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October 31, 2005

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

**By Fax: 585-7932**

DATE: **Wednesday, November 2, 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**

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

This task force was positioned to recommend a solution to a problem defined for it by the legislature. It would be responsible or normal for individuals selected for their expertise to either call on their own knowledge and resources to make the recommendation this session; or, to have displayed sufficient curiosity to have received the requisite information from outside sources on time.

There are three chronic problems within the main problem. First, there is a growing number of uninsureds which has received significant media attention. Second, there is the more dangerous, yet unspoken, problem of refusal by the myriad of Hawaii payers to reimburse health providers as agreed; or, by statute. Third, there are two federal racketeering cases, in Florida, which could wipe out

HMSA's reserves at any time. These federal claims have priority over any action by the commissioner in this state, to seize HMSA's reserves.

The members of this task force are collectively well-versed in these separate but related problems. Individually you can propose, or recommend, to lawmakers how you conclude health a providers will be satisfactorily paid, so that they will stay here and treat all of our citizens; and, so that health providers outside of the state will view Hawaii as provider friendly state, and migrate here.

No further expertise is needed to inform this task force what Hawaii health care professionals already know about the real amount of the health claims made each year. Together, you could easily the arrive at that figure. No, it is not 2 x the ±$1.4B that HMSA paid in 2003, because HMSA is not paying anywhere near the amounts demanded of it. Assuming physicians only receive 0.30 on each $1.00 billed, then this state's annual "claims made" figure is probably ±$9 billion annually (if billed and paid by a competent, honest, and well regulated mutual benefit society).

For health providers who do not want to work for Kaiser, or a similar organization, a Hawaii mutual benefit society paying claims of $9b annually might be an attractive single payer. It is from this summit that members of this task force, armed with their current knowledge and expertise, can now show lawmakers how to (1) keep, and attract health providers to Hawaii and (2) to extend health care to all the state's residents.

The taxing question is "what will the traffic bear?" Health-related premiums in 2003 were only about $2.4B. The property/casualty carrier health-related premium may be only $1.0b per year.

Before worrying about closing the gap between claims made and claims paid, the first question is "what changes can be made to make sure clean claims submitted to any payer will be paid within thirty days, no matter who is the payer?" There are several simple changes you can propose and support which will

case the health reimbursement crisis after the next session, and which will set the stage for providing quality health care to the entire state. These are:

1. Minor amendment to a simple state statute, or the constitution, to prevent anyone receiving income from parties with cases pending in the courts, from selecting judges; particularly insurers involved in health claims (who now have 4 out of the 9 votes to decide a state judge's fate).

2. Transfer all administrative remedies over treatment plans or billing and coding disputes from the department of labor, to the DCCA, and make DCCA administrative decisions binding on the labor director.

3. Establish a division of DCCA specializing in hearing treatment plan, coding, and billing disputes; with properly trained and certified hearing officers and a coding library.

4. Permit a private cause of action for violation of the Unfair Claims Settlement Practices Act, specifically for health care reimbursement issues, which can be brought in the DCCA or in the courts;

5. Minor amendment to HRS §607-14 to prevent use of "English rule" in any tort or statutory claim by a health provider against an insurer for reimbursement; that is, the losing party will no longer be liable for the winning party's attorney's fees, absent bad faith or frivolous conduct.

6. Minor amendment to state's theft statutes, allowing health providers a private civil cause of action, based on theft of services, against insurers who fail to pay; without the need for a separate criminal prosecution (similar to a Texas statute):

Without proposing a fair, prompt and equitable infrastructure to handle health provider reimbursement disputes your proposal on how to provide health care to all residents will have a hollow ring.

Respectfully Submitted,

Stephen M. Shaw

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

Before

Honorable Josh Green, MD, Chair
Patricia Blanchette, MD, Vice Chair
HEALTH CARE TASK FORCE

Public Hearing
Wednesday, November 2, 2005
4:00 pm
Conference Room 309

**Hawaii Essential Insurance Plan**

Chair Green, Vice Chair Blanchette, and members of the Health Care Task Force, I am Chris Pablo, Director, Government & Community Affairs, Kaiser Permanente. In addition, I am a member of the Leadership Group of the Hawaii Uninsured Project and have served on a number of its work groups including the Prepaid Health Care Act and Working but Uninsured work groups. My comments today are being offered in my capacity for Kaiser Permanente.

I have examined the white paper entitled "Hawaii Essential Insurance-A plan to end the problem of the uninsured in Hawaii" mindful of the lengthy, difficult, and complex work that went into producing the recommendations of the Hawaii Uninsured Project. We were blessed with the resources that enabled us to engage expert technical advice to assist us to diagnose the problem, identify the sub-populations of the uninsured in Hawaii, and to critically examine what approaches might be successful in bringing Hawaii's uninsured under coverage or providing access to health care. Our work product provides a set of policy options to either provide coverage or to finance access to health care services for each of the sub-populations of the uninsured. In order to make our options actionable, we provided cost estimates for each option and a set of financing alternatives to implement the policy options to be selected by the policy makers. This work tells me one thing about solving the problem of the uninsured—there are no *silver bullets!*

It is with this depth of experience that I appreciate the opportunity to offer these thoughts regarding the proposed Hawaii Essential Insurance Plan.

As I understand it, this plan offers to address the needs of approximately 120,000 of Hawaii's uninsured population. The plan has these features:

- Delivery system: 13 federally qualified health centers and 12 hospitals run by HHSC
- Benefit package: "prevailing plan"

- Premium cost: $80 month (annual premium increase capped at 2%)

The proposed Hawaii Essential Insurance Plan must be analyzed from a number of dimensions as follows:

## Organization & Delivery Infrastructure

1. Specialty care:
    a. Who will provide it?
    b. Will specialists be available on all-islands? If not, will this plan cover transportation to other islands where specialty care is available?
    c. At what rate will specialists be compensated
2. Inpatient services:
    a. Who will provide services to Oahu enrollees of the plan since HHSC's principal hospitals are located on the neighbor islands?
    b. Will the plan contract with Oahu hospitals?
    c. Can the HHSC system accommodate an additional 120,000 potential patients with its current infrastructure?
3. Outpatient Services
    a. Primary Care
        i. Do the 13 community health centers have the capacity to accommodate 120,000 additional patients on all islands?
        ii. If not, will the plan expand its primary care network to include other clinics or individual physician practices
    b. Pharmacy, Diagnostic Laboratory, Radiology, and other services
        i. Do the 13 community health centers and the 12 hospitals in the HHSC system have the capacity to provide these services for an additional 120,000 enrollees on all islands?
4. Other questions re infrastructure
    a. Will the community health centers and community hospitals need to expand to meet the needs of an additional 120,000 enrollees? If so, what will this expansion entail (staff, buildings, equipment, land, etc.)? How much is "modest injection of state funds"?
    b. Can you explain how the $10 million dollars to be expended in 2006, 2007, and 2008 will be used for?

## Financing

5. Actuarial Analysis: have you conducted an in-depth actuarial analysis or profile of this population of 120,000 uninsured persons? If so, was this plan designed based on this actuarial analysis?
6. Financing Operations
    a. Premiums to be charged to enrollees

i. Is it realistic to charge a premium of this amount when comparable commercial plans are charging over $200 per month for a single plan? How was the rate of $80 month determined?

ii. Will all enrollees be paying for premiums? If so, how much? What if an enrollee cannot afford to pay the premiums?

iii. Do you have a pro-forma income and expense statement to demonstrate the adequacy of the financing method to deliver this plan?

iv. What will the leaders of this plan do to manage operating costs and health care consumption to keep the annual increase in cost to consumers at no more than 2% per year?

v. Will taxpayers be asked to subsidize any shortfalls in the operating budget of this plan? If so, what will be the taxpayers' burden? Please compare the total cost (premium charged plus tax burden) for this plan with the current cost of health care financing.

7. Capital financing
   a. Is there a capital plan to ensure that the physical infrastructure can be maintained, expanded, and improved to meet the needs of 120,000 additional patients?
   b. How will the capital needs (e.g., the plan suggests $10 million per year in 2006, 2007, and 2008) be financed?
   c. What is the "universal medical records plan for Hawaii"? How will this be financed—via premiums or capital financing?
8. Financial burden of charity care
   a. The plan identifies as one of its benefits "the state of Hawaii no longer absorbs 'charity care costs' estimated at $525 million over 5 years. Can you explain via financial analysis how this will be accomplished?
   b. Can you explain "the HHSC hospitals decrease their % of charity care and their need to go to the legislature annually for money in excess of $50 million/year? Does HHSC concur with this statement?

## Benefit Package

9. Can you explain the benefit package to be provided to enrollees?
10. Please explain what is meant by the statement "prevailing plan mandates are met because the CHCs and Community Hospitals offer all necessary services?

## Projected Cost Savings

11. Can you explain how the "state of Hawaii can realize savings in excess of $1 billion by 2015 by covering its uninsured and limiting waste in the form of uncontrolled chronic disease, misuse of ER facilities, duplicative tests and unnecessary non-reimbursed hospitalizations?
    a. How do you propose to change provider behavior to achieve these results? Can you demonstrate that these work to achieve these results?
    b. What will you do to change consumer behavior and expectations to achieve these results? Can you demonstrate that these work to achieve these results?

c. What cost containment methods or strategies will be employed to achieve the projected cost savings and limits on annual premium increases?

12. What degree of government or private regulation will be required to achieve the results you project in question #11? Please describe.

**Attribute Analysis:**

13. I urge you to consider applying this plan to a test using four primary attributes suggested in a brief entitled "The Framework" by the California Health Care Foundation [http://www.chcf.org/topics/healthinsurance/coverageexpansion/index.cfm?itemID=104810# Coverage]. See attached. The four attributes are: (1) coverage, (2) cost and efficiency, (3) fairness and equity, and (4) choice and autonomy.

**Implementation, Administration, and Quality**

14. How much will it cost (in dollars and as a percentage of revenue) to administer this plan?
15. Can you describe the degree of change from status quo that this will require to implement this plan?
16. What legal or regulatory changes would be required to implement this plan?
17. What would be the effect on the labor markets, i.e., employment levels, skill sets, compensation, and composition of the labor force in business and government to implement this plan?
18. Who has accountability for ensuring good performance for quality and efficiency (such as insurers, health plans, employers, health care providers, and government)?
19. Under the status quo all health plans are required to be accredited (i.e., by NCQA) and to provide performance data (e.g., HEDIS, CAHPS, and other performance measures). Will these be required?

**Other questions**

20. Will this plan reimburse an enrollee for care that is provided out-of-network (e.g., urgent or emergent care in state, out-of-state, out-of-country)?
21. 
22. Will this plan provide or pay for services that are not "medically necessary"?
23. Will this plan provide or pay for services that are experimental or investigational?
24. Will the Hawaii Patient Rights & Responsibilities Act provide consumer protections to enrollees (e.g., external appeal)?

Before the Hawaii Essential Insurance or any proposal can be considered, it must be subject to the rigor of questions like these. I urge you to conduct such an analysis as you evaluate all proposals that come before the Health Care Task Force.

I appreciate the opportunity to testify and share these thoughts with you.

**Coverage**
The coverage attribute includes a number of related considerations, such as who is covered and which benefits are offered.

**People Covered**
- How many people will be covered who previously were not.

- Which particular populations will be newly covered and which will not (for example, most needy vs. less needy).

- Access to care (for example, language or culture differences, geographic distance, physical barriers for people with disabilities).

If you create it will they come? How will you provide care for those who do not enroll in the plan?

**Portability of Coverage and Continuity of Care**
- Portability of coverage (maintaining coverage as life circumstances change).

- Continuity of care (maintaining relationships with health care providers over time).

Will out-of-network (e.g., urgent/emergent care provided on the mainland/out-of-country or outside of the plan's network) care be reimbursed? If so, how much?

**Benefits**
- Which services are covered and to what extent.

- Consumer cost-sharing and other financial limits that could affect accessibility.

**Quality of Care/Effect on Delivery System**
- Effect on quality of care (for example, medical outcomes and patient satisfaction).

- Effect on the way physicians practice (for example, greater adherence to practice guidelines).

- Whether the proposal promotes or discourages greater integration and coordination among parts of the delivery system (for example, between primary care providers and specialists).

- Adequacy of provider supply including the safety-net system.

TO: Hawaii Health Care Task Force (11/2/05)
FROM: Renee Ing, for PNHP-Hawaii (Ph: 524-3332; P. O. Box 23094, Hon 96823, FAX 545-1989)

In our debate about consultants to advise this Task Force, I was surprised to hear that some think PNHP should not be asked to provide consultants since they are "biased" in favor of single-payer. However, those in favor of private insurance are "biased" towards their view——so bias is not the relevant point here. The real question is: When you compare both systems, which system works the most efficiently, affordably, and has higher quality.

[ In this regard, I would also like to mention that in discussions with PNHP people, I was told that the Lewin Group is not an advocate for single-payer. They are simply very good fiscal analysts. I was advised that "Lewin is still the best for a thorough fiscal analysis, but it will cost the state $30,000 or so." ]

Single-payer systems can keep the existing medical infrastructure—as Canada did, when it went to single-payer

Other advanced democratic countries have economies that are a mix of private and public sectors, depending on which they decide serves them better in particular instances. As we're aware, they all also have universal health systems. In Canada medical provision is largely in private hands, but it's financing is done through the public sector (ie. the governments) which collects the money and then pays the medical providers.

Converting to a single-payer system doesn't throw out a country's traditions and history. As Canada retained it's mostly private provision of healthcare, and Canadians have many different choices of providers — I believe we would also keep our diverse existing medical infrastructure.

To give good health care to everyone, we need to keep our existing medical infrastructure and build on it. The point of a single payer is not to convert to another system, but to rationalize the provision of health care——so we can have more access to quality health care, and less waste/ bureaucracy, duplication of effort, fraud, etc.

At HUP's excellent "Un-Insured" conference recently, their CNN speaker mentioned the pharmaceutical companies will no longer manufacture a particular drug the girl "Ally" needed, since the drug isn't widely used. Are we going to only treat widely prevalent conditions? That's not rational—it's profit driven.

People with "pre-existing conditions" have to pay high, unaffordable premiums and are often unable to get healthcare—while people who are healthy get discounted health care premiums and are the preferred customers of choice of insurance companies. That's not rational from a healthcare standpoint, but it's profitable

Expanding the present system with it's many competing risk pools won't avoid these traps of private insurance. A single payer consultant can point out how single payer avoids those traps because of it's **ONE** risk pool.

PNHP-national is an organization with intellectual rigor and a long, consistent record of articulating an alternative to the present private insurance structural dynamic that's obviously failing compared to single-payer systems in other advanced nations. PNHP can help us clearly understand what creates the glaring differences.

The offerings we see in the current Healthcare Task Force dialogue——built on making the case for simply solving Hawaii's healthcare "un-insured" problem——are still posed within the present private insurance model, and based on continuing the existing model——only expanded. But what about the "under-insured?"

PNHP is a very credible, high-level group that works in Washington, with Harvard, etc. The Task Force would benefit from PNHP's expertise (ie: conceptual consultant) to clearly understand single-payer 's rationale and strengths, **in addition** to a fiscal analyst (like Lewin) doing a feasibility study of single payer for Hawaii.

Since Act 223 instructs you to explore "various options...including...single payer," and gave you a budget that enables you to contract with a single payer consultant, I ask that you contact **Dr. Ida Hellander** at PNHP-national **<pnhp@aol.com>** for a conceptual / public policy consultant to ensure a level playing field.