Testimony of Charles Huxel to the Health Care Task Force
October 25, 2005

My name is Charles Huxel. I testify today as a member of **Health Care for All Coalition, Americans for Democratic Action**, and as an American citizen concerned about the state of health care in my country. I respectfully submit a simple request to the Task Force. Please investigate the feasibility of a single payer system for administering health care to the people of Hawaii. Retain a competent consultant who can provide the information on which a decision as to whether or not to employ such a system can be based. As of this moment I know of no study that refutes the feasibility of a single payer health care system either for our State of Hawaii or for the United States. On the contrary, the studies and the statistics that I have seen seem to validate the single payer system, especially when it is compared to the multi-server system that now dominates health care in the United States. The two books that each Task Force member was given earlier this year make this case very effectively (Critical Condition by Donald Barlett and James Steel and Health Care Meltdown by John Geyman and Don McCanne). More recently see the article "When Even Health Insurance Is No Safeguard" by John Leland in the New York Times, Oct. 23, 2005 page A1.

These studies are not the only ones to highlight the precarious condition of our national health care system and to question the economic premise upon which it is based: that a multiplicity of private, competitive health care insurance plans can provide to our citizens the necessary financing to secure for them adequate health care. This concept does not seem to be working. Further, our national concept of a private, market-oriented health care system dominated by competitive health maintenance organizations is being overwhelmed by the rising cost of medical care in this country. A large part of our population is becoming less healthy and less able to afford even the most basic preventive medical care. Such care is taken as a right in almost every other industrialized nation of the world.

We in Hawaii our fortunate to have the most inclusive health care system in the United States. Unfortunately that is not enough to ensure adequate health care for all our citizens. I believe the single payer system would provide for excellent health care for all of our people. We trust you to complete the necessary studies to determine the feasibility of an improved Hawaii health care system, including the costs and benefits. It is my understanding that consultants from the **Physicians for a National Health Plan** are available to help work out the details of single payer plan. The time for initiating such an investigation is now. Please do so or let us know the reasons for not doing so.

Respectfully submitted,

Charles Huxel
99-1362 Hele Mauna Pl.
Aiea, HI 96701

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email: nwond@hawaii.rr.com

Universal Health Care verses Integrative Health Care—
Cost/Benefit Comparison

The concept or desire to provide "universal health care" for Hawaii's uninsured has been discussed and implemented by various legislative bodies and administrations. This has been a good, compassionate, charitable thing to do. Nobody likes to see other people suffer; our hearts go out to them.

However, on the other side governmental costs, governmental resources are limited and budgeting decisions for entitlement services are faced every year. It is difficult for every government to meets their minimal mandatory expenditures without escalating taxation and slowing the economy. Balancing the Budget has required Welfare Reform.

Every person added onto a charitable entitlement program, such as health insurance, adds *per capita* incremental expenditures. However, State and Federal funding for the "gap group" does take financial and charitable burdens off of Hospitals and Medical Providers.

On the other hand, PROVIDING OR **MANDATING INTEGRATIVE MEDICINE** HAS BEEN DEMONSTRATED IN REAL WORLD ECONOMICS TO PROVIDE BOTH **COST CONTAINMENT** WHILE **IMPROVING HEALTH CARE DELIVERY SYSTEMS.**

THIS IS BOTH A SOCIALLY ACCEPTIBLE POSITION AND AN ECONOMICALLY BENEFICIAL HEALTH CARE ENHANCEMENT.

In real world economics, 80% to 90% of insurance companies have found that they actually save money by providing Integrative Medicine covering both the Natural Traditional Medicine in conjunction with high cost Pharmaceutical and Surgical Medicine. Only one or two companies have raised rates less than 0.1% to cover an entire family's annual premium. This negligible, minuscule, *manini* increase is less than minimal.

Current economic strategies in Hawaii actually drive up costs for employers and consumers of health care across the board. This is exactly the opposite of what any Social planner would want to do.

Any new health care legislation must provide for both cost containment and enhanced health care delivery.

Consumers, patients, seeking or needing Alternative, Complimentary, Traditional, Scientifically based, evidence based Natural Health Care Medicine have to pay twice—

once for their limited health care plan and again 100% out of pocket for necessary Scientifically based, evidence based Natural Health Care Medicine.
Language similar to SB1418 must be included in any health care planning for both cost containment and enhanced health care delivery.

This is consistent with FTC policies and practices and has also been proven effective in real world economics following the anti-trust action directed against the AMA over 30 years ago. Since the AMA isn't legally able to continue with their anti-competitive illegal trade practices, they now rely upon administrators and lobbyists to accomplish their monopolistic agenda.

HMSA reported that their internal studies were unable to demonstrate any cost increase or premium increase if coverage for Natural Medicine, Alternative Medicine, Complementary Medicine was wrapped into the basic Health Care Plans.

Currently HMSA has two insurance competitors, HMAA and UHA, who provide for Integrative Medicine at competitive prices to employers—Enhanced health care delivery at competitive pricing.

Under current practices HMSA provides limited coverage for "Alternative" medicine as a "rider" that drives up health care costs. If coverage were wrapped into the basic health care plan so that all licensed health care providers were economically accessible, this would reduce costs to consumers, employers and labor unions while providing enhanced health care delivery and improved health care outcomes.

This is also in consistent with the prior Legislative Auditor's Report on Mandating Coverage for Naturopathic Medicine. Review of real world insurance costs again demonstrated none to less than minimal cost increases while providing enhanced health care benefits.

These real world outcomes are supported by federal law, economic outcomes and evidence based scientific studies.

Across the Nation, as well as, at the University of Hawaii Medical School, physicians and administrators are developing Integrative Medicine programs to include Traditional Natural Health Care delivery.

You just can't get any better Cost Effectiveness than enhanced benefits with none to less than minimal cost increases. Why not jump on these cost savings and health care outcomes?

This issue needs to be fast tracked especially with the risk benefit ratio demonstrated in the real world. We need to overcome the artificial anti-competitive obstacles directed against non-AMA practitioners that drive up costs and reduce health care outcomes.

Under existing anti-competitive practices health care choices are made by insurance companies and employers on behalf of employees. Who really should be making health care decisions and choices? Patients not third party insurance companies or employers. HMSA feels more economically secure in escalating costs and enhancing their income. In support of this the best HMSA can do is mislead or lie to Legislators about actual cost benefit ratio or statements that there is no demand for non-AMA providers.

People have gotten so use to this Big Lie that they can't see the Truth.

These insurance company economic strategies in Hawaii actually drive up costs for employers and consumers of health care across the board. This is exactly the opposite of what any Social planner would want to do.

Any new health care legislation must provide for both cost containment and enhanced health care delivery.

Language similar to SB1418 must be included in any health care planning for both cost containment and enhanced health care delivery.

You just can't get any better Cost Effectiveness than enhanced benefits with none to less than minimal cost increases. Why not jump on these cost savings and health care outcomes?

Even if you don't believe me or don't agree with Natural Health Care practices—**You must believe real world economic outcomes and evidence based scientific health care results.**

Thank you for your attention and follow up on these matters.

Respectively,

Dr. Myron Berney

Dr. Myron Berney

H.B. NO.1304 H.D. 1 S.D. 2 C.D. 1 of the TWENTY-THIRD LEGISLATURE, 2005 STATE OF HAWAII states in part:

PART I SECTION 1 (c) The task force shall:

(2) Facilitate contracting for **expert testimony** or studies, or both, including but not limited to a **cost analysis comparing the costs under the status quo with various options under consideration**, including but **not limited to** a possible single-payer system and the recommendations **to decrease the uninsured population** made by the Hawaii Uninsured Project

A cost analysis comparing the costs under the status quo with various options under consideration, [such as SB1418] including but not limited to a possible single-payer system and the recommendations to decrease the uninsured population should or could include a Cost/Benefit Comparison concerning Universal Health Care verses Integrative Health Care. Currently over 99% of the Hawaii population is uninsured with respect to Integrative Health Care.

Integrative Health Care has consistently been demonstrated to decrease cost, provide for cost containment and deliver new and enhanced health care services and improved health care outcomes.

I would respectively request your attention to this most important aspect of delivering enhanced health care for Hawaii's insured and uninsured.

STEPHEN M. SHAW
Attorney At Law
P.O. Box 2353, Honolulu, Hawaii 96804
Telephone: (808) 521-0800
Fax: (808) 531-2129
Email: shawy001@hawaii.rr.com

October 24, 2005

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

By Fax: 585-7932

DATE: **Thursday, October 25, 2005**
TIME: 4:30 p.m. – 6:00 p.m.
PLACE: State Capitol, Room 211, 415 Beretania Street, Honolulu, HI 96813

TESTIMONY OF STEPHEN M. SHAW
SUPPORTING SINGLE PAYER INSURANCE
EXHIBITS "A" AND "B"

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

A. Invitation To Competitors

At the last meeting, the HCTF agreed on Hawaii government employees' health benefits as the point of beginning for analysis of the cost of the benefits if provided to everyone in the state.

The only problem with this is the length of time EUTF will take to provide those benefits to the task force. I have had a hard time getting routine actuarial calculations from them.

As you can see by the attached letter to AETNA Inc. and CIGNA I am in the process of notifying insurers about this task force, in the event other large insurers

wish to weigh in on coverage for an entire state. If the EUTF is slow in providing information about benefit plans, other carriers can bid using the stripped-down policies in the Prepaid Health Care Act)("PPHCA") at Hawaii Administrative Rules 12-12 (HMSA Plan 4).

If insurers with financial strength comparable to Kaiser or HMSA bid a rate 75% lower than the existing rate for the PPO plan in the PPHCA by using 1,000,000 lives, then the gold-plated EUTF plans will be lower as well.

Once this task force proposes formation of a risk pool equal to the state's population (less about 26K federal employees and others locked into similar plans) it will allow insurance principles to work, instead of the current predatory rating practice of segmenting risk pools, and a hodge-podge of payers.

B. Health Insurance Is Only As Good As Reimbursement To Health Providers

1. Creating A New Policy For Uninsureds Wont Work

One approach is to develop an insurance plan to cover the growing number of residents who are not working over 20 hours a week and can't afford, or find, comprehensive health insurance. While large and growing, this pool is not numerous enough to spread risk in a way to reach affordable premium levels, for the entire state.

HMSA, Kaiser and others would propose a solution of stripping benefits or raising deductibles. This ends with offering empty insurance to people most in need of the lost benefits; and who cannot afford high deductibles.

Underlying abstract quibbles over benefits offered, is the decades – old problem of delays, reductions and denials by payers of payments for any mix of advertised or agreed-upon benefits.

Using the existing insurers in this state to cover the uninsured will do nothing to either improve chronically low reimbursements to health providers, or to provide incentives to doctors to live here and to treat the formerly uninsured.

2. Increase Reimbursement And Increase Risk Pool Size

Assuming the gold-plated government employees' benefits and guaranteed reimbursement levels on procedures acceptable to health providers, what will be premium be? For the ±100,000 currently uninsured it will be quite high. In reality, this group is an assigned-risk pool, and the rates would be much higher than any employer group of 100,000 healthy workers.

Adding another 900,000 to this risk-pool increases its attracterness by adding large numbers of young, healthy individuals, to offset the losses. So, it is fair to ask what would the premium be for 1,000,000 people? Shouldn't the task force now decide on risk pool sizes to propose to lawmakers?

If Kaiser or HMSA were eager to truly compete for this business, they would also be competing with one another. For example, HMSA would be crunching numbers for super-large group sizes with good benefits; and Kaiser would would be proposing a statewide HMO (similar to Rep Green's plan, only based on laws of large numbers). Please see my comments about Kaiser and HMSA in the attached letter to AETNA Inc. and CIGNA.

C. Promised Reimbursement Levels To Providers Is only As Good As The System Of Enforcement Of Those Promises

Health insurance is oxymoronic, in that a health insurer can meet its administrative expenses and provide a balanced financial statement by not performing its primary mission, which is to pay claims. Private health insurers can increase profits by not performing their business task of paying claims.

This is the opportunity to make sure that whatever scheme is proposed, that health providers have new, strong remedies against payers which refuse to reimburse, or who delay, or partially pay valid claims.

Texas has found a good way to help health providers deal with payers. It changed its theft of services law to allow a statutory civil remedy without the necessity of a criminal prosecution. In an apparent effort to help doctors in malpractice cases, Hawaii judges are creating caselaw which will allow doctors to recover attorneys' fees against losing tort plaintiffs under a contract theory. Hawaii Revised Status 607-14 (HRS 607-14).

Unfortunately, the same caselaw hurts all health providers who sue payers for reimbursement. Unless this problem is cleaned up by lawmakers, it won't matter what kind of system is adopted; most doctors will not want to risk paying insurers' attorney's fees by suing for reimbursement.

In the event insurance will be used to fund the state's health systems then the insurance commissioner and this administration must propose allowing a limited exception for health providers under the Unfair Claims Settlement Practices Act. Providers need to be able to proceed under this Act against insurance payers for delays in reimbursement in small claims courts and district courts, without asking the commissioner to handle these extremely numerous, and often small cases.

D. System Of Employer-Paid Premiums Makes Insurers Immune From Suits For Failure To Pay Health Care Providers Or To Approve Health Services

Please resist the temptation to propose that Hawaii employers pay directly for employee health insurance. Rep. Green's plan advocates this and it won't help providers or patients. This temptation is based on the wrong interpretation of Hawaii's Prepaid Health Care Act (HPHCA).

There is no violation of HPHCA when employees have other, good insurance. HPHCA has clear exceptions for this. Hawaii employers have long complained about the burden that this statute places upon them, but here is another less obvious problem which seriously damages health providers.

When employer-based insurers deny procedures based on interpretation of exclusions; or, when they deny full reimbursement for health services, the patients, who would normally sue the insurers for damages, have so few remedies that insurers have no incentive to change their payment practices. This broad tort immunity is conferred by ERISA, which shields insurers who provide employer group insurance under Hawaii's Prepaid Health Care Act.

By avoiding employers as a direct premium source, insurers have far greater incentives to reimburse at agreed or statutory levels, because they are no longer under ERISA's immunity from state regulation or tort law. The Prepaid Health Care Act, left intact, would still provide legal protection for a small number of insurance plans which would not be subject to that law's waivers and exclusions. Those plans, in turn, would be ERISA plans.

E. Task Force must Propose Health Provider Control Over Reimbursement Levels For All Procedures

It doesn't matter how rich a plan is without reimbursement follow-through. Health providers, and not state departments should decide what the levels are and what remedies are available to enforce them.

For example, if CIGNA wins the bid to underwrite Hawaii's single payer plan for three years, this body's work is wasted if CIGNA keeps reimbursement levels secret, or delays, obstructs, and reduces physician and other health providers' claims.

To minimize these problems, this task force must propose health provider control (not mere input) over the reimbursement process, before payers are selected.

F. Task Force Must Propose Changes In Judicial Selection To Provide Fair Resolution Of Provider Claims

Health Providers and HMA lose in Hawaii's courts in most reimbursement litigation. Why? Hawaii's judges and justices sit for 6 or 10 year terms. Selecting and renewing them is controlled by a nine-member commission packed by the insurance companies and their attorneys, who routinely delay and deny payments to health providers. By "packed" I mean 4 out of 9 votes are insurance industry votes picking our state's judges.

Part of the task force efforts is to change this process, so that any company or person with cases pending in the courts may not, directly or by proxy, pick our judges.

Respectfully Submitted,

Stephen M. Shaw

Encls. Exhibits "A" & "B"

STEPHEN M. SHAW
Attorney At Law
P.O. Box 2353, Honolulu, Hawaii 96804
Telephone: (808) 521-0800
Fax: (808) 531-2129
Email: shawy001@hawaii.rr.com

October 21, 2005

Charles H. Klippel
Sr. Vice President
Deputy General Counsel
AETNA Inc.
151 Farmington Avenue
Hartford, CT 06156

By Fax: (860) 952-2065
& 1st Class Mail

Dear Mr. Klippel:

Here is an opportunity to write a group health insurance policy to the State of Hawaii, for up to about 1.2 million of its residents.

Public testimony (oral and written) is invited for a series of task force meetings mandated by state law. There has been testimony in support of, and against, a "single payer" plan and other proposals to provide health care to all Hawaii residents.

My idea is why not write group health policies for an entire state? This might work with your company as a single payer model if your representatives can convince health providers that they will be adequately compensated.

Historically, the Hawaii market was controlled by Blue Cross and Kaiser. In the event state lawmakers want to see a bid for a "super" group of up to 1.2 million lives, these two insurers will probably quote a rate, if they cannot derail the legislation through lobbying.

This is the opportune time for your company to propose super group health insurance for an entire state in a form which cannot go unnoticed by state lawmakers.

To get involved in the Hawaii Health Care Task Force, and submit testimony you may contact the Hawaii Uninsured Project, 1001 Bishop Street, Suite 1132, Honolulu, HI 96813, by calling Laurel Johnston at (808) 585-7931 or Carol Taniguchi at (808) 585-7931.

EXHIBIT "A"

Please feel free to call me if there are any questions.

Sincerely,

Stephen M. Shaw

STEPHEN M. SHAW
Attorney At Law
P.O. Box 2353, Honolulu, Hawaii 96804
Telephone: (808) 521-0800
Fax: (808) 531-2129
Email: shawy001@hawaii.rr.com

October 24, 2005

Edward H. Hanway
Chairman of The Board
CIGNA
One Liberty Place
Philadelphia, PA 19192-1550

Michael W. Bell
Executive Vice President & CFO
CIGNA
One Liberty Place
Philadelphia, PA 19192-1550

Gentlemen:

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EXHIBIT "B"

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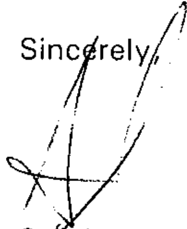
Please feel free to call me if there are any questions.

Sincerely,



Stephen M. Shaw

THE LEAGUE OF WOMEN VOTERS OF HAWAII

49 SOUTH HOTEL ST. RM. 314, HONOLULU, HAWAII 96813 PH. (808)

Testimony before the Health Care Task Force
October 25, 2005

By Jean Aoki, Legislative Chair,
League of Women Voters of Hawaii

Representative Josh Green, chair of the Task Force, and members,

Thank you for this opportunity to address the League's hopes and concerns.

Just the formation of a task force such as this is a hopeful sign that Hawaii takes the issue of universal health care seriously, and we applaud the effort. We know that this particular task force has not had much time since its appointment, and the deadline for a report to the Legislature looms near.

From the League's viewpoint, health care should be included as one of the basic human needs, together with food, clothing and shelter. It is a quality of life issue. There must be universal access to health care. It is unconscionable for this wealthy country to have over 40 million uninsured prople and tens of millions of underinsured residents. For Hawaii which has been one of the more progressive states when it comes to social issues, to have approximately 10% of its people without dependable access to health care is unacceptable.

Hawaii's Prepaid Health Care Act has served Hawaii well, but is now challenged by escalating health care costs which leaves employers looking for ways to cut those costs which only leads to less security for employees. H. B. 1617 introduced in 2003 and referred to in your minutes frames the issue well. We also look forward to Dr. Russo's report on the uninsured population. We need all the information we can get.

We are of the opinion that the universal, single-payer health care system may be the answer, not just for Hawaii but for the nation to make healthcare accessible to all and to stem the escalating cost of health care to the benefit of all residents and to businesses who contribute to the health care costs of their empoloyees. Others have reported on statistics to bear this out so I will not go into that.

This Task Force has been given the resources to contract with experts to do feasibility studies and you have received suggestions of people and groups who have done credible work in doing such feasibility studies.on the universal single-payer system. If you act immediately, it may not be too late to get one done for Hawaii in time to include in your report to the Legislature in January. Including such a study in the your report with all the other information you will have gathered will give the Legislature a more comprehensive look at the problems and options for an improved health care system for Hawaii.

I thank you again for this opportunity to testify before you.

Christian Science Committee on Publication – Hawaii
3448 Alani Drive, Honolulu, HI 96822
808 721-2012 cscommittee@hawaii.rr.com

Testimony for Health Care Task Force: Tuesday, October 25, 2005
Presented by Nancy Walden, Christian Science Committee on Publication for Hawaii

Distinguished ladies and gentlemen,

Some revolutions happen so quickly, people stand in awe. Others happen so slowly, we are barely aware of what is taking place. Healthcare is one of those revolutions. One day soon we may wake up and realize that our world of medicine would hardly be recognizable to people of just a few decades earlier. On the surface, it appears that Western medicine is still largely an industry of drugs and surgery. Yet below the surface (and not too deep), a giant reordering is going on. Some people may think this is related to economic factors. But it is far more. The very meaning of medicine has been changing over the last decade.

Many trends give us clues to this transition. One of them is the growing shift to a realization that the human mind is far more connected to the body than was previously believed. This could lead to a huge transformation in the way we care for our health. Society may be marching toward the treatment of quite a different "patient" – that is the treating of thought as the most effective way of healing the body.

Another significant trend is seen in America's Schools of Medicine. Our own Medical School at the University of Hawaii instituted a Department of Complimentary and Alternative Medicine a few years ago. You all likely are aware of the alternatives and their growing use in Hawaii – herbal, massage, acupuncture, prayer, spiritual healing and more.

I am sure you are aware of the enormous interest in alternative healing methods now being employed in Hawaii and throughout the country. Surveys indicate that roughly **two-thirds** of all Americans have used such methods in recent years. *And it is interesting to note that the most widely used such method is prayer!* Last year the federal government's Center for Disease Control reported that prayer for one's health, either by one's self or by others, constitutes the most commonly used CAM therapy.

The healthcare industry also recognizes the importance of CAM. The February 1, 2005 issue of "Managed Healthcare Executive" magazine states: "More than 60% of health plans now include CAM services as a covered benefit or offer affinity programs in which members receive discounts to CAM providers in a given network." Employers are increasingly eager to cover CAM services because of growing evidence that it helps reduce employee medical utilization and the overall costs of healthcare.

The first 30 years of my life were involved with traditional medicine with no complaints or complications. But when Christian Science treatment was brought to my attention I

gradually learned from experience that I could safely rely on this prayer-based system to meet both the curative and preventative aspects of my healthcare needs.

For those in Hawaii who turn to prayer treatments for healing, I ask that you include coverage of such treatment. In some parts of the country, private insurance companies, for example, have covered Christian Science treatment for more than 80 years. The Federal Employee Health Benefit Plan covers Christian Science treatment and nursing care.

The revolution in healthcare has been underway for some years now. As you make your plans and draft the "request for proposals", you ask that you include benefits which include these new directions.

Thank you for your consideration and again, I stand ready and willing to work with any of you on this matter.

Nancy Walden

Americans for Democratic Action/Hawaii

TESTIMONY TO STATE OF HAWAII HEALTH TASK FORCE, OCTOBER 25, 2005

George Simson, Vice President. 988-3452, simsongm@verizon.net

ANY PROGRESS?

Representative Joshua Green, Chairman

After consultation with colleagues, we find that we do not know whether you have made any progress and time grows short. We have the following concerns.

1. We have found nothing in your reports indicating your discussions, preliminary or otherwise, about SINGLE PAYER contributions by the people of Hawaii for health care. We have heard nothing about the mandated comparisons between the current state of affairs and single-payer.

2 We have found nothing in your reports indicating your discussions of the CRITERIA for the a New Model Health Service: **universality, portability, equality, singularity, affordability, accessibility, professionality, non-profitability, and non-profiteering.**

3 We have found nothing in your reports indicating the BASIC GOODS AND SERVICES to be delivered: **primary care and prevention, inpatient care, outatient care, emergency care, prescription drugs, durable medical equipment, long-term care, mental health and services, substance abuse treatment, chiropractic and other licensed health services, vision, dental and hearing treatment, and primacy of the doctor-patient relationship.**

4 We have found nothing in your reports, interim or otherwise, which begins to outline the INCOME AND OUTGO RESULTING IN NET SOCIAL BENEFIT projected for a single payer program, and how much it will save over the current profit-driven non-system. Such comparisons are mandated by your enabling legislation. We citizens are afflicted by a thunderous silence in this regard, replete with stereotypes and anecdotes of Canadians forced to flee Canada and mooch off US largesse, and the different tune when the pharmaceutical firms lose money when Americans go to Canada to buy drugs.

5 We have not found the PAPER TRAIL of all documents presented to or by your Task Force, particularly testimony and other documents, including those entered by opponents of New Model Reform.

6 Finally (for now), we have found nothing in your reports about the connection needed between the public-service IDEALS OF THE US AND HAWAII CONSTITUTIONS: the "general welfare" in the former, and the right of the people "to preserve the quality of life we deserve." (from the respective preambles). Instead, it seems to some of us that we are witnessing clever and small-minded trade-offs between interest groups, or, even less in the public interest, the vigorous huckstering of Steve Case and his consortium of Big Names (eg Carly Fiorina) who are planning clinics in Walmart among other money making gambits. There's a pre-emptive strike. This issue, as great as civil rights in 1964, needs an infusion of the spirit of 1791, 1863, 1932, 1959 and 1964.

Those of us following the Task Force proceedings of the past few months hope that we are mistaken about your silence on these fundamentals of the needed legislation. We hope that you are really proceeding progressively. We recommend that as you start drafting you keep foremost in mind the basics outlined here:: **single payer capitation, criteria for reform, basicsof services delivered, and constitutionality..**

#####.

National Association of Social Workers Hawaii Chapter

October 24, 2005

TO: Rep. Josh Green, Chairman
And members of the Health Care Task Force

FROM: Debbie Shimizu, LSW
National Association of Social Workers, Hawaii Chapter

RE: Establishing Universal Health Care in Hawaii

Chairman Green and members of the Health Care Task Force, I am Debbie Shimizu, Executive Director of the National Association of Social Workers, Hawaii Chapter (NASW) and a member of the Health Care For All Coalition. NASW, Hawaii Chapter represents over 1000 professional social workers in the state of Hawaii. Our members work in hospitals, community clinics, long term care and other health and mental health facilities. Thank you for the opportunity to provide comments on the issue of universal health care.

NASW urges the Task Force to immediately decide on a consultant regarding a single payer health plan. Time is of the essence and we need to allow the consultant ample time if we are to have meaningful information from them.

Thank you for the opportunity to testify.

677 Ala Moana Blvd #911 ● Honolulu, HI 96813 ● TEL (808)521-1787 ● FAX (808)521-3299 ● Email: info@naswhi.org

Carol Taniguchi

From:
Sent: Tuesday, October 18, 2005 1:26 PM
To: ctaniguchi@hipaonline.com
Subject: uninsured

Here is my story as an uninsured Hawaii resident.

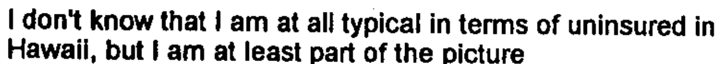
I am self-employed, 54 years of age. For years I did not have enough income to afford health insurance, but my income was too high to qualify for QUEST (which is a difficult thing to get when you are self-employed anyway). Last year, when I was in the process of checking into acquiring health insurance, having an income level that I felt I could afford the monthly fee, I suffered a TIA and was hospitalized for 3 days. Subsequently I was refused insurance by Kaiser Permanente, and I have a $10,000 bill from the hospitalization. I am now having to spend $250 per month trying to pay off that debt, plus I've accrued quite a credit card bill trying to pay the neurologist, primary care physician, etc. for follow up care. Since then I have been diagnosed with a patent foramen ovale, making it even less likely that I will be able to get insurance. I have also spent hundred of dollars trying to get the tests and doctor visits required to apply for HMSA. That application is still in process. I don't hold out much hope for approval, or at least for approval at a rate I can afford.

I am now in the situation of having a high enough income to afford medical insurance IF I didn't have huge medical bills already. In addition, even if I qualify for insurance, my main health issues won't be covered for a couple of years because they are previously existing conditions. Thus, if I do get insurance and can manage to pay for it, should I have another TIA, or a full-blown stroke, it won't be covered. I personally don't see a way out of this mess - it will take me years to pay off the medical debt even if I don't have to visit a doctor again during the next 4 years.

In addition, even people with insurance often end up with huge, crippling out-of-pocket medical expenses (see http://www.washingtonpost.com/wp-dyn/articles/A9447-2005Feb8.html). So while the health industry may view insurance as the answer, it doesn't seem to work out that way for many people. Thus while I am trying to get insured, even if I am successful, I could still end up with even more medical debt.

For someone like myself, self-employed for decades, my future looks like one of continually mounting medical bills and guaranteed poverty in old age. Not only have I no hope of building a retirement fund, I won't even be able to keep my head above water.

I don't know that I am at all typical in terms of uninsured in Hawaii, but I am at least part of the picture



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Sick and Broke

By Elizabeth Warren

Wednesday, February 9, 2005; Page A23

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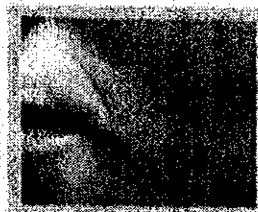

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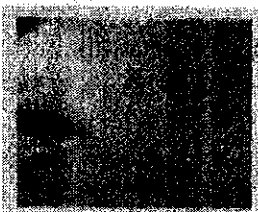

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Nobody's safe. That's the warning from the first large-scale study of medical bankruptcy.

Health insurance? That didn't protect 1 million Americans who were financially ruined by illness or medical bills last year.

A comfortable middle-class lifestyle? Good education? Decent job? No safeguards there. Most of the medically bankrupt were middle-class homeowners who had been to college and had responsible jobs -- until illness struck.

As part of a research study at Harvard University, our researchers interviewed 1,771 Americans in bankruptcy courts across the country. To our surprise, half said that illness or medical bills drove them to bankruptcy. So each year, 2 million Americans -- those who file and their dependents -- face the double disaster of illness and bankruptcy.

But the bigger surprise was that three-quarters of the medically bankrupt had health insurance.

How did illness bankrupt middle-class Americans with health insurance? For some, high co-payments, deductibles, exclusions from coverage and other loopholes left them holding the b- for thousands of dollars in out-of-pocket costs when serious illness struck. But even f. .ies with Cadillac coverage were often bankrupted by medical problems.

Too sick to work, they suddenly lost their jobs. With the jobs went most of their income and their health insurance -- a quarter of all employers cancel coverage the day you leave work because of a disabling illness; another quarter do so in less than a year. Many of the medically bankrupt qualified for some disability payments (eventually), and had the right under the COBRA law to continue their health coverage -- if they paid for it themselves. But how many families can afford a $1,000 monthly premium for coverage under COBRA, especially after the breadwinner has lost his or her job?

Often, the medical bills arrived just as the insurance and the paycheck disappeared.

Bankrupt families lost more than just assets. One out of five went without food. A third had their utilities shut off, and nearly two-thirds skipped needed doctor or dentist visits. These families struggled to stay out of bankruptcy. They arrived at the bankruptcy courthouse exhausted and emotionally spent, brought low by a health care system that could offer physical cures but that left them financially devastated.

Many in Congress have a response to the problem of the growing number of medical bankruptcies: make it harder for families to file bankruptcy regardless of the reason for their financial troubles. Bankruptcy legislation -- widely known as the credit industry wish list -- has been introduced yet again to increase costs and decrease protection for every family that turns to the bankruptcy system for help. With the dramatic rise in medical bankruptcies now documented, this tired approach would be no different than a congressional demand to close hospitals in response to a flu epidemic. M ng bankruptcy harder puts the fallout from a broken health care system back on families, leaving them with no escape.

The problem is not in the bankruptcy laws. The problem is in the health care finance system and in chronic debates about reforming it. The Harvard study shows:

• Health insurance isn't an on-off switch, giving full protection to everyone who has it. There is real coverage and there is faux coverage. Policies that can be canceled when you need them most are often useless. So is bare-bones coverage like the Utah Medicaid program pioneered by new Health and Human Services Secretary Mike Leavitt; it pays for primary care visits but not specialists or hospital care. We need to talk about quality, durable coverage, not just about how to get more names listed on nearly-useless insurance policies.

• The link between jobs and health insurance is strained beyond the breaking point. A harsh fact of life in America is that illness leads to job loss, and that can mean a double kick when people lose their insurance. Promising them high-priced coverage through COBRA is meaningless if they can't afford to pay. Comprehensive health insurance is the only real solution, not just for the poor but for middle-class Americans as well.

Without better coverage, millions more Americans will be hit by medical bankruptcy over the next decade. It will not be limited to the poorly educated, the barely employed or the uninsured. The people financially devastated by a serious illness are at the heart of the middle class.

Every 30 seconds in the United States, someone files for bankruptcy in the aftermath of a serious health problem. Time is running out. A broken health care system is bankrupting families across this country.

The writer is a law professor at Harvard University.

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October 24, 2005

To: Health Care Task Force:

My name is Dayle Bethel. Until my recent retirement, after fifty years in academia, I was professor of education and anthropology with The International University in Kansas City, Missouri.

Since coming to Hawaii, I have been impressed by this State's efforts to provide for the health care needs of the people of the State. But despite those efforts, there are still significant numbers of people in the State without any form of health insurance, and many of those who have joined one health care plan or another, are struggling under the steadily increasing costs of their health care insurance plans.

I was, therefore, greatly encouraged by the Legislature's action of creating a Health Care Task Force charged with studying all aspects of providing adequate health care for the people of Hawaii, including funding in the amount of $200,000 to enable the Task Force to conduct its study.

My understanding is that some part of those funds would be used to bring people who are nationally recognized professionals and specialists in the health care field to Hawaii to advise the Task Force and the people of the State on the various options and means available to provide health care for all the people of Hawaii at the least possible cost.

I understand, also, that a cutoff date for inviting such professionals has been set for the end of October, and that as yet this has not been done. This, I believe, is cause for deep concern. If the Task Force does not use the resources made available to bring in professionals who can advise them and us as to how the people of this State can make the best and wisest decisions about healthcare for every person and family in the State it will, I believe, be perceived as being seriously negligent in fulfilling its responsibilities to the legislature and the people of the State of Hawaii.

I sincerely hope and request that action will be taken on this at this Task Force session.

Respectfully,

Dayle Bethel
1441 Victoria Street, #402
Honolulu, Hawaii 96822
Phone: 808-523-2906
Email: dbethel@verizon.net

From:

Powering Down America:

Local Government's Role in the Transition to a Post-Petroleum World

By Jennifer Bresee and David Room

Global Public Media

Thursday 20 October 2005 -- (Excerpts)

Once oil crests and goes into decline, much of today's global-scale transport, industry, and trade will become economically unviable. With the diminishing viability of global-scale human activities, local economies, transport, governance, and culture will become increasingly effective and necessary. As national and global-scale operations and institutions peter out in the face of energy shortages and price shocks, local and community-supported organizations will need to step up and assume responsibility for many social services like food security, transportation, and energy security. Relocalization of key activities and local provisioning could make the difference between a sustainable future and social breakdown. What is in question, at this juncture, is how much effort local governments will put in now, while energy is still relatively cheap and plentiful, to prepare for an energy-constrained future, and how hard we, as the constituents of local governments, are willing to push for timely and substantive action.

....

Ecological cities rely on renewable energy sources that are, as much as possible, integrated with the city itself, and are therefore energy independent, using, for example, solar and wind generators on the tops of buildings. They are also compact, built for pedestrians and bicyclists rather than motorists, and zoned for a diverse number of uses in a small area so that residents can walk or take public transit to workplaces, schools, and commercial centers. At the same time as being densely developed, ecological cities also leave space for gardens and parks where residents can grow some of the food consumed in the city, reducing the food shipments from outside and maintaining a healthy and pleasant environment even in the city's core. Compact, diverse cities that provide for their own energy needs are the only way to preserve urban populations while letting go of our car culture and all of its energy demands.

If we cut down on the energy demands from our normal ways of being, we will then have more energy resources available for making other, vital transitions, such as weaning our agricultural system from its dependence on oil and natural gas, and redesigning (and in some senses reverting) our transportation systems to run on electricity rather than liquid fuels. Since an energy-constrained future is inevitable, ecological city design is the best prospect for an urban lifestyle that we can sustain for generations to come.

Cities, suburbs and towns, as we construct and live in them today, stand to lose nearly all of their services and comforts as life-supporting environments in our energy-constrained future. But if those in power act now to change our constructed environments to better reflect the coming reality of expensive energy, cities could preserve far more services for their citizens than could higher levels of government or national organizations. With informed and timely action on the part of both local governments and individuals, cities could adjust to an expensive-energy environment. Given the energy expense associated with engaging in global-scale transport, production, and politics, and energy savings associated with staying local, cities have a better chance of retaining their effectiveness while national-level transport, production and government goes into decline.

JORY WATLAND
3030 HOLUA PLACE
HONOLULU, HAWAII 96819
808 847-2301

TESTIMONY
10/25/2005

TO: Members of the Health Care Task Force

Due to the news coming out of Florida last week regarding the Medicaid program (reducing benefits and increasing co-pays) and due to the Advertiser story (10/17/2005) regarding" network of health centers sought for the uninsured" (which suggests replaying the State Health Insurance Program – SHIP, which was a costly abysmal failure), I urge the Task Force to move the intent of HB 1304 – health care for all Hawaii residents into legislation that guarantees health care that is UNIVERSAL and COMPREHENSIVE for ALL fo Hawaii's residents.

Several of us have been working on this plan for over ten years and are available to the Task Force.

THE PLAN is based on the four national health plans in the U.S. – all government funded and administered – Medicare, Medicaid, the VA Health Plan, and the medical services for the uniformed services. The two that are most comprehensive (covering preventive, primary, tertiary, and long term health care) are the VA Health Plan and Medicaid.

THE PLAN has four basic financing legs (some exclusive to Hawaii): Medicare, Employer payments for employee health coverage (i.e., the Hawaii Prepaid Health Care Act), Medicaid (the reestablishment of the 1115 waiver of 1994), and utilizing the State Health Trust Fund to provide the match for all Medicaid beneficiaries and services under 1115.

THE PLAN envisions the State Health Authority to collect the resources; pay all eligible providers; and determine the menu of covered services (modeled on all Medicaid options under Title XIX). Legislation would need to be proposed to establish the State Health Authority with the authority to care out the scope of work referenced above.

Please do not get side tracked into words and concepts. The intent of HB 1304, and therefore the intent of the Task Force is "to develop a plan to implement health care for all Hawaii residents". **THE PLAN** is available to the Task Force.

Alex Malabey

From: JimBrewer Reneelng [jimrene@hi.net]
Sent: Tuesday, October 25, 2005 10:36 AM
To: Rep. Josh Green; Alex Malabey
Subject: PNHP Consultants/ recommendations

Hi, I just got the okay from PNHP-Hawaii chair to give this testimony which includes recommendations for consultants.
Alex, could you get this to Josh? Thanks!
And thanks for all your hard work on the Public Meeting!
Renee

TO: Hawaii Health Care Task Force (10/25/05)

FROM: Renee Ing, for PNHP-Hawaii (Ph: 524-3332, P.O.Box 23094, Hon 96823, FAX 545-1989)

With all due respect, may I remind you that Act 223 established this task force to "develop a plan for implementing health care for all Hawaii residents...comparing...the status quo with various options...including...single payer." With $200,000 for studies and consultants, you were advised by your facilitator that you should commit to contracts in October in order to meet your deadlines. Towards this purpose, it was mentioned that consultants can advise you on the: 1) Conceptual framework; 2) Public Policy details; and 3) Feasibility studies needed for you to accomplish your task.

Single payer consultant(s) for aspects 1.) and 2.) are essential to get everyone on the same page. **PNHP-National can send a consultant to Hawaii up through the end of November** to advise you on the conceptual framework & public policy aspects of single payer. **(E-mail DR. IDA HELLANDER at pnhp@aol.com)**

On 10/12/05, **a second consultant was asked for by a Task Force member. DR. ROBERT McMURTRY (519) 646-6287 <robert.mcmurtry@sjhc.london.on.ca> a Canadian,** would be a good second consultant. He is an Orthopedic surgeon, a former dean of a medical school, and chair of Canada's Waiting Lists Commission. He's now involved in Canada's work to reinvigorate their health system, after drastic federal funding cuts (from 50% down to 14%) negatively affected it. Canada has wait times similar to ours (see: www.statcan.ca/english/freepub/82-401-XIE/2002000/tables/html/t007_en.htm) , but finds them unacceptable, and is working to improve their wait times, among other things.

For this Task Force to make your deadlines, a single payer consultant for the first two phases (conceptual framework and public policy) can be immediately contracted with—separate from the process you are now going through for the feasibility studies (ie. in order to contract with Lewin and other fiscal analysts). At the 10/12/05 meeting, Chairman Green tried to get a decision on consultants, but was not successful.

Unfortunately, we all realize there are some among you who are against single-payer. However, this Task Force is expected to responsibly study all viable options, including single payer, for Hawaii's sake. And with all due respect, PNHP-Hawaii feels that, were you not to contract with a single payer

consultant in a timely manner, it would be a departure from Act 223 on your part. Thus, PNHP-Hawaii strongly requests that this Task Force come to an agreement——at this meeting——on the hiring of consultants to advise you about single payer, as your facilitator has advised you that your timeline necessitates.

The advantages of single payer—which aren't possible in a tweaking or expansion (which requires additional public money) of our present system——should be investigated by Hawaii because: 1) We could use the 31% or so of health care dollars now wasted on bureaucracy to provide healthcare, etc. for everyone; 2) We could have one coordinated computer system, and be able to contain costs by creating inherent efficiencies, avoiding unnecessary duplication, and reining in fraud, malpractice, and pinpointing medical mistakes; 3) An electronic data base would also enable us to find successful medical strategies; 4) Work Comp costs and high medical insurance costs wouldn't plague businesses; 5) Doctors can again concentrate on doctoring, everyone can access healthcare and medical bankruptcy would become a moot issue.

To: Hawaii Health Care Task Force
From: David Brezel, O.D., F.A.A.O.

October 25, 2005

Public testimony

My name is David Brezel. I am a Doctor of Optometry and Fellow of the American Academy of Optometry. I taught clinical procedure at the Pennsylvania College of Optometry for 35 years.

I am appalled at the state of health care in the United States and am particularly sympathetic to the practitioners who are forced (by economics) to rush their patients through. In my field a simple example of consequent problems comes to mind:

Recently a patient was referred to me with a complaint that when she was driving and tired that she would have double vision! She saw two streets, one going up. So she drove with one eye closed. Her glasses were recently prescribed after a 10 minute eye exam, but the practitioner apparently did not test her eye muscles for vertical imbalance. A proper eye examination requires over 20 tests, which cannot be performed in 10 minutes. A 60 minute, (not 10 minute), exam found and corrected her problem.

Our present system is not working. The third party--insurance companies and their administration-- are taking such a big bite of the pie that practitioners and patients suffer.

David Brezel, O.D., F.A.A.O.
160 South Kainalu Drive
Kailua Hawaii 96734
(808) 263-4040

TESTIMONY BY JIM BREWER
BEFORE THE ACT 223 2005 HEALTHCARE TASKFORCE
Tuesday, 10/25/05

Aloha Healthcare Taskforce members,

My name is Jim Brewer. I am here today to testify in favor of your taskforce adopting something similar to the single-payer model of healthcare-for-all in Canada. In that regard, I wish to make known my concerns and to make some requests which address those concerns.

I am concerned that after sitting through taskforce these meetings since they began August 24, 2005, almost nothing has happened. It was gratifying at first to see that you were listening to those of us from the public and that the taskforce seemed to be taking seriously the mandate given by Act 223 to present a legislative plan to the 2006 session of the Hawaii legislature for moving Hawaii to Healthcare for All. And, you acknowledged that part of Act 223 required you to consider single-payer as a way of delivering healthcare for all in Hawaii.

Your contracted facilitators, from the Hawaii Uninsured Project, basically laid out a timetable which you agreed was necessary for you to get you to your end of December deadline. That timetable set October as the latest time to contract with the necessary consultants to evaluate such mandated options as single-payer universal healthcare. That would—according to the plan—allow you to begin preparing in November and finalizing your final draft submission to the legislature twenty days before its opening day, January 17, 2006.

But as time has gone by, we the public have yet to see the necessary contracting with the appropriate consulants. With this meeting, October has essentially gone by without contracting with consultants. And this evening we don't see it as the first item on the agenda. The first item on the agenda is the anchoring pillar of Hawaii's present declining healthcare system, the Hawaii Prepaid Healthcare Act of 1974. It should however probably been presented at the very first meeting or possibly the second. We as mentioned above should be far ahead of this as mentioned above.

Frankly I view this as a tragedy unfolding. The people of Hawaii were presented by the 2005 legislature with possibly a defining moment for Hawaii's future healthcare. A moment when good people were given $200,000.00 of taxpayers' money to do something great for Hawaii—with implications for Hawaii's reputation as the state which led the way to Healthcare for All throughout the U.S. It would indeed be a tragedy if you have already dropped the ball and the game is over. My simple request is that you contract immediate for the necessary consultants; even if it means meeting one week from now. Aloha, Jim Brewer 267-0117 – P.O. Box 23403, Honlulu, HI 96823

Testimony by James R. Olson before House committee on universal health care

I'd like to talk about a friend of mine, Bobby Tangaro. Bobby makes about $9 an hour, and his wife makes a little bit more. They have two children in elementary school.

Last December, Bobby's wife had a hysterectomy, and because of complications, she had to spend seven days in the hospital. Despite the fact that she has health insurance, the uncovered portion of the bill came to $14,000. She and Bobby struggled with the question of whether to declare bankruptcy, but in the end, they decided to pay the bill off as they could, so every month, they pay a couple of hundred dollars on it. At that rate, it will be more than a decade before they manage to pay it off, but that's all they can afford, and it cuts deeply into their family budget as it is.

It's a fact of life that we all need medical care. The level of care needed varies from person to person, since only a few of us find ourselves in the position of Bobby's wife, but there is no way to predict what the medical costs you will face in your life will be. That's why we have insurance: everyone pays into a common fund, and we take out of it as we need it. Those who don't need as much don't get as much out as they pay in, but they get the security of knowing that if they are one of the unlucky ones, they'll be covered.

That's the ideal version of insurance. The real life version has a little twist to it. It's run for profit, and that profit consists of the difference between what the customers pay in, and what the insurance company pays out. That gives the insurance company a strong motive not to pay out, since the lower their costs, the higher their profit...and recently, that profit has been skyrocketing, despite the otherwise slack economy.

When an insurance company is run for profit, it has a strong motive to exclude those people who are unlucky enough to need medical care, and limit its services to those who don't. So we see things like the refusal to cover existing conditions, and the reluctance of insurers to cover pediatric care.

The only way out of this conflict is to take health insurance out of the realm of profit. That doesn't mean making all health insurers into non-profit corporations like HMSA, since even though they are technically non-profit, they still charge more than they pay out. It means making health insurance a function of the government, just as it is in every other industrialized country in the world. Because of the reluctance of the federal government to do its part for the health care of its citizens, it falls to our state government to step into the breach and shoulder the burden.