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.
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> "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.
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> 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

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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

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.

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.