the HAWAI`I Uninsured Project

PROPOSALS TO INCREASE HEALTH CARE ACCESS IN HAWAI`I

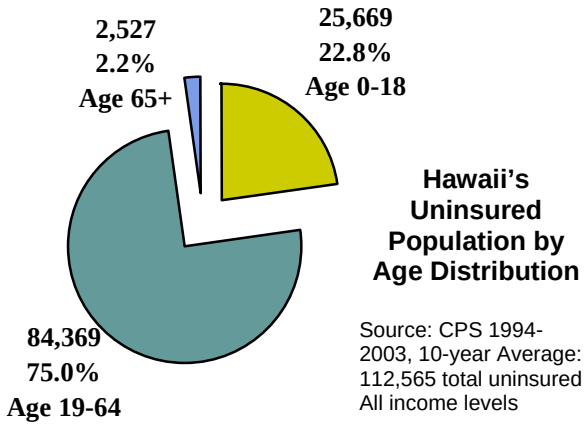
OVERVIEW

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); and
- A substantial number of the uninsured are working full-time and should be receiving coverage under the PHCA, raising questions about enforcement of the law.

The "Coverage for All" proposals offered in this briefing paper are based upon the U.S. Census Bureau Current Population Survey and U.S. Bureau of Labor Statistics data collected and analyzed over a ten-year period from 1994-2003. Thus, the figures cited in this document represent estimates and trends computed over 10-years and are the most reliable data upon which to inform deliberations about and development policy options for the uninsured.



The long-term benefit of "Coverage for All" -providing health insurance coverage and maintaining a strong safety net - means the opportunity to manage people's care. It is well-documented that the uninsured suffer from poor health status and many die prematurely. Uninsured children lose the opportunity for normal development and educational achievement when preventable health conditions go untreated. Further, the adverse social and financial impacts of having uninsured in our society can be both far-reaching and have long-term consequences. However, while "Coverage for All" is the focus of our efforts, related issues must be considered.

- Even a system that provides universal health insurance will have some individuals who "opt out," and there are others who may be "uninsurable." A stable source of government financial support for Hawaii's safety net providers is critical to providing for the health needs of those who are not able to or will not participate in public or private insurance programs.
- There are dual challenges to attracting and retaining health care providers and health care plans willing to care for government insurance patients due to reimbursement levels and administrative issues. For any government expansion program to be successful, there must be enough health care providers and health care plans available to serve an additional consumers of government insurance.

In order to address the lack of coverage in our gap groups, whose members represent all income levels, a menu of policy proposals and financing options has been developed for the estimated 112,565 Hawai`i residents without health insurance, of which 75 percent are working age adults and 23 percent are children (age 0 to 18). These proposals are based on research of coverage options implemented or proposed in other states, presentations and discussions with national health care policy experts, and proposals and ideas generated in the HUP work groups.

COVER ALL KIDS

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Prior to 2000, federal data on the uninsured indicated that approximately 14,000 children were eligible for, but not enrolled in, a government health insurance program. With the implementation of the SCHIP program in 2000, additional children in families with incomes up to 200% federal poverty level (FPL), became eligible for enrollment. Thus, adding three years of data results in an ***estimated*** 19,548 uninsured children who qualify for government health insurance coverage.

HAWAII'S UNINSURED CHILDREN BY FPL	
0-100%	10,622
101-200%	8,926
201-300%	2,874
301+%	3,247
Total	25,669

Source: U.S. Census Current Population Survey, 1994-2003, 10-year average

In response, the Department of Human Services in partnership with Hawai`i Covering Kids, developed a simplified application, a passive renewal process, and conducted extensive outreach to enroll ***8,449*** additional children as of November 2004, and thereby reduced the number of uninsured children. Continued progress could be supported through the following proposals.

Outreach and Education. Use state and federal funds to support the outreach and education efforts of Hawai`i Covering Kids and the Department of Human Services to enroll and retain eligible children. *Target group: 19,548 uninsured children 0-18 (0-200% FPL).*

Proof of Insurance. Identify uninsured children regardless of income level by requiring proof of health insurance upon enrollment in any Hawai`i public or private school. Provide educational materials and resource and referral information. *Target group: 25,669 uninsured children 0-18.*

Incremental Expansion of SCHIP. Leverage unexpended SCHIP funds to expand eligibility to children in families 201-300% FPL. The federal government currently contributes up to 71 cents for every coverage dollar under SCHIP. Expansion to be incremental based on availability of state and federal funds. *Target group: 2,874 uninsured children 0-18 (201-300% FPL).*

Crowd-Out and Take-Up

While expanding coverage to children in families with income up to 300% FPL would allow an additional 2,874 children in Hawai`i to enroll in SCHIP, policymakers should be concerned with "crowd-out", or the substitution of public health insurance coverage for private health insurance coverage, and with "take-up", where newly eligible children are enrolled in SCHIP**.** *UH SSRI estimates that a Hawai`i SCHIP expansion to 300% FPL will result in crowd-out of private insurance on a 2.4-to-1 basis for every newly insured child.*

The existing research on SCHIP finds that the rate of newly eligible children that take-up SCHIP benefits is fairly low because families of eligible children are often not aware of their new eligibility status, especially if these households do not receive other public benefits. In addition, transaction costs, and/or the possible stigma associated with public programs, may also inhibit enrollment. Further, when crowd-out occurs, already limited public resources are used to cover those who are otherwise covered by private insurance, reducing available resources for the uninsured population.

Crowd-out occurs in three ways: 1) when a family drops private dependent coverage to enroll their child in public health insurance program; 2) when a previously uninsured family whose child is enrolled in SCHIP chooses to maintain that coverage and refuses an offer of employer-sponsored insurance; and 3) an employer changes coverage offerings in response to the existence of a public program.[1]

Crowd-out is an important issue for those who want to ensure that expanded public health insurance initiatives target children who are uninsured and who do not qualify for other public programs. If expanded public coverage simply substitutes for private coverage, decreases in the rate of uninsured children will be smaller and fewer improvements in access to care and health status may result. Such substitutions may also lead to greater-than-expected increases in program expenditures.[2]

[1] The Robert Wood Johnson Foundation, The Synthesis Project, *Public Program Crowd-out of Private Coverage: What are the Issues?*, June 2004.

[2] Lutzky, Amy Westphal, Urban Institute, *Has the Jury Reached a Verdict? States' Early Experiences with Crowd-out under SCHIP*, June 2001

UNINSURED ADULTS

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Analysis of U.S. Census Bureau and Bureau of Labor Statistics data by the UH SSRI indicates that an estimated 84,369 Hawaii adults ages 19-64 are uninsured. This group represents 75% of Hawaii's total uninsured. A number of solutions are necessary to address the varied circumstances and needs of this population. A cross tabulation of this population by employment status and income level shows the following:

HAWAII'S UNINSURED ADULTS BY INCOME LEVEL AND EMPLOYMENT STATUS

	0-100%	101-200%	201-300%	301+%	Total
Sole prop & part-time	3,809	4,629	3,106	4,329	15,873
Full-time	6,253	9,222	5,262	10,639	31,376
Not Working	14,396	9,440	5,646	7,638	37,120
Total	24,458	23,291	14,014	22,606	84,369

Source: Current Population Survey, Annual Social & Economic Supplement, Annual Demographic Supplement, Public Use Files, 1994-2003. Weighted tabulations for internal use only.

Given that the PHCA is the basis for Hawaii's system of health care coverage for adults, the following incremental approaches are suggested to build upon or supplement this system.

Enhanced Education and Enforcement of PHCA. Increase efforts to educate employers and employees about the requirements of the PHCA; increase compliance through monitoring and auditing. Support additional funding to Department of Labor and Industrial Relations (DLIR) for enhanced education and enforcement. *Target group: 31,376 uninsured working full-time (less exempt government employees).*

Individual Responsibility for Health Insurance. Require working individuals who are exempt from PHCA (sole proprietors and part-time workers) and whose income is between 101-300% FPL to purchase an affordable and portable limited-benefit plan, with state-subsidized premium assistance on a sliding scale based on income, OR with state individual tax credits. *Target group: 7,735 sole proprietors and part-time employees (4,639 at 101-200% + 3,106 at 201-300% FPL).*

EUTF Buy-In with Premium Subsidies. Allow sole proprietors and part-time employees with family income between 101-300% FPL to purchase insurance through the state employees' health fund, with state-subsidized premium assistance on a sliding scale based on income OR with state individual tax credits. *Target group: 7,735 sole proprietors and part-time employees (4,639 at 101-200% + 3,106 at 201-300% FPL).*

Allow small businesses (10 employees or less) whose owner and majority of employees (51%) have incomes between 101-300% FPL, to purchase insurance through the state employees' health fund, with state-subsidized premium assistance on a sliding scale based on income OR with state individual and business tax credits. *Target group: 15,000 Hawai`i firms with 10 employees or less (101-300% FPL)*

Health Savings Accounts (HSAs). Encourage sole proprietors and part-time employees with family income at 301%+ FPL to establish a health savings account with a high deductible health plan. *Target group: 4,329 sole proprietors and part-time employees (301+% FPL).*

Expand Eligibility to PHCA-Exempt Government Employees. Amend Hawai`i law to expand health insurance eligibility to state and county employees currently exempt from the PHCA. *Target group: Approximately 1,000 employees.*

Remove QUEST Enrollment Cap. Remove the current cap of 125,000 to allow enrollment of adults eligible for QUEST benefits. *Target group: 24,458 uninsured adults (0-100% FPL).*

COST PROJECTIONS

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Ultimately, the cost of the uninsured comes out of everyone's pockets. However, investing additional resources in providing health care coverage for the uninsured will have a longer term benefit than the current uncontrolled costs of subsidizing the uninsured through increased premiums and uncompensated care paid by those who are insured.

Cost Estimates

In order to determine a cost estimate for the various policy proposals, the following assumptions and data were considered:

Average premium per uninsured:

- Child = $1,500 per year
  (average premium amount reported by Med-Quest program for single child coverage)

- Adult = $3,000 per year
  (average premium amount paid for single adult coverage through the Employee Union Trust Fund)

Number uninsured:

Data from the University of Hawai`i Social Science Research Institute based on the U.S. Census Bureau Current Population Survey and U.S. Bureau of Labor Statistics, 1994-2003.

Annual cost per uninsured:

Annual average premium **X** number uninsured

Federal Medical Assistance Percentage (FMAP) Reimbursement:

The state portion of the total annual cost was based on a FMAP reimbursement rate of:

- 58-71% for children
- 58% for adults

NOTE: These reimbursement rates are applicable only to healthy enrollees in the SCHIP & QUEST managed care programs, and fluctuate depending upon age of the enrollee and federal negotiations.

The Hawai`i Uninsured Project staff has developed the following figures ***for discussion purposes, to reflect a baseline annual cost*** to the State for public assistance to the gap groups. These estimates do not include costs of crowd-out or take-up and other factors affecting health care coverage and health care costs.

PROPOSAL	ESTIMATED COST
Enroll children currently eligible but not enrolled in Medicaid/SCHIP. (using 71% FMAP reimbursement rate) *Target group: 19,548 children (0-200% FPL)*	$8,796,600
Expand SCHIP eligibility to include children up to 300% FPL. *Target group: 2,874 children (201-300% FPL)*	$1,302,300
EUTF buy-in and sliding scale premium assistance or subsidize individual responsibility initiative. *Target group: 7,735 sole proprietors and part-time employees (101-300% FPL)*	$7,042,500
Remove QUEST enrollment cap. *Target group: 24,458 adults (0-100% FPL).*	$30,817,080
TOTAL: 54,615 uninsured	$47,958,480
NOTE: *Costs for: (1) state subsidy for small business buy-in to the EUTF and (2) state share to expand eligibility to PHCA-exempt government employees were not calculated because of insufficient data on the number of eligible employees*	

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REVENUE SOURCES and FINANCING OPTIONS

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Several scenarios have been explored to determine how additional funds could be generated to finance some or all of the policy proposals. The underlying premise is that revenues, whether from existing or new sources, would be earmarked to support health care coverage options to assure a continuing source of funding for enhancement or expansion of public programs, or to use public funds in combination with private funds.

Revenue Sources

- Direct appropriations from state general fund to support any of the policy options, to be matched by federal funds and/or individual funds, as appropriate.
- Appropriations from existing revenue sources, including:
  - The Hawai`i Tobacco Settlement Special Fund (SCHIP expansion)
  - The 4.265% premium tax presently collected on revenues of for-profit insurers
- Appropriations from new revenue sources, including:
  - Assessment of 4.167% general excise tax on all health care plans operating in Hawai`i (in lieu of current 4.265% premium tax currently imposed only on for-profit insurers)
  - Assessment of current premium tax of 4.265% on revenues of all health care plans in Hawai`i
  - Assessment of reduced premium tax of 2.13% on revenues of all health care plans in Hawai`i (in lieu of current 4.265% premium tax)
  - Annual surcharge of $50 per insured life
  - A percentage of reserves and administrative overhead reported to the Insurance Commissioner of all health care plans operating in Hawai`i

Financing Options

Each of the financing options involves diversion of existing revenue sources or the earmarking of new revenues that would impact the state general fund bottom line. Further, any new tax could potentially impact private business due to the "pass-through" effect wherein insurers include the tax in the premiums paid by employers or individuals. These revenue options must be weighed against the costs of uncompensated care that are passed on to the insured through increased provider fees and increased premium amounts. These amounts are "hidden" subsidies for uncompensated care provided to the uninsured. The creation of a nexus between revenues generated within the insurance industry and the commitment of such revenues to support programs for the uninsured provides not only a more stable source of funding, but also provides more direct government oversight through rate regulation of health insurers.

REVENUE SOURCE	AMOUNT
General Funds	Appropriation
Tobacco Settlement Funds *(for SCHIP expansion only)*	Appropriation
4.265% Premium Tax Current Revenues *(actual amount collected in FY2003-2004)*	$19,090,504
4.167% Excise Tax in Lieu of Premium Tax *(projected amount based upon premiums written by health care plans)*	$99,161,824
4.265% Premium Tax on All Health Plans *(projected amount based upon premiums written by health care plans)*	$101,493,923
2.13% Premium Tax in Lieu of current 4.265% Tax *(projected amount based upon premiums written by health care plans)*	$50,687,470
$50 Annual Surcharge per Insured/Enrollee *(projected amount based upon insured lives covered by health care plans)*	$50,613,300
10% Earmark of Mandatory Reserves & Administrative Expenses *(projected amount based upon financial reports from health care plans)*	$75,996,787

CONCLUSION

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The Hawai`i Uninsured Project believes that implementation of the aforementioned policy proposals will substantially lower Hawaii's uninsured rate. For example, enrolling all children currently eligible for SCHIP would reduce our uninsured rate by two percent. The benefit of covering more people and enhancing the safety net increases our ability to manage people's care, which equates to a healthier society. Nationwide statistics and extensive research on the multi-sectoral consequences of an uninsured population confirm this dynamic.

Costs to Employers

- Employers incur costs when their employees miss work, quit, or retire early for health reasons.
- The economic vitality of the society is diminished by productivity lost as a result of the poorer health and premature death or disability of uninsured workers.

Costs to the Health Care System

- Nationwide, the uninsured received approximately $34.5 billion in uncompensated care in 2001. [3]
- An Ernst & Young study for the Healthcare Association of Hawai`i revealed an average annual expenditure of $79,380,000 on charity care from 1998 to 2003.

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Costs to Taxpayers

- A recent, widely cited estimate of the net cost of providing insurance coverage to all uninsured people is $34 billion per year for public coverage and $69 billion per year for private coverage.[4] In contrast, the Institute of Medicine reports that the value of covering the uninsured measured primarily in terms of better health and longer life is between $65-$130 billion annually.[5]
- A recent study documented that the costs that federal, state, and local governments spend on the uninsured through public health clinics and safety net hospitals amounts to $30.6 billion a year. Doctors donate services valued at another $5 billion.[6]

Costs to Society

- Additional costs to society that are associated with the uninsured include:
  - Expenses borne by families, especially those with a member who suffers a chronic health condition, catastrophic illness or injury
  - Uncompensated care subsidized by health care providers and facilities
  - Higher public program costs
  - Higher health insurance premiums to cover cost-shifting

[3] Hadley, Jack and John Holahan. 2003. *How Much Medical Care Do the Uninsured Use and Who Pays for It?*, Health Affairs Web Exclusive (1): W66-W81, February 2003.

[4] Ibid.

[5] Institute of Medicine (IOM). 2004. *Hidden Costs, Value Lost*. Washington, DC: National Academy Press; Miller, Wilhelmine, Elizabeth Vigdor, and Willard Manning, 2004. *Covering The Uninsured: What is it Worth?*, Health Affairs Web Exclusive, available at content.healthaffairs.org/cgi/reprint/hlthaff.w4.157v1, accessed May 17, 2004.

[6] Institute of Medicine Committee on the Consequences of Uninsurance, *Hidden Costs, Value Lost*, June 2003.