*Health Insurance: The Hawaii Experience*

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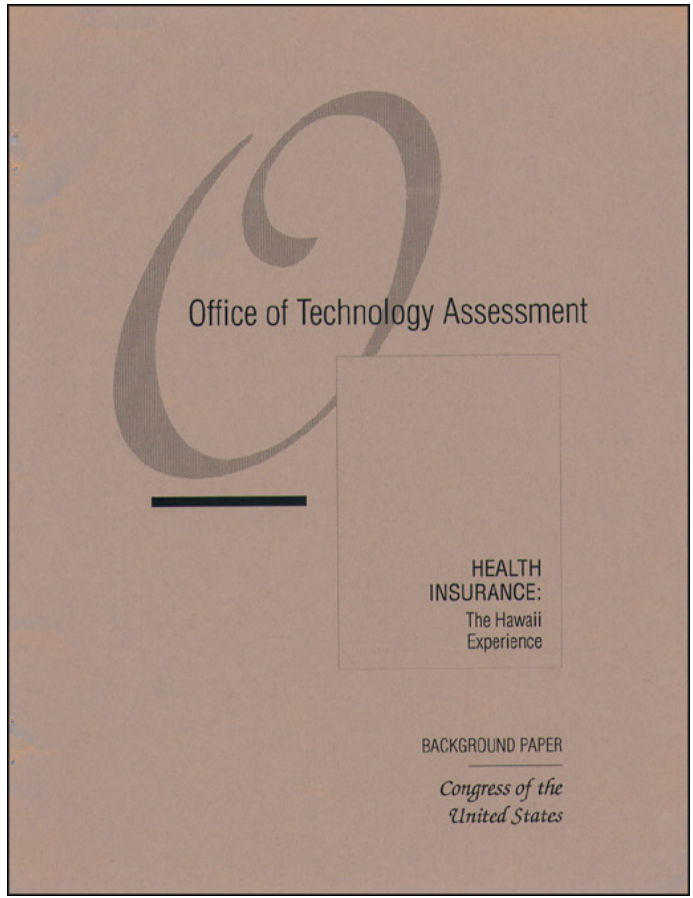

**U.S. Congress**

**Office of Technology Assessment**

**Background Paper:**

# HEALTH INSURANCE: THE HAWAII EXPERIENCE

**Prepared Under Contract to OTA**
**by**
**Lawrence Miike**
**University of Hawaii**

**June 1993**

# FOREWORD

**Reform of the Nation's health insurance system is at or near the top of the Nation's domestic policy agenda. As policy makers consider the many directions the Nation could take, they often look to the States as laboratories.**

**This Background Paper provides a detailed look at the State that is often considered a model for what States can do to help provide universal or near-universal health insurance coverage for their residents. The Background Paper discusses the history of health insurance provision in Hawaii, emphasizing two relatively recent State insurance laws: 1 ) the 1974 law that required employers to offer coverage to most of their employees, and 2) the 1989 law that provided a State subsidy for coverage of those individuals who fell in the gap between employment-based coverage and Medicaid coverage. The paper addresses the difficulties faced in evaluating the impact of Hawaii's various attempts to provide coverage and access, and speaks to whether all or parts of Hawaii's experience can be transferred to other States or to the Nation as a whole.**

**This paper was prepared as background for OTA's assessment Technology, *Insurance, and the Health Care system.* The assessment as a whole was requested by the Senate Committee on Labor and Human Resources (Edward M. Kennedy, Chairman), the House Committee on Energy and Commerce (John D. Dingell, Chairman), the House Committee on Ways and Means Subcommittee on Health (Willis D. Gradison, then Ranking Minority Member), and Senator Charles E. Grassley (Committees on Budget, Finance, Special Committee on Aging).**

**This background paper was prepared under contract to OTA by Lawrence Miike, M. D., J. D., Professor of Medical Policy at the John A. Burns School of Medicine, University of Hawaii at Manoa. It was reviewed by an advisory panel, chaired by James L. Hunt, University Distinguished Professor, University of Tennessee-Memphis, and by other distinguished individuals. OTA gratefully acknowledges the contribution of each of these individuals.**

**ROGER HERDMAN**
***Director***

**HEALTH INSURANCE: THE HAWAII EXPERIENCE**

**PROJECT STAFF**

**Clyde J. Behney**
**Health Program Manager**

**Denise Dougherty**
**Project Director**

**Matthew Hahn**
**Research Assistant**

***Administrative Staff***
**Beckie Erickson**
**Office Administrator**

**Dan Carson**
**PC Specialist**

**Carolyn Martin**
**Secretary/Word Processer**

**Eric Gille**
**Secretary**

**LAWRENCE MIIKE**
**University of Hawaii**
**Contractor**
**Principal Author**

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# HEALTH INSURANCE: THE HAWAII EXPERIENCE

## SUMMARY

### Introduction

**Health care and health insurance reforms are currently high priority items on the nation's agenda. There is interest in the State of Hawaii's health insurance experience, because of that State's near-universal health insurance coverage through a variety of private and public programs. This background paper describes the health insurance situation in Hawaii.**

### History of Congressional Request

**This background paper is part of a larger assessment being conducted by OTA entitled Technology, Insurance, and the Health Care System. The assessment was requested by the Senate Committee on Labor and Human Resources (Edward M. Kennedy, Chairman), the House Committee on Energy and Commerce (John D. Dingell, Chairman), the House Committee on Ways and Means Subcommittee on Health (Willis D. Gradison, then Ranking Minority Member), and Senator Charles E. Grassley (Committees on Budget, Finance, Special Committee on Aging). The overall assessment is described in Attachment D to this background paper.**

### Summary of Findings

**The background paper demonstrates many of the complexities of providing health insurance and health care access to an entire population and evaluating the impacts of such efforts. Through mandatory employment-based insurance coverage, Medicare, Medicaid, and the State Health Insurance Program (SHIP) -- which was enacted to cover those not covered through employers, Medicare, Medicaid, and other public programs--perhaps less than 3 percent of Hawaii's population remains uninsured. Thus, while in some respects Hawaii's approach remains an imperfect and incomplete patchwork of insurers, insureds, payers, and providers,[1] unlike many other States, Hawaii's patchwork appears to have**

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**1 Hawaii's migrant worker and other populations are still more likely than other people in Hawaii to lack coverage and/or access to services. Insurers and health maintenance organizations have been reluctant to bid on the SHIP program, and some providers are reluctant to participate because of low reimbursement rates under SHIP. Administrative costs--including the transaction costs of switching from one program to another as eligibility changes with economic circumstances--are high. As individuals switch from one plan to another, the scope and depth of their benefits can change rather markedly. Hawaii's SHIP was conceived against the background of the needs of the uninsured "gap group", and enacted as a primary care and preventive services bill put into operation initially as a limited benefits health insurance program, but evolved quickly into a funding mechanism that is attempting to meet the minimum health needs of the great variety of uninsured people in a variety of ways. For example, following the devastation of the island of Kauai by Hurricane Iniki in the fall of 1992, more than 4,000 residents of that island obtained SHIP coverage after losing their employment-based health insurance. In other instances of need, the State has allocated public SHIP money to direct services.**

**achieved an enviable rate of health insurance coverage. Nonetheless, the country, and other States, should be aware of the limits to what can be learned from Hawaii's experience.**

**Factors that May Limit Other States' Ability to Adopt Hawaii's Methods**

**Hawaii is a unique State in many respects: its climate, geography, generally low unemployment rate, recent tradition of budget surpluses, and history, including its tradition of comprehensive, employment-based health care. For example, Hawaii's tourist-oriented businesses subject to the State's mandatory employment-based coverage are likely to find it difficult to move to another State with more favorable health insurance laws.**

- **Hawaii received a special exemption from the Federal Employee Retirement Income Security Act (ERISA) of 1974, which passed a few months after Hawaii's 1974 act passed; thus, Hawaii's employment-based coverage act may only work for Hawaii.[2]**

- **The State of Hawaii lacks the kind of health services research that would permit researchers to analyze with confidence the impact of Hawaii's legislative efforts on patients, health care providers, and businesses, and help to separate the impact of Hawaii's insurance system from its other features. For example, whether Hawaii residents' relatively low health care utilization and insurance rates are caused by, or independent of, any changes in coverage, is unknown. Any *health impacts of differences in utilization resulting from differences among plans in covered services is as yet unknown.***

- **There are boundaries within which Hawaii's publicly-funded Medicaid and SHIP programs operate, including:**

  - **Eligibility and relation to Medicaid: Hawaii's Medicaid program has fairly liberal eligibility criteria so that, combined with the mandated employment-based health insurance, the "gap" between public and private health insurance coverage is relatively small in Hawaii, compared to other States. *States in which Medicaid eligibility criteria are lower (i. e., many States[3]) and employers are not required to offer insurance coverage to their employees (i. e., all States other than Hawaii) might have a larger population to cover with a "gap" program like SHIP, depending on the eligibility criteria they set for the "gap" program.[4]***

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**2 For further discussion of the impact of ERISA on States' attempts at reform, see: U.S. General Accounting Office, Access to Health Care: States Respond to Growing Crisis GAO/HRD-92-70 (Washington, DC: U.S. GPO, June 1992); and U.S. General Accounting Office, Access to Health Care: State Efforts to Assist Small Businesses GAO/HRD-92-90 (Washington, DC: U.S. GPO, May 1992).**

**3 Within some broad Federal guidelines (e.g., applying to pregnant women, infants, and young children), income-related Medicaid eligibility criteria are set by the States and vary considerably (see U.S. Congress, House of Representatives, Committee on Ways and Means, Overview of *Entitlement Programs; 1992 Green Book: Background Material and Data on Programs Within the Jurisdiction of the Committee on Ways and Means,* Committee Print 102-44 (Washington, DC: U.S. Government Printing Office, 1992).**

**4 In Hawaii, individuals are eligible for SHIP coverage if they are otherwise uninsured and have a gross family income not exceeding 300 percent of the Federal poverty level for Hawaii.**

**A global budget for SHIP: A legislatively-appropriated total budget for SHIP operations, amounting to $10 million for the second (first full) year of operation, with a separate budget limit for hospital care, a State subsidy of $500 per person per year, premium copayments on a sliding scale, and a core benefit package that was fairly comprehensive in the scope of outpatient services covered. Insurance carriers were obligated to provide supporting information on their actuarial assumptions. Within these constraints, insurance carriers could price their own services and set reimbursement rates for providers. *A policy issue for other States and national policymakers is the utility and potential impact of a cap on hospital expenditures and its translation into benefits for individual patients.***

## Future Directions for Hawaii and National Policy Implications

**Hawaii's current administration would like to develop a "seamless system of care," with standardized patient benefits and provider payments. As a first step, in April 1993 the State applied for a Medicaid waiver to combine Medicaid, General Assistance, and SHIP into one basic health insurance plan, to be marketed on a prepaid, managed care basis.**

**The questions now being faced by Hawaii resemble those being faced at the national level, and include:**

- **what (if any) should be the standard for breadth and depth of coverage?**
- **what is the likelihood that significant additional public funds would be provided to support people who are unemployed and their dependents? what (if any) cross-subsidies among the various private and public insurance programs are acceptable?**
- **what (if anything) should be done about those people who remain unisured by choice?**
- **what are the limits to a program based solely on insurance coverage? what additional direct efforts may be needed to improve access and health?**

## Organization of the Background Paper

**This background paper begins with a short history of health insurance provision in Hawaii. This brief history is followed by descriptions of: the employment-based health insurance system that was mandated by the State in 1974; the relatively brief experience Hawaii has had with the State Health Insurance Program (SHIP) that was enacted in 1989 to serve the people not being served by either Medicaid or employment-based insurance; and current thinking in Hawaii concerning the goal of a seamless system of health care delivery. The paper also addresses the difficulties in evaluating the impact of Hawaii's various attempts to provide coverage and access, and speaks to whether all or parts of Hawaii's experience can be transferred to other States or to the Nation as a whole.**

# HEALTH INSURANCE: THE HAWAII EXPERIENCE

## Introduction

**Health care and health insurance reforms are once again high priority** items on **the national public policy agenda, as they were in the early 1970's. The national efforts faded, but the State of Hawaii managed to implement its health insurance agenda. Hawaii's 1974 enactment of mandatory, employment-based health insurance was nearly defeated because of "imminent" national health insurance legislation, and Hawaii's Prepaid Health Care Act (HPHCA) had to contain a clause that would terminate the State program when federal health insurance legislation was enacted.**

**Nearly two decades have passed. At the national level, the debates are reminiscent of the 1970's, but with a cost-containment focus because of double-digit annual cost increases and the doubling 01 GNP dedicated to health care since the early 1970's. Meanwhile, Hawaii has moved on to address the remaining gaps in health insurance availability for its residents by enacting a State Health Insurance Program (SHIP) (33), directed at the "gap group" without health insurance, thereby leading to near universal health insurance availability to Hawaii's residents through a variety of private and public health insurance programs.**

**Is there anything to be learned from the Hawaii experience that is of value to the national health policy agenda and to other states?**

> **It is not possible to export Hawaii's (environment and economic) climate. But the techniques which have evolved in Hawaii can be deliberately preserved there, and deliberately transferred to other environments (40).**

This conclusion was made in 1978, referring to the experience with the June 1974 HPHCA, Hawaii's mandatory, employment-based health insurance legislation. Adoption of that approach by other states was precluded by the 1974 federal Employee Retirement Income Security Act (ERISA), which was enacted in September 1974, a few months after HPHCA. In 1981 the U.S. Supreme Court confirmed 1977 lower court rulings that ERISA preempted such state actions, including the HPHCA (4), but in 1983 the U.S. Congress granted exemption from ERISA for the original HPHCA but not for any further expansions of its benefits, nor for any other state (31).

Thus, the effect of federal policy has been to exclude the adoption of Hawaii's mandatory, employment-based health insurance system by other states. We will never know what the impact on current national health care policy would be, had other states not been constrained by the ERISA preemption. A window of opportunity of only three months in 1974 provided Hawaii's workers with mandatory health insurance.

In this case study, the health insurance situation in Hawaii is described, beginning with a short history of health insurance in Hawaii, followed by summary descriptions of how the state's mandatory, employment-based health insurance system works and the state's Medicaid program, and ending with a special emphasis on the admittedly short experience of SHIP, the state's "gap group" insurance legislation.

## Health Insurance in Hawaii

Albert Yuen, retired President of the Hawaii Medical Service Association (HMSA) (the Blue CrOSS\Blue Shield organization in Hawaii), who was also one of the

Vice-Chairs of the **Advisory Committee to SHIP, Hawaii's "gap group" health** insurance program, recently described the history of health insurance in Hawaii **(40).**

His recollections are as follows:

A Brief History of Health Insurance in Hawaii[1]

The 1930's:

Between 1932 - 1935, a call for "Compulsory Health Insurance" was hotly debated in Congress and in State legislatures. This proposal acquired the label of "socialized medicine" and never passed in Congress or in any State. Concurrent debate on Social Security, however, resulted in passage of the Social Security Act in 1935.

By 1932 the sugar and pineapple industries -- Hawaii's two major employers at the time -- already provided their employees and dependents with comprehensive medical care through plantation dispensaries, hospitals, salaried physicians, and contracts with specialty clinics.

At the 1935 Annual Conference of Social Workers, Miss Mary Cotton, a social worker, introduced a Resolution to study the prospect of developing a voluntary prepayment Hospital Plan for Hawaii, The study resulted in the founding of Hawaii Medical Service Association, or HMSA, which started operations in May 1938,2 Social **workers and** school teachers were the initial enrollees. From its inception, HMSA benefits covered office visits, surgery, hospital services, and maternity care. Coverage for office visits was essential, as many employers and employees in business had experienced Plantation Plan benefits. Competitive medical insurance coverage came from insurance carriers offering "Indemnity Program with Deductibles. " Active carriers were Prudential, Aetna Life, and Mutual of Omaha. These carriers used the offer of health insurance coverage as a "door opener" to market their group life programs.

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[1] **From a speech by Albert H, Yuen, retired President of the Hawaii Medical Services Association (HMSA) and Vice-Chair of the State Health Insurance program (SHIP) Advisory Committee, "From PHCA to SHIP: A Personal Recollection, " presented at the "Workshop on the Hawaii State Health Insurance Program, " Ilikai Hotel, Honolulu, Hawaii, March 26-27, 1992,**

[2] **HMSA has been affiliated with the Blue Shield Association since 1946, and became a Blue Cross Plan on January 1, 1990. Blue Cross, which formed as a nationwide association in 1938, and Blue Shield, which formed in 1946, merged in 1982** to **become the national Blue Cross and Blue Shield Association, a trade organization representing 73 independent plans throughout the United States. Source: Hawaii Medical Service Association, " 1990 Annual Report, " Honolulu, HI.**

The 1940's:

The "War Years" -- 1941 - 1945 -- brought an influx of Federal employees to Pearl Harbor, Hickam Air Force Base, and the army bases at Schofield Barracks and Fort Shafter. Due to their experience with Blue Cross/Blue Shield on the "mainland, " many of these employees gravitated to HMSA for health insurance coverage.

In September 1946 **the pineapple industry discontinued their comprehensive "Plantation Plan, " and contracted** with HMSA in its "Free Choice of M.D. and Hospital" Plan. Shortly thereafter, through labor/management negotiations, a special "Stevedore" Plan was developed for International Longshoremen's and Warehousemen's Union (ILWU) members. These special plans helped HMSA develop sound cost data and utilization patterns, permitting HMSA to expand benefits and extend its group coverage to employers with 5 or more employees,

The 1950's:

Negotiated health care plans became a vogue in contract renewals between labor and management in various industries and among large employers. Many of these contracts called for 100 percent employer contribution to employee premiums and 50 percent contribution for dependent coverage.

By 1957 HMSA had introduced Plan 4, offering coverage from the first office visit to a $20,000 Major Medical Benefit Rider. Commercial carriers often matched these benefits in competitive bidding. 1959 was an important year, for the "Federal Employees Health Benefit Act" was passed by Congress. This brought about a large increase in growth of membership enjoying very comprehensive benefits. The same year, the Kaiser Plan began, with its Closed Panel Practice and own hospital to serve its members.

The 1960's:

In 1961 **the State Public Health Fund Law was passed by the Hawaii State Legislature. The Plan was patterned after the Federal Plan, and State and county employees were allowed a choice of HMSA, Kaiser, or Aetna Life plans.** With Medicare, Medicaid, and CHAMPUS (for military dependents) in place by the mid-1960's, over 85 percent of Hawaii's population had access to some type of health insurance coverage.

In 1967 the Hawaii State Legislature passed "Act 198, " calling for the Legislative Reference Bureau to conduct a study on Prepaid Health Care for Hawaii, The Study was under the direction of Dr. Stefan Riesenfeld, a professor of law at the University of California and an authority on social legislation. The Riesenfeld Report recommended a scheme with the following principles:

1. Every regular employee in **private employment** should be protected by a prepaid plan providing hospital, surgery, and medical benefits.
2. The level of benefits should conform to community standards.
3. The "free choice" of physician by the employee should be protected.
4. Prescribed coverage could be provided by any existing Prepayment Plan such as HMSA, Kaiser, or commercial carriers.
5. The Scheme should not interfere with the bargaining process or collective agreements such as existed in the sugar industry.

The 1970's:

Based on the Riesenfeld Report, a Draft Bill for a Prepaid Health Care Act was introduced by State Senator Nadao Yoshinaga, Chairman of the Senate Ways and Means Committee. Hearings and debates were held in the 1971, 1972, 1973, and 1974 sessions of the Legislature. Support came from health-related organizations, social workers, and labor unions. Opposed were the Health Insurance Association of America, the Inter-Industry Study Committee (an employers' group), and the Hawaii Medical Association. These latter groups questioned the necessity of the Act, as a majority of Hawaii's residents were already covered, and passage of a National Health Insurance Program seemed imminent. To resolve this last concern, the final Draft Bill contained a clause that would terminate the State program when the Federal law passed.

The Hawaii Prepaid Health Care Act (HPHCA) was passed in June 1974 and became effective in January 1975. Administration of the program was assigned to the Department of Labor and Industrial Relations. Operations were handled by the Disability Compensation Division with the support of an appointed citizens' group -- TW Prepaid Health Care Advisory Council.

In 1978 under a Federal contract with the Department of Health, Education and Welfare's Region IX office, the Martin Segal Company conducted an Evaluation of Impact of Hawaii's Mandatory Health Insurance Law. In its report, the following findings were made:

> "The Hawaii Prepaid Health Care Act has been viewed as a success -- it has resulted in the intended expansion of health insurance coverage, both in terms of numbers of people and the extent of their benefits. This has caused no major dislocations which can be identified. It has not resulted in any identifiable strain on the health care delivery system. Employers have not reported significant economic problems. Administration of the Act is simple.
>
> "We are impressed that Hawaii is a microcosm. We are also impressed that its elements are accessible and understandable. Thus it seems that it is possible not only to learn from the Hawaii experience, it is also possible to extrapolate lessons for practical applications.

"It is not possible to export Hawaii's climate. But the techniques which have evolved in Hawaii can be deliberately preserved there, and deliberately transferred to other environments. "

The 1980's and into the 1990's:

With the success of the Hawaii Prepaid Health Care Act, there still were concerns over an estimated 4.5 percent of the population with no health insurance -- what became known as the "Gap Group. "

In 1986 Governor John Waihee introduced a "New Initiative for Universal Access to Health Care, " targeting the "Gap Group. " Under Director of Health John Lewin, surveys were conducted to identify people without health insurance, and lobbying of the State Legislature began on what became known as "SHIP" (State Health Insurance Program).

In April 1989 the Legislature passed the SHIP Act and the Governor signed it into law on June 26, 1989, Between April and June, the Director of Health appointed a 20-member Advisory Committee. Six subcommittees addressing different aspects of the Plan were given 60 days to develop recommendations. The firm of Coopers & Lybrand was selected as consultant, and coordinated the work of the Advisory Committee and designed the final Plan. A SHIP administrator was appointed in October 1989. By June 1990, contracts were signed with HMSA and (by August 1990, with) Kaiser Permanence, and the program began operations within a year of the Act's passage. By 1992, after 18 months of operations, nearly 16,000 people were enrolled.

Clearly, Hawaii's economic climate vis-a-vis health insurance availability is special. Its pre-World War II economy was dominated by two industries, pineapple and sugar cane, which provided comprehensive medical care services to their plantation-based employees, Labor unions have also been a powerful force in the state, and through the collective bargaining process, comprehensive health care benefits were an integral part of the collective bargaining process, Private insurance companies thus were created or entered into business in the state to service these large groups of clients.

A crucial step in Hawaii's march to universal health insurance was the national health insurance debates of the early 1970's, which provided the impetus for support

from key legislators in the Hawaii state legislature to enact the HPHCA, requiring employers to provide health insurance for any employee who worked 20 or more hours a week. And finally, in 1989, a new governor and new director of the state department of health, during a time of state budget surpluses, were able to push through, in a single legislative session, the State Health Insurance Program (SHIP), to provide health insurance to the remaining "gap group. "

Thus, in Hawaii, through private health insurance, the Medicare and Medicaid public programs (and to a limited extent for ex-military and military dependents, the CHAMPUS and Veterans' Administration programs), and SHIP, health insurance is now available, at least potentially, to every resident. The current Director of Health, John Lewin, now sees his task as developing this patchwork of health insurance programs into a "seamless system of care, " in which benefits and payments are standardized:

> Such a system would guarantee Medicaid, other government sponsored insurance programs, private insurance and Medicare recipients a standard package of benefits. Providers of care would be similarly guaranteed standard and fair reimbursement for services, regardless of insurance or financing mechanism. This type of system brings parity to the delivery of health care services, by allowing both public and private insurance recipients to receive comparable benefits and provider reimbursement.
>
> To be effective, each state's standardized benefits package should encompass preventive and primary care, emergency care, inpatient care, tertiary and catastrophic care, mental health and substance abuse benefits, preventive dentistry and prescription drug coverage. Long term care coverage must include home and community based services for our elderly .,. (26)

Whether such a seamless, standardized system of care can be quilted out of a patchwork of programs is a very tall order, because Director Lewin's vision is not only to standardize but also to expand the benefits package. Given Hawaii's current economic climate, which is drastically different from only three years ago when SHIP

was enacted, it seems that the vision of a seamless system of care will have to be put on hold for a while.

However, the fact remains that some type of health insurance is now potentially available to nearly all of Hawaii's residents. Variability in benefits, and whether all persons in fact have health insurance, of course remain as issues.

## Health Insurance in Hawaii

### The Extent of Health Insurance Coverage

The Hawaii Medical Service Association estimated that, at the beginning of 1992, approximately 80 percent of Hawaii's residents were covered by private health insurance (including approximately 15,000 enrollees in the first full operating year of SHIP, see below), approximately 10 percent by Medicare, about 7-8 percent by Medicaid, and between 2-3 percent remained uninsured (table 1 ) (20).

The private health insurance market is dominated by two carriers, HMSA and Kaiser Permanence, with HMSA estimating that in 1991 **it covered about 54 percent** of the resident population; Kaiser Permanence, about 16 **percent; and 10 percent, by other private health insurance carriers.**

Not surprisingly, it is difficult to gauge how precise these estimates are of health insurance coverage for Hawaii's residents. HMSA estimated that its 620,000 enrollees represented 54 percent of Hawaii's resident population (20). This estimate that HMSA insures 54 percent of the resident population must be based on the total resident population in Hawaii, The 1990 U.S. Census count of Hawaii's population was 1,108,229, **of which 55,333 were armed forces personnel, and 59,935 were** military dependents. Thus, the non-military-related resident population of Hawaii in

b

**Table 1**

**Distribution of Health Insurance Coverage in Hawaii, 1992**

| Source | | Percent |
|---|---|---|
| Private | | 80 |
| | HMSA:(l) | 54 |
| | Kaiser Permanence: | 16(2) |
| | Other: | 10 |
| Medicare | | 10 |
| Medicaid | | 7.5 |
| Uninsured | | - |
| | Total: | 100.00 |

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(1) Includes approximately 15,000 enrolled in the State Health Insurance Program or SHIP, directed at the "gap group" of uninsured Hawaii residents

(2) Kaiser Permanence does not offer coverage in all geographic areas of Hawaii. In those areas in which coverage is offerred, the organization estimates that it covers 21.5 percent of the population (see reference 25).

(3) This number is probably fairly "soft," as the number of uninsured is a residual figure. It might easily be anywhere from 2 to 6 percent or higher.

Source: Hawaii Medical Service Association, Honolulu Advertiser, page A7, February 7, 1992.

1990 was 992,961 (8). HMSA'S 1992 enrollment of 620,000 would be 56 percent of the total population, 55 percent of the population if the 1990 Post-Enumeration Survey estimate of 1,136,000 (8) were used as the total population, and 62 percent if the non-military-related population were used.

HMSA also estimated that the Medicaid enrollment of 84,000 at the beginning of 1992 comprised 7.5 percent of Hawaii's population. Using the total population, 84,000 would be 7.6 percent. Using the non-military-related population, 84,000 would be 8.5 percent. interestingly, the Department of Health, at a recent conference, summarized the health insurance status of Hawaii's residents in the following manner, Prior to full implementation of SHIP in 1990, of 971,500 non-military-related residents, 88,3 percent were insured (presumably including Medicare and private health insurance), 6.7 percent were on Medicaid, and 5 Percent were uninsured (35). However, the average 1990 Medicaid enrollment was 73,364 (1 4), or 7.6 percent of the non-military-related population. (Note also that the non-military-related population of 971,500 that is used by the Department of Health differs from the published figure of 992,961. This difference may be due to subtracting the 18,360 residents temporarily out-of-state during the Census, as well as the institutionalized population. )

The point of this brief discussion on existing analyses of Medicaid enrollees, for which there is available data, is that estimating enrollment in private insurance plans is ineluctably more difficult. To illustrate, the author attempted to survey private insurance carriers, to estimate the number of Hawaii residents with private health insurance, and the demographics and utilization patterns of the privately insured. Besides HMSA and Kaiser, the dominant underwriters in Hawaii, the names of 17

other insurance carriers which were reported to underwrite health insurance in Hawaii were obtained from the State Health Insurance Program. Of these 19 carriers, one was no longer in Hawaii, 7 did not underwrite health insurance in Hawaii, and the remaining 11 did underwrite health insurance in the state, ranging from a few hundred clients to the approximately 620,000 clients reported by HMSA as enrolled in its various plans in 1991, **However, most of the companies who did underwrite insurance in Hawaii stated that they would not be able to provide information, as their** data were aggregated at either a regional (e. g., the western U. S.) or national level. Moreover, some insurers who did not underwrite health insurance in Hawaii (for example, they underwrote disability and/or life insurance) stated that they knew there were Hawaii residents covered by their companies, but through central health insurance policies with the Hawaii employees' parent companies' "mainland" headquarters (for example, a hotel chain), and that there was no way these policies could be identified.

An interesting fact uncovered in this attempted survey was that, because both the husband and wife were employed in many families, there was a significant amount of double coverage of the workers' dependents.[3] **(One** insurer estimated that as much as 10 - 15 percent of its enrollees were double covered (25). ) This double-coverage situation is not crucial to estimat ng the number of insured and uninsured in

[3] **In these situations, the "birthday rule" is applied, under which the health plan of the employee with the earliest birthday in the year, regardless of their comparative age, would be billed for dependent care. For example, suppose we have a family with one child and both the husband and wife were employed for *20* or more hours per week, but for different employers, and both employers provided health insurance for both their employees and their dependents. Suppose further that the husband's birthday is in March, and the wife's, in July. If their child becomes ill and incurs a medical bill, the health plan of the husband would be billed. Among all such double-covered families, the impact on their employers will be equitably distributed by the "birthday rule. "**

Hawaii, except to the extent that estimates of the insured are inflated by these double-coverage situations.

If various sources cannot agree on the number of people in the denominator, nor identify all potential sources of insurance, estimates of the number of uninsured will necessarily be "soft, " because the number of uninsured is the residual number after estimates of the insured have been attempted,

Mandatory, Employment-Based Health Insurance

We turn next to HPHCA, the mandatory, employment-based health insurance legislation enacted by the Hawaii state legislature in 1974, and which is the foundation of Hawaii's health insurance system.

HPHCA, under which employees are provided health insurance through the private firms identified above, has been succinctly described by Trauner and Crichlow of Coopers & Lybrand, the firm hired by the Department of Health to design the benefit package for SHIP, the "gap group" legislation enacted in 1989:

> The Prepaid Health Care Act, enacted in 1974, set specific benefit, eligibility, and contribution requirements for Hawaii's employer-sponsored health benefit plans. Health plans must include at least 120 days of inpatient hospital coverage per year, outpatient hospital, and emergency room care; surgical, medical, and diagnostic services; and maternity benefits for individuals covered for at least nine months prior to delivery (citation omitted) . . .
>
> The only permissible exemptions to the Prepaid Act are for "new hires" (employed less than four consecutive **weeks),** part-time employees (employed less than 20 hours per week), low-pay employees (those with monthly earnings of less than 86.67 times the minimum wage), and certain categories of workers (i. e., governmental, seasonal, commission-only, and self-employed) (citation omitted). All health plans offered in the state are subject to regulatory approval and, depending upon their benefit structure, are classified as Type A (comprehensive) and Type B (less comprehensive) plans.

When the Prepaid Act was enacted, the requirements for Type A plans were modeled on the prevailing benefit packages offered by Hawaii Medical Services Association (HMSA) and Kaiser Foundation Health Plan (KFHP). “HMSA Plan 4“ and “Kaiser Plan B“ were viewed as “prevailing” plans because they had the largest number of subscribers of any programs in the state. These two plans continue to be the dominant plans in Hawaii, covering a majority of the state’s residents under age 65. The general benefit structures of these plans have essentially been maintained since 1974. Carriers have taken the initiative to incorporate cost containment measures into their state-approved plans, including preferred provider arrangements and utilization review. For example, HMSA’S most prevalent Type A plan (HMSA Plan 4) requires preauthorization for certain surgical procedures and substance abuse treatments.

HMSA’S basic plus major medical plan offers 100% coverage for eligible charges related to the first 150 days of inpatient hospitalization; 100°/0 coverage for eligible surgical services; and 8070 coverage for certain other physician, medical, and diagnostic services. The major medical portion has a **$250 calendar year deductible and a $2,500 annual out-of-pocket maximum (including the deductible). KFHP’s plan offers prepaid health maintenance organization** (HMO) benefits for covered inpatient and outpatient services, with members having a $4 copayment for each medical office or emergency room visit.

Under the Prepaid Act, Type B plans offer reduced coverage, such as comprehensive plans with up-front deductibles and pre-existing condition clauses. However, few employers have elected to offer Type B indemnity/service plans because of the contribution formula built into the Prepaid Act.

Whether an employer offers a Type A or Type B plan, the Prepaid Act requires that the employer pay at least one half of the premium for employee-only coverage. Moreover, the Act limits each employee’s out-of-pocket premium cost for employee-only coverage to 1.5% of wages. There is no required employer contribution for dependent coverage for Type A plans, whereas for Type B plans, the employer must pay 50% of the cost, Today, the 1.5?% cap on employee-only costs means that the employer usually pays most of the cost of employee-only coverage, particularly for low-income employees. Because there is a relatively narrow spread in premium costs between Type A and B plans, most employers offer Type A plans. Accordingly, those employers with Type A plans who do not choose to pay for dependent coverage are not subject to the 50% contribution rule.

For example, small group rates under HMSA’S Plan 4, effective in April 1991, are $107.76 for a single, $215.52 for two-party coverage, and $323.28 for family coverage. Under HMSA’S Plan 9, an 80/20 Type B plan, small group rates are $94.52 for a single, $189.04 for two-party coverage, and $283.56 for family coverage. Under Plan 4 and Plan 9, the maximum contribution that

a clerical employee, earning $1,500 monthly, **would** pay for a single coverage is $22.50 per month. Therefore, the minimum employer contribution for single coverage under Plan 4 would be $85.26 and $72.02 under Plan 9. However, the added $13.24 that an employer pays for single-only coverage under Plan 4 is significantly less than the incremental cost for family coverage under plan 9 (i.e., 50$% of the family premium less the cost for single **coverage) (36).**

A voluntary community rating system is also applied, under which small businesses (under 100 employees) are consolidated into a larger risk pool, at premium rates the state director of health estimates average 50 percent less than rates of other states (26).

Finally, HPHCA has two penalties for noncompliance: 1 ) the employer is liable for the health care costs incurred by an eligible employee during the period which the employer fails to provide coverage; and 2) a noncomplying employer can be fined and enjoined from conducting business. A 1991 review of Hawaii Department of Labor and Industrial Relations reports by the contractor evaluating SHIP for the Department of Health could find no significant violations nor use of the subsidy provision (4).

Hawaii's Medicaid Program

Hawaii's Medicaid program is available to residents with incomes equal to or less than 62.5% of the federal poverty level (FPL), and with assets of less than $2,000 for one person, $3,000 for a family of two, and **$250** for each additional family member. In addition, recent expansions have included children age 6 and older but under age nineteen (but only children born after September 30, 1983, are eligible), the aged and the disabled, who are eligible if their (or their parent or guardian) incomes are equal to or less than 100 percent of the FPL; children age 1 through 5 (expanded to age 8), if income is equal to or less than 133 percent of the FPL; and

pregnant women and children under age 1, if income is equal to or less than 185 **percent of the FPL (table 2) (1 5).**

**The Hawaii Medicaid benefits package is summarized in table 3.**

**In January 1992 there were 84,744 enrollees** in the Medicaid program, while there were 178,417 persons enrolled during the course of calendar year 1991. Based on claims paid during the period April 1, 1991 through March 31, 1992, the unduplicated recipient counts total led 67,868 (16). Thus, about twice the number of enrollees on a given day were enrolled at one time or another during the course of the year, and about 2 of every 5 enrollees who were enrolled at any time in 1991 utilized medical services in 1991. In table 4 are identified: 1 ) the average 1990 enrollment; 2) the enrollment on January 1992, the total number of enrollees in calendar year 1991, and the number of enrollees who utilized services (based on claims paid during the period April 1, 1991 through March 31, 1992);' and 3) the estimated average enrollment for 1992.

The distribution of Medicaid enrollees by island is summarized in table 5. The percent of total Medicaid recipients for the islands of Hawaii (12.1 percent) and Moiokai (1 9.1 percent) markedly exceeded the statewide average (6.5 percent).

Because of expanded OBRA options affecting pregnant women with children, children, the elderly, and the disabled (see above), 22,000 enrollees have been added to the Hawaii Medicaid program between 1988 and 1992. (Some of this added enrollment is also due to the implementation of SHIP, in which applicants who may be eligible for Medicaid are referred there (see discussion below). )

The added enrollments (increasing from more than 73,000 in 1990 to nearly 85,000 **in January 1992, and to an estimated 89,000 at** the end **of 1992 -- see table**

## Table2

### Eligibility for Hawaii's Medicaid Program

| Category | Income Limit Percent of Federal Poverty Level (FPL) | Asset Limit |
|---|---|---|
| General | < or = 62.5% of FPL | $2,000 for one person$3,000 for family of two; $250 for each additional family member |
| Children age 6 but under age 19, the aged, and the disabled | < or = 100% of FPL | |
| Children age 1 through age 5 | < or = 133% of FPL | |
| Pregnant women and children under age 1 | < or = 165% of FPL | |

Source: Family & Adult Services Division, Hawaii Department of Human Services

**Table 3**

## Hawaii Medicaid Benefits Package

**Pays for the following services:**

- Inpatient hospital services
- Outpatient hospital and clinic services
- Physicians' (including osteopathic) services
- Skilled nursing facility services
- Intermediate care facility services
- X-ray and laboratory examinations
- Drugs, biological and medical supplies
- Podiatry (foot care)
- Whole blood
- Home health services
- Medical equipment and appliances
- Eye examinations, refractions and eye glasses
- Dental services
- Family planning services
- Diagnostic, screening, preventive and rehabilitative services
- Prosthetic devices, including hearing aids
- Transportation to, from, and between medical facilities. This includes interisland or out of state air transportation, food, and lodging as necessary
- Hospice care
- Psychological services
- Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) services

**As an alternative to institutional care, the chronically ill and disabled may receive:**

- Adult day health
- Case management
- Emergency alarm response system
- Environmental modification
- Habilitation
- Home-delivered meals
- Home maintenance
- Homemaker
- Moving assistance
- Nutritional counseling
- Personal care
- Respite
- Skilled nursing (emergency/24 hour)
- Transportation

**Hawaii Medical Benefits Package, Table 3 (continued)**

**Does not pay for the followig services:**

**Naturopathic, chiropractic and Christian-Science services**
**Priviate duty nursing**
**Cosmetic surgery**
**Unapproved drugs and medical procedures of an experimental nature**
**Personal comfort items such as radio, television or telephone**
**Orthodontic services and fixed bridgework**
**Certain vitamins and vitamin mixtures**
**Acupuncture**

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**Source:** **Family & Adult Services Division, Hawaii Department of Human Services**

## Table 4

## Hawii Medicaid Enrollees, 1990-1992

**1990:** Average enrollment: 73,364

**1991 :** Number of enrollees in January 1992: 84,744

Number of enrollees in Calendar Year 1991: 178,417
Number of enrollees who utilized services,
based on claims paid during the period
4/1/91-3/31/92: 67,868

**1992:** Average enrollment (estimated): 89,000

**Note: Since 1988, the Deparment of Health states that 22,000 persons have been added to the Medicaid roles because of OBRA options affecting pregnant women with infants, children, the elderly, and the disabled.**

**Source: Hawaii Department of Human Services, Health Care Administration Division**

Table 5

## Hawaii Medicaid Program
## Eligible Medicaid Recipients and State Population
## by Island, Fiscal Year 1990 Averages

| Island | Recipients | % Total Recipients | State Population Estimated Population | % State Population | % Population that are Recipients |
|---|---|---|---|---|---|
| Hawaii | 14,527 | 19.8 | 120,169 | 10.6 | 12.1 |
| Kauai | 3,097 | 4.2 | 50,003 | 4.4 | 6.2 |
| Lanai | 52 | 0.1 | 2,311 | 0.2 | 2.3 |
| Maui | 3,399 | 4.6 | 85,190 | 7.5 | 4.0 |
| Molokai | 1,343 | 1.8 | 7,038 | 0.6 | 19.1 |
| Oahu | 50,946 | 69.5 | 872,489 | 76.7 | 5.8 |
| Total | 73,364 | 100.0 | 1,137,200 | 100.0 | 6.5 |

Source: Hawaii State Department of Human Services, Health Care Administration Division.

4) led to a large shortfall in Medicaid's 1991-1992 budget. During the 1992 state legislative session, it was estimated that there would be a $142 million two-year deficit, and that funds would be depleted by February 1992 unless $64 million was provided to cover the period between February and July 1, 1992 (the state's fiscal year is July 1 through June 30). The $64 million was appropriated by the state legislature, and discussions on the deficit led the legislature to consider -- but not implement -- freezing eligibility at the 1991 federal poverty level (instead of increasing it to the 1992 level). One mitigating factor in not freezing the federal poverty level cutoff for Medicaid eligibility, was that the Medicaid ineligibles would then be eligible for SHIP (2). This switch from Medicaid to SHIP would have cost the state more, because the Medicaid cutoff is at 62.5 percent of the federal poverty level, and SHIP enrollees with incomes equal to or below 100 percent of the federal poverty level have no premium payments, with the state picking up all costs. Benefits to enrollees would also have been reduced, because SHIP benefits are more limited than Medicaid benefits (see below).

The 1992 Medicaid budget is estimated at $360 million; up from $214 million in 1990.

Table 6 summarizes claims paid by type of service for the period July 1, 1989 to June 30, 1990. Hospital inpatient care accounted for 24.6 percent of total payments; nursing home and intermediate care facilities, for 37.0 percent; and physician services for 14.2 percent.

Table 7 compares average benefits paid per recipient by type of service for the years 1988, 1989, and 1990. The costs of average benefits increased 7.7 percent between 1988 and 1989, and 8.8 percent between 1989 and 1990. Notable

## Table 6

**Hawaii Medicaid Program**
**Claims Paid by Type of Service**
**July 1, 1989 to June 30, 1990, Cash Payment**

| Service | Claims(1) | % of Total | Benefits | % of Total |
|---|---|---|---|---|
| Hospital Inpatient | 19,483 | 1.1 | $52,667,437 | 24.6 |
| Nursing Home Care | 9,815 | 0.6 | 16,683,972 | 7.8 |
| Intermediate Care Facility | 32,920 | 1.9 | 62,504,135 | 29.2 |
| Physician Services | 613,796 | 36.1 | 30,369,969 | 14.2 |
| Other Practitioners(2,3) | 32,029 | 1.9 | 2,518,709 | 1.2 |
| Dental Services | 86,637 | 5.1 | 6,417,098 | 3.0 |
| Hospital Outpatient(4) | 92,701 | 5.4 | 11,352,098 | 5.3 |
| Lab & X-ray | 125,974 | 7.4 | 4,893,720 | 2.3 |
| Home Health | 1,661 | 0.1 | 753,174 | 0.4 |
| Drugs(3) | 613,876 | 36.1 | 16,739,836 | 7.8 |
| Other Care(3,5) | 45,409 | 2.7 | 7,042,125 | 3.3 |
| Family Planning | 15,480 | 0.9 | 899,922 | 0.4 |
| Screening Services – | 11,998 | 0.7 | 1,064,106 | 0.5 |
| Total Net | 1,701,779 | 100.0 | 213,906,301 | 100.0 |
| Patient's share of medical bill | | | 12,481,416 | |
| Expenses covered by Patient's Medical Insurance &-Other Third Parties | | | 5,456,131 | |
| TOTAL GROSS BENEFITS | | | $231,843,848 | |

(1) A claim refers to a document submitted for payment and may consist of multiple service lines
(2) Includes services by optometrists, podiatrists, & psychologists
(3) Includes nursing home and intermediate care ancillary services
(4) Includes hospital clinic services
(5) Includes vision care, medical supplies, transportation, etc.

Source: Hawaii State Depatiment of Human Services, Health Care Administration Division

## Table 7

### Hawaii Medicaid Program
### Comparison of Average Benefits Paid Per User(1)
### Fiscal Years 1988 Through 1990, Cash Payments

| Service | IV 1988 | W 1989 | % Increase (Decrease) | FY 1990 | % Increase (Decrease) |
|---|---|---|---|---|---|
| Hospital Inpatient | $3,245 | $3,462 | 6.7 | $3,654 | 5.5 |
| Nursing Home | 12,357 | 11,684 | ( 5.4) | 12,313 | 5.4 |
| Intermediate Cafe | 16,652 | 17,041 | 2.3 | 17,935 | 5.2 |
| Physician Services | 301 | 323 | 7.3 | 299 | ( 7.4) |
| Other Practitioners(2,3) | 199 | 203 | 2.0 | 206 | 1.5 |
| Dental Services | 176 | 177 | 0.6 | 170 | ( 4.0) |
| Hospital Outpatient(4) | 288 | 319 | 10.8 | 323 | 1.3 |
| Lab & X-ray | 81 | 85 | 4.9 | 85 | 0.0 |
| Home Health | 1,030 | 819 | ( 20.5) | 1,016 | 24.1 |
| Drugs(3) | 165 | 180 | 9.1 | 201 | 11.7 |
| Other Care(3,5) | 467 | 529 | 13.3 | 479 | ( 9.5) |
| Family Planning | 146 | 152 | 4.1 | 163 | 7.2 |
| Screening Services | 56 | 64 | 14.3 | 132 | 106.3 |
| Total | $1,607 | $1,730 | 7.7 | $1,863 | 8.8 |

(1) Eligible recipients utilizing services in specific category of service
(2) Includes services by optometrists, podiatrists, & psychologists
(3) Includes nursing home and intermediate care ancillary services
(4) Includes hospital clinic services
(5) Includes vision care, medical supplies, transportation, etc.

Source: Hawaii State Department of Human services, Health Care Administration Division.

increases occurred in screening services, with an increase between 1988 and 1989 of 14.3 percent, increasing sharply by 106.3 percent between 1989 and 1990.

Table 8 compares benefits paid by type of service for the years 1988, 1989, and 1990. An increase of 4.2 percent occurred between 1988 and 1989; rising to 16.6 percent between 1989 and 1990. Again, there were sharp increases in screening services: 6.1 percent between 1988 and 1989, increasing to 218.7 percent between 1989 **and 1990.**

State Health Insurance Program (SHIP): Hawaii's "Gap Group" Insurance Program

In 1988 **- 1989 the stage was set for enactment of** SHIP with the election of a new governor, the appointment of a new state director of health, a large state budget surplus, increasing national attention to the large number of people without health insurance (the "gap group"), and the successful precedent of HPHCA.

The Department of Health considered six options:

1. Include the uninsured in HPHCA. However, this course was not available without express exemption from ERISA by the U.S. Congress.

2. Establish a state-subsidized uncompensated care fund to reimburse hospitals for services to the uninsured. However, such a fund would not ensure access to services nor provide preventive and/or ambulatory care services.

**3. Expand the Medicaid program to cover the uninsured.** However, the Hawaii Medicaid benefits package was comprehensive, and costs would be high.

4. Establish a subsidized insurance program for unemployed workers, under the Consolidated Omnibus Budget Reconciliation Act (COBRA) of 1985 (P. L. 99-272). However, only a small portion of the uninsured would be covered.

## Table 8

### Hawaii Medicaid Program
### Comparison of Benefits Paid by Type of Service
### Fiscal Years 1988 Through 1990, Cash Payments

| Service | FY 1988 | FY 1989 | % Increase (Decrease) | FY 1990 | % Increase (Decrease) |
|---|---|---|---|---|---|
| Hospital Inpatient | $43,794,555 | $44,821,076 | 2.3 | $52,667,~7 | 17.5 |
| Nursing Home | 15,569,413 | 15,223,729 | ( 2.2 ) | 16,683,972 | 9.6 |
| Intermediate Care | 48,189,511 | 52,009,240 | 7.9 | 62,504,135 | 20.2 |
| Physician Services | 26,138,617 | 26,733,6= | 2.3 | 30,369,969 | 13.6 |
| Other Practitioners(l ,2) | 1,794,987 | 2,154,752 | 20.0 | 2,518,709 | 16.9 |
| Dental Services | 6,806,050 | 6,374,597 | ( 6.3 ) | 6,417,098 | 0.7 |
| Hospital Outpatient(3) | 9,050,453 | 9,985,753 | 10.3 | 11,352,098 | 13.7 |
| Lab & X-ray | 4,383,543 | 4,400,073 | 0.4 | 4,893,720 | 11.2 |
| Home Health | 554,222 | 503,129 | ( 9.2 ) | 753,174 | 49.7 |
| Drugs# | 12,990,031 | 13,967,765 | 7.5 | 16,739,836 | 19.8 |
| Other Care(2,4) | 5,681,559 | 6,264,412 | 10.3 | 7,042,125 | 12.4 |
| Family Planning | 801,341 | 738,401 | ( 7.9 ) | 899,922 | 21.9 |
| Screening Services - | 314,81O | 333,911 | 6.1 | 1.064,106 | 218.7 |
| Total | $176,069,092 | $183,510,521 | 4.2 | $213,906,301 | 16.6 |

(1) Includes services by optometrists, podiatrists, & psychologists
(2) Includes nursing home and intermediate care ancillary services
(3) Includes hospital clinic services
(4) Includes vision care, medical supplies, transportation, etc.

Source: Hawaii State Department of Human Services, Health Care Administration Division.

5. Provide direct services through the Department of Health. However, this would mean establishing a new health care system for the uninsured.

**6.** Develop a subsidized health insurance program for the uninsured, based on income and family size and a special benefit package, This was the option pursued (4),

The strategy for the new gap group insurance program was as follows:

> The Department of Health recommended a combination of approaches. First, a subsidized insurance program emphasizing access to preventive and primary care should be offered to Hawaii's gap group. Second, Medicaid should be expanded to include pregnant women and children from zero to six years of age in accordance with federal OBRA provisions.[4] This latter step would provide coverage for children and pregnant women in families with incomes as great as 100 percent of the Federal Poverty Level and, in addition, would provide presumptive eligibility to allow care prior to actual certification of eligibility. Third, any approach should have the flexibility to adopt other Medicaid options that might, in the future, become available and be more cost-effective than the State Health Insurance Program. Finally, the new approach should be linked with prepaid health care, Medicaid, and hospitals to provide an integrated program to ensure that care needs are met and that beneficiaries do not fall into any remaining gaps (4).

In the 1989 **legislative session, SHIP was passed and signed into law by the** Governor on June 26, 1989 (see attachment A for the full text of the Act) (19)

One of the premises of the SHIP legislation was that the uninsured population in Hawaii was approximately 5 percent of the civilian population, or approximately **50,000 individuals.** SHIP, which was to be administered by the Department of Health (HPHCA is administered by the Department of Labor and Industrial Relations, and the Medicaid program, by the Department of Human Services), had the following expressed goals:

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[4] **As described above in the section on Hawaii's Medicaid program, this provision was implemented.**

1) subsidized health care coverage for gap group individuals, including but not necessarily limited to outpatient primary and preventive care;

2) encouraging the uninsured who can afford to participate in existing health plans to seek that coverage;

**3) discouraging individuals who are already adequately insured from seeking benefits under the state health insurance program;**

4) assuring that those persons who have the ability to pay for all or part of their coverage **be** appropriately assessed by the contractors on a sliding fee scale basis; and

5) ensuring that the state health insurance program is affordable to gap group individuals.

SHIP was signed into law on June 26, 1989. The advisory committee called for by the Act first met on June 28, 1989, and Coopers & Lybrand was hired as the consultant to turn the Act into an operating program (10). Six subcommittees were established within the Advisory Committee, with the following deadlines: 1 ) Rates and Benefits Committee, deadline of August 14, 1989; 2) Eligibility Committee, deadline of August 14, 1989; 3) Delivery System and Payment Committee, deadline of September 15, 1989; 4) Administration/Data/Interrelationship Committee, deadline of September 15, 1989; 5) Evaluation Committee, deadline of January/March 1990; and 6) Marketing Committee, deadline of January/March 1990 (9).

Three issues dominated the deliberations among the Advisory Committee, Coopers & Lybrand, and the Department of Health: 1 ) the size of the gap group and the information available to determine its size, its demographics, and its utilization of health services; 2) which providers currently served the gap group and under what

terms they would be willing to participate; and 3) under what terms would health care payers consider negotiating with the state to participate (10).

To estimate the size of the gap group, case load information from health care providers, surveys conducted in Hawaii, and nationally based estimates that included state-by-state estimates were reviewed. Methodological problems were encountered in all sources, and the Department of Health ended up using its original estimate of 5 percent as its starting **point (1O).**

**Information was sought from the largest hospitals** in Hawaii on the amount of uncompensated care they provided, but most hospitals could only provide information on "self pay" patients, without separating out the uninsured or with detailed diagnostic information on the uninsured. Thus, the hospital information could not be used to determine how to structure and price SHIP'S inpatient benefits (10).

Primary care centers were also requested to provide information on their patients, including estimates of the uninsured. This data did not allow for prediction Of utilization for the uninsured nor for pricing of services on an age-adjusted basis (10).

Finally, it was not possible to determine the cost of providing specific services from HMSA and Kaiser Permanence data because of technical and processing expense limitations; and for time and expense reasons, it **was decided not to use detailed claims and eligibility data for the Medicaid population to project utilization and costs** for SHIP (10).

Thus, it was determined that the carriers/health maintenance organizations would price their own services, using the proposed state contribution per SHIP eligible

and a minimum set of benefits, and providing supporting information on their actuarial assumptions ( 1 O).

The state legislature provided $14 million for the first two years of SHIP operations ($4 million in the first year and $10 million in the second year). The **Department of Health decided on an average state subsidy of $500/person/year, with a maximum expected enrollment of approximately 20,000** in the 1990-1991 fiscal year (July 1990- June 1991 ). Additional program income from premium copayments was estimated at approximately 15 percent of total premiums, which was expected to be more than offset by administrative and overhead costs (10).

**A sliding premium scale was adopted, with premium contributions required of families with incomes more than 100 percent of the federal poverty level, and with eligibility up to 300 percent of the federal poverty** level.

The eligibility requirements and monthly member contributions for fiscal years 1990 and 1991 are contained in tables 9 and 10. The members' contributions are the same regardless of sex. In 1992, the highest annual income level for **SHIP participation (at 300 percent of the federal poverty level for Hawaii) was $20,592** for **one person, and $41,760 for a family of four (35).**

**A** particularly problematic issue in designing SHIP'S benefits package was the scope of inpatient services to be covered. The final decision was to limit hospital reimbursement to no more than 20 percent of SHIP'S medical expense budget, excluding direct provider grants, Department of Health funded services, and any transfer of funds to other state agencies. Per enrollee, the hospital benefit was limited to no more than five days, predicated on a maximum inpatient benefit for fiscal years

## Table 9

## State Health Insurance Program: Eligibility Requirements

**In order to be eligible or to maintain enrollment in SHIP, an individual shall:**

(1) Be a resident of Hawaii;

(2) Have a gross family income at the time of application that does not exceed 300% of the Federal poverty for Hawaii, as adjusted for family size and as annualy determined by the U.S. Deparment of Health and Human Services;

(3) Not be eligible for any United States government sponsored program which provides for health care benefits including but not limited to Medicaid, Medicare, or CHAMPUS whether or not application for such program has been made (an exception shall be made for persons eligible for benefits under the Native Hawaiian Health Care Act);

(4) Be unemployed or not have been eligible for benefits under the Hawaii Prepaid Health care Act as a regular employee or enrolled as a legal spouse of a regular employee during the three months prior to the date of enrollment application. Children under age 19 of regular employees may be eligible for SHIP at the Director's discretion if the additional enrollment of such children would not jeopardize the orderly development of SHIP or would not result in an over-appropriation of SHIP funds; or

(5) Not have been covered by a private health insurance policy (excluding disease-specific and accident-only policies) for three months prior to application for enrollment in SHIP. An exception shall be made for individuals who become unemployed during the three month period occurring prior to the date on the enrollment application.

Source: Hawaii Department of Health, State Health Insurance Program (SHIP), "Request for Proposal," February 5, 1990.

## Table 10

### State Health Insurance Program,
**Monthly Member Contributions**
**Fiscal Years 1990 and 1991**

| Federal Poverty Level | Adult | Child |
|---|---|---|
| 100% or less | $0 | $0 |
| 101% - 125% | $10 | $5 |
| 126% - 150% | $15 | $7.50 |
| 151% - 200% | $20 | $10 |
| 201% - 250% | $40 | $15 |
| 251 % - 300% | $60 | $20 |

There may be a cap on the number of children per family for whom member contributions shall be made; in no event shall the monthly family contribution exceed: 1) two times an adult subscriber's monthly member contribution, plus two times a dependent child's member contribution, or 2) three times a dependent child's member contribution for families in which only the dependent children are enrolled. In cases of economic hardship, the Director reserves the right to limit the initial member contribution to one times the monthly member contribution. SHIP will assume financial responsibility for payments in excess of the member cap set by family size.

SHIP shall annually establish a maximum service copayment rate for office visits, emergency room visits, and in the future, possibly for hospitalizations. For fiscal years 1990 and 1991, the copayment per office visit shall not exceed $5 and for an emergency room visit, for other than trauma or conditions requiring hospital admissions, a charge of $25.

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Source: Hawaii Department of Health, State Health Insurance Program (SHIP), "Request for Proposal," February 5, 1989.

1990 and 1991 of $2,500/enrollee/calendar year ($50() for each inpatient day), plus an additional two days of inpatient maternity care per normal delivery ( 11 ).

The Request for Proposal was issued by the Department of Health *on* February 5, 1990, with a proposal deadline of March 5, 1990, Only HMSA and Kaiser Permanence responded. HMSA designed its benefits package: 1 ) by starting with a package commensurate with $200/month per enrollee, then designing it down to benefits commensurate with $60/month per enrollee; and 2) designing a hospitalization benefit consistent with the limit of $500/day for five days (26), Kaiser Permanence decided to offer a benefits package similar to its regular enrollees, but to limit enrollment to the amount that could be subsidized by its dues subsidies program (a portion of members' dues revenues is allocated by each region to support the medically uninsured and underinsured) (6). (The HMSA and Kaiser Permanence 1991 benefits package are summarized in Attachments B and C.)

HMSA initiated enrollment in June 1990, and Kaiser Permanence, in August **1990. The initial HMSA provider reimbursement rates were lower than** for providers participating in their standard plans. In 1991 **HMSA increased payment levels to that** of their other plans to increase provider participation, and in part because of low 1990 utilization rates, which also led HMSA to reduce premium rates by 14 percent, and to increase benefits to include some mental health outpatient care, antibiotics for children, and annual pap **smears** for all women of child-bearing age (13).

As mentioned above, Kaiser Permanence chose to participate by offering the same benefits package to SHIP enrollees as for their regular enrollees,[5] but to limit

[5] **Because of the SHIP requirement of a copayment of $5 per outpatient visit, SHIP enrollees pay $1 more for an outpatient visit than most regular Kaiser Permanence enrollees.**

**SHIP enrollment to its members on Oahu (Kaiser Permanence has outpatient but not inpatient facilities on the islands of Maui and Hawaii) who either lose eligibility for Medicaid or become unemployed and are canceled by their employer group (12), and** to limit enrollment to 1,000. The costs of its SHIP clients would be offset in part by the Kaiser Foundation Health Plan's dues subsidies program.

In November 1990, the original eligibility criteria established in August 1990 was expanded to include members in the Kaiser Permanence Service Area of the Hawaii Region who lost Medicaid or employment-based coverage, and in addition, dependents of Kaiser Permanence subscribers who have not been covered by medical **insurance for at least three months prior to application to SHIP and the subscriber's** employer does not contribute to the cost of the dependent's medical coverage. In addition, during open enrollment periods, applicants had the opportunity to elect coverage by Kaiser Permanence (23). However, within two months, Kaiser Permanence had to restrict its SHIP enrollees to Oahu, because of insufficient provider **capacity on Maui and Hawaii (25).**

**In 1991 Kaiser Permanence increased its SHIP premiums by 14.45 percent, and increased the maximum number of** SHIP **members** for 1992 to 3,500 **(13), which it** attained in April 1992 **(25).**

**Finally, at the beginning of 1992,** in addition to HMSA and Kaiser Permanence, another provider, Island Care, in response to another Request for Proposal, submitted **a proposal** to provide managed care benefits to a limited number of SHIP members on **Oahu and** Kauai through its participating facilities (1 3).

During 1990 and 1991, SHIP also contracted with five primary care clinics on Oahu to provide health assessments (at a rate of $75 per assessment) for any

potential SHIP enrollee who submits an application to SHIP. This agreement was expanded in October 1990 to also include a $50 capitated fee to provide health services at the clinic for each individual for up to 60 days while their application was being processed (1 **3). In 1992 a new contract** was signed to reimburse the clinics for episodic care of uninsured clients (those for whom insurance doesn't work, such as the migrant, homeless, etc. ) and the administration of an uninsured client survey from which SHIP will then analyze demographic and utilization data. This latter survey is one of several studies designed to examine "the impacts of uncompensated care at the primary care level and the 'hard to reach uninsured, ' the gap within the gap" (13). For the period January 1992 through June 1993, $1 million of the state appropriations for SHIP is to be provided to the six primary care clinics for direct services, using cost-based reimbursement similar to the provisions for Medicaid reimbursement for Federally Qualified Health Centers (3).

At the end of 1991, there were nearly 15,000 SHIP members, with about four of five enrolled with HMSA, and one-fifth with Kaiser Permanence. Monthly membership for calendar year 1991 is presented in table 11, and the number of SHIP members serviced from the onset of operations in June 1990 through December 1991 is presented in table 12.

Enrollment continued to increase over the intervening months. Kaiser Permanence, which had 2,739 SHIP members at the end of 1991, reported that it had reached its maximum enrollment of 3,500 in April 1992 (25), and the total SHIP enrollment had exceeded 15,000 by March 1992 (35).

For policy and budget reasons, SHIP has also transferred some of its funds to other programs. In the first year of operations, SHIP funds were transferred to the

## Table 11

## SHIP Membership by Month
## Calendar Year 1991

| Period | HMSA | Kaiser Permanence | Total | Change | Percent Change |
|---|---|---|---|---|---|
| Jan. '91 | 7,703 | 711 | 8,414 | 793 | 10.56 |
| Feb. '91 | 8,270 | 933 | 9,203 | 789 | 9.38 |
| Mar. '91 | 8,661 | 1,078 | 9,739 | 536 | 5.82 |
| Apr. '91 | 9,060 | 1,176 | 10,236 | 497 | 5.10 |
| May '91 | 9,363 | 1,268 | 10,631 | 395 | 3.86 |
| Jun. '91 | 9,917 | 1,531 | 11,448 | 817 | 7.69 |
| Jul. '91 | 10,333 | 1,828 | 12,161 | 713 | 6.23 |
| Aug. '91 | 10,745 | 2,025 | 12,770 | 609 | 5.01 |
| Sep. '91 | 11,135 | 2,186 | 13,321 | 551 | 4.31 |
| Oct. '91 | 11,277 | 2,298 | 13,575 | 254 | 1.91 |
| Nov. "91 | 11,519 | 2,529 | 14,048 | 473 | 3.48 |
| Dec. '91 | 11,828 | 2,739 | 14,567 | 519 | 3.69 |

Source: Hawaii Department of Health, 'State Health Insurance Program, Report to the Legislature," January 1992.

## Table 12

### SHIP Members Serviced
### Total, as of December 31, 1991

| | |
|---|---|
| HMSA Active Members | 11,828 |
| Kaiser Permanence Active Members | 2,739 |
| SHIP/Medicaid Expansion Program(l) | 722 |
| Disenrollments(2) | 3,048 |
| Capitated Seevices & Assessments(3) | 4,653 |
| Total: | 22,990 |

(1) Children under age 8 who were enrolled in Medicaid under expansion options, through the use of funds which were transferred by SHIP to Medicaid.
(2) Includes members who were disenrolled dueto employment, non-payment of dues, etc.
(3) Through contracts with primary care clinics. 1,166 were health appraisals, at $75 each, and 2,492 were for services for upp to 60 days while applications were being processed, at $50 each.

Source: Hawaii department of Health, 'State Health Insurance Program, Report to the Legislature," January 1992.

Medicaid program to finance the addition of 722 children under age 8 in the Medicaid expansion program (see **table 12), with Medicaid picking up** the costs in subsequent years. And as described above, contracts have been signed with the state's six primary care clinics for capitated services and assessments (see table 12), and $1 million is being provided to the six primary care clinics for direct service subsidies in the period January 1992 **through June 1993.**

**Various characteristics of** the **SHIP enrollee population are summarized** in tables 13- 17.

Excluding the "other" category, of the state's ethnic populations, the largest enrollee groups are, in descending order, Whites, Hawaiians, and Filipinos. Compared to the state's ethnic distribution in the 1990 U.S. Census, Koreans are the most overrepresented among SHIP enrollees (except for "other"), followed by Hawaiians and Samoans. Japanese are the most underrepresented, followed by Blacks and Filipinos (table 13). SHIP reports that there were no significant differences in ethnic distribution by carrier ( 13).

The distribution by island is summarized in table 14. The order of enrollees in absolute numbers reflects the proportion of residents on the various islands, but Hawaii and Molokai -- and Kauai to a more modest extent -- are overrepresented in SHIP.

SHIP enrollment by age is summarized in table 15. Enrollment in the age categories O - 4 **and 5 - 17 were much higher than the proportion of the state population** in these age categories, and enrollees under age 18 represented 42 percent of the total. All of the other age groups were underrepresented, with enrollees age 65 and older particularly underrepresented. In absolute numbers, the largest

Table 13

Comparison of Ethic Distribution Between 1990 Census and State Health Insurance Program's Population

| Ethnic Distribution | 1990 Census Population | PerCentage Distribution | SHIP Active Members for Dec. 1991 | Percentage Distribution | Difference in Distribution \ |
|---|---|---|---|---|---|
| Total | 1,108,229 | 100.00 | 14,567 | 100.00 | 1.000 |
| White | 369,616 | 33.35 | 3,959 | 27.18 | .815 |
| Black | 27,195 | 2.45 | 99 | 0.68 | .278 |
| Chinese | 68,804 | 6.21 | 938 | 6.44 | 1.037 |
| Filipino | 168,682 | 15.22 | 1,583 | 10.87 | .714 |
| Japanese | 247,486 | 22.33 | 515 | 3.54 | *159 |
| Korean | 24,454 | 2.21 | 1,066 | 7.32 | 3.312 |
| Hawaiian | 138,742 | 12.52 | 3,296 | 22.63 | 1.808 |
| Samoan | 15,034 | 1.36 | 282 | 1.94 | 1.426 |
| Other | 48,216 | 4.35 | 2,829 | 19.42 | 4.464 |

(1) Percentage distribution of SHIP members divided by percentage distribution of 1990 Census population. A ratio of less than one denotes that the ethnic group is less represented among SHIP enrollees than that ethnic group is represented in the general population; a ratio greater than one denotes that more of that ethnic group is represented among SHIP enrollees than that ethnic group is represented in the general population.

Source: Hawaii State DePartment of Health, state Health Insurance Program, Report to the Legislature," January 1992.

## Table 14

### Comparison of Island Population Distribution Between 1990 Census and State Health Insurance Program

| Island Distribution | 1990 Census Population | Percentage Distribution | SHIP Active Members for Dec. 1991 | Percentage Distribution | Difference in Distributional\ |
|---|---|---|---|---|---|
| Total | 1,108,229 | 100.00 | 14,567 | 100.00 | 1.000 |
| Oahu | 836,231 | 75.46 | 8,897 | 61.08 | .809 |
| Hawaii | 120,317 | 10.86 | 3,448 | 23.67 | 2.180 |
| Maui | 91,361 | 8.24 | 1,096 | 7.52 | .913 |
| Molokai | 6,717 | 0.61 | 218 | 1.50 | 2.459 |
| Lanai | 2,426 | 0.22 | 19 | 0.13 | .591 |
| Kauai | 51,177 | 4.62 | 889 | 6.10 | 1.320 |

(1) Percentagedistribution of SHIP members divided b ypercentage distribution of 1990 Census population. A ratio of less than one denotes that the ethnic group is less represented among SHIP enrollees than that ethnic group is represented in the general population; a ratio greater than one denotes that more of that ethnic group is represented among SHIP enrollees than that ethnic group is represented in the general population.

Source: Hawaii State Department of Health, "State Health Insurance Program, Report to the Legislature," January 1992.

## Table 15

### Comparison of Age Distribution Between 1990 Census and State Health Insurance Program's Population

| Age Distribution | 1990 Census 'Population | Percentage Distribution | SHIP Active Members for Dec. 1991 | Percentage Distribution | Difference in Distribution(1) |
|---|---|---|---|---|---|
| Total | 1,108,229 | 100.00 | 14,567 | 100.00 | 1.000 |
| 0 - 4 | 83,223 | 7.51 | 1,691 | 11.61 | 1.546 |
| 5 - 1 7 | 196,903 | 17.77 | 4,438 | 30.47 | 1.715 |
| 1 8 - 2 0 | 48,549 | 4.38 | 582 | 4.00 | .913 |
| 21 -24 | 72,636 | 6.55 | 666 | 4.57 | .698 |
| 2 5 - 4 4 | 379,035 | 34.20 | 4,838 | 33.21 | .971 |
| 4 5 - 5 4 | 108,775 | 9.82 | 1,251 | 8.59 | .875 |
| 5 5 - 5 9 | 45,375 | 4.09 | 436 | 2.99 | .731 |
| 6 0 - 6 4 | 48,728 | 4.40 | 488 | 3.35 | .761 |
| 65 + | 125,005 | 11.28 | 177 | 1.22 | .108 |

(1) Percentage distribution of SHIP members divided by percentage distribution of 1990 Census population. A ratio of less than one denotes that the ethnic group is less represented among SHIP enrollees than that ethnic group is represented in the general population: a ratio greater than one denotes that more of that ethnic group is represented among SHIP enrollees than that ethnic group is represented in the general population.

Source: Hawaii State Department of Health, 'State Health Insurance Program, Report to the Legislature," January 1992.

enrollment was among those ages 25 - 44 (4,838), followed by those ages 5 - 17 (4,438), O -4 (1 ,691), and 45-54 (1 ,251).

Age by sex distribution is summarized in table 16. Females represented 55 percent of enrollees, and males, 45 percent, and females outnumbered males in every age category except for enrollees under age 1 and ages 6 - 18, although the difference was very modest.

More than 62 percent of enrollees had gross family incomes equal to or less than 100 percent of the federal poverty level and thus paid no premiums (table 17). Approximately 96 percent of enrollees had gross family incomes equal to or below 200 percent of the federal poverty level. SHIP also reports that gross family income was not a major factor in choice of carrier, with the percentage distribution of SHIP members by income reflecting no significant differences between HMSA and Kaiser Permanence ( 1 3).

During the first full year of operations (1 991), the HMSA enrollee outpatient-visit rate **was 2,851 visits** per 1,000 members and the non-maternity hospitalization rate was 119 days per 1,000 members (table 18). The Kaiser Permanence enrollee rates were 2,876 outpatient visits and 263 non-maternity hospital days per 1,000 members. Hospital admission rates were similar: 48 per 1,000 enrollees for HMSA and 53 per 1,000 enrollees for Kaiser Permanence for non-maternity care; and 30 and 32 admissions per 1,000 enrollees, respectively, for maternity care. However, average lengths of hospital stay were higher for the **Kaiser Permanence enrollees; 4.95 days** for Kaiser Permanence versus 2.50 days for HMSA enrollees for non-maternity hospitalizations, and **3.00** days for Kaiser Permanence versus 2.32 days for HMSA enrollees for maternity hospitalizations.

**Table 16**

## State Health Insurance Program
## Age by Sex Distribution
## Active Members: December 1991

| Age Distribution | Total | Male | Female |
|---|---|---|---|
| **Total** | 14,556 | **6,541** | **8,015** |
| **Under 1** | 250 | **139** | **111** |
| **1 -5** | 1,800 | **892** | **908** |
| **6 - 1 3** | 4,257 | **2,140** | **2,117** |
| **19** | 158 | **55** | **103** |
| **2 0 - 2 9** | 2,071 | **788** | **1,283** |
| **3 0 - 3 9** | 2,594 | **1,062** | **1,532** |
| **4 0 - 4 4** | 1,144 | **551** | **593** |
| **4 5 - 4 9** | 726 | **328** | **398** |
| **5 0 - 5 9** | 924 | **361** | **563** |
| **6 0 - 6 4** | 479 | **163** | **316** |
| **65 +** | 153 | **62** | **91** |

**(one missing case)**

**Source:** **Hawaii State Department of Health, State Health Insurance Program, Report to the Legislature," January 1992.**

## Table 17

### Federal Poverty Level of State Health Insurance Clients, December 1991

| Federal Poverty Level (FPL) | HMSA Clients | Kaiser Permanence Clients | Total Clients |
|---|---|---|---|
| Total | 11,828 (100%) | 2,739 (100%) | 14,567 (1 00%) |
| 100% or less | 7,553 (63.9%) | 1,680 (61 .3%) | 9,233 (63.4%) |
| 125% or less | 1,542 (13.0%) | 378 (13.8%) | 1,920 (13.2%) |
| 150% or less | 1,113 (9.4%) | 247 ((9.0%) | 1,360 (9.3%) |
| 200% or less | 1,158 (9.8%) | 306 (1 1.2%) | 1,464 (10.1%) |
| 250% or less | 367 (3.1%) | 99 (3.6%) | 466 (3.2%) |
| 300% or less | 95 (0.8%) | 29 (1.1%) | 124 (0.9%) |

Source: Hawaii State Department of Health, "State Health Insurance Program, Report to the Legislature," January 1992

**Table 18**

## Utilization Rates of State Health Insurance Clients, HMSA and Kaiserr Permanence Enrollees, 1990-1991

| Health Plan | Outpatient visits (1) | Hospital (excluding maternity) Days | ALOS | Admissions | Maternity Days(l) | ALOS | Admissions |
|---|---|---|---|---|---|---|---|
| HMSA(2) | 2,851 | 119 | 2.50 | 48 | 76 | 2.32 | 30 |
| Kaiser Pemnanente(3) | 2,876 | 263 | 4.95 | 53 | 96 | 3.00 | 32 |

ALOS = Average Length of Stay

(1) Per 1,000 enrollees
(2) HMSA information based on services utilized 06/01/90 - 05/31/91
(3) Kaiser Permanence information based on services utilized 08/01/90 - 07/31/91

Source; Hawaii State Depatment of Health, "State Health Insurance Program, Report to the Legislature," January 1992

**SHIP found no significant differences in the SHIP populations enrolled** in the HMSA and Kaiser Permanence plans (1 **3).** The only difference in utilization between HMSA and Kaiser Permanence SHIP enrollees is in the average length of stay. Possible explanations include: 1 ) HMSA hospital data is based only on paid hospital days, which is 5 days under SHIP, and hospitalizations beyond five days may not have been reported; and 2) HMSA SHIP enrollees have more limited benefits compared to HMSA regular enrollees, while the Kaiser Permanence SHIP enrollees have the same benefits package as regular Kaiser Permanence enrollees. Furthermore, regular HMSA enrollees have shorter average length of stays than regular Kaiser Permanence enrollees (30), so the difference in hospital length of stays between the HMSA and Kaiser Permanence SHIP enrollees may also be reflecting differences in patient utilization and provider decisions to hospitalize or not between the fee-for-service HMSA system and the prepaid, capitated Kaiser Permanence system.

Finally, several surveys are being conducted or planned to better describe and understand the remaining uninsured in Hawaii. Since October 1990, the Health Surveillance Survey conducted annually by the Department of Health has included a Health Insurance Supplement. And as mentioned earlier, the six primary care clinics in the state, through the Hawaii State Primary Care Association, are also administering a survey of their uninsured clients. Two other pilot surveys are being planned: 1 ) a survey of the uninsured who visit the Emergency Room of the Queen's Hospital in Honolulu; and 2) a survey of students utilizing the student health service at the University of Hawaii at Manoa.

## Discussion and Conclusions

### The SHIP Experience

In SHIP, the 20 percent set-aside for hospital care led to the limitation of $500/day and five days per calendar year (plus another two days of normal delivery )." While the 20 percent limit has not been reached in the short operating experience of SHIP, hospitals are clearly vulnerable for partially subsidizing the care of SHIP recipients. On the other hand, hospitals in Hawaii have been providing care to the uninsured without compensation, so even with the SHIP limitation, their revenues have increased. If the subsidy is evenly distributed among hospitals or matches the distribution of SHIP patients, it should not be a major problem (28). A policy issue for other states and national policy makers is the utility of a cap on hospital expenditures and its translation into benefits for individual patients.

Similar caps on payments were initially imposed by HMSA for individual providers, but, unlike the hospitals, individual providers have a greater choice on whether or not they will provide uncompensated care and on participating in SHIP. In the particular situation of Kaiser Permanence, it chose to provide full benefits and partially subsidize its SHIP enrollees through its own dues payment program, but with **a cap** on its enrollment (presently at 3,500, which has already been reached).

On the neighbor islands outside of Honolulu on the island of Oahu, nearly all of the hospitals continue to be owned and managed by the state (through the Department of Health). Largely unexplored is the issue of how to relate payment to the state hospitals more closely to SHIP, For example, on Maui, Kaiser Permanence

[6] **According to HMSA, in 1991, hospital room-and-board charges averaged $490 per day (22).**

has **outpatient facilities but no hospital, and contracts with the state's Maui Memorial Hospital for inpatient care. Kaiser Permanence's Director** for the Neighbor Islands states that Kaiser on Maui will accept only AFDC (Aid to Families with Dependent Children) Medicaid enrollees, and does not accept SHIP enrollees because of Kaiser's vulnerability to high-cost, prolonged hospitalizations, If the state would renegotiate its charges for hospital care and reduce Kaiser Permanence's financial vulnerability, there is a possibility Kaiser Permanence would open its Maui membership to **SHIP** enrollees and to accept more Medicaid clients (24).

**With a specified amount of funding (currently $10 million** per year, in the case of SHIP), the choices on how to expend these funds are to increase benefits, increase provider reimbursement rates, and/or to increase enrollments through expanding eligibility. With current costs of SHIP below expenditures, benefits could be expanded, thereby not only providing more services to the currently enrolled, but also making SHIP more attractive to the eligible but still uninsured. Enrollments could be increased by reducing cost-sharing (premiums and co-payments) and/or by expanding eligibility (current eligibility extends to persons with incomes up to 300 percent of the federal poverty level).

On the other hand, the current surplus of appropriations and enrollee contributions over expenditures may not last. Hospital costs may not remain below 20 percent of appropriations/revenues (the current level of allocation for hospital

reimbursement), and provider costs continue to increase and can reach the point that they will not participate in SHIP.[7]

An additional reason for increasing hospital and provider reimbursement rates is SHIP'S relationship to Medicaid. Increased benefits would affect the spend-down provisions of Medicaid; i.e., more SHIP funds would have to be expended on a SHIP enrollee before he/she would be eligible for transfer to the Medicaid program (37). **However, there is currently no information on how much of a shift is occurring from** SHIP to Medicaid, in part because SHIP doesn't have an assets test, nor is there information on the extent of such shifts with varying levels of SHIP benefits.

Should the public policy goal be universal health insurance coverage, or universal access (28)? There may be an irreducible minimum of people who won't be insured, and for some of whom direct service delivery is more appropriate and effective. As described earlier, the SHIP program in fact is already a hybrid consisting of a health insurance program and direct payments for service delivery to eight (up from an initial six) primary care clinics. These multiple purposes have been feasible because of the shortfall that has been experienced so far between state appropriations and the costs of the insurance program, and because of pressure from key state legislators sympathetic to the primary care clinics and their clientele (the indigent, homeless, new immigrants, etc.). What will happen when funds are not as available and the insurance program component must compete with the direct service delivery component? While the primary care clinic payments come from the SHIP insurance

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[7] **HMSA provider reimbursement rates have been raised to the level of providers participating in their commercial plans and so are currently no longer at issue. However, it is conceivable that future reimbursement rate increases for HMSA'S commercial policies may not be applied to SHIP.**

**appropriation, these payments do not cover specialty and inpatient care. Thus, it only partially meets the needs of the clinics's uninsured clients. On the other hand, from the clinics' perspective, what are the relative advantages of a direct service subsidy versus payment at SHIP reimbursement rates?**

**SHIP eligibility extends to families with gross incomes up to 300 percent of the federal poverty level, and efforts are being made to target students and other persons 17 - 25 years of age, the** single and/or divorced, among others (39). Who is in **greater need of assistance? Is this a relevant question? It seems to be, as the uninsured are not homogeneous, and its component populations** not only vary in their need of health care, the type of health care they need, but also in their ability to choose whether or not to purchase health insurance.

## Relevance of the Hawaii Experience to National Health Policy

As the **national "gap** group" of uninsured has garnered increasing attention in **national health policy** debates, and as the United States Congress and the Executive **Branch** develop legislative approaches to the nation's "health care crisis, " attention has gravitated to **Hawaii's health insurance experience. At the same time,** however, Hawaii's experience has often been dismissed as irrelevant to other locales, for reasons such **as** its low-unemployment economy; its unique ethnic mixture and accompanying highest life expectancy among all of the states; the dominance of the insurance market by two carriers/providers (HMSA and Kaiser Permanence); its climate; and, one suspects, simply because it is geographically isolated from the "mainland" United States.

Unfortunately, health services research on the Hawaii situation is near non-existent. The lack of a research base has not impeded policy makers in Hawaii to conceive and implement programs that remain at the talking point in much of the rest of the rest of the nation and nationally, but the relevance of the Hawaii experience to other states and nationally has remained largely unknown. Whether or not such research would tip the balance toward implementing similar programs elsewhere is debateable, given the many factors on which important policy decisions are based. Nevertheless, the lack of a good research base on the Hawaii experience is at least an impediment toward its possible application elsewhere.

Hawaii is in fact unique. As summarized earlier, its early plantation-based economy and history of comprehensive, employment-based health care, and the subsequent enactment in 1974 of the only state-mandated employment-based health insurance program, are the foundations of Hawaii's health insurance system. In contrast, 23 million of the 34 million (68°/0) uninsured Americans in 1990 were employed full-time, 4 million ( 12°/0) were employed part-time, and only 7 million (20%) were unemployed (5). Thus, Hawaii's uninsured population is quite different from the rest of the United States, and it is not surprising that national policy makers are considering health insurance approaches that include employment-based/employer contribution approaches.

There seems to have been little negative impact on businesses in Hawaii from its 1974 mandatory, **employment-based health insurance legislation, although** admittedly, no studies **specifically addressing the issue have been conducted. In** terms of unemployment rates, Hawaii's and the overall U.S rates have converged and diverged over the past two decades, and in fact, the Hawaii unemployment rate

has on the whole been much better than the U.S. 'S over the past decade (figure 1 ). Over the past three years, Hawaii's unemployment rate has been under three percent, and even in the recession experienced in Hawaii during the post Desert Storm aftermath (Hawaii's tourist industry was hit hard by canceled vacations and has still not recovered), the unemployment rate increased only to 3.6 percent (21 ). But that increase was a full percentage point, and caused a 7 percent shortfall in the budget projections of the state legislature for 1992 (2), This economic situation has led one key **stat e legislator to conclude that, as the numb**er of SHIP enrollees increase, it is **unlikely there will be more funds made ava** able beyond the current annual **appropr iation of $10 million (32).**

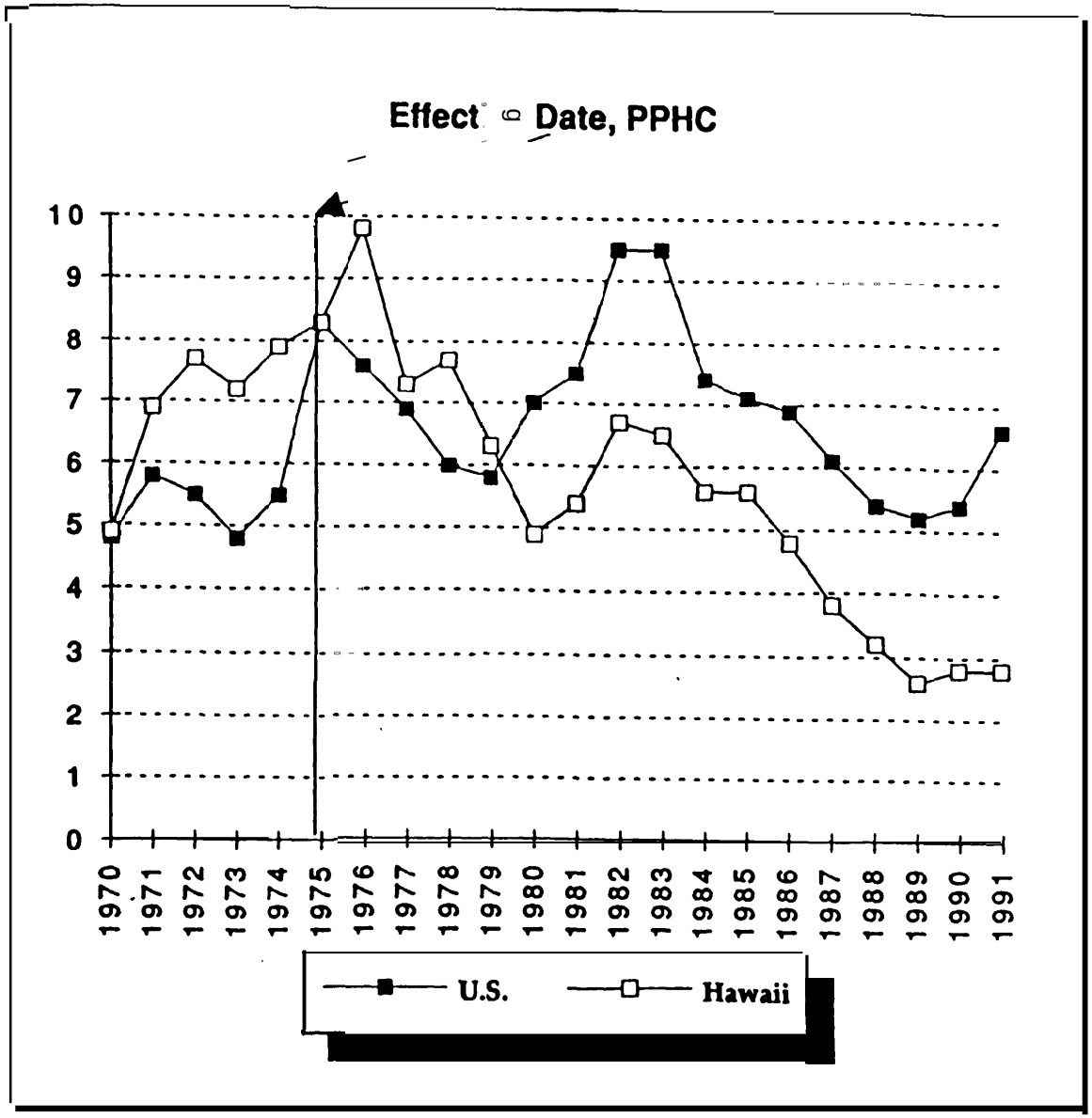
Hawaii residents' health care utilization and insurance rates are also well below the **national average. In 1992 the national average for the annual group health insurance premium for a single person was $2,301 (5'). In contrast,** for groups of less than 100 employees, the annual premium for a single person enrolled in the Kaiser **Permanence health plan in Hawaii was $1,286 (28), and in HMSA, $1,488 (22). HMSA'S single and family monthly premiums** for groups of less than 100 are summarized in table 19 for the years 1982 through 1992.

Utilization of health services in Hawaii is **also less than the national average (27) (see table 20). Possible contributing factors include ethnic patterns of care; reduced hospitalization rates for "neighbor island" residents, many of whom must come to Oahu for secondary and tertiary hospital care (37); and the fact that, at least since 1955, health insurance in Hawaii covers outpatient care from the first** office visit (41).

Hawaii's de facto approach toward universal health insurance coverage has been a patchwork approach, filling in the remaining gaps with new and expanded

# UNEMPLOYMENT PERCENTAGES FOR THE U.S./HAWAII

| | U.S. | HAWAII |
|---|---|---|
| 1970 | 4.8 | 4.9 |
| 1971 | 5.8 | 6.9 |
| 1972 | 5.5 | 7.7 |
| 1973 | 4.8 | 7.2 |
| 1974 | 5.5 | 7.9 |
| 1975 | 8.3 | 8.3 |
| 1976 | 7.6 | 9.8 |
| 1977 | 6.9 | 7.3 |
| 1978 | 6 | 7.7 |
| 1979 | 5.8 | 6.3 |
| 1980 | 7 | 4.9 |
| 1981 | 7.5 | 5.4 |
| 1982 | 9.5 | 6.7 |
| 1983 | 9.5 | 6.5 |
| 1984 | 7.4 | 5.6 |
| 1985 | 7.1 | 5.6 |
| 1986 | 6.9 | 4.8 |
| 1987 | 6.1 | 3.8 |
| 1988 | 5.4 | 3.2 |
| 1989 | 5.2 | 2.6 |
| 1990 | 5.4 | 2.8 |
| 1991 | 6.6 | 2.8 |




SOURCE: DEPARTMENT OF HEALTH, STATE OF HAWAII

## Table 19

## HMSA Average Monthly Premiums for Groups of Less Than 100

| Year | Sinde member | Family (3 or more\ |
|---|---|---|
| 1982 | $47 | $137 |
| 1983 | 52 | 156 |
| 1984 | 52 | 156 |
| 1985 | 52 | 156 |
| 1986 | 60 | 181 |
| 1987 | 70 | 209 |
| 1988 | 79 | 236 |
| 1989 | 94 | 283 |
| 1990 | 103 | 308 |
| 1991 | 113 | 338 |
| 1992 | 124(1) | 372(2) |

(1) Range: $102-$151
(2) Range: $306-$452

**Source: Hawaii Medical Service** Association (HMSA), 1992

programs. The next step in the current governor's administration is to develop this patchwork of private and public health insurance programs into a "seamless system of care, " with standardized patient benefits and provider payments (26). Clearly, however, benefits and payments cannot be reduced to the level of the insurance program with the lowest benefits and payments. For example, the SHIP hospitalization payment maximum of 5 days and current Medicaid physician payment rates would be clearly inadequate, Thus, threshold issues include: ) what would be the standardized level of benefits and payments; 2) what is the likelihood that significant, additional public funds would be provided, beyond the current levels of the SHIP and Medicaid programs; 3) what would be acceptable (if any) cross-subsidies among the various private and public insurance programs currently in operation; and 4) what to do about the uninsurable in an insurance-based strategy?

What lessons can be learned from the Hawaii experience?

Clearly, the linchpin of Hawaii's health insurance system is its landmark 1974 Prepaid Health Care Act, mandating employment-based health insurance coverage. Due to federal constraints on the states because of the ERISA legislation, similar comprehensive changes at the state level are not currently possible. Of course, such changes would be possible if federal legislation were enacted to ease the ERISA restrictions, and it will **be** interesting to see how the proposed "seamless system of care" might further improve Hawaii's system.

Even if a "seamless" system is implemented and patient benefits and provider payments are somehow standardized, other issues would remain unaddressed. These include:

*o* Access **to health care.** The previous discussion identifies three aspects of **access that may not be sufficiently addressed by health insurance coverage: 1 ) not applying for health insurance coverage because of social barriers (e. g., new immigrants, migrants, the homeless) or non-interest (e. g., college students); 2) low provider participation if reimbursement rates are too low; and 3) reluctance of carrier (Kaiser Permanence) participation if limits on hospitalization coverage leave it vulnerable to excess costs.**

o **High administrative costs of a system composed of multiple private and public health insurance programs, with wide variations in administrative costs, particularly between private and public health insurance programs (5).**

o **Substantial transaction costs of switching from one program to another as eligibility changes with economic circumstances. For example, in its brief period of operations, there has been a turnover of approximately 2 percent of SHIP enrollees per month (1 ), or about 25 percent over a calendar year. In the Medicaid program, enrollment at any one time is about half the number enrolled during a calendar year (see table 4).**

o **Piecemeal approaches leaving each piece vulnerable, especially those pieces which are publicly funded. Medicaid and each state's contribution is a typical example, with wide variations between state's on Medicaid benefits and eligibility. For SHIP, which was enacted during a time of state budget surpluses, its sustainability is soon to be tested,** if the state fiscal situation does not improve quickly.

Hawaii's State Health Insurance Program was conceived against the background of the needs of the uninsured "gap group" in Hawaii, enacted as a primary care and

preventive services bill,[8] put into operations initially as a limited benefits health insurance program, and has evolved, in the short space of less than two years, into a funding mechanism that is attempting , in a variety of ways, to meet the minimum health needs of the great variety of peoples who comprise the uninsured. Will the integrity of the health insurance component be compromised by the allocation to direct services? Is it fair to pit the health insurance needs of the "gap groups" against the health service needs of the most socially and economically disadvantaged, for whom health insurance may not be the answer to access to health care? Is this conflict among the needs of the various groups who comprise the uninsured inevitable, whether financing comes from a single program or separate ones?

Perhaps the greatest relevance of the health insurance system which has evolved in Hawaii -- especially its recent gap group insurance program, SHIP -- to national and other state policy makers is that the allocation of resources for the health care of its citizens -- rationing -- underlies every new effort and will surface in its operations. Hawaii's SHIP is not simply an insurance program for the "gap group, " but instead an experiment of alternate approaches to meeting the health care needs of the Hawaii's diverse uninsured groups, thereby serving as a stepping stone to some as-yet unrealized permanent program (as in the case of Medicaid). Temporary operational surpluses have enabled SHIP to fund both health insurance and direct, primary care services, as well as to provide a one-time transfer payment to Medicaid, These multiple uses are consistent with the underlying objectives of the enabling

[8] **The Act defined "health care coverage" as "contractually arranged medical, personal, or other services, including preventive services, education, case management, and outreach, provided to an eligible member. "**

**legislation, and with the current Director of Health's search for a "seamless" system of health care (26). Can SHIP evolve to meet these multiple objectives; will its experience lead to new paradigms; and will the rest of the country benefit from Hawaii's experience?**

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**Attachment A**

**"A** BILL **FOR AN** ACT RELATING TO

THE STATE HEALTH INSURANCE PROGRAM"

**Fifteenth Legislature, 1989**
**State of Hawaii**

HOUSE OF REPRESENTATIES
FIHTEENTH LEGISIATURE, 1989
STATE OF HAWAII

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# A BILL FOR AN ACT

RELATING TO THE STATE HEALTH INSURANCE PROGRAM.

**BE IT ENACTED BY THE LEGISLATURE OF THE STATE OF HAWAII:**

SECTION 1. The **Hawaii** Revised Statutes *is* amended by adeing a new chapter to be appropriately designated and to **read as** follows :

"CHAPTER

**STATE HEALTH INSUARANCE PROGRAM ACT**

-1 Findings **and** purpose. (a) The legislature finds that despite the **fact that Hawaii has** the only statutorily mandated prepaid health care program in the country, **as well as a** broad-based medicaid **program which** provides an array of medical benefits to **Hawaii's lowest income level residents,** there remain in the State uninsured 'gap group individuals". Available statistics consistently *reveal* **that an** estimated five per cent of the civilian population of this State, or 50,000 individuals, **Lack any** fog **of** medical insurance whatsoeve= and are therefore limited in **access** to medical care.

(b) These 'gap group individuals" are **characterized by one** or more of the following conditions or **factors** contributing to lack of insurance or 'medical indigency":

(1) They have too much income or too many assets to qualify

for medicaid, but too little to afford private insurance;

(2) They do not qualify for prepaid health care insurance coverage through employment;

(3) They *choose not to obtain* health insurance: o=

(4) They are dependents! primarily children of insureds who are not covered by their parent%, guardian's, **or** spouse's policies.

**(c)** The legislature further finds that it is **a** matter of compelling public interest to provide for the health **and well-**being of all the people of this State. This is also consistent with the health provisions of the Hawaii State Planning Act **as** set forth in section 226-20 (a) (1)which establish as an obective the 'fulfillment of **basic** individual health needs of the general public." This objective is construed to include access to basic *health insurance* coverage. To responsibly carry out this objective, it is therefore appropriate that the 1egislature use innovative means to ensure that **all** residents, regardless **of age,** income, employment status, or any other of actor, have access to health insurance coverage which will provide basic **medical** services necessary to sustain **a** healthy 1ife.

(d) The purpose of this chapter is to **establish** a program

l within the department Of health, funded through legislative
2 appropriations, to ensure basic health insurance coverage is
3 available for Hawaii residents who are medically uninsured and
4 who are defined in section -2 as "gap group individuals".

5 S -2 **Definitions. As used in** this chapter **unless**
6 otherwise indicated by the context:

7 "Gap group individuals" means medically uninsured persons
8 *who* **are** residents of the State.

9 "Health care coverage" **means** contractually **arranged** medical,
10 personal, or other services, including preventive services,
ll education, case management, and outreach provided to an eligible
12 member.

13 **"Health** care contractor" means **any** medical group or
14 0rganization **which** undertakes, under a prepaid health care
15 **program,** to provide health care, **or any** nonprofit organization or
16 insurer who undertakes, *under* a prepaid health care **program, to**
17 defray Or reimburse in whole or part, the expenses of health
18 **care.**

19 **"Medical indigence" means the status** of **a person who is**
20 **unisured or lacks** medical insurance.

21 **-3** State **health insurance program established.** There
22 is established within the department *of* **health the state health**
23 **insurance** program whose goals shall be to:

(1) Subsidize health care coverage for gap group individuals, including but not necessarily limited to out patient primary and preventive care;

(2) Encaurage the uninsured who can afford ,to participate in existing health plans to seek that coverage;

(3) Discourage individuals who are already adequately insured from seeking benefits under the state health insurance program;

(4) Assure that those persons **who have** the ability to pay **for all** or part of their coverage be appropriately **assessed by the** contractors on **a** sliding fee **scale basis;** and

(5) Ensure that the state health insurance program is affordable to gap group individuals.

The program shall be funded by legislative appropriations made to **the** department of health.

-4 *Transfer of* **funds.** The department of health shall have the authority to utilize funds appropriated under this chapter to *directly* purchase services in accordance with chapter 42 when it is determined that such a purchase is more effective and cost efficient in meeting the goals of this chapter. The department of health shall also have the authority to transfer **funds** appropriated under this chapter to the

department of human se--ices. The department of human services may receive and apply such funds for the purpose of maximizing medical care services to gap group individuals under the medicaid program contained in the medicaid state plan. The. departments of health and human servces shall develop and implement **an** inter-**agency** working agreement necessary to carry out the purpose of this section.

-5 rulemakig authority. The director of health shall adopt rules in accordace with chapter 91 which are **necessary to carry** out this chapter. The rules shall include, but need not be limited to:

(1) Establishment of guidelines for the purchase of health **care coverage** from health care contractors by the department=;

(2) Establishment of specific health care services to be covered, limited, and excluded by the program, including preventive services, outreach, and education strategies designed to reach gap group individuals;

(3) Establishment of eligibility requirements for participation in the program;

(4) **Development and implementation of an identification and notification process for eligible program patiicipants;**

(5) **Establishment of a payment schedule based on the**

person' s ability tO pay;

(6) Establishment **of** program participation criteria for health care contractors;

(7) Establishment of monitoring and evaluative guidelines for the program;

(8) Establishment of appeal procedures for denial of **eligibility** disqualification from program participation, assessment *of civil* penalties, or other negative action; and

(9) Establishment of procedures to exclude or remove from the program persons who drop individual **or** group **coverage** to obtain insurance.

**S** -6 Reporting, **continued** funding. The **department** of health shall report to the legislature on or about October 1, 1989 on the progress made in implementation of this act, including:

(1) Establishment of an advisory committee to review: the scope of the work to be done by a consultant, the input from the committee and the community to the consultant, **and the schedule** of **work of** the advisory committee;

(2) **Final scope** of work for the consultant, selection of the consultant, and the consultant's workplan;

(3) **Involvement** of the **departments of** labor, human services, and other **departments** needed to successfully develop the program;

(4) Required data collection efforts to successfully **develop the** program.

The department of health, in **collaboration** with the health **care** contractors, shall submit reports to the legislature and the governor no later than twenty days prior to the convening **of each** and every legislative session regarding program activities and **expenditures, needed resources~ participant demographics, evaluatiions, and such other information as may be necessary** to determine the usefulness of and continued need for the state health insurance **program.**

The purchase of insurance shall not proceed without the formal approval **of the** governor **and a** review by the **legislature** during the 1990 regular session. Implementation is **predicated upon the successful completion** of the **consultant's** reports and findings. The legislature, by concurrent resolution, may opt to withhold funding appropriated for implementation if not satisfied with the plan, **provided that such a concurrent resolution** must **be passed** within thirty days after **completion of the implementation plan or March 1,** 1990 whichever occurs **last.**

-7 **ViolatiOn, penalty.** **Any** person who violates this chapter or any rule adopted by the department of health pursuant to this chapter may be permanently disqualified from participation in the program, required to reimburse any benefits wrongfully obtained, and shall be fined not more than $500. Any action taken to impose Or collect the penalty provided for in this section may be considered a civil action.

s -8 **Severability.** If any provision of this chapter, or the application thereof to any person or circumstance is held invalid, the invalidity shall not affect other provisions or applications of this chapter which can be given effect without the invalid provision or application, and to this end the provisions of this chapter are severable."

SECTION 2. In accordance with Section 9 of Article VII of the Constitution of the State of Hawaii and sections 37-91 and 1637-93, Hawaii Revised Statutes, the legislature has determined that the appropriation contained in this Act will cause the state general fund expenditure ceiling for fiscal year 1989-1990 to be exceeded by $4,000,000 or 0.17 Per cent. The reasons for exceeding the general fund expenditure ceiling are that the appropriations made in this Act are necessary to serve the public interest and to meet the need provided for by this Act.

SECTION 3. There is appropriated out of the general

revenues of the State of Hawaii the sum of $4,000, 000, or so much thereof as may be necessary for fiscal year 1989-1990, for the purposes of this Act; provided that not more than $1,000,000 may be released in fiscal year 1989-1990 for planning, and designing a state health insurance program. There is appropriated out of the general revenues of the State of Hawaii the sum of $10,000,000, or so much thereof as may be necessary for fiscal year 1990-1991, for the purposes of this Act.

SECTION 4. The sum appropriated shall be expended by the department of health for the purposes of this Act.

SECTION 5. This Act shall take effect upon its approval.

Approved by the Governor on JUN 26 1989

ATTACHMENT B

**STATE HEALTH INSURANCE PROGRAM BENEFITS**

**HMSA**

## State Health Insurance Program Benefits: HMSA

| Services | Explanation | CoPavment |
|---|---|---|
| **Preventive:** | | |
| Well-baby care (O-5 years) | 12 visits during child's first 5 years of life. Visits include history, physical exam, developmental assessment, anticipatory guidance, appropriate immunizations and lab tests (see details on year-by-year exams) | Covered in full |
| Physical exam, child (6-18) | Height, weight, blood pressure general appearance, skin, mouth, teeth, gums, ear, nose, throat, neck, thyroid, abdomen, back, extremities, cardiovascular, neurological, genital, vision, audiogram, complete blood count, urinalysis, tine test (when required for school admission) | Covered in full, one every other year |
| Physical exam, adult (19-35) | Same as for child, plus chest x-ray (medically necessary), Pap smear, rectum-prostate | Covered in full, one every fifth year |
| Physical exam, adult (36-55) | Same as for adult (19-35), plus tonometry, electrocardiogram (12 lead), biochemistry (7 to 12 panel study), mammography | Covered in full, one every other year |
| Physical exam, adult (older than 550 | Same as for adult (36-55) | Covered in full, annually |
| Immunizations | Diptheria, whooping cough, tetanus, measles, mumps, rubella, and polio as needed. When appropriate, influenza/pneumovax, hemophilus influenza, cholera, typhoid, and typhus | Covered in full |
| **Medical:** | | |
| Physician office services | Up to 12 office visits/year | $5/visit |

| | | |
|---|---|---|
| **Office procedures** | **Diagnosis & treatment, specialist referral** | **$5/visit** |
| **Outpatient services** | **Selected outpatient services subject to prior authorization** | **Covered in full** |
| **Diagnostic tests** | **Laboratory, x-ray services** | **Covered in full** |
| **Treatment** | **Radiation therapy & Chemo-therapy for malignancy** | **50% per treatment** |
| **Surgical services** | Up to 3 office surgeries and short-stay surgeries per year | **Covered in full** |
| Psychiatric therapy | Up to 3 visits per year, one treatment per day | **Covered in full** |
| Mental health services | Initial evaluation, follow-up | **$5/visit** |
| Substance abuse | Screening and referral | **$5/visit** |
| Hospital inpatient | Up to 5 days per year, subject to preadmission **review** | **Covered in full** |
| **Room & Board** | **Semi-private room & board and general nursing care; intensive care room & board and general nursing care** | **Covered in full** |
| **Inpatient ancillary services** | **Operating room, surg. supplies, anesthesia & transfusion services, oxygen, inhalation therapy, drugs & dressings, lab tests, x-ray, radiation therapy & chemotherapy for malignancies** | **Covered in full** |
| **Physician's services** | **Operative procedures include post-operative hospital visits or up to 5 physician visits for non-surgical confinement, one consultation per year, assistant surgeon, anesthesiologist (physician visits not counted as part of 12-visit maximum office visit benefit)** | **Covered in full** |
| **Maternity services** | **Up to 2 days for normal delivery (not counted as part of 5-day maximum hospital benefit), Two-day maximum for normal routine newborn nursery care.** | **Covered in full** |

| | | |
|---|---|---|
| **Room & board** | **Semi-private room, newborn nursery** | **Covered in full** |
| **Inpatient ancillary services** | **Operating & delivery rooms, surgical supplies, anesthesia, transfusion, oxygen, drugs, & dressings** | **Covered in full** |
| **Professional services** | **Physician or certified nurse midwife for normal delivery or miscarriage or other termination of pregnancy, C-section, surgery from complications of pregnancy, prenatal care, physician routine nursery care of newborn child (see details on prenatal exams)** | **Covered in full** |
| **Dental services** | **Dental surgery for accidental injury only, subject to prior authorization; services must be rendered by a physician or dentist** | **Covered in full** |
| **Surgery** | **Surgery to correct accidental injuries to the jaw, cheeks, lips, tongue, roof or floor of the mouth, soft tissue, and gums** | **Covered in full** |
| **Emergency care facility/MD** | **Use of emergency room and physician services in conjunction with care** | **$25/visit** |
| **Ambulance services** | **Ground ambulance from site of injury or illness to hospital or facility** | **Covered in full** |

**<u>Supplemental</u>:**

| | | |
|---|---|---|
| **Blood** | **Blood, blood products, & blood bank services for inpatient confinement only** | **Covered in full** |
| **General health education** | **Health Plan orientation, routine patient education, healthy pregnancy classes** | **Covered in full** |
| **Managed care services** | **Preadmission review, concurrent review, prior authorization** | **Covered in full** |

**Well-baby Physical Examinations:**

**Younger than age 1**
- six office visits
- three diphtheria-tetanus-pertussis (DPT) injections
- three oral polio vaccines
- one tuberculin test
- one hemoglobin or hematocrit

**Age 1**
- two office visits
- one measles-mumps-rubella (MMR) vaccine
- one DPT injection
- one oral polio vaccine
- one conjugated hemophilus B vaccine (at 18 months)
- one tuberculin test

**Age 2**
- one office visit
- one tuberculin test
- one urinalysis

**Age 3**
- one office visit
- one tuberculin test
- one hemoglobin or hematocrit

**Age 4**
- one office visit
- one tuberculin test
- one vision screening (Titmus)
- one hearing screening (Maico)
- one DPT booster
- one oral polio booster

**Age 5**
- one office visit
- one tuberculin test
- one vision screening (Titmus)
- one hearing screening (Maico)
- one DPT booster
- one oral polio booster

**Prenatal Care;**

**First Prenatal Visit**
- Screening
  - History
    - dietary intake
    - tobacco/alcohol/drug use
    - risk factors for intrauterine growth, retardation, & low birth weight

- prior genital herpetic lesions
- Physical Exam
  - blood pressure
- Laboratory/Diagnostic Procedures
  - hemoglobin and hematocrit
  - Pap smear
  - ABO/Rh typing
  - Rh(D) antibody test
  - venereal disease research laboratory (VDRL)
  - Hepatitis B surface antigen (HBsAg)
  - urinalysis for bacteriuria
  - gonorrhea culture
  - rubella antibodies
  - tuberculin test
- High-risk groups
  - hemoglobin electrophoresis
  - chlamydia testing

- Counseling
  - nutrition
  - tobacco use
  - alcohol and other drug use
  - safety belts

- Follow-up Visits
  - Screening
    - blood pressure
    - urinalysis for bacteriuria
    - 50g oral glucose tolerance test
    - diagnostic tests if medically necessary
    - High-risk groups
      - amniocentesis
      - pre-term birth monitoring
  - Counseling
    - nutrition
    - safety belts
    - High-risk groups
      - tobacco use
      - alcohol and other drug use

**Coverage Limitations:**

- **Hospital benefits limited to no more than 5 days per year, maternity benefits and newborn nursery to no more than 2 days each per year,**

- **If the 5 days of hospital inpatient benefits are exhausted, physician charges and related services will not be covered, Ambulatory surgery facility charges will be paid only if outpatient surgery benefit is still available.**

- **Services of an assistant surgeon will not be paid unless the assistance was medically necessary based on the complexity of the surgery and the hospital did not have a resident or training program in effect so that a resident or intern on its staff could have assisted the surgeon.**

- **If the enrollee is already confined to a hospital when SHIP coverage becomes effective, benefits for the same illness or injury requiring confinement will not be paid until 30 days have elapsed.**

- **Dental services and services for temporomandibular joint problems will be be covered, except for repair necessitated by accidental injury to sound natural teeth or jaw, provided that such repair commences within 90 days of an accidental injury or as soon thereafter as is medically feasible, and provided further that the enrollee is eligible for covered services at the time that services are provided and at the time of the accident.**

- **Reconstructive surgery for developmental or acquired conditions will not be covered except for conditions that involve severe functional impairment, including but not limited to keloid removal, mammoplasty except after radical mastectomy, and deviated septum (subject to prior authorization), Psychological or psychiatric impairment alone shall not be a sufficient basis for reconstructive surgery.**

- **SHIP coverage for emergency care is provided only for urgent, emergent, and life-threatening conditions and is subject to retrospective review.**

- **SHIP coverage is provided only for services rendered within the State of Hawaii.**

- **The benefit schedule pertains to services provided by participating providers. Services rendered by non-participating providers requires prior authorization.**

**Coverage Exclusions:**

**Services and supplies not specifically listed are not intended to imply that all other services and supplies are covered benefits. The fact that a physician may prescribe, order, recommend, or approve a service or supply does not, of itself, make it medically necessary or make the charge an allowable expense, even though it is not specifically listed as an** exclusion.

**The following services and supplies are not covered:**

- **Acne surgery and removal or treatment of benign skin lesions or growths.**

- o Acupuncture and biofeedback.
- 0 AIDS/AIDS-related complex (ARC) -- services and supplies specifically related to intravenous therapy or inpatient treatment.
- 0 Air ambulance services.
- 0 Allergy testing and treatment.
- 0 Cardiac open heart surgery and coronary artery bypass.
- 0 Cataract surgery (with or without lens implant).
- 0 Chiropractic services.
- 0 Circumcision for newborns.
- 0 Complications accompanying or related to any of the exclusions listed in the Plan.
- 0 Congenital anomalies; any services related thereto.
- 0 Contraceptive supplies and devices. '
- 0 Cosmetic surgery
- 0 Dental care, dental and oral surgery, temporomandibular joint problems, and prostheses (i.e., false teeth, crowns, dental splints, bridges) except for dental surgical benefits as stated above.
- 0 End-stage renal disease, treatment, including hemodialysis.
- 0 Eye examinations including refraction, eyeglasses, exe exercises, contact lenses, and/or fittings, except as provided as part of routine examination under well-baby care and adult health appraisals.
- 0 Experimental or investigational medical, surgical, and diagnostic procedures, drugs and devices, as defined by the American Medical Association, National Institutes of Health, the U.S. Food and Drug Administration (FDA), or a comparable, nationally recognized health care organization. Inpatient drugs are not covered until approved by the FDA and may be used only for the treatment for which FDA approval has been granted.
- 0 Hearing aids.

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1 In 1992, SHIP began offering selected family planning services to its HMSA subscribers through agreements with the Department of Health's Office of Family Planning. Access to family planning supplies is dependent on whether SHIP members have providers who participate in the contraceptive Partnership program. Similar services were already available to SHIP members under Kaiser Permanence insurance, Source: Hawaii State Department of Health, "SHIP offers more family planning benefits, " Hawaii Health Messenger, V. 51, No. 1 (Spring 1992).

o Home health agency services, skilled nursing facilities, rest cures, custodial or domiciliary care, or homemaker services.

0 Infertility treatment, including artificial insemination, in-vitro fertilization, and reversal of sterilization.

0 Medical equipment (purchase or rental), including, but not limited to, hospital beds, wheel chairs, walk-aids, or other medical equipment and supplies not specifically listed as a covered service, except as used while in the hospital.

0 Medical services received from or paid for by the Veterans Administration.

0 Medical services received from any federal, state, territorial, municipal, or other governmental instrumentality or agency for which there is no charge.

0 Medical services that are payable under the terms of any workers' compensation, automobile medical, automobile no-fault, underinsured or uninsured motorist, or any other health plan coverage-group or non-group.

o Naturopathic services,

0 Neonatal intensive care services.

0 Nuclear Medicine,

0 Obesity treatment; any treatment relating thereto.

0 Occupational therapy.

o" Organ transplants/donor services.

o Orthodontic services and supplies.

0 Orthopedic shoes,

0 Personal comfort items such as telephone, television, and personal grooming services.

0 Physical therapy.

0 Podiatry services.

0 Prescription and non-prescription drugs or hormones and their administration, except those provided as an inpatient hospital benefit.

0 Prostheses.

0 Psychiatric hospitalization and inpatient psychotherapy.

0 Reconstructive surgery for developmental or acquired conditions that do not involve severe functional impairment, including but not limited to keloid removal,

**mammoplasty, and deviated septum. Psychological or psychiatric impairment alone is not a sufficient basis for reconstructive surgery.**

- **o Refractive keratoplasty (any procedure to the cornea to correct or improve vision).**
- **0 Rehabilitation hospitalization and/or services (e.g., cardiac or alcohol and drug rehabilitation).**
- **0 Respiratory therapy.**
- **0 Sex transformation, sterilization services, or treatment for sexual dysfunction.**
- 0 **Speech therapy.**
- **0 Stand-by services -- when the service of another physician may be necessary during a surgery so that the physician must "stand-by" at the hospital, the health care plan shall pay benefits for covered services that the physician actually provides but shall not pay for the waiting or "stand-by" time,**
- **0 War -- conditions resulting from,**

**Source: Center for Health Research, Kaiser Permanente, Portland, Oregon; School of Public Health, University of Hawaii at Manoa, Honolulu, Hawaii; and Hawaii Medical Service Association Foundation, Honolulu, Hawaii, The State Health Insurance Program of Hawaii: From Legislative Priority to Reality, submitted to Department of Health, State of Hawaii, December 10, 1991, 460 pp.**

# ATTACHMENT C

## STATE HEALTH INSURANCE PROGRAM BENEFITS

## KAISER PERMANENTE

## State Health Insurance Program Benefits: Kaiser Permanence

| Services | CoPayment |
|---|---|
| **Outpatient Services:** | |
| Unlimited doctor's and other health professional's office visits | $5/visit |
| Health evaluations for adults, children's physicals, and well-baby care | $5/visit |
| Eye examinations for glasses | $5/visit |
| Immunizations (except hepatitis B, mass immunizations, and new immunizations will be provided at 1/2 non-member rates). Immunizations not in general use are not covered | No charge |
| Diagnostic and routine laboratory tests and x-ray procedures | No charge |
| Minor surgical procedures | $5/visit |
| Inhalation therapy | No charge |
| Injections, including allergy medications | No charge |
| Chemotherapy medications for cancer treatment | No charge |
| Physical therapy and x-ray therapy | No charge |
| Occupational and speech therapy | 1/2 non-member rates |
| Routine casts and dressings | No charge |
| Take-home supplies | Reasonable charges |
| **Hospital Services:** | |
| All physicians' medical and surgical services | No charge |
| Room and board, general nursing, use of operating room, drugs and medicines, injections, special duty nursing (when prescribed). No limit on number of days | No charge |
| X-ray and laboratory tests | No charge |

| | |
|---|---|
| Inhalation therapy | No charge |
| Physical and x-ray therapy | No charge |
| Occupational and speech therapy | 1/2 non-member rates |
| Dressings, casts, blood transfusions (if blood is-replaced) | No charge |
| Extended care services (up to 60 days of prescribed extended care services in a skilled nursing facility each year) | No charge for first 20 days, 25% on non-member rates from 21st to 60th day |

**Emergency Services:**

| | |
|---|---|
| At any Kaiser Foundation hospital or medical facility | Regular benefits apply |
| At non-Kaiser hospitals or medical facilities, if conditions are deemed to be emergencies according to Kaiser Permanence guidelines | Regular benefits apply, with a $25 copayment for each claim (coverage for initial emergency treatment only) |

**Maternity, Family Planning, and Infertility Treatment Services:**

| | |
|---|---|
| No waiting period for benefit, Full physician's services (prenatal care, delivery, and care during confinement), laboratory tests, and all hospital services | No charge after pregnancy is confirmed |
| Interrupted pregnancy | No charge |
| In-vitro fertilization (limited to one procedure per lifetime after 12 consecutive months of membership) | 20 percent of charges |
| Family planning services | $5/visit |
| Infertility services | $5/visit |

**Mental Health and Alcohol/Drug Dependence Services:**

| | |
|---|---|
| Up to 20 office visits per year: | |
| 1st - 6th visit: | $5/visit |
| 7th - 20th visit: | 20 percent of applicable charges |
| Hospital care: | |
| 30 days/year | 20 percent of |

| | |
|---|---|
| | applicable charges |
| Physician visits: | |
| 30/year | 20 percent of applicable charges |

Each day of mental health hospitalization may be exchanged for two days of non-hospital residential treatment services, or two days of partial hospitalization services, or two days of day-treatment services. Limited to two treatment episodes per lifetime for alcohol/drug dependence services.

Other Services:
(when medically required and approved or prescribed by a Kaiser Permanence physician)

| | |
|---|---|
| Ambulance services | No charge |
| Home health care | No charge |
| Hospice care | No charge |

Copayment Maximums for 1990:

$700/member/year, and
$2,100/family unit/year

Services applicable to copayment maximums are: office visits, speech and occupational therapy, and the first 20 visits for mental health care.

**Drug Plan:**

**There is partial coverage for drugs for which a prescription by a physician or dentist is required by law, when such prescriptions are purchased at a Kaiser Permanence medical facility, The member pays $2 per prescription, provided the quantity prescribed does not exceed 34 days' supply, one cycle of a contraceptive drug, 100 dosage units for oral solids, or 4 oz. for liquid medications. If the medication prescribed is for a greater quantity, the member pays $2 for each multiple of that quantity or fraction thereof. Refills are handled in the same manner as original prescriptions and must be obtained from the same pharmacy and location.**

**In addition, when prescribed by a physician, members may obtain the following:**

- **Insulin and other diabetes supplies**
- **Diaphragms and contraceptive pills**
- **Certain medications that do not require a prescription, as listed in the Kaiser Permanente formulary**

**The following are not covered:**

- **Drugs for which a prescription is not required by law, except for those listed above**
- **Drugs obtained from a non-Plan pharmacy**
- **Vitamins**
- **Drugs and other medications when used primarily for cosmetic purposes**
- **Medical supplies such as dressings and antiseptics**
- **Medications injected by a physician or nurse in a medical office or in the home**
- **Reusable devices such as blood-sugar testing meters and finger lancet cartridges**
- **Drugs and other medications associated with treatment of, AIDS or AIDS-related complex (ARC)**

**Coverage Exclusions:**

**Conditions covered by workers' compensation or any other employer liability law**

**Care required to be provided by any government program except Medicaid**

**Custodial, domiciliary, or convalescent care**

**Plastic surgery and other services for cosmetic purposes**

**Dental care, including temporal-mandibular joint dysfunction**

**Certain physical examinations required for obtaining or continuing employment or government licensing**

**Services of podiatrists and routine foot care**

**Services to reverse voluntary surgically induced infertility**

**Experimental or investigational services**

**Procedures not generally and customarily available**

**Blood and blood products**

**Procedures, services, and supplies related to sex transformation**

**Organ transplants, except for kidney, liver, and heart transplants (HPMG criteria must be met); heart transplants and liver transplants for members older than 18 are not covered for those who have had less than 12 months of continuous membership**

**Durable medical equipment**

**Corrective appliances and artificial aids, such as braces, prosthetic devices, eyeglasses, and hearing aids**

**Eye examinations for contact lenses**

**Eye exercises**

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**Source: Center for Health Research, Kaiser Permanence, Portland, Oregon; School of Public Health, University of Hawaii at Manoa, Honolulu, Hawaii; and Hawaii Medical Service Association Foundation, Honolulu, Hawaii, The State Health Insurance Program of Hawaii: From Legislative Priority to Reality, submitted to Department of Health, State of Hawaii, December 10, 1991, 460 pp.**

## ATTACHMENT D: OVERVIEW OF OTA'S ASSESSMENT, TECHNOLOGY, INSURANCE, AND THE HEALTH CARE SYSTEM

**BACKGROUND: The Congress has been concerned for many years with serious and growing problems related to health care costs, access, and quality. In response to requests from the Senate Committee on Labor and Human Resources (Edward Kennedy, Chairman), the House Committee on Energy and Commerce (John Dingell, Chairman), the House Committee on Ways and Means Subcommittee on Health (Willis D. Gradison, then Ranking Minority Member), Senator Charles E. Grassley (Committees on Budget, Finance, Special Committee on Aging), OTA's assessment, "Technology, Insurance, and the Health Care System, " addresses these congressional concerns by focusing on the following issues:**

**1. What does the available literature say about the impact of lacking health insurance on access to care and patient health outcomes?**

**2. Can a minimum benefit package for uninsured people be fashioned from the perspective of effectiveness and cost-effectiveness? In addressing this question, focus on the chronic conditions in general, and on mental health/substance abuse treatment, clinical preventive services, and patient cost-sharing as particular areas of concern.**

**In addition, Senator Ted Stevens, then a member of the OTA Technology Assessment Board, asked OTA to review available estimates to address the following question:**

**3. What cost implications do the leading types of health care reform proposals have in 7 areas: health care spending and savings; Federal, State, and local budgets; employers (large and small); employment; households (low, middle, and upper income); other costs in the economy; and administrative costs?**

**SCHEDULE AND PLAN: The assessment was approved by the Technology Assessment Board in April 1991, and began in July, 1991. In June 1992, the letter was received from Senator Stevens.**

**An advisory panel for the overall assessment was formed in November 1991 (see Box D-1 ); the advisory panel met in January 1992, December 1992, and May 1993.**

**OTA has released, or plans to release, the following documents related to the assessment:**

**1. Does Health Insurance Make a Difference? (OTA-BP-H-99).**

**This Background Paper represents the interim report from the overall assessment. It was specifically requested by the U.S. Senate Labor and Human Resources Committee, and: summarizes the state of the literature on the relationships among insurance coverage, access, and patient health outcomes, provides a conceptual framework for evaluating access to health care and the health effects of such access, provides an overview of insured and uninsured populations in the United States as of 1990. The Background Paper is available from the U.S. Government Printing Office (GPO),**

Superintendent of Documents (phone number 202/275-3030; address: Washington, DC 20402; GPO stock number 052-003-01301-1, $5.00 per copy) or, for congressional purposes, from OTA (49241 ).

2. An Inconsistent Picture: A Compilation of Analyses of Economic Impacts of Competing Amroaches to Health Care Reform bv Experts and Stakeholders (OTA-H-540)

This report, which summarizes and reviews available analyses of the economic impacts of four major competing approaches to health care reform (popularly known as "single payer, " "play or pay, " "individual tax credits or vouchers, " and "managed competition"), was requested by Senator Ted Stevens, and is expected to be released in summer 1993. The report will be available for public use from GPO (phone number 202/783-3238; address: New Orders, Superintendent of Documents, P.O. Box 371954, Pittsburgh, PA 15250-7954; GPO stock number 052-003-01327-4, $8.00 per copy) , and for Congressional use from OTA (49241 ).

3* "Primary Care and Uninsured People: Efficacy and Access--Background Paper" (will not be printed by GPO)

This background paper will be available in summer 1993 from OTA.

4. "Nonfinancial Barriers to Access--Background Paper"

This background paper will be available in late 1993 from GPO or, for congressional use, from OTA.

5. A set of publications on Benefit Design in Health Care Reform which explores issues involved in designing a benefit package based on effectiveness and cost-effectiveness in relation to to other factors such as public preferences, professional judgment, and political concerns, with a focus on specific benefit areas. This set of reports was prepared in response to a specific request from Congressman Dingell.

- Benefit Design in Health Care Reform: Clinical Preventive Services (Report)

Benefit Design in Health Care Reform: Mental Health and Substance Abuse Treatment Services (Report)

Benefit Design in Health Care Reform: Patient Cost-Sharing (Background paper)

- Benefit Design in Health care Reform: General Policy Issues (Report).

The four publications in this set will be issued in September 1993, and will be available via the Government Printing Office and, for congressional use, from OTA.

6. "Care for Depression: Issues Raised in Using Effectiveness and Cost Effectiveness Information to Design a Mental Health Benefit"

This case study will be available in winter 1993; plans for distribution are not yet final.

7. "Insurance Status and Health Care Utilization: Analysis of Four Data Bases and Cost Implications of Universal Coverage--Background Paper"

This background paper is scheduled to be available in fall-winter 1993.

### *Box D-1: Advisory Panel for OTA Assessment, Technology, Insurance, and the Health Care System*

**James C. Hunt, Chair**
University Distinguished Professor
University of Temessee-Memphis
Memphis, TN

**Henry Aaron**
Director
Economic Studies Program
Brookings Institution
Washington, DC

**Robert Brook**
Director
RAND Health Sciences Program
RAND Corporation
Santa Monica, CA

**Arthur Caplan**
Director
Center for Biomedical Ethics
University of Minnesota
Minneapolis, MN

**Deborah Chollet**
Associate Director
Center for Risk Management and Insurance Research
Georgia-State University
Atlanta, GA

**Olivia Cousins**
Associate Professor
CUNY--Health Education
New York, NY

**Jane L. Delgado**
President and CEO
National Coalition of Hispanic Health and Human Services Organazations
Washington, DC

**Paula K. Diehr**
Professor
Department of Biostatistics
School of Public Health and Community Medicine
University of Washington
Seattle, WA

**M. Joycelyn Elders**
Commissioner of Health
State of Arkansas
Little Rock, AR

**Jack Hadley**
Co-Director
Center for Health Policy Studies
Georgetown University
Washington, DC

**Douglas E. Henley**
Physician in Private Practice
Hope Mills, NC

**William Hobson**
Executive Director
Central Seattle Community Health Centers
Seattle, WA

**John Lewin**
Director of Health
State of Hawaii
Honolulu, HI

**Barbara J. McNeil**
Ridley Watts Professor and Head
Department of Health Care Policy
Harvard Medical School
Boston, MA

**David Mechanic**
Rene Dubos Professor of Behavioral Sciences
Director
Institute for Health, Health Care Policy, and Aging Research
Rutgers University
New Brunswick, NJ

**Joseph Morris**
Vice President for Information Systems
Delaware Valley Hospital Council
Philadelphia, PA

**Patricia Nazemetz**
Director of Benefits
Xerox Corporation
Stamford, **CT**

**David G. Pockell**
Senior Vice President and Regional Manager
Kaiser Foundation Health Plan
Oakland, CA

**Carl Scott**
Senior Vice President
Mutual of Omaha
Omaha, NB

**Gordon R. Trapnell**
President
Gordon R. Trapnell Consulting Actuaries, Ltd.
Annandale, VA

**Cheryl B. Travis**
Professor of Psychology and Assistant Department Head
Department of Psychology
University of Tennessee
Knoxville, TN

Special Consultant
**Stephen H. Long**
Senior Economist
RAND Corporation
Washington, DC

NOTE: OTA appreciates and is grateful for the valuable assistance and thoughtful critiques provided by the advisory panel members, The panel does not, however, necessarily approve, disapprove, or endorse this Report. OTA assumes full responsibility for the Report and the accuracy of its contents.

## ATTACHMENT E: ACKNOWLEDGMENTS


**Luz Abcede**
**Hawaii State Department of Health**
**Honolulu, HI**

**Ginny Baresch**
**Hawaii State Primary Care Association**
**Honolulu, HI**

**William H. Dendle, III**
**State Department of Health**
**Honolulu, HI**

**Bonnie Faherty**
**University of California School of Nursing**
**Los Angeles, CA**

**Henry Foley**
**Leahi Hospital**
**Honolulu, HI**

**Mark C. Hornbrook**
**Kaiser Permanence Center for Health Research**
**Portland, OR**

**Richard F. Knobel**
**Kaiser Foundation Health Plan**
**Honolulu, HI**

**Harold Luft**
**Institute for Health Policy Studies**
**San Francisco, CA**

**Ah Quon McElrath**
**Honolulu, HI**

**Robert E. Mytinger**
**Hawaii Medical Service Association Foundation**
**Honolulu, HI**

**Winifred Odo**
**Hawaii State Department of Human Services**
**Honolulu, HI**

**Neil Oyama**
**Hawaii State Department of Health**
**Honolulu, HI**

**Representative James T. Shon**
**Hawaii State House of Representatives**
**Honolulu, HI**

**Peter Sybinsky**
**Hawaii State Department of Health**
**Honolulu, HI**

**Joan B. Trauner**
**Coopers and Lybrand**
**San Francisco, CA**