawn from an MSA for these purposes are not subject to income taxation.

#### **Program cost/potential financing**

- Individual payments
- Administrative costs of financial institutions and health plans
- Tax deductions

#### **Related experiences**

In 1996, Congress passed a law allowing for the establishment of a pilot program under which up to 750,000 small employers would set up Federally tax deductible MSA plans. Prior to this law, 20 states had enacted some form of MSA legislation. MSA sales have been slower than predicted and there appears to have been no negative impact on the health insurance market.

#### **Major Pros and Cons**

PRO – MSAs may appeal to the public

PRO – More responsibility is placed in the hands of health care consumers

CON – MSA plans may adversely affect market and increase risk segmentation

CON – Not much evidence on MSA effectiveness as of yet

CON – Reliance on individual may create inequitable outcomes

#### **Resources and Contacts**

- Riley & Yondorf, Access for the Uninsured: Lessons from 25 Years of State Initiatives, Flood Tide Forum, National Academy for State Health Policy (January, 2000).
- Mark Pauly, et al. "What Would Happen If Large Firms Offered MSAs? Health Affairs, Vol. 19 No. 3 May/June 2000.

**82,998**

Families below living wage

Source: U.S. Census Bureau, Demographic Surveys Division, 2001

**138,330**

"Middle-income" families with incomes from \$48,284 to \$101,405

Source: U.S. Census Bureau, Demographic Surveys Division, 2001

## 4. Reform Health Insurance Market

### OPTION 4.5

### *Scaled-Down or Basic-Benefit Policies*

*Some states have tried to encourage more small employers to offer and more employees to sign up for health insurance by allowing insurers to sell certain policies that are exempt from some or all of a state's insurance benefit mandates. These limited benefit policies reduce the cost of insurance and thus encourage more people to buy coverage.*

#### **Target Group(s)**

- Small businesses
- Low-income uninsured

#### **Key stakeholders in strategy**

- Insurance Commissioner
- Employers
- Health plans
- Individuals

#### **How the program might work**

The state would have to authorize insurance policies that restrict the insurance benefit package. A benefit package could be designed to limit use of some providers, some types of services, or certain drugs. Mandatory services may still be offered, but optional services dropped.

#### **Program cost/potential financing**

- Premiums
- Administrative costs

#### **Related experiences**

By 1995, 43 states had “bare bones” laws. These policies have not been as attractive as proponents had hoped. They have not substantially reduced insurance premiums. Federal and state health care reforms have also contributed to make them more difficult and less attractive to offer.

- **Oregon** has done extensive work to review and design a basic-benefit package, recognizing that both public and private insurers can restrict the use of an insurance benefit package in efforts to curb costs.
- **New York** recently launched the Healthy NY Program. Healthy NY offers scaled-down comprehensive benefits to encourage small employers to offer health insurance coverage to their employees, dependents and other qualified individuals. It is available for eligible businesses with 50 or fewer employees.

#### **Major Pros and Cons**

PRO – More affordable coverage

PRO – Appeal to low-risk employee

PRO – Allows choice to individual

CON – People prefer/demand richer benefits

CON – Lose non-economic benefits of mandated services

CON – Difficult to achieve consensus on benefits to be included

CON – Restrictions may reduce access to needed care

#### **Resources and Contacts**

- Riley & Yondorf, Access for the Uninsured: Lessons from 25 Years of State Initiatives, Flood Tide Forum, National Academy for State Health Policy. (January 2000).
- GA Jensen & M.A. Morrissey, “Employer-Sponsored Health Insurance and Mandated Benefit Laws.” Millbank Quarterly Vol. 77, no. 4 (1999): 425.
- State of Oregon, Issues Involved in Designing a Basic-Benefit Package and Determining Actuarial Equivalence.  
[www.statecoverage.net/statereports/or10.pdf](http://www.statecoverage.net/statereports/or10.pdf)
- Healthy New York Program:  
[www.ins.state.ny.us/healthyny.htm](http://www.ins.state.ny.us/healthyny.htm)

**22,340**

Uninsured cite inability to afford insurance premiums as main reason for being uninsured

Source: Hawai'i Health Survey 2000, Dept. of Health, analysis by SMS

**8,110**

Stated that they were no longer insured because their employer stopped offering coverage, or their employment was cut back to part-time

Source: Hawai'i Health Survey 2000, Dept. of Health, analysis by SMS

## ***5. Support Safety Net***

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Besides affordability of health insurance, access to health care services plays an important role in ensuring the health of a community. While we work to improve access to health insurance, many insured and uninsured Hawai‘i residents, particularly those who are disenfranchised and live in rural parts of the state, will continue to suffer from unaddressed health conditions. Even individuals who are insured are at risk for poor health outcomes if they do not have access to adequate health care services within their community. Thus, any effort to address access to insurance must also address access to health care services.

### **► 5.1 Support Safety Net Providers**

Each year, millions of uninsured people in the U.S. receive care from publicly supported health clinics, public health nurses, community hospitals, and other safety net providers. In addition, medical facilities and health care professionals donate significant amounts of free care to indigent patients. However, it is impossible to ensure regular access to necessary care for all the uninsured through indigent care programs. Such programs do not have the resources to care for the growing number of individuals without the means to pay for health care services.

One way to support providers is to establish a state fund to pay for basic health care services provided to the medically indigent. This fund, also referred to as an uncompensated care pool, could support safety net providers proportionately to the uncompensated service they provide.

Another way to support the safety net is to provide organizational and administrative support to networks of providers, including hospitals and physicians, who voluntarily agree to provide free or low-cost services to the uninsured.

### **► 5.2 Expand Safety Net Providers**

A strategy that results in access to primary care to people whose options are otherwise limited is establishing or expanding community health centers in more underserved communities.

Community health centers:

- Are community-based (over half of their board members are users of the centers)
- Are nonprofit entities
- Are cost-effective, caring for individuals for an average cost of \$581/year
- Are comprehensive, providing a full range of primary care, diagnostic, and therapeutic services
- Are culturally competent, specializing in care for Native Hawaiians and for individuals who do not speak English as a native language
- Are open on weekends and after hours
- Are accessible to all regardless of ability to pay



- Offer high quality care, meeting state and federal standards including those of their funding sources
- Leverage federal, state, and charitable funds and collect fees from patients where possible.

Hawai‘i has ten community health centers on the islands of Kaua‘i, O‘ahu, Maui, and Hawai‘i. There are no health centers on Ni‘ihau, Moloka‘i or Lana‘i. Currently, there are about 220,000 people in Hawai‘i who live in federally-designated Health Professional Shortage Areas and 330,000 who are in areas designated as being Medically Underserved. The ten health centers currently serve about 70,000 people per year. Ni‘ihau, Lana‘i, Moloka‘i, Kona and Kohala are all designated areas that have no health centers.

## OPTION 5.1

## Support Safety Net Providers

*Improving access to health insurance will take time. In the meantime, many uninsured and underinsured Hawai'i residents will continue to suffer from unaddressed health conditions. In addition, there are many individuals who do have insurance—particularly those who are culturally or linguistically disenfranchised, who live in rural parts of the state with few provider options, who are unacquainted with the business of using insurance, and who otherwise have trouble accessing the traditional health care system. This strategy focuses on shoring up existing safety net providers such as community health centers and hospitals, to provide continuous care to the uninsured and disenfranchised.*

### Target Group(s)

- Uninsured people
- Uninsurable people
- Rural residents
- Medically underserved areas

### Key stakeholders in strategy

- Safety net providers
- State government
- Federal government
- Legislature and other public/private funders

### How the program might work

Support safety net providers with funding to provide care for the uninsured. Establish a state fund (also called an uncompensated care pool) for basic health care for medically indigent.

### Program cost/potential financing

- Existing federal, state and local funds
- Private donations and grants
- New funds such as a tobacco tax

### Related experiences

- The **Colorado** Indigent Care Program uses state general funds and federal funds to provide financial assistance (up to 30 cents on the dollar in 1997) to hospitals and clinics for services provided to low income (up to 185% FPL) uninsured patients who are not eligible for Medicaid.
- **California** uses state tobacco surtax revenues to finance local indigent care programs.
- **New Mexico** passed a state law allowing counties to improve local taxes to pay for indigent health care. The County Indigent Care Fund is voluntary for counties, but all but four counties have elected to participate. In FY 1998, 29 counties raised \$23 million to serve the medically indigent through community health centers, individual providers, and hospitals. \$16 million went to local hospitals. Some of the funds collected were used to draw down additional federal funds.

### Major Pros and Cons

- PRO – Services available to all uninsured
- PRO – Culturally and linguistically appropriate community-based care
- PRO – Continuity of care
- CON – Potential duplication of effort
- CON – Sector is undercapitalized

**26,000**

Uninsured patients (55,000 visits) seen by Hawai'i's Community Health Centers

Source: Hawai'i Primary Care Association

**\$85,900,000**

Uncompensated care provided by Hawai'i's hospitals in FY 2001  
(\$67,100,000 in bad debt and \$18,800,000 in charity care)

Source: Hawai'i Primary Care Association

**\$92,600,000**

Anticipated uncompensated care provided by Hawai'i's hospitals in FY 2002

Source: Healthcare Association of Hawai'i

## OPTION 5.2

## Expand Safety Net Providers

*Community Health Centers (CHCs) provide a full range of preventative and primary health care services, including mental health and substance abuse treatment, case management, and referrals to and oversight of inpatient care. Patients are charged on a sliding scale and no one is turned away. Lower infant mortality rates, fewer hospital admissions, shorter hospital stays, and lower Medicaid costs characterize communities with health centers. CHCs are also a positive influence on problems of violence, child abuse, substance abuse and homelessness. CHCs stimulate education, empower communities, and contribute greatly to the neighborhood jobs and economy. Hawai‘i has ten CHCs on four islands. In addition, all of Hawai‘i’s hospitals provide uncompensated care to the uninsured.*

### Target Group(s)

- Uninsured people
- Uninsurable people
- Rural residents
- Medically underserved areas

### Key stakeholders in strategy

- Schools, social service agencies and other community organizations
- State government
- Federal government
- Legislature and other public/private funders
- AHEC or other professional/paraprofessional education programs

### How the program might work

Develop community health centers in underserved areas and provide linkages with hospitals, specialty services, and the private sector.

### Program cost/potential financing

Health centers vary considerably from one to another but, in aggregate:

- ~30% of their revenues come from federal, state, or county sources
- ~5% come from charitable giving
- ~60% comes from fees collected from patients or their insurance and more than half of this amount is paid by Medicaid

### Related experiences

**Community Clinic of Maui** started in the early 1990s and now cares for 6,000 patients, 64% of whom are uninsured, and two-thirds of whom are below 200% of poverty. They are one of the biggest providers of perinatal care for women covered by QUEST on Maui. They serve more HIV-positive patients than any other provider on the island and they serve 400 homeless individuals. They are also the most accessible provider for the growing number of Latino agricultural workers on the island and serve over 1,000 Native Hawaiians. Very few of their patients would be welcome or comfortable in other practices. In addition to medical and behavioral health services, Community Clinic of Maui’s essential services include assistance with applications for Medicaid/QUEST.

### Pros and Cons

PRO – Services available to all uninsured

PRO – Culturally and linguistically appropriate community-based care

PRO – Continuity of care

CON – CHCs require a steady budget supplementation to ensure continued operations

CON – CHCs have to meet all the same quality, administrative, confidentiality, corporate compliance, billing, and other regulations as any other facility while also meeting the special access needs of target groups—all with very little money

### Resources and Contacts

Hawai‘i Primary Care Association and the Department of Health are the most knowledgeable local resources. Nationally, a key resource is the federal Bureau of Primary Health Care.

**332,520**

Individuals live in Medically Underserved Areas/Populations

Sources: Department of Health, Family Health Services Division; Bureau of Primary Care, Health Services and Resource Administration [www.bphc.hrsa.gov/databases/](http://www.bphc.hrsa.gov/databases/); U.S. Bureau of the Census, 2000

**233,320**

Individuals live in Health Professional Shortage Areas

Sources: Department of Health, Family Health Services Division; Bureau of Primary Care, Health Services and Resource Administration [www.bphc.hrsa.gov/databases/](http://www.bphc.hrsa.gov/databases/); U.S. Bureau of the Census, 2000

# ACRONYMS & GLOSSARY OF TERMS

## Acronyms used in this report

<b>AFDC</b>	Aid to Families with Dependent Children
<b>BRFSS</b>	Behavioral Risk Factor Surveillance System
<b>CDC</b>	Centers for Disease Control (federal agency)
<b>CHAMPUS</b>	Civilian Health and Medical Program of the Uniformed Services
<b>CHC</b>	Community Health Center
<b>CMS</b>	Centers for Medicare and Medicaid Services (federal agency)
<b>COBRA</b>	Consolidated Omnibus Budget Reconciliation Act
<b>CPS</b>	Current Population Survey
<b>DHS</b>	Hawai'i State Department of Human Services
<b>DOE</b>	Hawai'i State Department of Education
<b>DOH</b>	Hawai'i State Department of Health
<b>ERISA</b>	Employee Retirement Income Security Act of 1974
<b>FHIAP</b>	Oregon's Family Health Insurance Assistance Program
<b>FMAP</b>	Federal Matching Assistance Percentage
<b>FPL</b>	Federal Poverty Level
<b>HIFA</b>	Health Insurance Flexibility and Accountability Initiative
<b>HIPAA</b>	Hawai'i Institute for Public Affairs
<b>HIPAA</b>	Health Insurance Portability and Accountability Act
<b>HIPC</b>	Health Insurance Purchasing Cooperatives
<b>HMO</b>	Health Maintenance Organization
<b>HRSA</b>	Health Resources and Services Administration (federal agency)
<b>HUP</b>	The Hawai'i Uninsured Project
<b>Medicaid FFS</b>	Medicaid Fee-for-Service
<b>MSA</b>	Medical Savings Account
<b>PHCA</b>	Hawai'i's Prepaid Health Care Act of 1974
<b>QUEST</b>	Quality Care, Universal Access, Efficient utilization, Stabilizing costs, and Transforming
<b>SCHIP</b>	State Children's Health Insurance Program
<b>SHIP</b>	State Health Insurance Program
<b>TANF</b>	Temporary Assistance to Needy Families

## A

### **Aid to Families with Dependent Children (AFDC)**

Formerly the major public assistance program for people eligible for public assistance because their income fell below state established standards (see FPL). This group was also eligible for Medicaid. See TANF/TAONF for current information.

### **Access**

Access is an individual's ability and willingness to obtain appropriate health care services. Barriers to access can be financial (insufficient monetary resources), geographic (distance to providers), organizational (lack of available providers), and sociological (e.g., discrimination, language barriers). Efforts to improve access often focus on providing or improving health insurance coverage.

**Administrative Costs**

Costs related to utilization review, insurance marketing, medical underwriting, agents' commissions, premium collection, claims processing, quality assurance programs, and risk management.

**Adverse Selection**

Among applicants for a given group or individual program, the tendency for those with an impaired health status, or who are prone to higher than average utilization of benefits, to be enrolled in disproportionate numbers and lower deductible plans.

**Allowable Costs**

Medical cost that is reimbursable by an insurance carrier.

**All Payer System**

A system under which both government and private insurance plans pay the same amount for the same service. Prohibits health providers from cost shifting.

## B

**Behavioral Risk Factor Surveillance System (BRFSS)**

BRFSS is an annual telephone survey conducted by the state under contract to the Centers for Disease Control and Prevention (CDC). All state residents aged 18 and over are eligible to be part of the sample of approximately 2000 respondents accessed through a random digit dial (RDD) computer assisted telephone interview (CATI). Questions related to a variety of behaviors that affect health are asked, such as diet, smoking and the use of preventive health services. BRFSS is used to: assist in assessing health care delivery and access to primary care; provide data to programs researching the extent of health insurance coverage; and document the association between lack of health insurance or inadequate health insurance, selected risk behaviors and factors, and utilization of clinical preventive services.

**Beneficiary**

Individual who is either using or eligible to use insurance benefits, including health insurance benefits, under an insurance contract.

**Benefit Payment Schedule**

List of amounts an insurance plan will pay for covered health care services.

**Budget Neutrality**

Budget neutrality is a limitation imposed on an overall budget to ensure that it will neither increase nor decrease the total amount of the previous budget. For example, section 1115 waivers are only granted if states can prove budget neutrality.

## C

**Capitation**

Method of payment whereby a physician or hospital is paid a fixed amount for each person in a particular plan regardless of the frequency or type of service provided.

**Carve Out**

An arrangement that eliminated coverage for a specific category of medical care services under an insurance policy or managed care plan.

**Case Management**

The process by which all health-related matters of a case are managed by a physician or nurse or designated health professional. Physician case managers coordinate designated components of health care, such as appropriate referral to consultants, specialists, hospitals, ancillary providers and services. Case management is intended to ensure continuity of services and accessibility to overcome rigidity, fragmented services, and the inappropriate utilization of facilities and resources. It also attempts to match the appropriate intensity of services with the patient's needs over time.

**Centers for Medicare and Medicaid Services (CMS)**

Formerly known as the Health Care Financing Administration (HCFA), this federal agency oversees all aspects of health financing for Medicare and also oversees the Office of Prepaid Health Care Operations and Oversight (OPHCOO). It is part of the US Department of Health and Human Services. In addition to its many other functions, CMS is the contracting agency for HMOs who seek direct contractor/provider status for provision of the Medicare benefit package.

**Certificate of Coverage (COC)**

A description of the benefits included in a carrier's plan. The certificate of coverage is required by state laws and represents the coverage provided under the contract issued to the employer. The certificate is provided to the employee.

**CHAMPUS**

Civilian Health and Medical Program of the Uniformed Services. A Department of Defense program that supports private sector health care for military dependents. The former military health care program, it has now become the "TRICARE Standard." The current TRICARE Standard has the same benefits and cost-sharing structure as the former CHAMPUS program. See TRICARE.

**Co-insurance**

A cost-sharing requirement under a health insurance policy that provides that the insured will assume a portion or percentage of the costs of covered services. After the deductible is paid, this provision forces the subscriber to pay for a certain percentage of any remaining medical bills, usually 20 percent.

**Community Rating**

Setting insurance rates based on the average cost of providing health services to all people in a geographic area, without adjusting for each individual's medical history or likelihood of using medical services.

**Consumer Price Index (CPI)**

CPI is prepared by the U.S. Bureau of Labor Statistics. It is a monthly measure of the average change in the prices paid by urban consumers for a fixed market basket of goods and services. The medical care component of CPI shows trends in medical care prices based on specific indicators of hospital, medical, dental, and drug prices.

**Coordination of Benefits (COB)**

Provisions and procedures used by thirdparty payers to determine the amount payable to each payer when a claimant is covered under two or more group health plans.

**Co-payment**

A type of cost-sharing which requires the insured or subscriber to pay a specified flat dollar amount, usually on a "per unit of service" basis, with the third party payer reimbursing some portion of remaining charges.

**Cost Sharing**

The general set of financing arrangements whereby the consumer must pay out-of-pocket to receive care, either at the time of initiating care, or during the provision of health care services, or both. Cost sharing can also occur when an insured pays a portion of the monthly premium for health care insurance.

**Cost Shifting**

Charging one group of patients more in order to make up for underpayment by others. Most commonly, charging some privately insured patients more in order to make up for underpayment by Medicaid or Medicare.

**Coverage**

Coverage is the guarantee against specific losses provided under the terms of an insurance policy. Coverage is sometimes used interchangeably with benefits or protection, and is also used to mean insurance or insurance contract.

**Crowd-out**

Crowd-out, also called substitution, is a phenomenon whereby new public programs or expansions of existing public programs designed to extend coverage to the uninsured prompt some privately insured persons to drop their private insurance coverage and take advantage of the expanded public subsidy.

**Current Population Survey (CPS)**

CPS is a U.S. Census Bureau survey conducted nationally to measure employment, health insurance status, income, and other variables. Results from this survey are used in many states to estimate the size and composition of populations that are potentially eligible for public programs and the number of persons without health insurance.

## D

**Deductible**

The out-of-pocket expenses that must be borne by an insurance subscriber before the insurer will begin reimbursing the subscriber for additional expenses.

**Diagnosis-Related Groups (DRG)**

A system used by Medicare and other insurers to classify illnesses according to diagnosis and treatment. All Medicare inpatient hospital operating costs are determined in advance and paid on a per-case basis, according to fixed amount or weight established for each DRG.

**Direct Contracting**

Individual employers or business coalitions contract directly with providers for health care services with no HMO/PPO intermediary. This enables the employer to include in the plan the specific services preferred by their employees. It is usually done under ERISA guidelines.

**Discounted Fee-for-Service**

A financial reimbursement system whereby a provider agrees to provide services on a fee-for-service basis, but with the fees discounted by a certain percentage from the physician's usual charges.

**Disproportionate Share Hospital (DSH) Adjustment**

A DSH adjustment is a payment adjustment under Medicare's Prospective Payment System (PPS) or under Medicaid for hospitals that serve a relatively large volume of low-income patients.

## E

**Early and Periodic Screening, Diagnosis and Treatment (EPSDT)**

EPDST program covers screening and diagnostic services to determine physical or mental defects in recipients under age 21, as well as health care and other measures to correct or ameliorate any defects and chronic conditions discovered.

**Employee Retirement Income Security Act (ERISA)**

ERISA exempts self-insured health plans from state laws governing health insurance, including contribution to risk pools, prohibitions against disease discrimination and other state health reforms.

**Employer-sponsored Insurance (ESI) Buy-in**

A program in which Medicaid or SCHIP pays premiums for employer-based health insurance to cover recipients when it is determined that buying the private insurance plan is cost-effective in comparison to the cost of covering the enrollee in the default program.

**Exclusions**

Clauses in an insurance policy that deny coverage for select individuals, groups, locations, properties, or risks.

**Exclusive Provider Organization (EPO)**

A managed care organization that is organized similarly to PPOs in that physicians do not receive capitated payments, but that only allows patients to choose medical care from network providers. If patient elects to seek care outside of the network, then he or she will not be reimbursed for the cost of the treatment.

**Experience Rating**

A system where an insurance company evaluates the risk of an individual or group by looking at the applicant's health history.

## F

**Family Coverage**

Family coverage is the concept of covering not only eligible children through public programs, i.e., Medicaid or SCHIP, but also covering the child's parents. For example, in the SCHIP program, states may receive CMS approval to cover eligible children and their parents through employer-sponsored insurance. In order to receive the CMS approval to provide family coverage, programs must be cost-effective and must not cause crowd-out.

**Federal Poverty Level (FPL)**

The Federal Poverty Level is the amount of income determined by the Department of Health and Human Services to provide a bare minimum for food, clothing, transportation, shelter, and other necessities. The level varies according to family size and changes yearly. Public assistance programs, such as Medicaid and SCHIP, usually define income limits in relation to FPL. Separate guidelines exist for Alaska and Hawai'i and are shown in the 2001 HHS – FPL Guidelines below.

## 2001 HHS Poverty Guidelines

Size of Family Unit	48 Contiguous States and D.C.	Alaska	Hawai'i
1	\$ 8,590	\$10,730	\$ 9,890
2	11,610	14,510	13,360
3	14,630	18,290	16,830
4	17,650	22,070	20,300
5	20,670	25,850	23,770
6	23,690	29,630	27,240
7	26,710	33,410	30,710
8	29,730	37,190	34,180
For each additional person, add	\$3,020	\$3,780	\$3,470

Source: Federal Register, Vol. 66, No. 33, February 16, 2001, pp. 10695-10697.

### **Federally Qualified Health Centers (FQHC)**

FQHC is a federal payment option that enables qualified providers in medically underserved areas to receive cost-based Medicare and Medicaid reimbursement and allows for the direct reimbursement of nurse practitioners, physician assistants, and certified nurse midwives. Federal legislation creating FQHC category was enacted in 1989.

### **Federally Qualified Health Maintenance Organizations**

HMOs that meet certain federally stipulated provisions aimed at protecting consumers, e.g., providing a broad range of basic health services, assuring financial solvency, and monitoring the quality of care. HMOs must apply to the federal government for qualification. The Centers for Medicare and Medicaid Services (CMS) of the Department of Health and Human Services (DHHS) administers the process.

### **Fee for Service**

The traditional payment method whereby patients pay doctors, hospitals, and other providers for services rendered and then bill private insurers or the government.

### **Fee Schedule**

A comprehensive listing of fees used by either a health care plan or the government to reimburse physicians and/or other providers on a fee-for-service basis.

### **Fiscal Intermediary**

The agent (e. g. Blue Cross) that has contracted with providers of service to process claims for reimbursement under health care coverage. In addition to handling financial matters, it may perform other functions such as providing consultative services or serving as a center for communication with providers and making audits of providers' needs.

### **Formulary**

A list of selected pharmaceuticals and their appropriate dosages felt to be the most useful and cost effective for patient care. Organizations often develop a formulary under the aegis of a pharmacy and therapeutics committee. In HMOs, physicians are often required to prescribe from the formulary.

### **Full Cost Buy-in**

A full cost buy-in, in relation to public insurance programs, is an unsubsidized health insurance program. These state programs allow people who do not meet the income requirements for their Medicaid or SCHIP plans to enroll in the state plan by paying the full premium.

## G

### **Group Insurance**

Any insurance policy or health services contract by which groups of employees (and often their dependents) are covered under a single policy or contract, issued by their employer or other group entity.

### **Group Model HMO**

An HMO that contracts with a multi-specialty medical group to provide care for HMO members; members are required to receive medical care from a physician within the group unless a referral is made outside the network.



**Guaranteed Issue**

Guaranteed issue is the requirement that each insurer and health plan accept everyone who applies for coverage and guarantees the renewal of that coverage as long as the applicant pays the premium.

**Guaranteed Renewal**

Guarantee renewal is the requirement that each insurer and health plan continue to renew health policies purchased by individuals as long as the person continues to pay the premium for the policy.

# H

**Hawai'i Household Health Interview Survey (HHIS)**

HHIS is a continuous statewide household survey of health and socio-demographic conditions. The survey is conducted as a means of providing Hawai'i Department of Health (DOH) programs, other agencies, and the public with statistics for planning and evaluation of health services, programs, and problems. The survey provides demographic information for observing population changes during the intercensal decade. It is the primary source of statewide estimates of gender, age, income, race, education, household size, insurance status, health status, morbidity and food security.

**Health Care Financing Administration (HCFA)**

The Health Care Finance Administration is now known as the Centers for Medicare and Medicaid Services (CMS). For information, see *Centers for Medicare and Medicaid Services (CMS)*.

**Health Insurance Portability and Accountability Act (HIPAA) of 1996**

HIPAA (previously called the Kassebaum-Kennedy bill) is a federal act that protects people who change jobs, are self-employed, or who have pre-existing medical conditions. HIPAA standardizes an approach to the continuation of healthcare benefits for individuals and members of small group health plans and establishes parity between the benefits extended to these individuals and those benefits offered to employees in large group plans. The act also contains provisions designed to ensure that prospective or current enrollees in a group health plan are not discriminated against based on health status.

**Health Insurance Premium Payment (HIPP) Program**

The Health Insurance Premium Payment Program is a Medicaid program that pays for the cost of health insurance premiums, coinsurances, and deductibles. The program pays for health insurance for Medicaid-eligible persons with access to employer-based insurance when it is proven cost-effective to do so.

**Health Insurance Purchasing Cooperative (HIPC)**

Health insurance purchasing cooperatives are public or private organizations that secure health insurance coverage for the workers of all member employers. The goal of these organizations is to consolidate purchasing responsibilities to obtain greater bargaining clout with health insurers, plans, and providers, and to reduce the administrative costs of buying, selling, and managing insurance policies. Private cooperatives are usually voluntary associations of employers in a similar geographic region who band together to purchase insurance for their employees. Public cooperatives are established by state governments to purchase insurance for public employees, Medicaid beneficiaries and other designated populations.

**Health Maintenance Organization (HMO)**

HMOs offer prepaid, comprehensive health coverage for both hospital and physician services. An HMO contracts with health care providers, e.g., physicians, hospitals, and other health professionals, and members are required to use participating providers for all health services. Members are enrolled for a specified period of time. Model types include staff, group practice, network and IPA (for additional information, see staff, group, network and IPA model definitions).

**High-Risk Pool**

A high-risk pool is, typically, a state-created, nonprofit association that offers comprehensive health insurance benefits to individuals with pre-existing health problems: people who have been denied coverage in the private market due to a chronic illness or condition; who have found they can only access restricted coverage; or have found coverage that costs more than what is available from the pool. Funding for the pool is subsidized through assessments on insurers or through government revenues.

**Hill-Burton**

The system under which hospitals that receive funds for modernization and construction under the Hill Burton Act of 1946 have an obligation to provide a certain amount of charity care.

**Hospital-Physician Alliance (HPA)**

A partnership between a hospital and some or all of its staff physicians. There are many different types of hospital-physician alliances, ranging from an informal sharing of expertise, in which the hospital provides assistance in office staff training, marketing, educational programs, etc., to a more structured arrangement, involving computer networking, assistance with physician recruitment, and practice development. Examples of formal business structures include: physician-hospital organizations for managed care contracting, management services organizations for practice management, and integrated delivery systems for joint development of a broad range of clinical services (e.g., ambulatory care, home health care).

# I

**Income Disregards**

Income disregards, in relation to state health insurance programs, are certain amounts of income deducted in counting allowable income for eligibility for a certain program, such as Medicaid or SCHIP.

**Independent Practice Association (IPA)**

A health maintenance organization delivery model in which the HMO contracts with a physician organization, which, in turn, contracts with individual physicians. The IPA physicians practice in their own offices and continue to see fee-for-service patients. The HMO reimburses the IPA on a capitated basis; however, the IPA usually reimburses the physicians on a fee-for-service basis. This type of system combines prepayment with the traditional means of delivering health care.

**IPA Model HMO**

An open panel type of health maintenance organization that contracts with an association of physicians, called an independent practice association, to provide services to its members. The IPA is set up as a separate legal entity for contracting purposes. Physician members remain independent practitioners, maintain their own offices, medical records and office staff, and continue to see their non-HMO patients. An IPA Model HMO compensates the IPA on a physician capitation basis. The IPA in turn compensates its members on either a fee-for-service basis or a combination of a fee-for-service and "primary care capitation" (i.e., primary care physicians are paid on a capitated basis and specialists are paid on a fee schedule or UCR basis). Typically, the IPA withholds a portion of payments for risk-sharing and incentive purposes.

**Inpatient Services**

Inpatient hospital services are items and services furnished to an inpatient of a hospital by the hospital, including bed and board, nursing and related services, diagnostic and therapeutic services, and medical or surgical services.

**Integrated Services Network (ISN)**

A network of medical care institutions and providers that provide a coordinated continuum of services to a defined population and is held clinically and fiscally accountable for the outcomes of the population served.

# J K L

# M

**Managed Care**

A general term for organizing doctors, hospitals, and other providers into groups in order to enhance the quality and cost-effectiveness of health care. Managed Care Organizations include HMOs, PPOs, POSs, EPOs, etc.

**Managed Care Organization (MCO)**

A generic term applied to a managed care plan. Some people prefer it to the term HMO because it encompasses plans that do not conform exactly to the strict definition of an HMO. It may also apply to a PPO, EPO, or OWA.

**Medicaid (Title XIX)**

Medicaid is an entitlement program financed by both the state and federal government (through Social Security Administration). This state-operated and administered program provides medical benefits for eligible poor or low income persons under the age of 65 years who cannot afford to pay for private health insurance coverage. The federal government matches the states' contribution on certain minimal levels of available coverage. Though the federal guidelines are broad, the states determine the benefits covered, program eligibility, rates of payment for providers and methods of administering the program. The states may institute additional services beyond those allowed by federal guidelines, but at their own expense.

**Medical Expenditure Panel Survey (MEPS)**

MEPS is a nationally representative survey of health care use, expenditures, sources of payment, and insurance coverage for the U.S. civilian non institutionalized population, as well as a national survey of nursing homes and their residents. MEPS is co-sponsored by the Agency for Healthcare Research and Quality (AHRQ) and the National Center for Health Statistics (NCHS). This survey is designed to yield comprehensive data that estimate the level and distribution of health care use and expenditures, monitor the dynamics of the health care delivery and insurance systems, and assess health care policy implications. Data for the State of Hawai'i are not stable because of the extremely small sample size of Hawai'i residents surveyed.

**Medical Savings Account (MSA)**

A medical savings account is a consumer-contributed, tax-deferred account to be used for future medical expenses. The plan encourages patients to accept more responsibility for medical expenses and use of health care resources by contributing a certain amount of money per year. Rules for proposed MSAs include: (1) such accounts may be established only if the consumer has no insurance other than catastrophic coverage, usually with high deductibles; (2) there is a limit to the amount that may be contributed to an MSA and excluded from gross income; (3) funds drawn from an MSA to cover health care costs are excludable from gross income, but funds used for non medical purposes would be taxed as ordinary income with an additional penalty. The medical savings account pilot project was established through the HIPAA of 1996. Currently MSAs remain as an experimental program under the IRS.

**Medicare (Title XVIII)**

A medical insurance program for people aged 65 and older and for persons eligible for social security disability payments for two years or longer, and for certain workers and their dependents who need kidney transplants or dialysis. Two separate but coordinated programs: Part A that covers hospital insurance and Part B supplementary medical insurance that covers doctor visits.

**Medicare Risk Contract**

A type of managed care arrangement whereby the federal government prepays HMOs and competitive medical plans (CMP) for services provided to Medicare beneficiaries who join the managed care plans and agree to receive all their care through the plans. The government makes monthly fixed payments to the plans. Payments are based on a percentage of the adjusted average per capita cost. Thus, the HMOs and CMPs are "at risk" (i.e., financially liable) for Medicare services regardless of the extent, expense, or intensity of services rendered.

## N

**National Committee for Quality Assurance (NCQA)**

NCQA is a private, not-for-profit organization that assesses and reports on the patient care quality and health plan performance of managed care plans. The goal of this accrediting body is to enable purchasers and consumers of managed care plans to distinguish among the plans based on standardized quality indicators.

**National Health Interview Survey (NHIS)**

NHIS is a survey conducted by the National Center for Health Statistics (NCHS) to collect health-related information, such as illness and injury recall, health conditions and related disabilities, hospitalization, and physician visits from a sampling of American households. The Hawai'i Health Interview Survey is based on the NHIS.

**National Survey of America's Families (NSAF)**

NSAF provides a comprehensive look at the well being of adults and children in America. The survey over samples low-income families, looking for important aspects about their lives and how they differ from the lives of children and adults in families with higher incomes. NSAF is conducted in 13 states: Alabama, California, Colorado, Florida, Massachusetts, Michigan, Mississippi, New Jersey, New York, Texas, Washington, and Wisconsin.

**Network Model (HMO)**

An HMO that contracts with two or more independent group practices to provide health services. This type may include a few solo practices, but is primarily organized around groups.

## O

**Open-Ended HMO**

Enrollees are allowed to receive services outside the HMO provider network without referral authorization, but they are usually required to pay an additional co-pay and/or deductible

**Open Enrollment**

A period of time which eligible subscribers may elect to enroll in, or transfer between, available programs providing health care coverage.

**Out-of-Area Benefits**

The coverage allowed to HMO members for emergency situations outside of the prescribed geographic area of the emergency situations outside of the prescribed geographic area of the HMO.

**Outpatient Services**

Outpatient services are medical and other services provided by a hospital or other qualified facility, such as a mental health clinic, rural health clinic, mobile X-ray unit, or free-standing dialysis unit. Such services include outpatient physical therapy services, diagnostic X-ray and laboratory tests.

## P

**Participating Provider**

A health care provider who participates through a contractual arrangement with a health care service contractor, HMO, PPO, IPA, or other managed care organization.

**Per Member Per Month (PMPM)**

A unit of measure used by prepaid health plans (typically HMOs) to describe capitation payments. PMPM may relate to either revenues or costs expressed in terms of each effective member of a plan for each month that the member was effective. It is calculated by dividing the number of plan members (in terms of revenues) by member months. Sometimes called per contract per month.

**Personal Responsibility and Work Opportunity Reconciliation Act (PRWORA) of 1996**

PRWORA eliminated the open-ended federal entitlement program of Aid to Families with Dependent Children (AFDC) and creates a new program called Temporary Assistance for Needy Families (TANF), which provides block grants to states to offer time-limited cash assistance. PRWORA also makes far-reaching changes to childcare, the Food Stamp Program, Supplemental Security Income for Children, benefits for legal immigrants, and the Child Support Enforcement program.

**Physician Organization (PO)**

A managed care contracting entity composed exclusively of physicians, owned and run by physicians.

**Physician-Hospital Organization (PHO)**

These are legal (or perhaps informal) organizations that bond hospitals and the attending medical staff. PHOs are frequently developed for the purpose of contracting with managed care plans. They are sometimes called MeSH.

**Point-of-Service Plan (POS)**

Also known as an open-ended HMO, POS plans encourage, but do not require, members to choose a primary care physician. As in traditional HMOs, the primary care physician acts as a "gatekeeper" when making referrals; plan members may, however, opt to visit non-network providers at their discretion. Subscribers choosing not to use the primary care physician must pay higher deductibles and co-pays than those using network physicians.

**Preferred Provider Arrangement (PPA)**

Selective contracting with a limited number of medical care providers at reduced or pre-negotiated rates of payment.

**Preferred Provider Organization (PPO)**

A PPO is a health care arrangement between purchasers of care (e.g., employers, insurance companies) and providers that provide benefits at a reasonable cost by providing members incentives (such as lower deductibles and co-pays) to use providers within the network. Members who prefer to use non-preferred physicians may do so, but only at a higher cost. Preferred providers must agree to specified fee schedules in exchange for a preferred status and are required to comply with certain utilization review guidelines.

**Premium**

The periodic payment made to a carrier for providing coverage under a contract.

**Prepaid Health Care Act (PHCA)**

The Prepaid Health Care Act of 1974 designed to extend coverage of health care insurance to most inhabitants of the state by requiring mandatory employer contribution to employee health care insurance for employees working longer than 20 hours. Hawai'i is the only state in the Union to enjoy a waiver from the requirements of Employee Retirement Income Security Act (ERISA) of 1974 and the only state to require employer payments to medical care insurance.

**Purchasing Pool**

Purchasing pools are organizations/groups that bring employers and consumers together to collectively purchase health coverage from health plans. By purchasing collectively, it is believed that administrative and other costs will be reduced.

## Q

**QUEST**

**Q**uality Care, **U**niversal Access, **E**fficient utilization, **S**tabilizing costs, and **T**ransforming provision of health care. A program to provide medical care to Hawai'i's Medicaid population in a managed care environment as a cost saving venture for the state. Five organizations have been providing this care for approximately the last two years. They are HMSA, Straub, Kaiser, Aloha Care, and Queen's Hawai'i Care.

## R

**Reinsurance**

Reinsurance is a special insurance coverage obtained by a provider or health plan to protect against certain unanticipated and potentially crippling losses incurred on covered services for members. Such insurance may limit exposure on a per-case basis. In some cases, physicians can obtain reinsurance through the contracted health plan.

**Risk**

The chance or possibility of loss. For example, physicians may be held at risk if hospitalization rates exceed agreed upon thresholds. Risk is also defined in insurance terms as the possibility of loss associated with a given population.

**Risk Analysis**

The process of evaluating the expected medical care cost for a prospective group and determining what product benefit level and price to offer in order to best meet the needs of the group and the carrier.

**Risk Contract**

A contract between an HMO or competitive medical plans and CMS to provide services to Medicare beneficiaries under which the health plan receives a fixed monthly payment for enrolled Medicare members, and then must provide all services on an at-risk basis. It is also known as a Medicare Risk Contract.

**Risk Pool**

A pool of money that is to be used for defined expenses. Commonly, if the money that is put at risk is not expended by the end of the year, some or all of it is returned to those managing the risk.

**Risk Sharing**

Sharing the opportunity for reward or loss. Commonly, physicians and the HMO will share the risk.

## S

**Safety Net**

The health care safety net consists of inpatient and ambulatory health care providers that are legally obligated to provide care for those who cannot afford to pay for it. It includes public and private nonprofit hospitals (often teaching hospitals), public health departments, and community health centers (CHCs), including federally qualified health centers (FQHCs).

**Section 1115 waiver**

Section 1115 of the Social Security Act grants the Secretary of Health and Human Services broad authority to waive certain laws relating to Medicaid for the purpose of conducting pilot, experimental or demonstration projects which are "likely to promote the objectives" of the program. Section 1115 demonstration waivers allow states to change provisions of their Medicaid programs, including: eligibility requirements; the scope of services available; the freedom to choose a provider; a provider's choice to participate in a plan; the method of reimbursing providers; and the statewide application of the program. Demonstration waivers are granted for research purposes, to test a program improvement, or investigate an issue of interest to HCFA. Projects must usually include a formal research or experimental methodology and provide for independent evaluation. Most projects run for a limited time, no more than 5 years, and are usually not renewable.

**Section 1902(r)(2)**

Section 1902(r)(2) allows states to use other methods of counting income or assets for poverty-related pregnant women and children. Using this, some states greatly increase Medicaid eligibility by deciding not to count large portions of income. For example, even though the federal limit for younger children is 133 percent of FPL, a state could effectively increase the limit to 200 percent FPL by not counting an amount equivalent to 67 percent of FPL.

**Section 1915(b)**

Section 1915(b) waivers allow states to require Medicaid recipients to enroll in HMOs or other managed care plans in an effort to control costs. These waivers allow states to: implement a primary care case-management system; require Medicaid recipients to choose from a number of competing health plans; provide additional benefits in exchange for savings resulting from recipient's use of cost-effective providers; and limit the providers from which beneficiaries can receive non-emergency treatment. The waivers are granted for two-years, with two-year renewals. Section 1915(b) is often referred to as a "freedom-of-choice waiver".

**Section 1931**

The 1996 federal welfare reform law that erased the connection between Medicaid and welfare created section 1931. Section 1931 is related to the AFDC standards in use before the law's passage. Under section 1931, states may modify methods of counting income and assets when judging Medicaid eligibility. Section 1931 offers states the ability to expand coverage to families, including parents. Section 1931 is also called the Family Coverage category.

**Self-Insurance**

The practice of an employer or organization assuming responsibility for health care losses of its employees. This usually includes setting up a fund against which claim payments are drawn and claims processing are often handled through an administrative organization.

**Shared Risk**

In the context of an HMO, an arrangement in which financial liabilities are apportioned among two or more entities. For example, the HMO and the medical group may each agree to share the risk of excessive hospital cost over budgeted amounts on a 50-50 basis.

**Single Payer System**

A universal coverage plan in which the government collects insurance premiums and administers medical care benefits for every one in a country.

**Small Group Market**

The small group market is the insurance market for products sold to groups that are smaller than a specified size, typically employer groups with between 1 and 50 employees, or 2 and 50 employees. The size of groups depends on state insurance laws and thus varies from state to state.

**Staff Model HMO**

An HMO that delivers health services through a physician group that is controlled by the HMO unit; most physicians are salaried employees who deal exclusively with HMO members.

**State Children's Health Insurance Program (SCHIP, Title XXI)**

SCHIP is a federal program passed in 1997 through the Balanced Budget Act (BBA), jointly funded by states and the federal government. Title XXI was added to the Social Security Act, thus establishing a new state children's health insurance program. SCHIP provides funds to states at a higher matching rate than Medicaid to enable them to initiate and expand the provision of child health insurance to uninsured, low-income children who do not meet the Medicaid eligibility levels.

**State Health Insurance Program (SHIP)**

This Hawai'i "gap-group" health insurance program became law on June 26, 1989. It provided a bare bones coverage for those not eligible for Medicaid because of excess earnings and allowed people to pay prorated premiums based on their incomes. The benefits of the health insurance were minimal but could be expanded in case of need. The program was phased out when QUEST, Hawai'i's Section 1115 waiver program, was implemented August 1, 1994.

**Stop Loss Insurance**

That point at which a third party has reinsurance to protect against the overly large single claim or the excessively high aggregate claim during a given period of time. Large employers, who are self-insured, may also purchase "reinsurance" for stop-loss purposes.

**State-only program**

A state-only program is a comprehensive, major medical health insurance program that is funded only through state support (without federal funding). Oregon's Family Health Insurance Assistance Program and Washington Basic Health Plan are examples of state-only health insurance programs.

# T

## **Tax Incentive**

A tax incentive is a credit or deduction that reduces the cost of purchasing health insurance through a reduction in an individual's or employer's tax burden. Tax credits are amounts subtracted from the income tax liability itself, unlike deductions, which merely reduce adjusted gross income or taxable income. Tax credits may be refundable or non-refundable. Most tax credits are non-refundable, meaning that if a taxpayer's credit exceeds his/her income tax liability, the taxpayer does not receive the difference as a refund. However, with a refundable tax credit, taxpayers whose credits exceed their income tax liabilities receive the difference in the form of a tax refund.

## **Temporary Assistance to Needy Families (TANF) / Temporary Assistance to Other Needy Families (TAONF)**

TANF/TAONF are the welfare reform programs designed to protect those who cannot work and need financial assistance and to require those that can work to work. Unlike the old welfare program, the TANF/TAONF programs require work and promote self-reliance, responsibility and family stability. TANF/TAONF offer a package of strong incentives and penalties, childcare support for working parents and restructured welfare benefits so it "pays to work".

## **Third Party Payer**

Any payer for health care services other than the consumer. This can be an HMO, a PPO, or government.

## **Transitional Medical Assistance (TMA)**

Transitional Medicaid was created by the 1998 Family Support Act (FSA), which required states to extend Medicaid coverage for up to 12 months to families who lost their AFDC eligibility due to increased earnings. Under the FSA, individuals could access TMA if they received welfare benefits and were eligible for Medicaid at least three of the six months prior to entering the job. The PRWORA of 1996 extended the states' obligation to provide TMA through the year 2001. It provides for the continuation of Medicaid benefits for families that have increased their earnings in excess of the July 1996 AFDC income and family composition standards as authorized in the statute. Eligible families are those who were receiving Medicaid benefits while receiving cash assistance under Temporary Assistance to Needy Families (TANF) based on those eligibility standards.

## **TRICARE**

This is a voluntary health maintenance organization (HMO)-type option for veterans and active duty dependents. TRICARE PRIME charges an annual enrollment fee (except for active duty members and their families, who may enroll free) and enrolls for a continuous period of time. TRICARE EXTRA does not require enrollment or paying an annual fee. There is an annual deductible for outpatient care that must be paid. TRICARE STANDARD is the former CHAMPUS program with a new name. It pays a share of the cost of covered health care services obtained from an authorized non-network civilian health care provider. There's no enrollment in TRICARE STANDARD. The individual pays the normal TRICARE STANDARD deductibles for outpatient care, and the cost-sharing percentages will be the same as they were for regular CHAMPUS.

# U

## **Underinsured**

The underinsured have public or private insurance policies that do not cover all necessary health care services, resulting in out-of-pocket expenses that exceed their ability to pay.

## **Uninsurables**

Uninsurables are high-risk persons who do not have health care coverage through private insurance and who fall outside the parameters of the risks of standard health underwriting practices.

## **Uninsured**

An uninsured person is one who, for various reasons (typically economic), is not covered by a health insurance contract to pay for medical expenses.

# V W X Y Z

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# ACKNOWLEDGEMENTS

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## **Peter S. Adler, PhD**

Dr. Adler moderated the discussion at the Uninsured Policy Summit. He is a partner in The Accord Group, LLC, an international firm specializing in facilitating, planning and problem solving. He has served in executive positions with the Hawai‘i Justice Foundation (1992-2001), the Hawai‘i Supreme Court’s Center for Alternative Dispute Resolution (1985 to 1992), and the Neighborhood Justice Center (1979-1985). His specialty is multi-party negotiation and problem solving.

## **Jeremy Alberga, MA**

Mr. Alberga was a member of the panel at the Uninsured Policy Summit. He is an associate at the Academy for Health Services Research and Health Policy where he primarily works on The Robert Wood Johnson Foundation’s State Coverage Initiatives program. His responsibilities include providing technical assistance to state policy makers on health policy reform, specifically expanding and maintaining health insurance coverage; disseminating state models of expansion through the program’s written products; convening workshops and small group consultations for policy makers; and assisting in the development of technical assistance documents. Mr. Alberga received his MA in international health from the George Washington University and his BA from McGill University, Montreal.

## **Linda Colburn**

Ms. Colburn oversaw community facilitation efforts leading to this report. She is well known for her facilitation and mediation skills and activities in Hawai‘i as well as her professional activities in the public arena. Previously, Ms. Colburn served as the Felix Consent Decree Operations Manager in the Office of the Governor; was the Administrator for the Office of Hawaiian Affairs; and Executive Director of Aina Kupa‘a O Ma‘ili, Inc., a transitional housing project for the homeless. She currently serves on the boards of the Hawai‘i Council on Economic Education, Friends of ‘Iolani Palace, Hawai‘i Women’s Business Resource Center and ‘Olelo: The Corporation for Community Television. Ms. Colburn received her bachelor’s in business administration from Lewis and Clark College.

## **Tomiko Conner, MPP, MPH**

Ms. Conner was a member of the panel at the Uninsured Policy Summit. She is the director of Community Voices – Oakland, a project of Asian Health Services and La Clinica de La Raza in collaboration with the Alameda Health Consortium, the Alameda Alliance for Health, and Alameda County. The project is one of thirteen prestigious learning laboratories nationwide funded by The W.K. Kellogg Foundation. Ms. Conner was the first Executive Director of the California Pan-Ethnic Health Network, a statewide multicultural health policy and advocacy organization. Ms. Conner did her graduate work in international economic development policy and health policy at the Schools of Public Policy and Public Health at the University of Michigan and received her undergraduate degree from Mount Holyoke College.



### **Susan Forbes, DrPH**

Dr. Forbes oversaw data collection and analysis efforts for this report. Her background includes more than 25 years in health care planning, project implementation, and program evaluation. Dr. Forbes' role is to support the health information business, by creating shared knowledge that supports action (e.g., improving the health care delivery system); collecting, analyzing and reporting health care data; and communicating results to customers for use in quality improvement, cost-efficiency enhancement, and improvement of health status. Dr. Forbes earned her masters and doctorate in public health at the University of Hawai'i at Manoa, where she periodically teaches a course in strategic management. She earned her bachelor's degree in anthropology from Stanford University.

### **Malaya P.F. Rogers, MPP, MPH**

Ms. Rogers conducted policy analysis and research for this report. She has 11 years of experience in health planning, policy analysis and evaluation. She held analyst positions with the Public Policy Research Institute (College Station, TX), the California Health Federation (Sacramento, CA), the Texas Department of Health (Austin, TX), and the Asian/Pacific Islander American Health Care Forum (San Francisco, CA). She holds a bachelor's degree from Harvard University and masters degrees in public health and public policy from the University of California at Berkeley. She served on the American Public Health Association's Task Force on Public Health and Managed Care and was on the board of the Hawai'i Public Health Association (1994-2000).

### **John Santa, MD**

Dr. Santa was a member of the panel at the Uninsured Policy Summit. He is a general internist with experience in a diverse array of clinical, administrative, community, and research activities. Dr. Santa attended Stanford University, Tufts Medical School and is now pursuing a Masters in Public Health at Oregon Health Sciences University. He practiced medicine for 13 years in solo, group, and employed settings. He has worked in administrative positions for hospitals, insurers, medical groups, and now the State of Oregon. His activities have often involved implementation of health policy initiatives. Dr. Santa is currently the Administrator of the Office for Oregon Health Policy and Research.

### **Barbara Yondorf, MPP**

Ms. Yondorf was a member of the panel at the Uninsured Policy Summit. She is President of Yondorf & Associates, a health policy consulting firm, specializing in the analysis of health policy and social service issues for clients in the government, consumer, and nonprofit sectors, both locally and nationally. Before starting her own company, Ms. Yondorf was Director of Policy and Research for the Colorado Division of Insurance. She has also worked for the National Conference of State Legislatures as Managing Director of Research and Program Development, Senior Program Director of the Budget, Tax and Revenue Program, and Health Care Project Director. She has served as staff to the Colorado Legislature's Joint Budget Committee, and Director of Planning for the Colorado health department. Earlier, she served on the faculties of Brown University and the University of Washington. Ms. Yondorf received her Masters in Public Policy from the John F. Kennedy School of Government at Harvard University and her undergraduate degree from the University of Chicago.

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