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September 7, 2005

Temporary Health Care Task Force
Rep. Josh Green, M.D.,
Chair
Rep. Patricia Blanchette, M.D.
Vice Chair

DATE: Thursday, September 8, 2005
TIME: 4:30 p.m.
PLACE: State Capitol, Room 329

TESTIMONY OF STEPHEN M. SHAW, ESQ.

Dear Chairman Green, Vice Chair Blanchette and Members Of The Task Force:

This reiterates my earlier objection to the presence of individuals serving on the task force who also serve with, or are employed by organizations whose members are reasonably likely to suffer financial loss by a plan implementing health care for all residents of Hawaii. HB 1304(c)(2).

I thank Mr. John Radcliff for his candid disclosure of his lobbying client the Hawaii Insurance Council. Because the council is dominated by Hawaii's property casualty insurers I respectfully demand his resignation.

In the short term the P&C insurers stand to lose hundreds of millions in annual premiums if their "Rube Goldberg" version of health insurance is finally outlawed. The Council, which Mr. Radcliff represents, is concerned about the short term because very few of its members have the financial strength to bid on a statewide single payer plan, descried in "A" (not passed).

From any vantage point, Mr. Radcliff has fast access to important numbers, which I trust he will quickly share. As a board member of the EUTF Mr. Radcliff can tell everyone (1) how

many individuals other than retirees (28,000) and employees (39,000) make up the risk pool for the public employees' health plan.

The significance of this number to the Task Force is that a $34,162,092.06 check was written in August for what appears to be a monthly premium. Assume 200,000 lives in the pool, at $34M per month and multiply by 6 to get the state's population of about 1.2M, and the task force has a valid estimate of how much a plan for the state will cost: about $204M per month.

Mr. Radcliff can also help out, whether on the task force or disqualified from it, by disclosing the actuarial bases for the EUTF 34M premium calculation. This will give the task force experts a point of beginning, with recognized tools.

Finally, Mr. Radcliff can disclose the health insurance portion of premiums for auto insurance, worker's compensation, and related lines of insurance written by industry members, some of whom are officers of the Insurance Council.

Commissioner Schmidt's 2004 Report at p.45(Exhibit "B") shows that Mr. Ratcliff's client's members and other P&C insurers wrote over 1.9 billion in Hawaii premium in 2003! A good share, as Mr. Radcliff knows, was for duplicative health insurance.

Page 47 ("C") of the same report shows that HMSA's claims paid were over $1.3 billion for 2003. This is an important number because HMSA covers about half of the state's 1.2 million people.

From HMSA's experience, a fair estimate of the anticipated claims for the entire population is around $2.8 billion a year, and rising. Putting these figures in the context of applying the Hawaii government employees' premium rate to the entire state may require an annual premium of $2.4 billion. Doubling HMSA's premium is closer to $3 billion. Exhibit "C".

Looking at page 47 of the commission report ("C") again, the fantastic news is that Hawaii residents already pay annual health premiums to HMOs and mutual benefit societies in excess of $2.4 billion!

So, to respond the Doctor Chung's facetious suggestion of "throwing money" at this problem, that has already occurred and wastefully so. The job of this task force is to apply the

existing money residents pay to extend coverage to everyone in the state. Exhibit "A".

Next, where will the difference between total health premium paid now (±$2.4B) and the expected claims of ±$2.8b come from? Some will come from the "hidden health insurance" premium in the property/casualty carriers' 1.9 billion a year. Additional savings will be realized by a large risk pool size and competitive bidding for the state's 1.2 million resident risk pool. Exhibit "A".

Mr. Jory Watlin also has information about additional sources of existing revenue to fund a single payer plan. But, in terms of new money, only about $400M per year is needed.

Finally, a word about unfound fears:

1. The Prepaid Health Care Act is not affected at all, because the single payer plan ("A") falls under the exemptions in that Act, at HRS §393-17.

2. Insurers losing premium dollars for health insurance in auto insurance and worker's compensation will complain that they give up medical "control", exposing their insureds to additional losses. This is not true. These insurers have used their stable of physicians to opine, for decades, which part of a claimants health care relates to the conduct of their insured employers or drivers. A single payer plan does not detract from these insurers' efforts to allocate which health care interventions relate to their claims, and which do not.

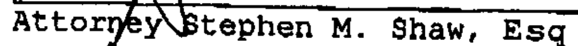
3. ERISA. This federal bogeyman only applies to certain types of insurance policies sold to employers for employees. It does not apply to non-employer based plans which, as here, are also exempt from the Prepaid Health Care Act.

4. Taxes. State residents pay $2.4 billion to a hodge-podge of health insurers with different plans, reserves and payment practices. Exhibit "C". Doubling HMSA's claims experience for half the population yields about $3 billion (Ex. "C"). Stripping hidden health insurance from worker's compensation and auto insurance premiums will close the gap as will Mr. Watlin's data. The question really becomes would one rather pay a state insurance premium as a tax for better insurance, or continue the spiral downward with this patchwork of companies which have segmented the risk pool. See Ex."A".

UNINTENDED CONSEQUENCES

As a result of assurance of health care access to the entire state as the risk pool ("A") attorneys in medical malpractice and other tort cases will not be able to argue the value of medical care as an element of damages. This will occur when access to medical care is guaranteed by a single payer plan and has nothing to do with damages claimed against a tortfeasor. Another rule which will pass away naturally and quietly is the "collateral source rule" which bars consideration by juries of payment by others for medical costs.

Respectfully Submitted,

By: 

Attorney Stephen M. Shaw, Esq

THE SENATE

TWENTY-THIRD LEGISLATURE, 2005

STATE OF HAWAII

S.C.R. NO. 30 S.D. 1

SENATE CONCURRENT RESOLUTION

requesting an ASSESSment of THE COST TO INSURE A GROUP HEALTH INSURANCE PLAN FOR THE STATE of hawaii BASED ON a RISK POOL EQUIVALENT TO THE STATE'S POPULATION.

WHEREAS, according to the State Executive Office on Aging, it is projected that of Hawaii's population of 1,366,770, there will be 437,327 residents between the ages of forty and sixty-four, by 2010; and

WHEREAS, in an attempt to help finance the health care of Hawaii's residents, the Hawaii Legislature has been presented at various times with bills to provide universal health care financing through a "single payer" system whereby a state entity pays health care providers; and

WHEREAS, a single payer system necessarily involves the pooling of risks of health care expenses over all or nearly all of Hawaii's population; and

WHEREAS, the national industry standard for risk transfer insurance is to spread the total cost of the losses over the entire insured

population; and

WHEREAS, insurance companies already providing various forms of health insurance in the State include global property and casualty (P & C) insurers, as well as the traditional health insurance companies, such as Kaiser and HMSA; and

WHEREAS, pooling of risks of health care financing through a legislated single payer or similar concept, from time to time, may be insured or underwritten on fixed enrollment periods of one to three years by global insurance companies, combinations of insurance companies, or other entities; and

WHEREAS, privately insuring all or part of a single payer plan, or similar concept, presents a method of financing which may reduce the cost to taxpayers for the program; and

WHEREAS, because of unique features of Hawaii law, it is prudent to begin the search for global insurers qualified to underwrite risk pools equivalent to the size of extremely large corporations or an entire state of over 1.2 million residents, before and during the creation of legislation; and

WHEREAS, an assessment of the market of insurers qualified to underwrite a health insurance risk pool the size of Hawaii's population necessarily includes discussions of "best estimate" premium rates on a contingent or "trial application" basis, for example determining what premium rates would be based on the following assumptions: (1) a risk pool of 1.2 million people; (2) an enrollment period of one year; (3) locally-based claims adjustment and dispute administration; (4) use of the basic policy form required by the Hawaii Prepaid Health Care Act; and (5) appropriate waivers of requirements deemed to be protective of local insurers; and

WHEREAS, the insurance industry standard is that group insurance policies involving 25,000 individuals or more are negotiated contracts, and not offered on preprinted forms on a "take-it-or-leave-it" basis; and

WHEREAS, assessment of and early involvement of qualified global insurers from the property and casualty field, as well as from the traditional health insurance industry is essential to the success of a proposed single payer system that at times may look to world financial markets to underwrite risk pools large enough to finance health care for an entire state or combination of states; and

WHEREAS, Hawaii's unique insurance laws make it imperative that the proposal-counter proposals between qualified global carriers and the State be flexible enough to support the modification, amendment, or even repeal laws that either obstruct the bidding process or enactment of the State's universal group health plan; and

WHEREAS, central to Hawaii's case law impacting insurer involvement in

financing health care for the entire State is a line of cases that hold that statutes in force at the time a policy is written are part of the contract, and where the contract and the statutes conflict, the statutes prevail (see Doe v. Paul Revere, 86 Haw. 262, 271, 948 P.2d 1103, 1112 (1997)); and

WHEREAS, the favorable aspects of competition between companies offering health insurance in Hawaii have proven unable to spread the financial risk of health care over the most cost-effective risk pool which is now over 1.2 million people; and

WHEREAS, recent rate increases in HMSA's small business "pool" of about 80,000 members, in comparison with businesses with over one hundred one employees, demonstrate the inability of insurance companies to compete when the premiums are calculated based upon the State's population as the correct risk pool, and competition would be best served by open bidding for the State's program on a one to three year enrollment period; now, therefore,

BE IT RESOLVED by the Senate of the Twenty-Third Legislature of the State of Hawaii, Regular Session of 2005, the House of Representatives concurring, that the Senate and House Committees on Health are requested to conduct an assessment of the availability of insurance to help finance a single payer health insurance program for all of Hawaii's residents based upon a risk pool size of the State population, that includes:

(1) "Best estimate", contingent, or "trial application" premium quotes from global and national insurers qualified to insure groups of over 1,000,000 individuals; and

(2) At a minimum, an estimated premium for the plan required under the Hawaii Prepaid Health Care Act; and

BE IT FURTHER RESOLVED that if H.B. 1304 passes in any form, the temporary healthcare task force established under that measure is requested to conduct any research required in this concurrent resolution under the direction of the Senate and House Committees on Health and to submit a report to the Senate and House Committees on Health; and

BE IT FURTHER RESOLVED that the Senate and House Committees on Health are requested to submit their findings and recommendations to the Legislature, including any necessary implementing legislation, no later than twenty days prior to the convening of the Regular Session of 2006; and

BE IT FURTHER RESOLVED that certified copies of this Concurrent Resolution be transmitted to the President of the Senate, the Speaker of the House of Representatives, and the Chairs of the Senate and House Committees on Health.

Insurance Program

Report Title:

Feasibility of Insurer Financing of Hawaii Single Payer HEALTH

STAND.
COM.
REP.
NO.
1304

Honolulu
Hawaii

, 2005

Honorable Robert Bunda

President of the Senate

Twenty-Third State Legislature

Regular Session of 2005

State of Hawaii

Sir:

Your Committees on Health and Commerce, Consumer Protection, and Housing, to which was referred S.C.R. No. 30 entitled:

"SENATE CONCURRENT RESOLUTION REQUESTING AN ASSESSMENT OF THE COST TO INSURE A GROUP HEALTH INSURANCE PLAN FOR THE STATE OF HAWAII BASED ON A RISK POOL EQUIVALENT TO THE STATE'S POPULATION,"

beg leave to report as follows:

The purpose of this measure is to request an assessment of the cost to insure a group health insurance plan for the State of Hawaii based on a risk pool equivalent to the State's population.

Americans for Democratic Action/Hawaii submitted comments.

Your Committees find that at various times the Legislature has been presented with bills that would provide universal health care financing through a "single payer" system whereby a state entity pays

health care providers. A single payer system involves the pooling of risks of health care expenses over all or nearly all of Hawaii's population. It is prudent to begin the search for global insurers qualified to underwrite risk pools equivalent to the size of extremely large corporations or an entire state of over 1.2 million residents. Further, Hawaii's unique insurance laws make it imperative that the proposal-counter proposals between qualified global carriers and the State be flexible enough to support the modification, amendment, or even the repeal of laws that either obstruct the bidding process or the enactment of the State's universal group health plan.

This measure will begin the process of assessing the availability of insurance to help finance a single payer health insurance program for all of Hawaii's residents based upon a risk pool the size of the state population, including "best estimate", contingent, or "trial application" premium quotes from global and national insurers; and at a minimum, generate an estimated premium for the plan required under the Hawaii Prepaid Health Care Act.

Upon further consideration, your Committees have amended this measure by requesting that if H.B. 1304 passes in any form, that the temporary healthcare task force established under that measure be tasked with conducting any research necessary for the purpose of this measure under the direction of the Senate and House Committees on Health and for that task force to submit a report to the Senate and House Committees on Health.

As affirmed by the records of votes of the members of your Committees on Health and Commerce, Consumer Protection, and Housing that are attached to this report, your Committees concur with the intent and purpose of S.C.R. No. 30, as amended herein, recommend that it be referred to the Committee on Ways and Means, in the form attached hereto as S.C.R. No. 30, S.D. 1.

Respectfully submitted on behalf of the members of the Committees on Health and Commerce, Consumer Protection, and Housing,

RON MENOR, Chair

ROSALYN H. BAKER, Chair

Table 1: INSURANCE COMPANIES AUTHORIZED TO TRANSACT INSURANCE IN HAWAII DURING 2003 (INCLUDING FRATERNAL BENEFIT SOCIETIES)

NAME OF COMPANY	HAWAII BUSINESS FOR THE YEAR ENDED DECEMBER 31, 2003					
	DIRECT PREMIUMS WRITTEN			CLAIMS BENEFITS PAID		
	LIFE	ANNUITIES	FIRE, CASUALTY, & MISC.	LIFE	ANNUITIES	FIRE, CASUALTY, & MISC.
ALIEN - LIFE						
GREAT WEST LIFE ASSUR CO	$ 25,104	$ —	$ 29,833	$ 79,680	$ —	$ 6,399
INDEPENDENT ORDER OF FORESTERS US BR	341,690	6,950	3,059	337,697	303,518	1,563
US BRANCH OF INDUSTRIAL ALLIANCE PAC	109,056	—	—	160,463	—	—
US BRANCH SUNLIFE ASSUR CO OF CANADA	6,820,479	—	37,497	5,247,484	—	41,672
US BUS OF CROWN LIFE INS CO	870,865	100	40,543	1,537,129	52,068	81,110
US BUS OF THE CANADA LIFE ASSUR CO	600,733	160,749	34,700	660,509	506,849	21,204
TOTAL ALIEN - LIFE	$ 8,767,927	$ 167,799	$ 145,632	$ 8,022,962	$ 862,435	$ 151,948
ALIEN - PROPERTY & CASUALTY						
AIG NATL INS CO INC	$ —	$ —	$ 11,273	$ —	$ —	$ —
TNUS INS CO	—	—	—	—	—	—
NIPPONKOA INS CO LTD U.S. BRANCH	—	—	543,942	—	—	233,922
TOKIO MARINE & FIRE INS CO LTD US BR	—	—	4,277,027	—	—	1,152,823
TOTAL ALIEN - PROPERTY & CASUALTY	$ —	$ —	$ 4,832,242	$ —	$ —	$ 1,386,745
TOTAL ALIEN - LIFE & PROPERTY & CASUALTY	$ 8,767,927	$ 167,799	$ 4,977,874	$ 8,022,962	$ 862,435	$ 1,538,693
GRAND TOTAL DOMESTIC, FOREIGN & ALIEN (2)	$ 602,830,176	$ 1,048,925,728	$ 1,981,739,030	$ 604,335,968	$ 280,030,731	$ 734,097,140

Notes

(1) See The Travelers Ins Co under Foreign - Life section for assets, liabilities, policyholders' surplus and capital information.

(2) Figures may not total due to rounding.

"B"

Table 2: MUTUAL BENEFIT SOCIETIES & HEALTH MAINTENANCE ORGANIZATIONS AUTHORIZED TO TRANSACT INSURANCE IN HAWAII DURING 2003

NAME OF COMPANY	HAWAII BUSINESS FOR THE YEAR ENDED DECEMBER 31, 2003	
	DIRECT PREMIUMS WRITTEN	NET CLAIMS BENEFITS PAID
MUTUAL BENEFIT SOCIETIES		
HAWAII MANAGEMENT ALLIANCE ASSOCIATION	$ 66,899,152	$ 43,036,350
HAWAII MEDICAL SERVICE ASSOCIATION	1,458,860,761	1,337,999,861
MUTUAL BENEFIT ASSOCIATION OF HAWAII	562,649	466,923
UNITED PUERTO RICAN ASSN OF HI	—	—
UNIVERSITY HEALTH ALLIANCE	56,269,891	44,761,293
VOLUNTARY EMPLOYEES' BENEFIT ASSN OF HI	5,206,309	815,648
TOTAL (1)	$ 1,587,798,762	$ 1,427,080,075

NAME OF COMPANY	HAWAII BUSINESS FOR THE YEAR ENDED DECEMBER 31, 2003	
	HEALTH CARE RELATED REVENUES	TOTAL MEDICAL & HOSPITAL EXPENSES
HEALTH MAINTENANCE ORGANIZATIONS		
ALOHA CARE	$ 87,209,964	$ 69,269,159
KAISER FOUNDATION HEALTH PLAN, INC. (2)	710,453,638	685,996,137
TOTAL (1)	$ 797,663,602	$ 755,265,296

N/A Not Available
(1) Figures may not total due to rounding
(2) Hawaii Region

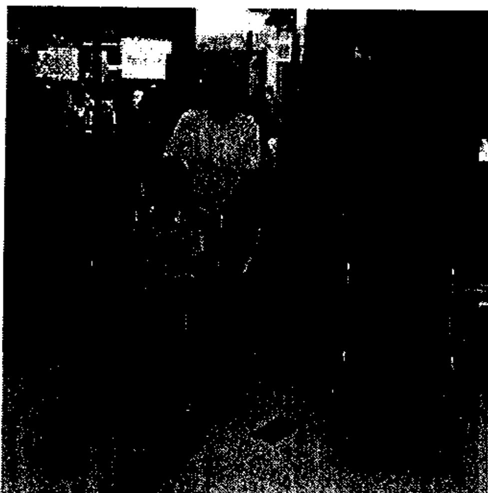
"C"

Received from: Hmsl 9/7/05

Few solutions on horizon as health costs rise

By Julie Appleby and Richard Wolf, USA TODAY

As Americans face growing health care expenses, Congress and state lawmakers say they're working to close the gap between prices and pocketbooks.

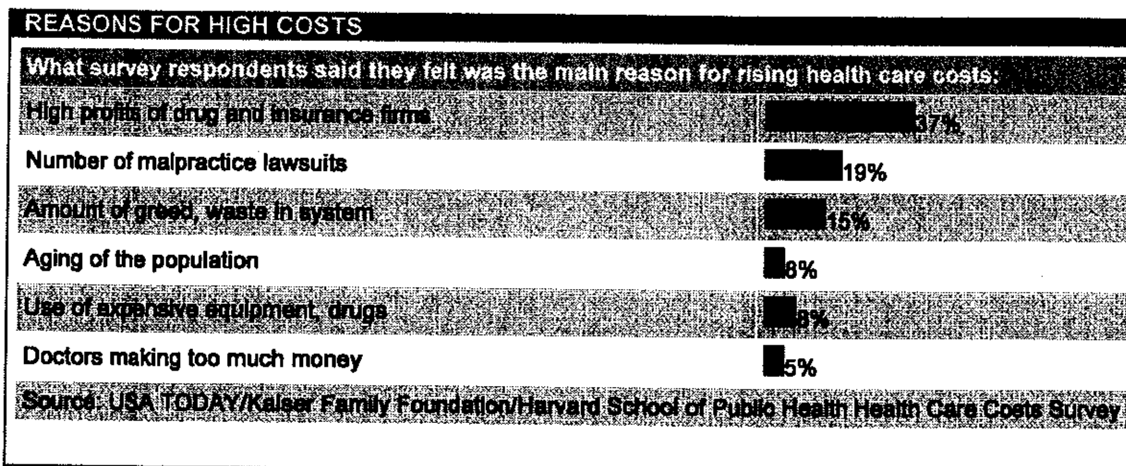


Marvella Davis, left, is raising two daughters with arthritis. The twins' grandmother, Sylvia Davis, helps her out.

By Michael Schwarz, USA TODAY

Despite the activity, skeptics say government's impact will be limited.

"There are lots of things on the table, but there's nothing that will have a significant impact on the rate of increase of health care costs," says Drew Altman of the Kaiser Family Foundation, a non-partisan research group in California.



REASONS FOR HIGH COSTS

What survey respondents said they felt was the main reason for rising health care costs:

Reason	Percent
High profits of drug and insurance firms	37%
Number of malpractice lawsuits	19%
Amount of greed, waste in system	15%
Aging of the population	8%
Use of expensive equipment, drugs	8%
Doctors making too much money	5%

Source: USA TODAY/Kaiser Family Foundation/Harvard School of Public Health Health Care Costs Survey

Unlike the efforts of the 1970s and 1990s that included broad government mandates, most of today's prescriptions are intended to influence the private health marketplace by encouraging quality and giving consumers more choices.

"The health system in the country is fundamentally broken," says former U.S. senator John Breaux, a moderate Democrat who has organized "Ceasefire on Health Care" forums that bring Republicans and Democrats together to work on solutions. For now, he says, only incremental steps are possible: "I don't think the Congress or the country is ready for wholesale change."

A USA TODAY/Kaiser Family Foundation/Harvard School of Public Health poll released Wednesday shows that 28% of Americans had trouble paying a medical bill in the past year. Of those, 62% had insurance.

More than one in three of those polled said the top reason for rising health care costs is the profits of insurers and drug companies. Nearly one in five cited medical malpractice awards, and 15% blamed greed and waste in the health care system.

Such sentiment will put pressure on lawmakers to act, says Robert Blendon, a professor and expert on public opinion research at Harvard.

SPECIAL REPORT

Day 1: Wednesday

- Survey shows even the insured can buckle under growing costs
- Son's cancer devastates a family
- **Interactive graphic:**See and hear one family's struggle
- Results from the USA TODAY/ Kaiser Family Foundation/Harvard School of Public Health survey questionnaire

Day 2: Thursday

A nationwide survey of adults found that people with chronic diseases face significant problems in paying for their medical care. Profiles of the five diseases most likely to cause hardship:

- Asthma patients struggle with financial bills
- Diabetic faces tough choice: Pay more or lose coverage
- Twin girls with arthritis struggle on Medicaid
- If treatment is vital, you 'find a way', cancer survivor says
- Heart patient's money, time, options are running out

Day 3: Today

- Remedies for the health care crisis?
- Managing your health care costs
- Interactive graphic: Prevention tips to stay healthy

"It affects a lot of families in the prime voting age," he says. While many factors have led to rising medical costs — and the ones the public blames aren't always the biggest factors — few big solutions are on the horizon. Some of the smaller ones include:

•**Health savings accounts.** These tax-free accounts, which must be coupled with high-deductible health insurance policies, are now held by about 1 million Americans. Money in the accounts can be used to pay for medical expenses today or saved to cover medical expenses in retirement. By next year, the accounts are expected to be offered in almost every state and by 25% of big employers.

•**Preventing disease and rewarding quality care.** Medicare and private insurers are experimenting with "pay-for-performance" programs that reward doctors and hospitals for positive results. Other programs are aimed at helping doctors and patients manage chronic diseases without resorting to unnecessary care.

•**Information technology.** Both parties in Congress agree on the need to set standards and encourage the expansion of electronic record-keeping by doctors and hospitals. The issue even brought together Sen. Hillary Rodham Clinton, D-N.Y., and former Republican House speaker Newt Gingrich. Legislation could pass this fall.

Those and other efforts to work within the private health marketplace are viewed skeptically by some outside experts. "There's no way to control spending without making some tough choices,"

says Meredith Rosenthal, professor of health economics and policy at Harvard University. "The only way to slow it down is to say there are some things we're not going to pay for."

But the Bush administration and Republicans in Congress insist that such piecemeal efforts on cost can work. Rep. Phil Gingrey, R-Ga., an obstetrician-gynecologist, says the key is to involve consumers financially so that "they have skin in the game."

Rising health care costs have the attention of congressional leaders, including Republicans House Speaker Dennis Hastert and Senate Majority Leader Bill Frist. Hastert wants to let consumers cross state lines to purchase insurance policies. Frist wants to give tax deductions to purchasers of high-deductible policies.

"The system today is almost absent the basics of market forces," says Frist, a heart-transplant surgeon before coming to Congress.

The Bush administration favors a series of incremental changes that include tax credits as well as "pay-for- performance" and disease-management incentives.

"The challenge in policymaking is to take all the steps we can to help avoid unnecessary costs, to help people save money, to drive costs down wherever possible," says Mark McClellan, director of the Centers for Medicare & Medicaid Services. "That's the way to have both affordability and better and better health care."

Price controls to managed care

Despite the optimism of public officials, pessimists abound. Medical inflation has pushed insurance premiums into double-digit territory for much of the past four years. Health care spending growth is running at triple the rate of inflation. And a host of new, expensive biotech drugs are soon to hit the market.

Everything tried in the past, they say — from wage and price controls under President Nixon to managed care under President Clinton — has ultimately failed to stem costs.

ABOUT THE SURVEY

This is the first in a new series of surveys to be conducted jointly by USA TODAY, The Henry J. Kaiser Family Foundation and the Harvard School of Public Health. The three organizations worked together to develop the questionnaire and analyze the results. USA TODAY retains editorial control over the content published by the paper. USA TODAY and the Kaiser Family Foundation (KFF) — a non-profit organization that conducts research on health care and other public policy issues — paid for the surveys and related expenses. The project team included Jim Norman, polling editor of USA TODAY; Mollyann Brodie, Ph.D., vice president and director of public opinion and media research, and Erin Weltzien, research associate, from Kaiser; and Robert J. Blendon, Sc.D., professor at the Harvard School of Public Health and John F. Kennedy School of Government, and John Benson, M.A., managing director of the Harvard Opinion Research Program.

Here is a selection of the questions asked about the following topics:

- Condition of your health
- Cost concerns
- Health care costs
- Health care factors
- Health care usage
- Health insurance
- Payment problems

"There have been temporary successes, but always health care costs have bounced back with a vengeance," Altman says.

Historically, lawmakers have been reluctant to embrace large-scale changes. Presidents from Nixon to Clinton have tried to create some kind of national health care program, but all efforts have fallen victim to lobbying by labor groups, doctors or insurers.

For some American families, a national health program seems a good idea. Jeffrey Herchenroder, a high school teacher who lives near Albany, N.Y., says his middle-income family has good insurance but still struggles. Co-payments for prescriptions for himself, his wife, Cindy, and two children, run $280 a month. He says people without insurance have it far worse.

"If we can pay for a war, we can pay for medical coverage," Herchenroder says. "I don't see any excuse for not having at least basic national health coverage."

Anthony Stout of Blackwell, Okla., has health insurance through his job, but it doesn't cover his wife or six children. His children are covered through a state Medicaid program, but his $15-an-hour job as a journeyman mechanic provides too much income for his wife, Stacy, to qualify for Medicaid.

Stout says the government needs to take more action: "Why is it so expensive in America? It has to do with government paying too much or not regulating enough. Canada has a national health program. Why don't we do something like that?"

But critics of a national health care program say a Canadian-type health system is unlikely to occur in the USA. State efforts may occur, but federal ones are unlikely, says John Goodman, president of the National Center for Policy Analysis.

"Giving government control over the health system doesn't really solve problems, and it creates new problems," he says. "The main problem is you have rationing by waiting. In Canada, the average wait for an MRI is three months. Here, you can get one in a shopping mall."

But proponents of a national health plan say it need not involve long waits for care and is the only way to guarantee all Americans access to care and protection from catastrophic costs. "National health insurance is no longer the best solution, it's the only solution: All other alternatives have been proven disastrous failures," says Quentin Young, national coordinator at Physicians for a National Health Program, a Chicago-based non-profit.

After Clinton failed to win approval for revamping the health care system in 1994, the nation turned to market forces to control costs. Managed care held down medical inflation for a while in the mid-'90s, but patients and lawmakers objected to some of the restrictions. Looser forms of managed care became more popular.

As cost-control measures ebbed, national spending on health care began to rise rapidly, jumping 11.3% from 2000 to 2001 before slowing slightly last year to an increase of 8.2% — still three times the rate of inflation. Insurance premiums paid by large employers for their workers jumped, too, rising more than 57% since 2000.

The bottom line is that costs will continue to rise so long as there are new drugs, new treatments and growing demand from aging baby boomers, says Alan Weil, president of the National Academy for State Health Policy. The goal, he says, should be to help people pay the higher costs for better care.

'A whole new set of strategies'

Others are more optimistic. Insurance-premium increases are coming down to single digits, says Karen Ignagni, president of America's Health Insurance Plans, and "we have a whole new set of strategies" to bring costs down further. Among them: reducing unnecessary imaging tests, such as MRIs and CAT scans, and encouraging greater use of generic drugs.

Health insurers are among those who say that educating Americans to be better consumers of health care will help control costs. Such efforts focus largely on allowing tax-free health savings accounts to be coupled with high-deductible policies. By paying more, the theory goes, workers will use health care more judiciously. Such plans come with at least a $1,000 annual deductible for individuals and $2,000 for families, meaning patients must themselves pay for care until reaching those limits.

A growing percentage of employers say they will consider them, but health savings accounts remain less popular than insurance with smaller deductibles. The USA TODAY/Kaiser/Harvard poll found that 61% of people who have insurance through their jobs would rather pay $50 to $100 a month more to keep their current coverage than switch to a high-deductible policy.

Critics of health savings accounts say they won't really save much money and could mean that people, especially those with chronic illnesses, will put off needed medical care. The USA TODAY/Kaiser/Harvard poll found that households where someone had a chronic illness are far more likely to report being unable to pay a medical bill in the past year than those without.

Blendon, at Harvard, says such findings indicate that policymakers must be careful when designing high-deductible policies. Medications and other treatment for chronic conditions should be exempted from the annual deductible, he says.

"In the rush to have people pay more out of pocket, I don't think there's a recognition that we need to protect people with serious illness," Blendon says.

- REPRINTS & PERMISSIONS

Statement of Jory Watland
(Former Exec. Dir. of Kokua Kalihi Valley – 30 years.)
On HB 1304, CD1
State Capitol, Rm 329
September 8, 2005

I urge the Task Force to propose the establishment by statute a single entity with the capacity to:

COORDINATE PLANNING AND EVALUATION; (All functions now performed by SHPDA, insurance companies, and public and private program entities. All data on all reimbursed services would be consolidated in a single repository.)

ADMINISTER FINANCING: (All current budgeted sources of income for all approved (i.e. covered) services would be received by the single entity and all payment for approved services would be administered by the same entity.)

DETERMINE DEFINITION OF ELIGIBLE BENEFICIARIES AND COVERED BENEFITS; (Using current Medicaid – all options included – as a model for comprehensive reimbursable services.)

ADMINISTER THE SINGLE ENTITY; (Contracting for management of services delivered and financial services from experienced entities, e.g. DOH, DOL, DHS, HMSA, Kaiser, AlohaCare, TIFFE, local banks and/or financial services entities.)

DEVELOP POLICIES AND ASSURE FISCAL ACCOUNTABILITY THROUGH AN APPOINTED GOVERNING BOARD OF DIRECTORS.

Some of the underlying assumptions that are a part of designing a comprehensive, affordable, sustainable, quality based program for health care for all in Hawaii:

Continue the Hawaii Prepaid Health Act and assure the continuation of the ERISA waiver.

Amend the Prepaid Health Act (HPHA) to assess employer payments on all compensation from the first hour compensated with no cap on hourly pay. (All salaries adjusted to hourly to determine employer payment.) Include all self employed as self pay assessed employers.

Amend the HPHA to assess employers based on an inverse percentage-to-pay formula. (Lower hourly pay/higher percentage of each hour paid. Higher hourly pay/lower percentage of each hour paid.) Cap the total monthly payment by employers at $250/month for employees paid $25/hour or less.

Reinstate the 1115 Medicaid Waiver of 1994 to 300% of poverty.

Eliminate by statute the medical portions of Workers' Comp, Auto Ins., Homeowners Ins., Public Liab. Ins., and return that portion of premiums to current premium payers.

Establish with CMS of the Federal Govt. the single payment of Medicare payments to the single entity.

Use the State Health Trust fund as a match source for Federal agency services and programs including Medicaid, Administration for Children and Families, USDA, HUD, etc.

In order to consider HB 1304 and its intent, three things need to happen at the Health Task Force.

- Think out of the box.
- Set aside preconceived biases.
- Remove the barriers of inertia that stop our progress and dreams.

Statement of A. Q. McElrath
(Retired ILWU Local 142 Social Worker)
On HB 1304, CD1
State Capital, Rm. 329
September 8, 2005

1. <u>To carry out the work of the Task Force to "develop a plan to implement health care for all Hawaii Residents"</u>

   A finding that the present system of health care delivery--availability, affordability, and quality of care--is unable to take care of the needs of Hawaii's business community covered under the Prepaid Health Act; organized and unorganized workers; growing number of aged residents; residents denied care for various reasons.

2. <u>Ways in which present system can be restructured to provide for availability, affordability, and qualify of care</u>

   Establishment of a health care authority (HCA) whose function will be to work towards health care for all Hawaii residents through the rationalization of the following multiple factors:

   a. A benefit structure for all residents through:

      1. Prospective/retrospective payments of Medicare to HCA
      2. Return of Section 1115 waiver under Medicaid to original 300% of poverty
      3. Transfer of SHPDA operations to HCA
      4. Assessment of State/County health plans operation for inclusion under HCA
      5. Elimination of health care coverage under worker's compensation, auto, home owners, and public liability insurance
      6. Assessment of Prepaid Health Act--implications of ERISA preemption; need for continuation
      7. Financing of benefit package

TO: Hawaii State Health Care Task Force
(Universal Health Care Task Force)

FROM: William E. Woods, MPH

Subject: Written statement given at initial meeting of the Task Force

Aloha Task Force Members:

I wish to acknowledge the long process that has lead up to the establishment of this task force and process to achieve universal health care in Hawaii. We were very close to achieving the goal of universal health care about 15 years ago, but somehow got off track and now have a population more uncovered with quality accessible and affordable health care.

While I appreciate the coming together of this group and effort, I wish to convey a deep concern about the make up of the task force which does not reflect important elements, particularly any individual who is presently uncovered for health care. Importantly, several members of this task force who have clear conflicts of interest in serving the community need and mission of the effort as they are receiving compensation and direction from businesses and activities that clearly represent the barriers that Hawaii has faced in achieving lowest cost, quality and accessible health care in the past.

The is very real issue of profits vs health care needs to be fully explored Where conflicts of business interests are present, I sincrely request that those members so conflicted refrain from influencing proper study and passage of relevant universal health care recommendations.

I sincerely hope that the limitations of this group transends its inherent problems and creates the necessary study and recommendations for the best results and the eventual establishement of universal health care in Hawaii.

Mahalo

P.O. Box 37083
Honolulu, Hawaii 96837

808 537-2000

September 8, 2005

TESTIMONY OF JIM BREWER TO THE ACT 223 HEALTH CARE TASK FORCE

Aloha Task Force members,

My name is Jim Brewer and I'm here today to thank you for being willing to take on the challenge of doing the groundwork for the 2006 State of Hawaii Legislature; in order that they may initiate a system of quality healthcare for every Hawaii resident.

It was gratifying to see the openmindedness you demonstrated at your first meeting, August 24, where you made a definite commitment to examining single-payer universal healthcare as a possible solution to Hawaii's ongoing and building healthcare crisis.

We have been doing television programs on Canada's Single-Payer Universal Health Care System since the early nineties and it was somewhere around 1989 when I first wrote an article on the subject.

Every time I did the reading and research on the various systems it always seemed to me that Canada's system was the simplest, most direct and most cost-efficient of all of the other systems from Scandanavia to Taiwan.

The only upside to me to in dragging up the rear in moving to healthcare for all, is that the 28 countries who've gone ahead of the U.S.A. have already, experienced the problems and fixed most of them.

That brings me to the recommendation that you hire the Virginia-based Lewin Group to do an unbiased audit/actuarial study of Hawaii's present patchwork quilt costly and inefficient system—just as California, Maryland and several other states have already done.

Two other invaluable information sources I recommend are to be found at these two websites: http://citizen.org/publications/print_release.cfm?ID=7271
and, http://www.cms.hhs.gov/statistics/more_statistics.asp

Hawaii's Pre-Paid Health Care Act served to make Hawaii known as the "Health State" for some time. And, it is still a firm anchor in Hawaii's total healthcare picture. But, the tremendous savings in Canada's system and the much slower inflation rate in healthcare costs make it an attractive possibility for Hawaii. Canada started along the path to its system with one province, Saskatchewan. Hawaii could be that same kind of milestone for the U.S.A. as a whole.

The issue of single-payer healthcare for all is a win, win, win... situation all around. For unions it means taking this vital issue off the negotiating table; once and for all time.

For patients/consumers it means serious reductions in costs, increases in benefits and significant slowing in annual inflation in healthcare costs.

For businesses, large and small, it seriously reduces a significant overhead expense.

For the local economy and government it means keeping almost all healthcare dollars in the State.

For doctors it means a lot less paperwork and more time to doctor; and, for hospitals it means sufficient and dependable annual "global budgets."

Because of the timeline from August 24 to approximately the 24th of December is short, I want to suggest today that you contact the Lewin Group YESTERDAY—if only it were possible.

Mahalo for listening

http://www.lewin.com
The Lewin Group
3130 Fairview Park Drive, Suite 800
Falls Church, VA 22042
ph 703.269.5500
fax 703.269.5501

To: Health Care Task Force September 8, 2005

From: Physicians for a National Health Program (PNHP-Hawaii Chapter Rep, Renee Ing)

Good afternoon, Chair Green, Vice Chair Blanchette, and members of the Health Care Task Force. My name is Renee Ing, and I am the Legislative Representative for the Hawaii Chapter of Physicians for a National Health Program (or PNHP).

As I am sure many of you are aware, PNHP is a national organization which has been advocating for many decades for one health care system, such as exists in all other advanced, modern nations of the world, which provide health care to all their citizens at a cost on average about half of what the U.S. pays. There are many advantages to such an approach to health care provision, such as the simplicity and efficiency of the financing (especially in comparison to the U.S.), the ability to budget rationally, provide quality affordable health care to all residents, and pinpoint successful medical strategies which maximizes quality.

I had intended to briefly cover these points today, but given your pressing agenda, which includes (item V.) Review and Select Experts for Cost Analysis" and (item VI.) "..Other Experts," I will cover those points at your next meeting on September 20th .

Regarding the selection of experts, PNHP-Hawaii suggests that, given the simplicity and transparency of a single health system for the state, that you have a PNHP consultant speak to this Health Care Task Force about the rational advantages of such a system. In studying how to provide health care to all residents that is accessible, affordable and efficiently provided, this Task Force faces the predicament of too much to do in too little time—precisely because you are dealing with the U.S. system which is inaccessible, unaffordable and inefficient financially.

This Task Force's work would be very much simplified if you were to consider a one health care system for Hawaii. Not only would citizens, medical practitioners, and businesses gain from a one health-care-system-for-all, the present medical people we have in Hawaii can also be retained to provide that care.

Therefore, as you select the expert consultants to advise this Task Force, PNHP-Hawaii suggests you contact PNHP Advisory Board member, Karen Palmer, MPH. She speaks on single-payer frequently, and trained in public health in Hawaii. Her contact info is:
Karen Palmer, Logan Utah, <Kpalmer@mtwest.net> (435) 755-9333.

In addition, if Karen Palmer is able to speak Saturday, October 15th at a Public Forum, she could also fulfill your desire (item VII.) to "Solicit Community Input."

My name is Beatrice Becker, former Sec'y & VP. of ADA/HI
Now in my 8th decade. During World War II I worked
as an epidemiologist for the USPH and subsequently
married a GP. In my lifetime the population has doubled.
We now have elec, radio, TV, automobiles, airplanes, satellite
communication. Lifestyles have changed. Yet we permit
our health care to be intrusively piggy-backed by non-medical
19th cent. for profit "entities" making medical decisions, tripling our
costs, bringing us to the brink of crisis. This "monkey on the back
of our nation, states, businesses & people consumes 15% of
our GDP, strips Drs. of their ability to freely practice, our people
of universal health, hospitals of delivering proper care. Recently,
a WSJ article quoted Gen. Motors threat to dump their health
plan, loudly dittoed by Ford. Toyota decided to build a large
plant in Toronto rather than in the Carolinas because "upon
investigation they found the Canadian work force better
educated and they have a better health plan". According to
the WHO the US is now 23rd in infant mortality, 20th in
life expectancy for women, 21st in life expectancy for men,
67th in immunizations right behind Botswana. I urge
this committee, putting aside prejudice or personal gain
to establish a Hawaii Health Authority Act charged with
creating a single-payer system, accountability, monitoring,
& data research, adding to our job base and keeping
health dollars in the islands. Change comes slowly at first
but if held back becomes a tsunami. Better to plan
before we are over-whelmed.

THE LEAGUE OF WOMEN VOTERS OF HAWAII

49 SOUTH HOTEL STREET, ROOM 314 HONOLULU, HAWAII 96813 PH. (808) 531-7448

September 9, 2005

Chair Green and Members
Healthcare Task Force
State of Hawaii

Chair Green and Members of the Healthcare Task Force,

My name is Jean Aoki, and I am the Legislative Chair for the League of Women Voters of Hawaii.

The League thanks all of you for consenting to serve on this task force. You are addressing an issue of critical importance to all and in a very short time. It is important that your contribution of time, energy, and thought lead to the means of making healthcare accessible and affordable to all residents of Hawaii.

The League of Women Voters, nation-wide, did a study of health care years ago, and came to a consensus in support of a universal, single-payer system. We regard health care as one of the basic human needs of all people, and believe that meeting this need can best be achieved through a universal single-payer system. We believe it is the most cost-effective way of achieving the state's goal of making health care accessible to all.

We look forward to seeing the day soon when no one in Hawaii needs to postpone or forgo having one's health problems tended to by professional health care personnel because of one's inability to pay for this care. This task force can lead us in that direction, and we wish you well in your efforts to achieve this end.

Thank you for this opportunity to address you.

Jean Y. Aoki, Legislative Chair
League of Women Voters of Hawaii