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).**

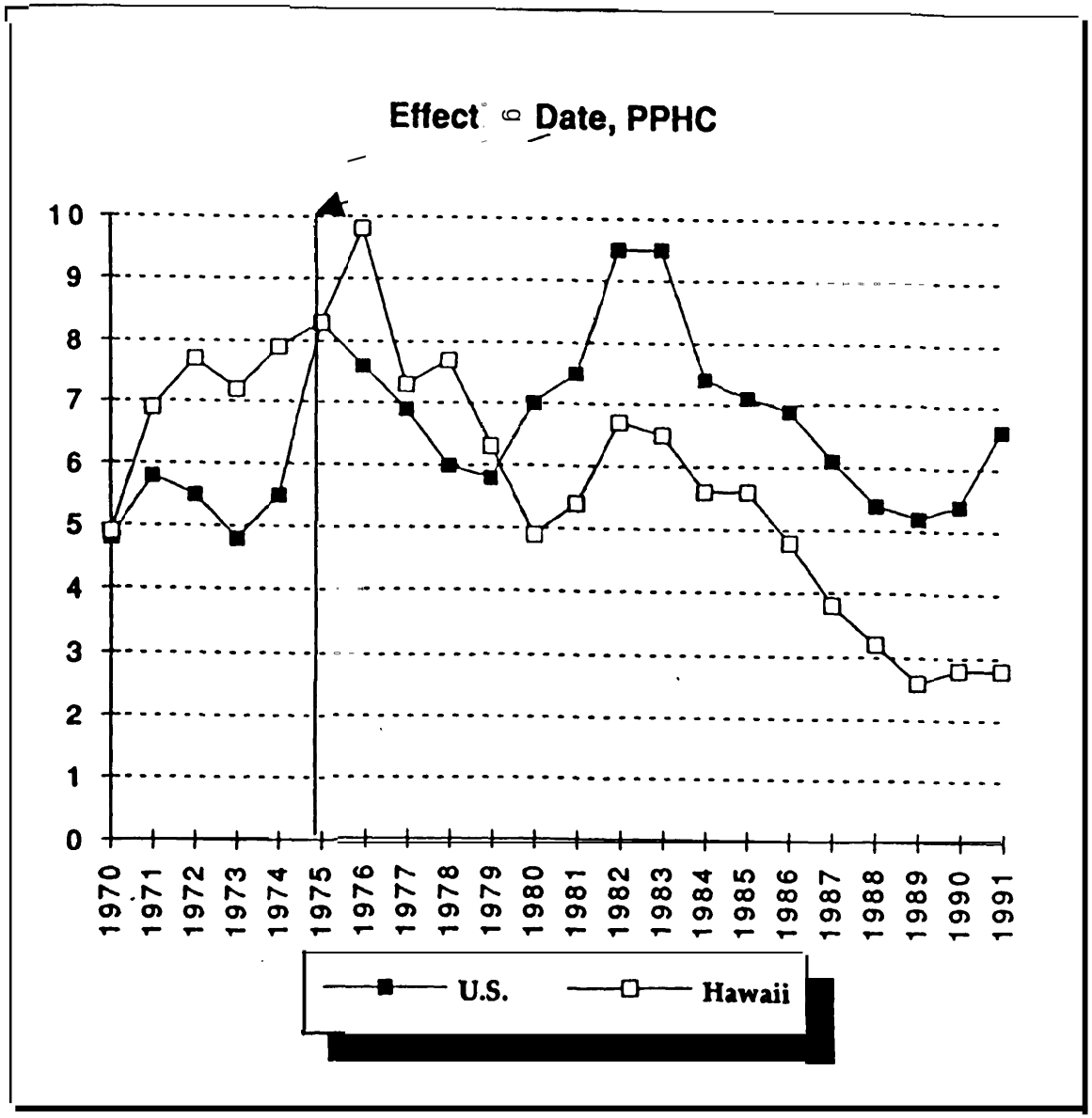
Hawaii residents' health care utilization and insurance rates are also well below the **national average. In 1992 the national average for the annual group health insurance premium for a single person was $2,301 (5'). In contrast,** for groups of less than 100 employees, the annual premium for a single 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?