KAISER PERMANENTE® Government & Community Affairs

Testimony
Of
Christopher G. Pablo
Director, Government & Community Affairs

Before
Health Care Task Force

Thursday, April 13, 2006
4:00 PM
John A. Burns School of Medicine
Medical Education Building, Room 314

Comments and Concerns about the Lewin Group's Analysis of a Single Payer Health Financing System

Capacity/Capital Formation/ Adequacy of Reimbursement

1. Did the study consider whether the current health care delivery system in Hawaii has the capacity to serve 100,000 additional patients? If not, why not?

2. Did the study consider data (e.g., via Health Care Trends, HHIC, HAH, etc.) that indicates that Hawaii's hospitals have been operating at a deficit due to inadequate reimbursement from public and private payers?

3. What reimbursement rate was assumed by the Lewin Group? What were their assumptions or rationale behind that reimbursement rate/method?

4. Did they consider the impact of the reimbursement on the following:

   a. Availability of physicians and other medical workers in rural areas?
   b. Availability of nurses and other medical workers?
   c. Availability of physicians to take call in Hawaii's hospitals, especially in rural areas?

Organization & Delivery, Payment System

1. It appears that the proposal only considered the use of a freedom of choice fee for service based organization and delivery system. Is this so? Why?

2. Could the Lewin Group estimate the cost savings under a capitated, closed-panel model delivery system? If so, how much savings could be derived?

3. Will complimentary and alternative medicine be covered/provided under the proposal?

Performance Measurement/Health Status of Enrollees

1. How do we know that we are "getting our money's worth" from the new system? In other words, is there any way of measuring whether the new system will improve the status of Hawaii's population? If so, how?
2. Will individual health care providers (i.e., doctors, hospitals, other health care providers, networks, etc.) be accountable for performance (i.e., health outcomes, quality, cost-effectiveness)?
    a. If so, how will this be measured?
    b. If there are targets, what will be incentives or disincentives?

Winners and Losers

In his presentations, Mr. Sheils has said that there will be "winners" and "losers" under this proposal. Who are they and please describe the "wins" and "losses" of each stakeholder?

What are the assumptions used by the Lewin Group?

1. Explain methodology/assumptions behind the analysis, especially on pages 15-16.
2. Why does the Lewin Group assume that there will be increased utilization when HMO enrollees are converted to enrollees under a single-payer system?
    a. Do they assume that there will be inappropriate or excessive utilization under a fee-for-service system?
    b. Do they assume that HMO enrollees are not provided with the services they need that are medically necessary?
3. Explain methodology behind "administrative costs" of $69 million on page 15.
4. Explain the reduction in "safety net" in the amount of $87.4 million.

TO: HAWAII HEALTHCARE TASK FORCE April 13, 2006
FROM: PNHP-Hawaii, Renee Ing (267-0117) P.O.Box 23094, Honolulu 96823

My name is Renee Ing, testifying on behalf of the Hawaii Chapter of PNHP, or Physicians for a National Health Program. PNHP-Hawaii is encouraged by this Task Force's discussion of the Lewin Group's study for a single payer. In today's meeting when you decide what changes to make to the Lewin Group's model, we would like to suggest the following:

1.) There has been much mention of adverse effects on providers & small business but not on persons working part-time or full-time at minimum wage. Though averaged out, others people with annual incomes from 0 to $10,000 might not be hurt, common sense tells you it probably won't be the case for some at that extremely low income level—and that some low income people would be hurt by a 5.6% payroll tax.

PNHP suggests a **Sliding Scale** for the payroll tax for employees, which Mr. Shiels said is possible in the Lewin model. It would be much less regressive than an across-the-board 5.6%.

An income of 0 to $12,000 is minimum wage, and is the income of a person maybe already under Medicaid, and perhaps should be exempt from the payroll tax.

A sliding scale of 1.5% ~~up through 5.6%~~ should be considered on all higher (than $12,000) incomes, with no cap on a top income required to pay this payroll tax.

PNHP suggests a sliding scale should be structured according to the income of the employee, not the size of the business, and be very simple (not more than three tiers), say:

Up to $50,000 $50,000 to $100,000 and, Over $100,000

2.) When I asked Mr. Shiels about it, he said it would be possible under the model studied by Lewin to give hospitals **"Global Budgets."** Global budgeting would avoid much paperwork—assets testing, billing paperwork, prior authoriza-tions, etc.—and further avoid costs to the system, such as uncompensated care.

PNHP suggests we should do global budgets. Administrative costs in Hawaii hospitals are the highest in the country, according to a NEJM study (August 5, 1993) , the only one done comparing administrative costs in U.S. hospitals by state.

3.) Regarding the **Benefits Package**, PNHP says the main thing is that everyone have the same package (including legislators). And that: a.) Co-pays and deductibles be low, and b.) there be no "co-insurance" (ie. paying a certain percent for certain types of care, which is an administrative nightmare and makes it very hard to protect the poor).

PNHP suggests we: a)Eliminate co-pays and deductibles for incomes under $50,000;

b.) Make the co-pay no higher than $10, and
c.) Make the deductible no higher than $100 individual or family for all higher income (ie. earning over $50,000 per year), and
d.) Drug co-pays should not exceed $5 generic, and $10 brand name (for higher income---above $50,000).

PNHP suggests you re-analyze the numbers with this structure.

4.) Regarding the carved out population—Medicare/ Military/ Federal employees—In his presentation to you, Mr. Shiels mentioned that administrative savings "would be a greater reduction if Medicare and everybody else wee in." He also mentioned that California did include Medicare in it's study.

PNHP also advises that you have to include Medicare in a Hawaii single payer system to get any administrative savings and to be able to (truly) globally budget a hospital. You have to get the transient military (CHAMPUS, etc) group covered by the single payer. The funds for their care need to flow through the single payer.

Now, I'd like to speak to you as a private citizen and comment on the cap on benefits for EUTF. I know of one young man with acute leukemia whole bill (after a minimum of 2 years of hospitalizations, chemotherapy, bone marrow surgery, etc) will pay over a million for his co-pays and deductibles for that 2 years of care.

Rather than there be a limit on care for those most needing care, I suggest Eliminating the cap on benefits as other countries do. People don't suffer medical bankruptcies in other advanced nations the way our people do.

In the U.S.---even within the Medicare population---it's known that a very small percentage of the population uses much of the healthcare dollars. The Healthiest 20% need no healthcare, and use none of our resources. The Healthier 50% use an average of $500 each a year, and the Healthy 90% use $1,200 each a year.

It's the sickest 10%---actually 5%---who use most of the money. And of course, a lot of the expense is for end-of-life care.

With about $6,000 spent per capita on healthcare in Hawaii, the point is to save enough on administrative costs to cover everyone's needs and what is needed and already being spent on healthcare in Hawaii at great cost (financial and emotional) to Hawaii people. In effect, we are already paying for universal health insurance, but we're not getting it.

If other countries can cover everyone so no one goes medically bankrupt (on half of what we spend), shouldn't the U.S. and Hawaii be able to do it also?

What is the purpose of the cap? Most people will never reach it. But those who do really, really need the health care.

Therefore, I suggest that you remove the cap on benefits in a Hawaii Single payer system.

Thank you for this opportunity to testify.

TO: HAWAII HEALTHCARE TASK FORCE Thursday, April 13, 2006

FROM: Jim Brewer (545-1989) P.O.Box 23403, Honolulu 96823

Aloha members of the Healthcare for All Act 223 Task Force (2005 SLH)

My name is Jim Brewer of the EmployeesTODAY TV Program

I am here to testify in favor of a Healthcare-for-All model for Hawaii based upon an integration of the principles found on the three pages attached.

This is what I would call a true single-payer model similar to Canada's. It has modifications which I believe would serve Hawaii well in providing healthcare-for-all.

I would just like to go thru briefly the high point of the schematic diagram on the first page of the 3-pages attached.

I thank you for the consideration of this material.

PAY-AS-WE-GO
means healthcare funding is raised each ongoing month and is paid-out right now—today—to those needing "medically necessary" healthcare! It's not done through borrowing against the future and leaving a "birth-tax" to our children, who would have to—at some point—pay off our healthcare debts as well as their own.

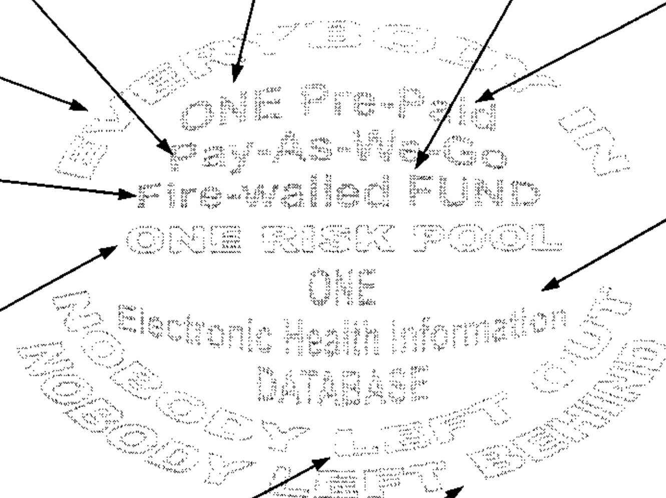
ONE FUND is assembled by a single-payer state healthcare financing agency from various now-existing federal, state and employment-related collection sources ...BY COMBINING
- State-mandated healthcare insurance for full-time employees, employee union trust funds, etc...
- Federal Medicaid and Medicare Funds, etc...

THIS ONE FUND finances healthcare payments to doctors, dentists and other care-givers for "medically necessary" treatments or other services given to patients—as well as pay-out fees to providers of other medically necessary healthcare services—such as for preventive healthcare. The authority also funds hospitals and community clinics through annual "global budgets." Global budgets represent another huge savings due to the elimination of patient billing.

PRE-PAID
means everybody's healthcare premium is paid for each month through now-existing funding sources—IN ADVANCE of our actual need for "medically necessary" healthcare later on! Our healthcare is "pre-paid." We never have to pay any bills at time of need. This in invaluable to our families. No debts! No bankruptcy! It represents HUGE savings overall by eliminating patient BILLING!!!

EVERYBODY IS IN
Nobody is left out. Healthcare is considered to be a basic human right. "Universal Healthcare" is Healthcare-for-All ...From birth to death.

FISCAL FIREWALL To prevent budget raiding by the State Legislature, the Single-payer Fund is overseen and guided by an elected seven-member independent State Health Insurance Planning and Financing Authority (SHIPFA) based upon demographics and the "medically necessary" principle in rate-setting.



ONE CENTRAL DATA-BASE
for comprehensive, complete and accurate ***ELECTRONIC HEALTH INFORMATION*** (EHI)
This is another major source of savings which also helps make public financing of comprehensive single-payer universal quality healthcare possible.
This unified hi-tech health information system enables:
- ✔ Accurate future projections
- ✔ Unprecedented planning and cost-containment
- ✔ Early detection of medical mistakes, malpractice and and fraud
- ✔ Early system-wide sharing of emerging "best practices" ...etc.

ONE RISK-POOL - Having this is a major source of real and immediate savings which helps make single-payer universal healthcare possible. (Canada got a 1/3 per-capita cost cut.) The multiple risk pools created by the many cost-shifting, pay-out reluctant private high-profit insurance companies create costly bureaucracies and leave the poor and unhealthy to our de-funded government programs.

NOBODY IS LEFT-OUT from birth to death. When you are born you get a healthcare card for a lifetime of healthcare freedom and security... with never a bill or a bankruptcy!
NOBODY IS LEFT BEHIND Healthcare benefits are comprehensive strictly according to whether a treatment is "medically necessary." There is only one "class of care." "First class"—regardless of income, etc.!
NOTE: Healthcare for all—in addition to being considered a basic human right—is also considered to be a basic public health need; ...to protect everybody from untreated contagious diseases.
As taxpayers, it also saves us from having to pay extra for the many costs associated with late and emergency-room treatments for the uninsured.

GOT FREE HEALTHCARE?

Public school seems like it's free. When your kids kids need it, they get it. And, you never see a bill.

That's how it is with single-payer healthcare-for-all. When anybody needs healthcare they get it and never see a bill. That means no medical debts or bankruptcy.

But, we know that nothing is free. We pay school taxes; and, our single-payer healthcare will be paid for each month, with the now-existing funds mentioned above. (See "One Fund.") And, you have peace of mind because you know it's there when your family needs it. No stress!!!

*Jim Brewer and Renee Ing, Employees*TODAY*TV* 4/12REV

An Hawaii state-funded single-payer universal healthcare insurance system should be based upon twenty functional concepts:

(1) "**Universal**" the State of Hawaii single-payer universal healthcare insurance system finances "healthcare-for-all" which means quality healthcare is "universally available" on a "prepaid" basis to permanent residents;

(2) "**Prepaid**" - Hawaii's state-funded single-payer healthcare-for-all insurance system provides medically-necessary healthcare services without fees, co-payments, or deductibles at the time of healthcare need—"no bills." The system operates on a "pay-as-we-go" basis. Income and other taxes are collected by the system on an ongoing basis through payroll deduction or through other appropriate revenue raising methods, including existing funding from federal and state; including, but not limited to, for instance, medicaid; as well, temporarily, prepaid health care act funds and employee union trust fund funds—until full transition is completed—as the funds for pre-paying for healthcare services when they are needed. Therefore persons with healthcare needs may present their healthcare registration cards to receive medically necessary healthcare services without ever seeing a bill for them. This pre-paid function represents great savings over previous after-the-fact billing procedures;

(3) "**Comprehensive**" – The State of Hawaii single-payer universal healthcare insurance system is "comprehensive" in that it covers <u>all</u> "medically necessary" hospital, physician, dentist, home-care, and long-term care services for every Hawaii permanent resident;

(4) "**Medically necessary**" – Medically necessary procedures, treatments, and other services are primarily the responsibility of physicians and other qualified healthcare practitioners according to well-established past practices which are recognized by the authority. In addition, the county healthcare review boards shall may assess which prescription drugs, appliances, services, and delivery modes are medically necessary; and, accordingly make their recommendations to the authority;

(5) "**Accessible**"/ "**Affordable**" – There is accessibility to one high-quality level of healthcare for all Hawaii permanent residents without income (affordability) or other barriers. The many savings of single-payer make it possible to cover everyone while reducing overall costs;

(6) "**High-quality**" – Uniformly high quality of systemwide healthcare provision is the standard of Hawaii's single-payer universal healthcare system;

(7) "**Choice**" – Patients have their choice of physician, dentist, and other single-payer universal healthcare system caregivers;

(8) "**Portable**" – single-payer universal healthcare system coverage is portable for permanent residents within and outside the State of Hawaii. Portability applies primarily between islands and counties. Also, portability within the state means that when employees change employers there is no problem with having to change healthcare plans. This Act also entitles Hawaii permanent residents to "receive medically necessary services in relation to an emergency when absence from the State is temporary, such as on business or vacation";

(9) "**Publicly administered**" – The State of Hawaii single-payer universal healthcare insurance system shall be maintained and administered by one elected independent healthcare financing authority. Private healthcare insurers are prohibited from duplicating the coverage provided by Hawaii's single-payer universal healthcare system;

(10) "**Publicly funded**" – Healthcare insurance premiums are directly and indirectly collected through: (A) Taxes; or (B) Other authority revenue-raising measures; or (C) Both; and deposited immediately into the State's universal healthcare provision fund. It is used by the authority to receive and pay out healthcare provider claims and global budget funds to homecare agencies and institutional providers on a pay-as-we-go basis or allocated as needed into the universal healthcare provision fund healthcare pay-outs reserve or both. There shall be a fiscal firewall between the universal healthcare provision fund and the state budget;

(11) "**Single-payer**" – Financing of Hawaii's healthcare-for-all system shall be publicly funded and healthcare insurance claims shall be paid out to doctors, dentists, hospitals, and other eligible caregivers and providers by a single pay-out government agency, or the authority, on a "pay-as-we-go" basis;

(12) "**Pay-as-we-go**" – Healthcare funding is raised each ongoing month and medical provider/caregiver claims are paid-out as soon as practicable, without any deductibles, co-pays or other out-of-pocket expenses, for those receiving medically necessary healthcare. The pay-as-we-go principle is based on the concept of not incurring healthcare debts to be paid later by a succeeding generation while having to also pay for the healthcare needs of their generation as well;

(13) "**Universal healthcare provision fund**" – The universal healthcare provision fund is fundamental to the single-payer universal healthcare system and is used by the authority to receive and pay out healthcare insurance claims and global budget funds to homecare agencies and institutional providers on a pay-as-we-go basis or to be allocated as needed into the universal healthcare provision fund healthcare pay-outs reserve. Part of the purpose of the reserve fund is to provide retraining grants. The other part is for healthcare related contingencies and to build up capital improvement support funding;

(14) "**Fiscal firewall**" – "Medically necessary" is the operative term throughout Hawaii's single-payer universal healthcare system; but, nowhere more so than in regard to the funding of the system. It is the basic principle which ensures that healthcare financing is based upon the actual healthcare needs of Hawaii's People. The autonomous authority sets rates accordingly and collects, oversees and maintains the universal healthcare provision fund completely independent of the state budget. In other words the universal healthcare provision fund may not be raided to fund the state budget;

(15) "**Central unified electronic health information system database**" The State of Hawaii single-payer universal healthcare insurance system collects and maintains in real-time an up-to-the-minute single central database for comprehensive, complete, and accurate electronic healthcare information. This is a very significant major source of savings and cost-containment which makes the low-cost financing of comprehensive single-payer universal healthcare possible. This unified high-tech health information system, for instance, enables: (A) Accurate future projections; (B) Unprecedented planning and cost-containment capabilities; (C) Early detection of medical mistakes, malpractice and fraud; and (D) Early system-wide sharing of emerging "best practices";

(16) "**County healthcare review boards**" - County healthcare review boards are elected, independent bodies established by each county government — along the lines of Oahu's elected neighborhood board system — to continuously monitor healthcare conditions in their respective counties to watch and assist the authority in making the State of Hawaii's single-payer universal healthcare insurance system fit the specific healthcare needs of each island;

(17) "**Retraining fund**" – A retraining fund is collected as part of the universal healthcare provision fund. The purpose is to provide cost-effective funding for health field workers displaced by the transition to the single-payer universal healthcare system;

(18) "**Global budgets**" – the authority pays each hospital, community health clinic, home-care agency, and long-term care facility an annual or monthly global lump sum to cover all operating expenses – that is, a global budget. Hospitals, long-term care facilities, and home-care agencies, and the authority negotiate the amount of these payments annually, based on past expenditures, previous financial and clinical performance, projected changes in levels of services, wages and input costs, and proposed new and innovative programs. Hospitals, long-term care facilities, and home-care agencies may not bill for non-operating expenses. Hospitals, long-term care facilities, and home-care agencies may not use any of their operating budget for expansion, profit, excessive executives' incomes, marketing, or major capital purchases or leases. Major capital expenditures come from the universal healthcare provision fund, but will be appropriated separately based upon community needs. Investor-owned hospitals will be converted to not-for-profit status, and their owners compensated for past investment. Global budgets for institutional providers eliminate billing, while providing annual predictable and stable financial support;

(19)"**Lifetime individual identification number**" - the authority systematically registers each and every Hawaii permanent resident with an assigned lifetime identification number so that they are covered by the system. This is the first step in bringing all of Hawaii's healthcare information into one secure, constantly updated, central unified electronic, computerized health information system database; and

(20) "**Healthcare registration cards**" – Eligible healthcare users of the State of Hawaii single-payer universal healthcare insurance system shall register with the system and be issued a lifetime I.D. number and user card. Newborn citizens will be registered at birth, in most cases by the facility where the birth occurs.