Health Care Task Force
Office of the Insurance Commissioner
April 4, 2006
John A. Burns School of Medicine, Room 314

Minutes

In Attendance: Gary Allen, Patricia Blanchette, Lynn Finnegan, Susan Forbes, Beth Giesting, Josh Green, Roseanne Harrigan, David Heywood, Rich Meiers, Virginia Pressler, John Radcliffe, J.P. Schmidt

Staff Support: Laurel Johnston and Carol Taniguchi Hawai'i Uninsured Project, Miki Lee, Leeway Enterprise, James Nagle, Department of Attorney General, Lloyd Lim, Insurance Division

I. Call to Order

Chairperson Josh Green called the meeting to order at 4:10 PM with 12 of the 13 members present.

II. Review and Approval of February 7, 2006 Minutes

John Radcliffe made a motion to approve the minutes. Gary Allen seconded and the Task Force voted unanimously to approve the February 7, 2006 Minutes.

III. Public Testimony

Nancy Walden, Jim Brewer, Ken Akinaka and Kevin Killeen offered testimony.

IV. Chairs Report on Legislative Priorities

There is a House Concurrent Resolution requesting that the Governor designate or appoint a working group to take over once the Task Force disbands.

There is a bill proposing a Hawaii Healthcare Authority is still alive, but its future is uncertain.

An initiative is making progress designed to expand health insurance coverage for children through a reformulation of the poverty level and with the support of HMSA and the Department of Human Services.

There is a bill to fund a comprehensive provider map that is continuing to make progress through the legislature.

V. Act 223, SLH 2005 Scope of Work and Tasks

Presentation of the Analysis of a Single Payer Health Care System

John Sheils, a representative from the Lewin Group, the firm retained to conduct the single payer health care system analysis, was on-hand to present the initial findings and to answer questions by task force members and by the public. A copy of the presentation was distributed and was displayed on a screen for those present.

Questions and Comments from the Task Force (Mr. Sheils' responses are noted in italics) Note: There were numerous questions/comments from task force members, including but not limited to:

A question was asked about the tax implications of a single payer health care system. *Mr. Sheils noted that in their analysis of a single payer system for California, payroll taxes ended up being approximately 11% and income tax 22%. Because the proposed Hawaii model was not "cradle to grave" and had different reimbursement rates and benefit structure, he estimated that in Hawaii, a 5.6% payroll tax could generate the balance of revenues needed after re-distribution of existing state and federal revenues.*

A question was raised on what type of long-term care would be covered under the proposed system. *Mr. Sheils noted that long-term care would not be covered, per the parameters of the RFP developed by the task force.*

More information was requested explaining how self-employed individuals participate in a single payer system, how fees are paid and to whom, and how enforcement is handled. *Mr. Sheils discussed these issues.*

The Task Force would prefer to modify the Medicare reimbursement rates, which were used to formulate this first iteration of a Hawaii single payer proposal. It was noted that using current rates, which are some of the lowest in the nation and are insufficient, is not practical. A recommendation was made to use 130% of current Hawaii reimbursement rates (at a minimum). *Mr. Sheils considered this modification.*

As a means of ensuring that the cost analysis is accurate, the Task Force is requesting to review all the assumptions that Lewin Group is using in its analysis. It was suggested that a period of 30 days would be adequate to complete a thorough review of the assumptions. *Mr. Sheils will make the assumptions available.*

Questions were raised about the potential impacts to the State if it were to become the first state in the nation to provide universal coverage. It is not known whether the positive benefits would outweigh the negative impacts.

The current proposal suggests coverage for all citizens. The Task Force is interested in seeing an alternative proposal that offers coverage only for those who are currently uninsured.

Task force members believed that the estimated administrative savings seemed generous and questioned how these figures were developed ~~was questioned~~. ~~Review~~ Mr. Sheils will review the analysis assumptions will help validate these ~~estimated~~ estimations.

It was noted that it would be nearly impossible to modify the Hawaii Prepaid Healthcare Act. However, a supplemental or voluntary program that ~~encourage~~ encourages employers to insure part time employees was suggested.

Under the proposed single payer healthcare system, if an eligible resident travels out of state on business or pleasure (and not to change residency), would that resident be covered in the event of an emergency? *Mr. Sheils noted they would be covered.*

Questions and Comments from the Public (Mr. Sheils' responses are noted in italics) Note: Due to time constraints and the number of questions posed by the public for Mr. Sheils, only some of the questions from the public were discussed at the meeting, including but not limited to:

Your numbers have changed substantially since last month's draft. How reliable are the new numbers? What accounts for the change? *The numbers in the current draft are updated and more accurate than the previous draft. However, some data is still not available, such as accurate healthcare spending figures.*

How will the plan help providers with reduced liability insurance and reduced paperwork? *There will be no expected change in liability issues. There will be an expected drop in administrative overhead associated with paperwork.*

Hawaii hospitals are significantly older than hospitals on average for the country as a whole. Because Hawaii hospitals have been under-reimbursed for so long, hundreds of millions of dollars in deferred capital investments need to be considered. Has the proposed model been adjusted to provide adequate reimbursements to hospitals to support these substantial capital requirements? *This has not been accounted for in the current draft proposal.*

Medicare rates (payment to providers) are lower in Hawaii that for the country as a whole. Is the proposed model based on Hawaii rates or national averages. *Mr. Sheils will check the numbers that were used and report back to the Task Force.*

Employee premiums drop from $793 million to $190 million. Presently, employee contribution to premiums is 1.5% maximum. New employee payroll tax will be 5.6%. Can you explain this apparent contradiction? *Mr. Sheils did not see this as a*

contradiction, but will check the numbers that were used and report back to the Task Force.

Medicaid disappears under the single payer system. What about long-term care that is covered by Medicaid? *This proposal anticipates that whatever Medicaid is presently covering for long-term care will continue to be covered, as long-term care is not included in this single payer proposal. We will review all figures to ensure that an error was not made.*

How do you see the figures changing if complementary and alternative care systems are included in what is provided? *We estimate a difference of one to two percent. When California included these components it increased spending by one or two percent.*

Are there estimates of the savings incurred as the result of overall better health of the population (early detection, prevention, reduced emergency care)? *Data indicates that a healthier population lives longer and uses more health care. It's not clear whether there are actually cost savings.*

What leads you [Lewin Group] to believe that government control of health care financing will be any more successful that the same government's control of retail gas prices in Hawaii? The health care financing system is vastly more complex that the market system for gas pricing. Is it not? *A private-public partnership might be a good solution to ensure efficiency.*

Are the assumptions and equations of your model available for public scrutiny? In the absence of open review and without a real world test in a state in the U.S., we are being asked to accept a large number of assumptions on faith. *The data used to develop the cost analysis will be included in the final report.*

Will there be a positive impact to the workforce, such as increased productivity, if more people have health insurance? *Possibly, though it's not fully known.*

If retirees over the age of 65 (covered by Medicare) are not covered in this plan, will this group have less coverage than younger people (with dental, vision and long-term care) and will retirees from public employment over 65 lose current benefits (dental, vision, drugs, etc.)? *That depends upon how the program is implemented through law and administrative rules.*

Have you [Lewin Group] considered that HIPAA promised similar reductions in administrative costs based on the same thesis: uniformity equals efficiency? We have yet to see any such savings. *This analysis did not consider savings from HIPPA.*

Employers providing healthcare to their employees are "reimbursed" by the federal government. By how much? *Employers and employees both receive tax benefits from participating in employer-sponsored health insurance programs.*

Please clarify the intent of the legislature, the intent of the Task Force and the intent of the Lewin Group relative to the imposition of a single payer system on the people of the State of Hawaii. Specifically with respect to compulsory versus voluntary and the scope of this plan (who is or may be excluded). *The Lewin Group cannot speak to the intent of the Legislature, we were given proposed legislation and parameters for the proposed single payer system as specified in the RFP issued by the task force.*

You claim that you are unbiased in your recommendations but your contract was to analyze a plan for single payer in Hawaii was it not? Don't your recommendations/results contain built-in bias in this report? *This analysis is based upon the parameters contained in the RFP issued by the task force and certain assumptions made in our model that is used for these types of single payer studies.*

VI. Future Meeting Dates and Locations

The next Task Force meeting is scheduled for April 13, 4:00. Location to be determined.

VII. Adjournment

Chairperson Josh Green adjourned the Task Force meeting at 7:00 PM.