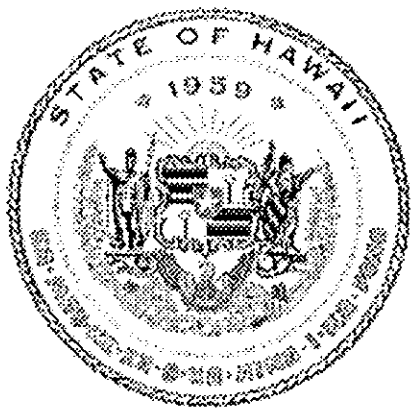

Report of the Hawai`i Health Care Task Force

to the

Hawai`i State Legislature Regular Session of 2006

In Accordance with
Act 223, Session Laws of Hawaii 2005

Prepared by
The Hawai`i Uninsured Project
for the
Insurance Division
Department of Commerce and Consumer Affairs
State of Hawaii

December 2005

Background

Act 223, Session Laws of Hawai`i 2005 (Attachment ___) established a temporary health care task force (Task Force) within the Insurance Division of the Department of Commerce and Consumer Projection to develop a plan to implement health care for all Hawaii residents and report its finding and recommendations, including recommended legislation and a cost analysis and detailed rationale for implementation, to the 2006 Legislature. Act 223 also required the Task Force to contract with the Hawai`i Uninsured Project[1] to: (1) facilitate Task Force meetings; (2) provide meeting minutes and other staff support; and (3) facilitate contracting for expert testimony or studies, including a cost analysis comparing the costs of the status quo with various coverage options including a single-payer system and recommendations of the Hawai`i Uninsured Project to decrease the uninsured population. The Task Force will cease to operate on June 30, 2006.

Membership

The Task Force consists of thirteen members appointed by the Governor from recommendations submitted by the Senate President, Speaker of the House, and Insurance Commissioner. In accordance with the membership specifications set forth in Act 223, the following individuals were appointed to the Task Force:

Gary Allen
Executive Director, Hawaii Business Health Council

Dr. Patricia Blanchette
Chair, Department of Geriatric Medicine, John A. Burns School of Medicine

Representative Lynn Finnegan
Minority Leader, House of Representatives
State of Hawaii

Susan Forbes, DrPH
President & Chief Executive Officer, Hawaii Health Information Corporation

Ms. Beth Giesting
Executive Director, Hawaii Primary Care Association

[1] The Hawai`i Uninsured Project is an initiative of the Hawai`i Institute for Public Affairs (HIPA), a nonprofit research and educational organization. The Project is a collaboration between HIPA, the Hawai`i State Department of Health, University of Hawai`i Social Science Research Institute, and the Hawai`i Health Information Corporation and is led by a diverse group of community stakeholders. The Project is funded by grants to the Department of Health from the U.S. Department of Health and Human Services, Health Resource and Services Administration and the Robert Wood Johnson Foundation.

Representative Josh Green, MD
Member, House of Representatives, State of Hawaii

Dr. Roseanne Harrigan
Chair, Complementary and Alternative Medicine Department, John A. Burns School of Medicine

Mr. David Heywood
Executive Director, Medicare Complete Choice – Hawaii Region

Mr. Richard E. Meiers
President & Chief Executive Officer, Healthcare Association of Hawaii

Dr. Virginia Pressler
Vice President, Service Line Development, Marketing & Government Relations, Hawaii Pacific Health

Mr. John Radcliffe
Associate Executive Director, University of Hawaii Professional Assembly

Mr. J. P. Schmidt
Insurance Commissioner, Department of Commerce & Consumer Affairs

Dr. Calvin Wong
Chief Executive Officer, Pacific Cardiology LLC

Representative Josh Green, MD was elected Chair and Dr. Patricia Blanchette was elected Vice Chair of the Task Force.

Task Force Activities

Focus Areas. To facilitate the work of the Task Force, the following focus areas were established:

- **Delivery of Health Care:** analysis of existing data on the availability of physician and non-physician providers by specialty; identification of barriers to recruiting and retaining health care professionals.
- **Health Insurance Coverage:** identification of problems and barriers in the current system; development of a menu of potential solutions and options to provide health care coverage to the uninsured; exploration of the viability of a basic health care plan and consumer-driven health care models, i.e., health savings accounts.
- **Efficiency of Delivery System/Business Model:** review of various health care business models with a focus on efficiency and prevention; development

of a list of patient care needs as well as barriers and inefficiencies in the current system; review of administrative costs in the current health care delivery system.

- **Single Payer System:** Review and comparison of various single payer models.

A detailed description of findings and recommendations in each of the focus areas follows.

Website. In order to provide information about Task Force activities and enhance public participation, a website was established in September 2005. Meeting information and materials, research, public testimony, and other information is available online at:

www.healthcoveragehawaii.org/taskforce/

Focus Areas

Delivery of Health Care

This area focuses on issues related to the health care workforce – identifying and analyzing the current availability of health care providers, barriers to recruiting and retaining health care professionals, and meeting our future health care needs.

Currently, there is a growing shortage of both physician and non-physician health care professionals in Hawai`i, especially on the neighbor islands and in rural areas. Even if people have health insurance, they are often unable to access appropriate care. The state's growing aging population will increase demand for health care services and long-term care, straining the workforce even further. In addition, low reimbursement rates for providers, issues related to living and working in remote communities, and challenging working conditions continue to create barriers to recruitment and retention.

The Task Force also plans to solicit input from major providers, including the Hawaii Health Systems Corporation, Kaiser Permanente, community health centers, the Department of Health, and the State Health Planning & Development Agency (SHPDA), to identify provider and workforce issues and develop possible solutions.

In addition, several health agencies and organizations in the State have created the Hawai`i Health Workforce Collaborative to address these issues. The Collaborative is working on a comprehensive plan to improve access to and quality of health care by creating a database to map the health workforce infrastructure statewide and make projections for future needs. (See Attachment ___). The Task Force will monitor and support the efforts of the Collaborative.

Recommendation: The Task Force recommends that the Legislature provide support for the development of a comprehensive health care provider map to include an analysis of existing data on the availability of physician and non-physician providers by specialty, including all doctors, specialists, nurses, dentists, mental and behavioral health providers, nutritionists, educators, and other health care professionals; and focus on workforce needs.

Health Insurance Coverage

This area focuses on identifying Hawaii's uninsured population and issues that prevent or restrict provider coverage, and developing coverage options for the uninsured.

According to a policy brief developed by the Hawai`i Uninsured Project in January, 2005, Hawai`i has one of the lowest rates of uninsured in the country and a substantially higher percentage of employers offering health insurance because of the Prepaid Health Care Act (PHCA) of 1974. However, national and state data about the uninsured analyzed by the University of Hawai`i Social Science Research Institute (SSRI) indicates that:

- Hawaii's proportion of part-time workers is greater than the national rate;
- Gaps in coverage exist for the self-employed, part-time workers, and certain government employees;
- Hawai`i has below average rates of coverage through public insurance programs, i.e., QUEST and the State Children's Health Insurance Program (SCHIP)[2]; and
- A substantial number of the uninsured are working full-time and should be receiving coverage under the PHCA, raising questions about the efficacy of the law.[3]

The Task Force is reviewing the issues of the uninsured and will continue to explore options to provide coverage for and access to health care including:

[2] The Department of Human Services, in partnership with Hawai`i Covering Kids, developed a simplified application, a passive renewal process, and since 2000, conducted extensive outreach to enroll 16,885 additional children as of September 2005, significantly reducing the number of uninsured children in the state. The U.S. Census Bureau confirms that according to its latest estimates, the number of uninsured children in Hawai`i has decreased by almost 4 percent between 2001 and 2004.

[3] The Department of Labor and Industrial Relations initiated a Compliance Assistance program in March 2005, which involved review and site visits of randomly selected employers throughout the state to determine whether eligible employees were denied health insurance coverage. In addition, these Compliance Assistance visits focused on educating employers about their responsibilities under the law. As of September 2005, 160 employers with a total of 1,950 employees were visited. 14 employers were found to have employees who should have been provided with health insurance coverage, and a total of 39 eligible employees were not covered.

- Consumer-driven health care models such as health savings accounts;
- Policy changes such as removing the QUEST enrollment cap and other options to cover uninsured gap groups;
- The viability of a basic health care plan that provides the minimum amount of coverage for the uninsured. Basic health care plans, or "bare bones" plans, reduce premiums by decreasing the number of covered services in comprehensive health benefits plans or by raising deductibles and other consumer costs for covered services.

Efficiency of Delivery System/Business Model

This area focuses on identifying alternatives for improving efficiency and cost in health care delivery. The hypothesis is that improving the efficiency in health care delivery will result in lower cost and produce opportunities to generate revenue to finance new alternatives for access to care for the currently underinsured or uninsured.

Health care costs have been described by several experts as reaching a crisis level in the United States. A 2002 study by the National Center for Health Care Statistics, the World Health Organization, and the Rand Corporation determined that the U.S. has the highest cost per capita among G-7[4] and Organisation of Economic and Co-operation and Development (OECD) countries. The study also highlighted that the health status of U.S. citizens ranked 7th among the G-7 countries and 18th among OECD countries, and that in the area of efficiency, the U.S. ranked 7th among G-7 and 22nd among OECD countries.

In addition, the health care cost crisis was summarized in a September 2005 study by Towers and Perrin: "In flat dollar terms, next year's gross health care expenditure is expected to rise by an average of $597 per employee, to an average total cost of $8,424 -- representing a 140% increase over the last 10 years." A July 2005 Price Waterhouse Coopers Health Research Institute study stated that, "One in four companies said double-digit healthcare cost increases may force them to lower wage increases for employees, and one in five expects to slow hiring of new permanent employees in the year ahead." All of these citations are clear indications that significant cost and efficiency improvements are needed in our health care delivery system.

Experts have divided health care into three major areas -- cost, access, and quality. According to a study produced in 2000 by the Department of Health and Human Services (DHHS), Hawaii's health care industry ranks as low as 48th in the US in computer systems expenditures. The DHHS estimates that as much as $81 billion dollars in current administrative costs could be reduced if the U.S. implemented new IT systems. Implementing new information technology (IT) infrastructure will improve

[4] A group of seven heads of state from major industrialized democracies, consisting of the United States, France, Germany, Italy, Japan, the United Kingdom, and Canada.

efficiency, reduce costs, improve quality of care, and provide new opportunities for monetary resources to provide health care coverage to the currently underinsured and uninsured population.

Developing electronic information systems will allow the health care delivery system to provide and share information in a timely manner, identify duplicate services ordered and services not medically necessary or needed, measure outcomes, and reduce costs.

The Task Force will continue to look at quality and cost efficiency alternatives including:

- Computerized electronic infrastructure to connect all providers, health plans, employers, and patients
- Proposals to change the focus of the current health care model to prevention and improving health status.
- Analysis of administrative costs incurred by providers in complying with various delivery requirements.

Single-Payer System

Act 223, SLH 2005, charged the task force with investigating a single-payer health insurance system as one option to address Hawaii's uninsured.

While there are many variations of a single-payer health care system, the most common definition of single-payer health insurance is the financing of health care expenditures for a nation's entire population through a single source, presumably the government, with funds collected through progressive taxation of citizens and businesses.[5] Unlike 'socialized medicine,'[6] in a single-payer health insurance system, the government collects and distributes money for health care but interferes minimally with the actual practice of medicine. A single-payer system is just one model towards universal health coverage. Another model would be to extend and improve Medicare, proposed by Rep. Dennis Kucinich and Rep. John Conyers.[7]

On an individual state level, no state has succeeded in passing legislation to implement a single-payer health system. However, states such as California, Massachusetts, Wisconsin, Maine, Rhode Island, and Missouri have either introduced

[5] Hackney, David, and Rogan, Debra, *A Single Payer Health Care System for the U.S.*, American Medical Student Association, November 2005

[6] Refers to the direct government ownership of hospitals and clinics and control over the daily operation of the health care industry.

[7] In 2003, Rep Conyers introduced HR 676, The United States National Health Insurance Act, co-sponsored by Dennis Kucinich, (D- OH), Jim McDermott, (D-WA, and Donna Christensen (D-VI). Under HR 676, Medicare is extended and improved so that all individuals residing in the United States would receive high quality and affordable health care services.

legislation, or have had studies done on the viability of a statewide single-payer health system. Studies have found that a single-payer system would reduce health spending while covering everyone and protecting the doctor-patient relationship.[8]

Internationally, in Western industrialized nations, single-payer systems exist in Australia, Canada, Finland, New Zealand, Sweden, and the United Kingdom. See comparison of single-payer health systems in Canada, England, and Taiwan done by HUP (Attachment ___). Generally, funds for health services are primarily raised through taxes and premiums, and paid from a single source for hospital services.

The Task Force spent significant time developing a Request for Proposals (RFP) to hire a consultant to conduct a cost analysis of a single payer system in Hawai`i. An RFP was issued on November 2, 2005 and three proposals were received.

(Include information on selection of consultant if available.)

The Task Force will continue its review of and analyze Federal, state, and international findings on single-payer systems.

Other Issues/Options to be Explored

1. Feasibility of gathering information to assist in workforce planning through a questionnaire to be included in the license renewal applications for health care professionals. Modeled after questionnaires in other states, such as Vermont (see Attachment ___), licensees would be asked questions related to age, type and location of their practice, whether they are practicing part-time or full-time, and their intention to return or to leave Hawaii within five years. For physicians, questions about whether or not they currently accept new Medicare or Medicaid patients, and an estimate of what percent of their practice includes these patients might be included. The data collected would give the State a continuously updated source of information about the health care workforce, and would also assist in projecting future workforce needs. The Department of Commerce and Consumer Affairs is the agency that currently processes professional license renewals. The additional administrative burden to distribute the questionnaires, collect and analyze the data, as well as issues regarding privacy, access, and use of the data, must be considered and explored.

2. Hawai`i Essential Insurance plan targeting the uninsured working poor and uninsured children. Under this plan, any Hawai`i resident who is not receiving health insurance through an employer, or through Medicaid, can receive

[8] The Lewin Group, *Cost and Coverage Analysis of Nine Proposals to Expand Health Insurance Coverage in California,* Prepared for the California Health and Human Services (CHHS) Agency, April 2002.

health care at any of the State's 13 federally qualified community health centers and at any of the 12 hospitals managed by the Hawai`i Health Systems Corporation. It is estimated that half of the enrollees in the Hawai`i Essential Insurance will include individuals who purchase their own coverage, and half will be part-time workers whose employer will pay for their coverage.

3. Legislation to facilitate the implementation of a computerized electronic records system in a timely manner.

4. Funding strategies to pay for any proposed coverage options.

5. Cost/benefit analysis of dollars spent on community health centers.

6. Community health centers to specialize in certain pervasive problems: crystal methamphetamine problem, obesity, chronic care.

7. Partnership with the community health centers system as a way to reach the broad community for both primary and preventive care and specialty care. Dental and behavioral needs must also be addressed.

8. Free health screenings and immunizations to every child in Hawai`i.

9. Project Access, an Asheville North Carolina community-based program to provide health care to the uninsured (see Attachment ___).

10. A preventive medicine model where the uninsured are covered based on their ability to meet defined health milestones. The greater the ability to meet the milestones, the better the coverage.

11. A preventive medicine model that encourages consumers to participate and be responsible for their own health care.

12. Strategy to provide care for the chronically ill – those who may not qualify for a traditional health plan.

Next Steps

The Task Force will continue to meet and gather information through June 30, 2006 to develop a plan to implement health care for all of Hawaii's residents.