GET Committee

From: Single Payer Hawaii Healthcare For All Hawaii <singlepayerhawaii@gmail.com>
Sent: Monday, August 24, 2020 8:44 PM
To: GET Committee
Subject: GET Hearing Aug 25, 9:00 am Item #3
Attachments: Maui single payer testimony.pdf; HHA Report 2020.pdf

Good Morning!

I've attached my testimony as a pdf, and ann additional report from the Hawaii Health Authority, and in the event a security program blocks opening that, I'm also copying the text here:

Dennis B Miller
2330 Kalakaua Ave Ste 146
Honolulu, HI 96815
(808) 227 8241

24 August, 2020

GET Committee
Maui County Council
Vice Chair Keani Rawlings-Fernandez
Members

Aloha GET committee,

Re: HAWAII STATE ASSOCIATION OF COUNTIES (HSAC) (2021 HSAC LEGISLATIVE PACKAGE) (GET-3(2))

Item #3, relating to a bill for Single Payer

Please support the bill for Single Payer in Hawaii, however, please support the writing of the single payer bill to be done by the existing law HRS322H The Hawaii Health Authority.

The Hawaii Health Authority has the statutory authority to design the best possible Universal Healthcare System for Hawaii.

Single Payer is ideal, however, due to the requirement for a federal waiver for Medicare, it should be held in waiting until a POTUS is in office who will approve a state's request to fold Medicare into a state based single payer system.

Until that time, Hawaii can still utilize the Hawaii Health Authority to implement the recommendations in the recent report to the HHA, which is attached to this testimony.

If the state, via the HHA establishes an admin-simple Self Insured system for Public Employees, and, reclaims MedQuest Hawaii from private contractors in order to establish an identical admin-simple Self Insured system for Medicaid, the state could reasonably duplicate the savings achieved by Connecticut. Applying Connecticut's 14% reduction in Medicaid costs to Hawaii's current Public Employee + Medicaid costs would result in around $350 million in savings.

Please host a meeting on this topic with a health policy expert who can go into the details.

After setting up 'admin-simple' Self Insured systems for Public Employees and Medicaid, the state could then allow private businesses to buy in, which would provide desperately needed cost savings for businesses.

However, the savings are not limited to the state, or to the business who is paying for employee health insurance. Clinics and hospitals will see their budget for billing insurance companies go down by a significant amount. Right now, Hawaii is facing a physician shortage because HMSA's reimbursement complexities have added costs which clinics cannot afford, so they are closing. Many physicians are either retiring early, leaving the state, or limiting their practice to higher paying patients. This is because HMSA is set on continuing with their Managed Care reimbursement 'scheme.'

The unification of all health insurance business plans, in which all health insurance providers in Hawaii offer the same comprehensive benefit package, bill for it via the same admin system, and reimburse the same rate regardless of Medicaid, private insurance, or Medicare Advantage, will save our clinics from admin costs which are currently harming their ability to operate.

Doing this will establish the premise of single payer, which is that one form of health insurance costs vastly less than the 900 health insurance companies in the USA.

The state and businesses will immediately save money. Healthcare providers will immediately save money. Patients will immediately see a reduction in out of pocket costs, which will allow people to afford to use their health insurance. In 2018 47% of people with employer provided health insurance did not use it when they needed it because they couldn't afford the co pay and deductible.

In order to establish the truth of these statements in the minds of the community, I urge all county councils to host town halls at which anti-single payer disinformation can be debunked. The health insurance lobby spends around $100 million per year, every year, on disinformation aimed at misleading the public into believing that a federal Medicare For All is too expensive or takes away patient choices. In fact, it costs vastly less, and gives all patients all choices.

Thank you for your time.

Please pass item #3 regarding a bill for Single Payer and specify that it will be written by the Hawaii Health Authority. This requires persuading Governor Ige to allow the HHA to be funded, and, for the governor and leaders of the legislature to appoint the nine HHA board members. If those board members support the mission of single payer as described by local single payer leader Dr. Stephen Kemble, then a successful plan will be developed. If the appointees try to defend HMSA's costly practices, the plan will fail.

Dennis B Miller
Medicare For All Hawaii
Email: singlepayerhawaii@gmail.com

Hawaii Health Care Savings Achievable through Administrative Simplification

Report to Governor David Ige and Hawaii Legislature
The Hawaii Health Authority
June, 2020

The Hawaii Health Authority

The Hawaii Health Authority (HHA)[1] is charged under Hawaii law, HRS 322H, with designing a universal healthcare system covering all residents of Hawaii. The HHA met regularly from 2011 until April 2013, working toward this goal. Due to lack of support from recent administrations the HHA has not met since 2013, but the remaining members have remained committed to finding ways to improve access and reduce cost for the state of Hawaii.

The last HHA report in November 2019 documented the failures of Hawaii's health transformation effort, spearheaded by the health plans, to achieve any of the goals of reform. Outcomes include a worsening physician shortage, worst in primary care and on the neighbor islands, and an epidemic of physician demoralization and burnout and rapid destruction of independent primary care practices. As primary care practices are squeezed financially by HMSA's payment transformation, we have witnessed a wave of practices refusing new patients with either Medicare or Medicaid, leading to a crisis in access to care. In July 2019, Wallet Hub rated Hawaii 51st, worst in the nation, for finding doctors accepting new patients with Medicare. Meanwhile, the cost of health care to the state has continued to rise at an average rate of about 7% per year over the past decade, with no end in sight.

Payment Transformation and Hawaii's Primary Care and Physician Workforce Crisis

Hawaii Public Radio (HPR) reported recently on a study by Aimed Alliance, done prior to the COVID-19 pandemic, on the effects of HMSA's Payment Transformation (PT), which pays primary care doctors a flat payment per attributed patient per month (capitation). This was supposed to avoid the presumed incentive under fee-for-service payment to increase income by increasing the volume of services, and presumably provide unnecessary service.

However, primary care doctors do not think like insurance executives and are generally focused on meeting the needs of their patients, not taking maximum advantage of financial incentives. Hawaii primary care doctors have always been too busy to expand volume of services, and there never was any evidence of excessive volume of primary care services in Hawaii when everyone was paid with fee-for-service.

Pure capitation is a simpler way to pay doctors, but it introduces perverse incentives to skimp on care and to avoid care of sicker, poorer, and more complex patients. The counter-incentives used by HMSA and Medicare are pay-for-quality or outcomes and risk adjustment, both of which depend on very detailed documentation and data reporting. The result is increasing administrative costs for both the payer and for the primary care practices, and there have been no offsetting savings from reduced utilization.

Even worse, these counter-incentives fail to prevent skimping on care, "cherry picking" easier patient populations and avoiding sicker, poorer, and more complex patients and populations that require more of the doctor's time, and gaming of documentation to increase payment, which are the problems they were intended to counter. The only practices that are able to do well under HMSA's payment transformation are large, stable practices with mostly middle-class patients and few new patients. Newer practices that take a lot of new patients and don't discriminate against "difficult" patients are not surviving financially.

The Aimed Alliance report found that a majority of Hawaii primary care doctors say HMSA's PT has reduced quality of care by causing them to refrain from providing treatment or services, caused them to refer patients to urgent care or specialists instead of seeing them in the office, and caused an increase in administrative tasks that requires them to work longer hours and/or hire more staff. About half say low capitation rates and higher overhead have resulted in reduced practice revenue, and over 80% felt PT has contributed to Hawaii's physician shortage. 80% would discourage new doctors from starting a primary care practice in Hawaii. Other surveys confirm that primary care practices squeezed financially by PT have stopped accepting new patients with Medicare or Medicaid, because their fees are even lower than commercial insurance plans.

The COVID-19 Pandemic and Its Effects on Hawaii Health Care

Since the COVID-19 pandemic, social distancing and fear have markedly reduced primary care office visits, with many practices reporting about 60-70% drop in fee-for-service practice revenue, even with ramping up telehealth. Hospitals have had to curtail elective surgeries and patients with strokes and heart attacks and complications of diabetes are avoiding coming to the hospital for fear of catching COVID-19, so hospital revenues have plummeted, while deaths and complications from all causes are increasing. The rapid rise in unemployment in Hawaii means many will soon lose their health insurance or be forced onto Medicaid.

Capitation has a positive feature, in that payments are independent of whether the patient comes to the office or not, but this does not solve the problems of excessive administrative burdens and cost, perverse incentives to skimp on care and avoid sicker patients, inadequate capitation rates, and loss of insurance. It appears we are well on the way to losing most of Hawaii's independent primary care practices by the end of this year, with devastating consequences.

The immediate need is for all of Hawaii's health plans, including the Medicaid managed care plans, to significantly increase primary care payment. It would be very helpful if Medicaid rates for evaluation and management services (much of primary care) could be raised at least to the level of Medicare. Over the next 1-2 years, Hawaii must take major steps to reduce the administrative waste in health care that has been causing steady increases in the cost of health care, while primary care payment has become so inadequate that our doctors are being forced out of practice.

Self-Insuring Hawaii Employee and Retiree Health Benefits and Medicaid

Substantial savings could be achieved if the state of Hawaii were to adopt HB 1462 and move from a fully insured health benefits model to a self-insured "pay-as-you-go" model, provided payment were simplified and standardized so as to reduce administrative costs for both the state and for doctors. Twenty nine other states now self-insure all their state and county employees and retiree health benefits, with savings of up to 22%.

Philadelphia switched from fully insuring city employees through an insurance company to self-funding in 2008, and over the next 5 years their health benefit costs dropped from $98.4M in FY 2008 to $76.4M in FY 2013, a 22% drop. Utah switched to self-insurance and saw their health benefits administrative costs drop from 15% to 5% of their health care budget.

Similar savings could be achieved if the Department of Human Services were to take Medicaid back from managed care organizations and return to a self-insured model with joint federal and state funding, as Medicaid was originally designed, but with enhanced payments to primary care for care coordination. Oklahoma's Medicaid program tried turning over some counties to managed care organizations and in the rest they paid primary care doctors directly an extra fee to cover care coordination (Primary Care Case Management, or PCCM). After several years, PCCM proved significantly more cost-effective. Connecticut followed the lead of Oklahoma and after 12 years of managed care they terminated their Medicaid managed care contracts in 2012, self-funding Medicaid with primary care case management and raising Medicaid rates for physicians to Medicare levels. Six years later, physician participation in Medicaid had improved substantially, emergency room and hospital costs had dropped 25%, and Connecticut saw their per-member Medicaid costs drop from $706 per member per month in 2012 to $610 per member per month in 2018, a 14% drop.

Self-insuring does come with a caveat – It must be paired with an administratively simple and more cost-effective payment system, and cannot be simply turned over to a health insurance company offering an "Administrative Services Only" (ASO) contract that enables the insurance company to retain what they think should be "their share" of the health care budget, perpetuating the administrative waste in the current system while sticking the state with the risk of high cost cases. Self-insured states do need to hire a third party to administer claims processing, but an Internet search for "Self-funding state health benefits" will quickly show pages of ads from insurance companies offering ASO contracts to states and large corporations wanting to self-fund, and they would not be advertising if they did not expect to profit from these ASO contracts. David Belk's book, The Great American Healthcare Scam, has a whole chapter on how self-insurance can be exploited by insurance companies.

Self-insuring can save significant money for the state of Hawaii, but only if the state sets up a mechanism to define how doctors and hospitals will be paid and how care will be managed, and writes the RFP (Request for Proposal) for an ASO contract so as to limit it to claims processing, and not controlling rates, fees, payment systems, prior authorizations, etc. This means Hawaii can't just switch to self-funding and ask a health plan to take care of the details using the same strategies that have gotten us into our current crisis with health care access and cost. How health care financing is structured must be controlled by a state appointed board that is not tied to health insurance plans. The Hawaii Health Authority is already in statute with a mandate to handle just such things, and it needs to be activated and used in order to do self-insuring in a way that will actually save money.

Before the COVID-19 pandemic the Hawai`i state budget was almost 8 billion per year. Health care costs comprise 30% of $8B, with about half of that 30% attributable to employee/retiree EUTF health benefits and the other half to Medicaid (state share). Based on the experience of Connecticut, self-funding Medicaid would save about 14% per year, and on the employee/retiree side, if we move to a simpler, more cost-effective payment system than that of HMSA, we could save at least 15% there as well. 30% of $8B is $2.4B, and 14% - 15% of $2.4B is about $350M in savings per year.

Simplifying and Standardizing Physician and Hospital Payment

A more cost-effective way to pay doctors would be with standardized fee-for-service, as HMSA used to do before the passage of the ACA. We could do even better with a simplified time-based fee-for-service system similar to how independent psychiatrists were paid prior to 2013, but we recommend that the time include time for documentation and care coordination, and not just face-to-face time, and also that the hourly rates be negotiated collectively with physicians to assure that physician payment continues to be reasonable over time. Collective negotiation would require an anti-trust exemption (not difficult to justify if fees are going to be standardized and not determined by a "market") and a requirement that all physicians must, as a condition of licensure, be members of the organization representing them in fee negotiations. Alaska already has a federal anti-trust exemption allowing collective mediation on fees between a physician organization and their dominant health plan, a situation similar to Hawaii. The Hawaii Medical Association (HMA) would be the logical organization to do this, and if all doctors had to join, dues would be reduced substantially.

Other functions that health insurance companies have coopted include network development and contracting, credentialing, rooting out fraud and abuse (other than their own), and quality improvement projects. All of these could and should be turned over to the same physician organization empowered to negotiate fees, and all but quality improvement could be covered by the dues paid to the professional organization, at no cost to the state. Quality improvement should be funded with grants from the state for projects and should function similarly to Mountain Pacific Quality Health. The expense of doing quality improvement this way would be nominal.

Hospitals should be paid with global budgets, with pooled funding from all health plans and other payers, and not with fees for every item and procedure attributed to individual patients and controlled by a hospital "chargemaster", or through competing risk-bearing ACOs (Accountable Care Organizations). Savings from eliminating hospital billing and collections would be in the range of 15% of total hospital revenues. Hospital based physicians should be paid with salaries from the hospital's budget. This would require a state agency to negotiate budgets with hospitals, and to gather the funds from all payers and allocate them to hospitals based on community needs. The HHA could assist with designing how the system would work, and with assuring it was done in the community interest, and not primarily the interests of health insurance plans.

The other component necessary for a high-performing, cost-effective health system would be programs for special needs. These should be community based, and not contracted to health plans, so as to assure availability of such services to everyone in the community based on patient need, not insurance status. These community-based programs would be multidisciplinary and funded with global budgets pooled from all payers, in the same way as hospitals, with professionals paid on salaries. Examples include programs for the seriously mentally ill and substance abuse, community health centers, team-based care of complex medical and surgical patients in the community, and specialist consultations to primary care such as Collaborative Care in psychiatry. The same model would work well for many other specialist consultations besides psychiatry, that do not involve procedures.

All of this depends on an adequate and healthy primary care work force. Assuring adequate pay and minimizing administrative burdens for primary care practices must be a priority. The HHA could help with this also. In addition to assuring adequate pay, the availability of community-based programs for special needs as described above would provide essential support to make primary care viable and rewarding again.

Conclusions

In the face of a drastic drop in state tax revenues due to the COVID-19 pandemic, Hawaii urgently needs to find ways to reduce cost. There are substantial opportunities for savings in health care if the state were to pass HB 1462 and move from a fully insured model to a self-insured health benefits program for state and county employees and retirees, and if DHS were to terminate our Medicaid Managed Care contracts and go back to self-insuring Medicaid with enhanced primary care case management.

In order to achieve savings, the state must retain control of physician and hospital payment and fees, and contract with a health insurance plan under an "Administrative Services Only" contract that was limited to claims processing and a few other essential services. The state could then move to an administratively simple standardized payment system instead of the very complex and expensive claims adjudication system now in place. These changes could restore the viability of independent physician practices in Hawaii and reverse our loss of doctors. They would enable Hawaii to save our neighbor island and critical access hospitals from bankruptcy. We could achieve markedly improved access to care for the people of Hawaii, while saving around $350 million per year for the state budget.

Stephen Kemble, MD
Marion Poirier, RN
(Remaining Members of the Hawaii Health Authority)

Dennis B Miller
2330 Kalakaua Ave Ste 146
Honolulu, HI 96815

24 August, 2020

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In the face of a drastic drop in state tax revenues due to the COVID-19 pandemic, Hawaii urgently needs to find ways to reduce cost. There are substantial opportunities for savings in health care if the state were to pass HB 1462 and move from a fully insured model to a self-insured health benefits program for state and county employees and retirees, and if DHS were to terminate our Medicaid Managed Care contracts and go back to self-insuring Medicaid with enhanced primary care case management.

In order to achieve savings, the state must retain control of physician and hospital payment and fees, and contract with a health insurance plan under an "Administrative Services Only" contract that was limited to claims processing and a few other essential services. The state could then move to an administratively simple standardized payment system instead of the very complex and expensive claims adjudication system now in place. These changes could restore the viability of independent physician practices in Hawaii and reverse our loss of doctors. They would enable Hawaii to save our neighbor island and critical access hospitals from bankruptcy. We could achieve markedly improved access to care for the people of Hawaii, while saving around $350 million per year for the state budget.

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Hawaii Health Care Savings Achievable through Administrative Simplification

Report to Governor David Ige and Hawaii Legislature
The Hawaii Health Authority
June, 2020

The Hawaii Health Authority

The Hawaii Health Authority (HHA)[1] is charged under Hawaii law, HRS 322H, with designing a universal healthcare system covering all residents of Hawaii. The HHA met regularly from 2011 until April 2013, working toward this goal. Due to lack of support from recent administrations the HHA has not met since 2013, but the remaining members have remained committed to finding ways to improve access and reduce cost for the state of Hawaii.

The last HHA report in November 2019 documented the failures of Hawaii's health transformation effort, spearheaded by the health plans, to achieve any of the goals of reform. Outcomes include a worsening physician shortage, worst in primary care and on the neighbor islands, and an epidemic of physician demoralization and burnout and rapid destruction of independent primary care practices. As primary care practices are squeezed financially by HMSA's payment transformation, we have witnessed a wave of practices refusing new patients with either Medicare or Medicaid, leading to a crisis in access to care. In July 2019, Wallet Hub rated Hawaii 51st, worst in the nation, for finding doctors accepting new patients with Medicare. Meanwhile, the cost of health care to the state has continued to rise at an average rate of about 7% per year over the past decade, with no end in sight.

Payment Transformation and Hawaii's Primary Care and Physician Workforce Crisis

Hawaii Public Radio (HPR) reported recently on a study by Aimed Alliance, done prior to the COVID-19 pandemic, on the effects of HMSA's Payment Transformation (PT), which pays primary care doctors a flat payment per attributed patient per month (capitation). This was supposed to avoid the presumed incentive under fee-for-service payment to increase income by increasing the volume of services, and presumably provide unnecessary service.

However, primary care doctors do not think like insurance executives and are generally focused on meeting the needs of their patients, not taking maximum advantage of financial incentives. Hawaii

primary care doctors have always been too busy to expand volume of services, and there never was any evidence of excessive volume of primary care services in Hawaii when everyone was paid with fee-for-service.

Pure capitation is a simpler way to pay doctors, but it introduces perverse incentives to skimp on care and to avoid care of sicker, poorer, and more complex patients. The counter-incentives used by HMSA and Medicare are pay-for-quality or outcomes and risk adjustment, both of which depend on very detailed documentation and data reporting. The result is increasing administrative costs for both the payer and for the primary care practices, and there have been no offsetting savings from reduced utilization.

Even worse, these counter-incentives fail to prevent skimping on care, "cherry picking" easier patient populations and avoiding sicker, poorer, and more complex patients and populations that require more of the doctor's time, and gaming of documentation to increase payment, which are the problems they were intended to counter. The only practices that are able to do well under HMSA's payment transformation are large, stable practices with mostly middle-class patients and few new patients. Newer practices that take a lot of new patients and don't discriminate against "difficult" patients are not surviving financially.

The Aimed Alliance report found that a majority of Hawaii primary care doctors say HMSA's PT has reduced quality of care by causing them to refrain from providing treatment or services, caused them to refer patients to urgent care or specialists instead of seeing them in the office, and caused an increase in administrative tasks that requires them to work longer hours and/or hire more staff. About half say low capitation rates and higher overhead have resulted in reduced practice revenue, and over 80% felt PT has contributed to Hawaii's physician shortage. 80% would discourage new doctors from starting a primary care practice in Hawaii. Other surveys confirm that primary care practices squeezed financially by PT have stopped accepting new patients with Medicare or Medicaid, because their fees are even lower than commercial insurance plans.

The COVID-19 Pandemic and Its Effects on Hawaii Health Care

Since the COVID-19 pandemic, social distancing and fear have markedly reduced primary care office visits, with many practices reporting about 60-70% drop in fee-for-service practice revenue, even with ramping up telehealth. Hospitals have had to curtail elective surgeries and patients with strokes and heart attacks and complications of diabetes are avoiding coming to the hospital for fear of catching COVID-19, so hospital revenues have plummeted, while deaths and complications from all causes are increasing. The rapid rise in unemployment in Hawaii means many will soon lose their health insurance or be forced onto Medicaid.

Capitation has a positive feature, in that payments are independent of whether the patient comes to the office or not, but this does not solve the problems of excessive administrative burdens and cost, perverse incentives to skimp on care and avoid sicker patients, inadequate capitation rates, and loss of insurance. It appears we are well on the way to losing most of Hawaii's independent primary care practices by the end of this year, with devastating consequences.

The immediate need is for all of Hawaii's health plans, including the Medicaid managed care plans, to significantly increase primary care payment. It would be very helpful if Medicaid rates for evaluation and management services (much of primary care) could be raised at least to the level of Medicare. Over the next 1-2 years, Hawaii must take major steps to reduce the administrative waste in health care that has been causing steady increases in the cost of health care, while primary care payment has become so inadequate that our doctors are being forced out of practice.

Self-Insuring Hawaii Employee and Retiree Health Benefits and Medicaid

Substantial savings could be achieved if the state of Hawaii were to adopt HB 1462 and move from a fully insured health benefits model to a self-insured "pay-as-you-go" model, provided payment were simplified and standardized so as to reduce administrative costs for both the state and for doctors. Twenty nine other states now self-insure all their state and county employees and retiree health benefits, with savings of up to 22%. Philadelphia switched from fully insuring city employees through an insurance company to self-funding in 2008, and over the next 5 years their health benefit costs dropped from $98.4M in FY 2008 to $76.4M in FY 2013, a 22% drop. Utah switched to self-insurance and saw their health benefits administrative costs drop from 15% to 5% of their health care budget.

Similar savings could be achieved if the Department of Human Services were to take Medicaid back from managed care organizations and return to a self-insured model with joint federal and state funding, as Medicaid was originally designed, but with enhanced payments to primary care for care coordination. Oklahoma's Medicaid program tried turning over some counties to managed care organizations and in the rest they paid primary care doctors directly an extra fee to cover care coordination (Primary Care Case Management, or PCCM). After several years, PCCM proved significantly more cost-effective. Connecticut followed the lead of Oklahoma and after 12 years of managed care they terminated their Medicaid managed care contracts in 2012, self-funding Medicaid with primary care case management and raising Medicaid rates for physicians to Medicare levels. Six years later, physician participation in Medicaid had improved substantially, emergency room and hospital costs had dropped 25%, and Connecticut saw their per-member Medicaid costs drop from $706 per member per month in 2012 to $610 per member per month in 2018, a 14% drop.

Self-insuring does come with a caveat – It must be paired with an administratively simple and more cost-effective payment system, and cannot be simply turned over to a health insurance company offering an "Administrative Services Only" (ASO) contract that enables the insurance company to retain what they think should be "their share" of the health care budget, perpetuating the administrative waste in the current system while sticking the state with the risk of high cost cases. Self-insured states do need to hire a third party to administer claims processing, but an Internet search for "Self-funding state health benefits" will quickly show pages of ads from insurance companies offering ASO contracts to states and large corporations wanting to self-fund, and they would not be advertising if they did not expect to profit from these ASO contracts. David Belk's book, The Great American Healthcare Scam, has a whole chapter on how self-insurance can be exploited by insurance companies.

Self-insuring can save significant money for the state of Hawaii, but only if the state sets up a mechanism to define how doctors and hospitals will be paid and how care will be managed, and writes the RFP (Request for Proposal) for an ASO contract so as to limit it to claims processing, and not controlling rates, fees, payment systems, prior authorizations, etc. This means Hawaii can't just switch

to self-funding and ask a health plan to take care of the details using the same strategies that have gotten us into our current crisis with health care access and cost. How health care financing is structured must be controlled by a state appointed board that is not tied to health insurance plans. The Hawaii Health Authority is already in statute with a mandate to handle just such things, and it needs to be activated and used in order to do self-insuring in a way that will actually save money.

Before the COVID-19 pandemic the Hawai`i state budget was almost 8 billion per year. Health care costs comprise 30% of $8B, with about half of that 30% attributable to employee/retiree EUTF health benefits and the other half to Medicaid (state share). Based on the experience of Connecticut, self-funding Medicaid would save about 14% per year, and on the employee/retiree side, if we move to a simpler, more cost-effective payment system than that of HMSA, we could save at least 15% there as well. 30% of $8B is $2.4B, and 14% - 15% of $2.4B is about $350M in savings per year.

Simplifying and Standardizing Physician and Hospital Payment

A more cost-effective way to pay doctors would be with standardized fee-for-service, as HMSA used to do before the passage of the ACA. We could do even better with a simplified time-based fee-for-service system similar to how independent psychiatrists were paid prior to 2013, but we recommend that the time include time for documentation and care coordination, and not just face-to-face time, and also that the hourly rates be negotiated collectively with physicians to assure that physician payment continues to be reasonable over time. Collective negotiation would require an anti-trust exemption (not difficult to justify if fees are going to be standardized and not determined by a “market”) and a requirement that all physicians must, as a condition of licensure, be members of the organization representing them in fee negotiations. Alaska already has a federal anti-trust exemption allowing collective mediation on fees between a physician organization and their dominant health plan, a situation similar to Hawaii. The Hawaii Medical Association (HMA) would be the logical organization to do this, and if all doctors had to join, dues would be reduced substantially.

Other functions that health insurance companies have coopted include network development and contracting, credentialing, rooting out fraud and abuse (other than their own), and quality improvement projects. All of these could and should be turned over to the same physician organization empowered to negotiate fees, and all but quality improvement could be covered by the dues paid to the professional organization, at no cost to the state. Quality improvement should be funded with grants from the state for projects and should function similarly to Mountain Pacific Quality Health. The expense of doing quality improvement this way would be nominal.

Hospitals should be paid with global budgets, with pooled funding from all health plans and other payers, and not with fees for every item and procedure attributed to individual patients and controlled by a hospital “chargemaster", or through competing risk-bearing ACOs (Accountable Care Organizations). Savings from eliminating hospital billing and collections would be in the range of 15% of total hospital revenues. Hospital based physicians should be paid with salaries from the hospital’s budget. This would require a state agency to negotiate budgets with hospitals, and to gather the funds from all payers and allocate them to hospitals based on community needs. The HHA could assist with designing how the system would work, and with assuring it was done in the community interest, and not primarily the interests of health insurance plans.

The other component necessary for a high-performing, cost-effective health system would be programs for special needs. These should be community based, and not contracted to health plans, so as to assure availability of such services to everyone in the community based on patient need, not insurance status. These community-based programs would be multidisciplinary and funded with global budgets pooled from all payers, in the same way as hospitals, with professionals paid on salaries. Examples include programs for the seriously mentally ill and substance abuse, community health centers, team-based care of complex medical and surgical patients in the community, and specialist consultations to primary care such as Collaborative Care in psychiatry. The same model would work well for many other specialist consultations besides psychiatry, that do not involve procedures.

All of this depends on an adequate and healthy primary care work force. Assuring adequate pay and minimizing administrative burdens for primary care practices must be a priority. The HHA could help with this also. In addition to assuring adequate pay, the availability of community-based programs for special needs as described above would provide essential support to make primary care viable and rewarding again.

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