2011 UPDATE TO:
"REPORT BY THE HEALTH FUTURES TASK FORCE ON A NEW HEALTH CARE ASSURANCE PROGRAM, JANUARY 1999"

THE HAWAII HEALTH AUTHORITY
December 2011

I. Introduction

Since the 1999 Health Futures Task Force report[1], Medicaid enrollment has expanded further, accelerated by the recession since 2008. There were 120,000 individuals in the QUEST program in 1999, 211,000 in June 2008, and 267,000 in December 2010. The MedQUEST budget was $606 million in FY 2011, projected to rise to $800 million in FY 2013.[2] Enrollment is projected to increase further with full implementation of the Patient Protection and Affordable Care Act (PPACA) in 2014.

MedQUEST for the General Assistance (GA) and Aid For Dependent Children (AFDC) populations has consolidated into 3 locally based managed care plans, AlohaCare, Kaiser, and HMSA. The Aged, Blind, Disabled (ABD) population was converted to managed care in February 2009 under two plans, Evercare and Ohana, which are subsidiaries of investor-owned national health insurance companies, United Health and Wellcare.

Full conversion of Hawaii Medicaid to managed care has enabled the State to contract for Medicaid expenditures with a fixed annual budget. However, outsourcing of Medicaid to private managed care plans has reduced accountability to the recipients and providers of care, and the State has not had the resources to adequately monitor the effects of this outsourcing on quality of care delivery. The concern of the Health Futures Task Force that Medicaid managed care might allow bottom-line cost considerations to overrule quality of care issues has become a reality.

In 1999, the Health Futures Task Force recommended that the State ensure adequate staffing for MedQUEST, but due to budget constraints staffing has become more inadequate than ever. This has been compounded by MedQUEST's efforts to tighten up eligibility determination, leading to widespread inappropriate disenrollments and re-applications, further bogging down overwhelmed staff. Providers caring for Medicaid patients have witnessed frequent disruptions in care, sometimes with serious consequences in morbidity and mortality, due to inappropriate disenrollments, and disruptions in coverage when patients change from one plan to another.

Medicaid recipients and providers have experienced numerous problems with unreasonable formulary restrictions and prior authorization policies that differ with each plan, requiring inordinate staff and professional time to enable prescriptions to be filled, especially for the ABD population whose pharmacy benefits are administered by a confusing array of Medicare D drug plans or by the ABD Medicaid managed care plans.

Access to care problems for Medicaid patients are escalating.[3] Problems with the administrative burdens of Medicaid managed care have led to markedly reduced acceptance of Medicaid patients by private sector professionals, even if they have signed participating provider agreements with the Medicaid managed care plans and are willing to accept Medicaid fees.[4,5] Medicaid patients who can no longer find private sector doctors willing to treat them are overwhelming the Community Health Centers

and emergency rooms. The CHC's often have long waiting lists and are sometimes closed to new referrals.

Those Hawaii hospitals with a high percentage of Medicaid patients are suffering serious financial problems and some have gone bankrupt, threatening loss of hospital beds and facilities that will jeopardize access to care for everyone in the State.

In 1999, the Health Futures Task Force expressed concern that Hawaii lacks comprehensive, coordinated data on which to base quality measures and quality improvement. This problem has not been solved to date, and fragmentation of Medicaid into 5 separate plans has made the problem worse.

II. Principles for Cost-Effective, Sustainable Health Care Reform

1. **Universality – single risk pool**
2. **Standardized benefits, adequate for effective medically necessary care**
3. **Simplify administration**
4. **Promote professionalism in health care**
5. **Quality Improvement**
6. **Ensure adequate professional workforce, especially for primary care**
7. **Accountability must be to the health needs of the population**
8. **Separate, sustainable funding for health care**

1. Universality – single risk pool

Large health care savings become possible if competing plans are consolidated into a universal program with a single risk pool. This will eliminate insurance costs of underwriting, adverse selection, multiple private bureaucracies, brokers, lobbying, and marketing and advertising. Health plan incentives to avoid covering the sick and to "cherry pick" healthier subscribers and risk pools will be eliminated. There will be no pre-existing condition exclusions, cost shifting, and disputes over who is responsible for paying for care. A broader risk pool will reduce per capita insurance reserve requirements. For businesses, a universal program will uncouple health insurance from employment status, and eliminate employer costs for health benefits administration. Patients will gain free choice of providers, with no restricted panels by plan. Everyone will have access to the same care, and the poor will no longer be relegated to an under-funded Medicaid program. The state will save the cost of eligibility determination for Medicaid. For care providers, there will be no uncompensated care. Universal coverage could remove health care costs from medical malpractice, worker's compensation, and auto insurance, greatly reducing insurance costs, even without tort reform.

2. Standardized benefits, adequate for effective care

A universal program will require comprehensive benefits, adequate for all medically necessary care, including medical, dental, vision, drug, and long-term care. Since those now covered under Medicaid will be included, co-pays and deductibles will have to be eliminated or so minimal that they could be waived for those who could not afford them. For the poor, there must be no financial barriers to seeking appropriate care. For those with moderate incomes, there will be no "under-insurance" or unaffordable costs for those with serious or disabling illness. Medical bankruptcy will be eliminated.

3. Simplify administration

With a universal program, billing and clams processing will be vastly simplified and standardized. Electronic health records and gathering of data for quality improvement will be standardized across all patients and providers. So will formulary and prior authorization policies for drugs. Incentives for cost-effectiveness should be at the point of service, between doctor and patient, minimizing central management of health care decisions by the program (managed

care) with its high administrative costs. Global budgets for hospitals and integrated care systems will eliminate billing costs that can consume up to 20% of hospital budgets.

4. **Promote professionalism in health care**
   In order to protect the public interest and safety, a universal health program must require maintenance of high standards for professional training. Professional scope of practice must be based on training, not lobbying. Physicians and other health professionals should be required to maintain membership in a professional organization, tied to licensure, to ensure that peer review and professional ethical standards are enforceable, and to promote continuing education. A universal program will also require organization of physicians and other professionals for participation in quality improvement, and for negotiation of fees with the program. The program should harness professionalism to keep health care equitable and cost-effective, and to help in recruitment of doctors and other professionals to practice in Hawaii. The net income potential for professionals must be commensurate with the training and skills necessary for their scope of practice, and any reduction in professional pay must be tied to reduction in administrative burdens (cost, time, and hassles), reduced risk of lawsuits, and subsidies for training costs.

5. **Quality Improvement**
   A system-wide quality improvement program with professional leadership should replace managed care administered by insurance companies. This program should follow William Deming's Continuous Quality Improvement (CQI) model and focus on improving processes of care, rather than just HEDIS style quality measures. Unlike CQI, other strategies to reduce unnecessary and inappropriate care such as capitation, rating providers, pay-for-performance, and incentives based on outcomes are problematic because they create disincentives to treat difficult and complex patients.

6. **Ensure adequate professional work force, especially for primary care**
   A universal program should improve payment for care coordination. Patients with significant chronic illnesses should be assigned to a "patient-centered medical home." Primary care can also be encouraged with a state-level program similar to the National Health Service, with subsidies for medical education and training tied to commitment to practice in underserved areas and specialties.

7. **Accountability must be to the health needs of the population**
   Health system policies, including fee structure, scope of practice issues, formularies, and covered benefits, must be set by a health authority that is accountable to the health needs of the community and insulated from special interests and lobbying. Funding for capital improvement in hospitals, nursing homes, diagnostic imaging centers, etc. should be determined by public health needs. Health care financing and institutions for delivery of care must both be not-for-profit. A universal health system will benefit from a continuous quality improvement program for

administrative systems as well as for health care delivery, with robust feedback from providers and patients that can actually influence policies.

8. **Separate, sustainable funding for health care**
A universal health system must have its own separate funding stream, whether this is called a health tax or a premium. There must be no mixing of health care funding with general tax revenues. Funding must be responsive to actual costs of care and public health priorities.

III. Recommendations

The Hawaii Health Authority confirms the recommendation of the 1999 Health Futures Task Force to restore the State to being the purchaser of care for Medicaid. The Department of Human Services should begin planning to de-privatize Medicaid, consolidating all the plans for the three categories of Medicaid recipients (GA, AFDC, ABD) into one plan run by the State as a public utility, with administration contracted to a single third party administrator. A consolidated Medicaid program could then be merged with other health plans and services funded by the State, including state and county employees, retirees, the Hawaii Health Systems Corporation, and specialized programs for the seriously mentally ill now run by the Dept. of Health and the Medicaid managed care plans. The eventual goal would be to merge this consolidated state-funded program into a universal, publicly funded health program covering everyone in the State of Hawaii.

Consolidation of all state-funded health plans into a single plan will require standardization of benefits at a comprehensive level, to ensure that benefits match or exceed those of all union negotiated plans, and those of former Medicaid recipients who cannot afford deductibles and co-pays for necessary care. A universal program will automatically eliminate many of the access to care problems now experienced by the Medicaid population and the uninsured.

A consolidated health program will ensure the participation of all credentialed, practicing health care providers in the state. It will require that providers of care be paid either on global budgets with professionals on salary (for hospitals and their employed physicians, and integrated systems such as Kaiser), or with a standardized, blended fee schedule representing an average of fees for Medicaid and employer based plans, discounted in proportion to administrative savings under a universal program. A universal health program could employ consolidated purchasing power to negotiate discounted prices for drugs and durable medical equipment.

The Hawaii Health Authority recommends that managed care strategies employed by private health plans be replaced with a system-wide quality improvement program, including a unified clinical data repository. This program should utilize a continuous quality improvement model focused on the processes of care, with professional leadership. Intermountain Healthcare in Utah and Rocky Mountain Health Plans in Western Colorado have successfully implemented this model, with substantial improvement in quality and reduction in the cost of care.[6,7] Continuous quality improvement has been shown to reduce variability in the processes of care without restricting the ability of doctors to deviate from guidelines on behalf of their patients when clinically necessary. It also encourages doctors to bring cost-effectiveness considerations to bear at the point of service, instead of relying on centrally administered controls by insurance plans, and is therefore much less expensive to administer than managed care. A system-wide quality improvement program enhances professionalism and ethics among health care professionals, improving professional

morale. Accountability is to effective delivery of health care, not to middlemen or investors. Quality improvement can also include programs to detect and reduce fraud and abuse.

In implementing a universal health program, the Hawaii Health Authority recommends that the State pursue all possible avenues to maximize federal matching funds, including full implementation of our Section 1115 Medicaid waiver and pulling in federal funds for quality improvement programs. If possible, the State should pursue a waiver to fold Medicare into a universal health program, or consider setting up one or two Medicare Advantage plans to capture this population, as is being done by Kaiser in Hawaii or by Rocky Mountain Health Plans in Colorado.

The PPACA calls for the creation of a statewide health insurance exchange for the individual and small group markets. However, attempts to set up exchanges elsewhere in the country have either failed due to adverse selection and other problems, or are adding 4-5% in administrative costs to health care (Massachusetts).[8,9,10] The Hawaii Health Authority recommends that the Administration pursue a federal waiver to either implement a universal health care program in lieu of an insurance exchange, or else create a minimally competitive exchange with 1-2 plans, with standardized comprehensive benefits and standardized provider fees, so that the exchange would be ready to be folded into a universal program as soon as waivers could be obtained (following the lead of Vermont.)

IV. Cost Implications

Federal matching funds for Medicaid could be based on population-level statistics rather than individual eligibility determination, saving the Hawaii Department of Human Services the cost of eligibility determination. A single program for all state-funded health care would markedly reduce administrative costs due to elimination of multiple administrative bureaucracies among the various plans we have now. It would eliminate the costs of marketing, lobbying, underwriting and risk adjustment, managed care costs, pharmacy benefit manager costs, profit, and confusion and costs associated with an array of formularies and prior authorization policies for drugs. With a fully implemented universal health care program, these savings are estimated to be around 15% of total healthcare costs.

Payment of hospitals and integrated systems with global budgets and eliminating their billing departments are estimated to save up to 20% of hospitals' costs.[11,12] Global budgets would also eliminate hospital incentives to encourage unnecessary but profitable procedures to compensate for losses in departments such as emergency rooms, psychiatry, and geriatrics, with a high percentage of Medicaid, Medicare, and uninsured patients. Paying independent professionals with a standardized, blended fee schedule from a single source of funding would save about 10% of practice costs.[11,12] Prices and fees could be reduced accordingly. Bulk purchasing of drugs and durable medical equipment could save another 5% of total healthcare costs.

With a universal program, health care could be removed from injury litigation, markedly reducing both the size of judgments and the necessity to sue for access to injury related health care, eliminating more than half the cost of medical malpractice, worker's compensation, and automobile insurance. Early disclosure of errors with an apology, financial compensation, and using analysis of errors to enhance a quality improvement program have also been shown to reduce medical malpractice costs by more than 50% in a pilot program at U. of Michigan,[13,14] and such a program should be implemented in Hawaii. These measures would be estimated to save 60-70% of the cost of worker's compensation and automobile insurance, and around 80% of the cost of medical malpractice.

The Hawaii Health Authority estimates that if fully implemented, a universal, publicly funded health care system could cover everyone in the State and could simultaneously save around 25-30% of total health care costs.

References

1. Graulty RD, Watland J, Miike L, Duarte C, Schwalbaum R, Confalone P, DeRauf D, Gire C, Meiers R, Mitsunaga R, Saruwatari K, Smallwood L, Wong C. Report by the Health Futures Task Force on a New Health Care Assurance Program. Department of Commerce and Consumer Affairs, State of Hawaii. January 1999.
2. Fink, K. Proposal for Addressing the Med-QUEST Division's Budget and for Moving Forward. Department of Human Services, State of Hawaii. May 10, 2011.
3. Consilio K, Locating a Doctor Who Takes Public Insurance Proves Difficult in Isles. Honolulu Star Advertiser. July 18, 2011.
4. Flanders C. HMA Medicare-Medicaid Survey. Hawaii Medical Association. September 12, 2011.
5. Tice A, Ruckle JE, Sultan OS, Kemble S. Access to Care: The Physicians' Perspective. Hawaii Medical Journal 70, February 2011; 33-38
6. James BC and Savitzdoi LA. How Intermountain Trimmed Health Care Costs Through Robust Quality Improvement Efforts. *Health Affairs* 30, no. 6 (2011); DOI:10.1377/hlthaff.2011.0358
7. N Bodenheimer T and West D. Low-Cost Lessons from Grand Junction, Colorado. *N Eng J Med* 2010; DOI: 10.1056/NEJMp1008450.
8. Jost TS. Health Exchanges and the Affordable Care Act: Key Policy Issues. The Commonwealth Fund, July 2010.
9. Sommers BD, Rosenbaum S. Issues In Health Reform: How Changes In Eligibility May Move Millions Back And Forth Between Medicaid And Insurance Exchanges. Health Affairs 30, No. 2 (2011); 228-236. http://content.healthaffairs.org/content/30/2/228.full.html
10. Nardin R, Himmelstein D, Woolhandler S. Massachusetts' Plan: A Failed Model for Health Care Reform. PNHP. http://www.pnhp.org/mass_report/mass_report_Final.pdf. Accessed February 18, 2009.
11. Sheils J, Murphy E, Haught R. Analysis of the Impact of an Illustrative Single-Payer System for Hawai'i. The Lewin Group. June 30, 2006.
12. Cost and Coverage Analysis of Nine Proposals to Expand Health Insurance Coverage in California. The Lewin Group. April 22, 2002.
13. Clinton HR, Obama B. Making Patient Safety the Centerpiece of Medical Malpractice Reform. N. Eng. J. Med 354;21 (2006); 2205-2208.
14. Localio AR. Patient Compensation Without Litigation: A Promising Development. Ann. Int. Med. 2010;153:266-267.