

**REPORT BY THE
HEALTH FUTURES TASK FORCE
ON A
NEW HEALTH CARE ASSURANCE PROGRAM**

Submitted by the

**DEPARTMENT OF COMMERCE AND CONSUMER AFFAIRS
STATE OF HAWAII
JANUARY 1999**

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I. EXECUTIVE SUMMARY

■ INTRODUCTION

Current estimates place the amount paid by the State of Hawaii in health care premiums for state and county employees and retirees, as well as those enrolled in QUEST, at over \$1 billion per year. Out of a total outlay of \$4 billion per year for health care in our State, this represents a sizeable piece of the health care "pie" as well as a sizable and growing portion of State expenditures of taxpayers' dollars.

■ DISCUSSION

A. Is There a Better Model Available for QUEST than the Managed Care Model?

The Task Force believes that QUEST is an improvement over the previous fee-for-service program and has also lowered per capita costs. Until such time a new model is developed and proves itself better, the State's Section 1115 waiver for the QUEST program should be continued.

Evaluations and Assessments of QUEST's Procurement Strategy and Program Design:

Last October, the National Association of State Medicaid Directors ("NASMD") suggested to the Center for Health Care Strategies and the Robert Wood Johnson Foundation that a review be conducted and a report prepared on these topics. This report will be entitled, "*Medicaid Managed Care Purchasing: What Works and What Doesn't.*" The DHS has requested that it be included in the list of states which will be reviewed more intensively.

Current Views on QUEST

The Task Force wishes to point out that the number of low income individuals enrolled in QUEST throughout the State has increased over the last four years. There are now 120,000 individuals, primarily women and children, enrolled in QUEST, up from 90,000 in 1994.

The ideas provided in this report will hopefully assist the Legislature and the QUEST Program to achieve the goal of not only providing almost universal access to health care in Hawaii, but ensure that there are no loss of benefits and no compromises in the quality of care.

This, and the adoption of managed care principles for the other populations in Medicaid - those enrolled in the high-cost Aged Blind & Disabled ("ABD") program and in Long Term Care ("LTC"), are the major challenges before the Legislature, the QUEST Program, the State as Payor, the health care providers, and all those with a stake in the continued viability and improvement of the health care system in our State.

- B. **Can Improvements Be Made to the Procurement Process So That Health Care Can Be Purchased for QUEST at a Lower Cost to Taxpayers?**
The Task Force respectfully requests that the Legislature's goal of providing "comprehensive coverage" not be solely based on bottom-line cost considerations and that quality of care issues never become completely subservient to a bottom- line cost mentality.

QUEST's Costs

One of the primary goals of QUEST is to demonstrate the effectiveness of managed competition in purchasing health care services for the public. The QUEST program has reduced its costs from \$191 per client/per month in 1994 to \$161 per client/per month in 1997.

Health Care Purchasing Cooperatives ("HCPC")

The potential for the HCPC model to provide cost-effective medical, dental, and other health care services at lower costs is due to its ability to utilize "purchasing power" to negotiate and obtain lower capitated rates and fixed maximum annual increases from health plans and health insurers.

Medicaid's experience with health care purchasing should be used as an example for other purchasing pools. The QUEST managed care purchasing model can also be expanded to include state employees or small business purchasing alliances.

Medicaid as Good Grantsmanship

The following are four examples of how Hawaii can benefit by taking advantage of federal revenue maximization opportunities:

- a. The Federal Drug Rebate Program.
- b. Family Planning Waiver and Other New Programs
- c. Third Party Liabilities
- d. The Private Sector

The Need for Adequate Staffing

The Legislative Auditor pointed out that inadequate staffing at QUEST led to an inability to properly monitor quality as well as QUEST clients' eligibilities. Appropriate investments in systems and staffing could lead to significant benefits and administrative savings in the program as well.

Considerations on Managed Care/Managed Competition in Hawaii

The success of managed care thus far has been in managing money, not care. The future of managed care lies in developing sophisticated information systems that empower both the providers and consumers of care to make intelligent health decisions, while allowing the payors to clearly evaluate whether their money is being well spent.

C. A Clinical Data Repository ("CDR")

The subcommittee's analysis of this concept is that the potential medical and economic benefits for establishing such a repository are far reaching.

- ▶ The Hawaii Medical Association, through its committee structure, can assist in bringing together several of the interested medical and health community parties to work on this concept.
- ▶ Data should be used to integrate the health care system rather than segregate the various components.
- ▶ The special subcommittee should be able to continue in some form and attempt to gather financial and human resources to further the goal of a CDR in Hawaii.
- ▶ The State should leverage its control of \$1 billion in health care to require a standardization of data from participating plans.

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- ▶ Standardization is necessary before a statewide CDR can be implemented.
- ▶ The State needs to hold the appropriate parties accountable for the use of government funds in providing services and for maintaining the quality of care at an acceptable level.

D. While Prudent Purchasing Remains a Goal of the QUEST Program, Prudent Purchasing by Itself May Not Result in Significant Economies.

There may not be enough money saved from "prudent purchasing" (i.e. "tweaking" the system) to cover the increased population needing to be covered.

- ▶ By consolidating purchasing power, you create "leverage" and provide the incentive not to cut benefits out when budget numbers become tight.
- ▶ By consolidating purchasing power, you gain the ability to take on policy issues such as the need to support graduate medical education and other issues critical to "quality of care."
- ▶ By consolidating purchasing power, you gain the ability to obtain whatever data you need to affect price, or establish standards with which to judge whether quality and access to health care have improved for the population being served.

E. The Concept of "Consolidating Purchasing Power among All Public Payors": Providing "Leverage" in the Purchase of Health Care Services – Can it Work in Hawaii?

California Public Employees' Retirement System

CalPers consolidated the management of health care; collected data from HMOs; aggressively negotiated premiums; and measured quality and performance. CalPers also standardized its benefit design by eliminating overly complex variations in design; required basic comprehensive services across all plans; and fostered competition among health plans.

The Hawaii Public Employees' Health Fund

Structural changes need to be made in order to bring the Hawaii Public Employees Health Fund in line with current purchasing strategies.

F. A Joint Purchasing Alliance

A coordinated prevention of illnesses at an earlier stage by professionals knowledgeable in the community's lifestyle must be the priority of this State if significant financial savings are to be made in the future.

Reaching this coordinated level of community care for citizens of our State cannot be achieved by merely addressing one or two issues. Rather, there will have to be a concerted effort by many individuals and programs in different fields to find a workable solution. This process will include people trained in education, health matters, and environmental engineering. Central to this effort, therefore, is the formation of a joint purchasing alliance ("JPA").

Intervention of the development of serious illnesses by professionals would significantly reduce long-term health costs, thereby freeing needed dollars to be either reinvested in the JPA or applied to other State programs.

G. The State as a Direct Purchaser of Services

The Present Situation

Currently, the State of Hawaii has done an excellent job of cost containment in the QUEST program through the introduction of managed competition. However, the State has failed to get the two most costly areas of medical services to the poor under control: the Aged, Blind, and Disabled ("ABD") Program; and Long Term Care ("LTC"). Savings realized through the implementation of QUEST are being devoured by the inability of the State to control costs in the ABD and LTC.

Open and Closed Systems

Presently, there are two predominant types of health care systems that service Hawaii's citizens: "open" and "closed." The State needs to recognize the limitations of "open" systems compared to "closed" systems of care.

A Future Possibility

The model being proposed here is to restore the State to being the purchaser of care. The State would contract with a TPA to process the claims; assign all entitled recipients to a PCP; gather and evaluate all the data, both service data and socio/demographic data, on all providers and recipients; and to merge QUEST with the ABD and LTC programs and the Health Fund into a single State purchasing alliance. The State would assume total risk for all recipients and would control a single TPA, hired by competitive bid, for the administration of the program.

This program would be controlled like a public utility, recognizing that public health is an entitlement, and not merely a marketplace commodity that the State purchases for its citizens. The State needs to take health care out of the marketplace, with the benefits package being determined by the State as purchaser, as opposed to the State purchasing health care insurance coverage from the plans, each with its own package of benefits to offer.

RECOMMENDATIONS FOR FUTURE ACTION

The following are three recommendations by the Task Force:

1. Improve QUEST along the lines discussed in Section III.B;
2. Move QUEST towards becoming a part of a joint purchasing alliance as discussed in Sections III. E and F; or
3. Change QUEST so that it becomes a direct purchaser of services as discussed in Section III.G.

The Task Force was limited by the amount of time given to fully address these very important courses of action. The Task Force hopes that these ideas and recommendations will lead to further discussion and development by the Legislature, the Administration and perhaps a succeeding task force. The need to move from "concept" to "statutory change" and to new "management models" was clear to the members of the Task Force. The individuals and organizations involved in the Task Force stand ready to further assist the Legislature in whatever manner the Legislature deems appropriate.

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II. INTRODUCTION

Current estimates place the amount paid by the State of Hawaii in health care premiums for state and county employees and retirees, as well as those enrolled in QUEST, at over \$1 billion per year. Out of a total outlay of \$4 billion per year for health care in our State, this represents a sizeable piece of the health care "pie" as well as a sizable and growing portion of State expenditures of taxpayers' dollars.

H.C.R. 119, H.D. 1, 1998 Legislature, directed the Health Futures Task Force to submit a report on "viable alternatives to the QUEST Program which will provide comprehensive coverage for a wider population than currently enrolled in QUEST, at no additional cost to the State of Hawaii[.]" Appointed to assist the Insurance Commissioner who served as Chair of the Task Force were representatives from the Department of Human Services, the Department of Health, the Hawaii Public Employees Health Fund, the Healthcare Association of Hawaii, the Hawaii Medical Association, the Hawaii Federation of Physicians and Dentists, the Hawaii Coalition for Health, the Hawaii State Primary Care Association, the Chamber of Commerce of Hawaii, a health plan under QUEST, a current provider of health care services under QUEST, and a person enrolled in QUEST.

Members of the Task Force included:

The Honorable Reynaldo D. Graulty, Insurance Commissioner, Chair
Rev. Jory Watland, Executive Director, Kokua Kalihi Valley,
representing the Hawaii State Primary Care Association, Vice-Chair
Dr. Lawrence Miike, Director of Health

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Mr. Charles Duarte, QUEST Administrator
Mr. Ronald Schwalbaum, Hawaii Public Employees Health Fund
**Mr. Perry Confalone, Esq., Chair, Human Resources Committee,
Chamber of Commerce of Hawaii**
Dr. David DeRauf, representing the Hawaii Coalition for Health
Ms. Carolyn Gire, HMSA, representing QUEST health plans
**Mr. Richard Meiers, President & CEO, Healthcare Association
of Hawaii**
Dr. Richard Mitsunaga, representing the Hawaii Medical Association
Dr. Ken Saruwatari, representing QUEST providers
Ms. Linda Smallwood, representing QUEST enrollees, and
**Dr. Calvin Wong, representing the Hawaii Federation of Physicians
and Dentists.**

This report presents the findings, conclusions, and recommendations of the Task Force.

III. DISCUSSION

There was strong doubt at the outset registered by the Healthcare Association of Hawaii, and others, that the goal of providing comprehensive coverage for more people than currently enrolled in QUEST, at no additional cost to the State, was realistic. Much of the cost of uncompensated care, for example, is being borne by the hospitals in our State and these costs are not being reimbursed by the State. While accepting that there was some convincing that needed to be done, the Task Force proceeded with its analysis of what might be possible both now and in the future.

A. Is There a Better Model Available for QUEST than the Managed Care Model?

The Task Force believes that QUEST is an improvement over the previous fee-for-service program and has also lowered per capita costs. Until such time a new model is developed and proves itself better, the State's Section 1115 waiver for the QUEST program should be continued.

1. Managed Competition

Hawaii's QUEST Program uses a managed competition approach to purchase health care services from full-risk managed care plans for Medicaid beneficiaries. The purchasing specifications used in this approach spell out the purchaser's expectations for potential managed care vendors. The purchaser, the Department of Human Services ("DHS"), establishes its procurement strategy based on current marketplace realities. The DHS also specifies in its RFPs, the requirements for health plan structure, process and outcomes. These include access, network management, clinical and quality management, reporting, financial stability, and financial management -- all elements of "quality" as the DHS sees it.

Medicaid is undergoing revolutionary reform across the nation. Today, over 30 states have approved research and demonstration project waivers to purchase risk-based managed health care through a managed competition approach. These programs are transforming themselves from reactive, passive payers of bills, as defined by the traditional

Medicaid fee-for-service system, to prudent purchasers using marketplace forces and managed care to better serve beneficiaries.

2. Evaluations and Assessments of QUEST's Procurement Strategy and Program Design

Evaluations of the effectiveness of the managed competition approach to procurement and the use of risk-based managed care plans are being conducted by many private and public agencies. Last October, the National Association of State Medicaid Directors ("NASMD") suggested to the Center for Health Care Strategies and the Robert Wood Johnson Foundation that a review be conducted and a report prepared on these topics. This report will be entitled, *"Medicaid Managed Care Purchasing: What Works and What Doesn't."* The report will focus on: (1) procurement strategy; and (2) program design. The DHS has requested that it be included in the list of states which will be reviewed more intensively.

Examples of the issues to be examined under Procurement Strategy are:

- ▶ Should managed care organization contracts be awarded to all qualified bidders, or limited to a smaller number chosen through competitive bidding?
- ▶ How frequently should contracts be re-bid or re-negotiated?
- ▶ How should capitation rates be set – as prescribed by the State - or by competitive bidding within a range?

Similarly, under Program Design:

- ▶ Should managed care be limited to risk-based managed care organizations, or should the state retain or create the primary care case management option?
- ▶ Should some services (e.g., mental and behavioral health, prescription drugs, dental) be excluded or carved out from capitated risk-based plans?
- ▶ Should provisions for beneficiary education, grievance and appeals, optional benefits and network composition be included in managed care contracts?

3. Current Views on QUEST

The Task Force wishes to point out that the number of low income individuals enrolled in QUEST throughout the State has increased over the last four years. There are now 120,000 individuals, primarily women and children, enrolled in QUEST, up from 90,000 in 1994.

While the Task Force was unable to come up with any hard and fast numbers on the number of uninsured in our State today, as compared to when QUEST was started in 1994, the Task Force believes that it would be fair to assume that, in the eighth year of our economic recession, the number of QUEST-eligible but uninsured individuals has increased.

The Task Force hopes that the Legislature and the QUEST Program will resist the tendency to reduce benefits and/or make eligibility requirements more stringent as a result of budgetary pressures and achieve the goal of not only providing almost universal access to health care in Hawaii, but ensure that there are no loss of benefits and no compromises

in the quality of care.

This, and the adoption of managed care principles for the other populations in Medicaid - those enrolled in the high-cost Aged Blind & Disabled ("ABD") program and in Long Term Care ("LTC"), are the major challenges before the Legislature, the QUEST Program, the State as Payor, the health care providers, and all those with a stake in the continued viability and improvement of the health care system in our State.

B. Can Improvements Be Made to the Procurement Process So That Health Care Can Be Purchased for QUEST at a Lower Cost to Taxpayers?

The Task Force respectfully requests that the Legislature's goal of providing "comprehensive coverage" not be solely based on bottom-line cost considerations and that quality of care issues never become completely subservient to a bottom-line cost mentality.

I. QUEST's Costs

One of the primary goals of QUEST is to demonstrate the effectiveness of managed competition in purchasing health care services for the public. The QUEST program has reduced its costs from \$191 per client/per month in 1994 to \$161 per client/per month in 1997.

Managed competition works in Medicaid purchasing by providing just enough regulation to organize the health care market while protecting public clients. It allows

market pressures to work by forcing cost-effective choices among a small group of competing plans. This approach is also characterized by the use of capitation for a large purchasing pool of clients. Other characteristics include:

- ▶ Responsibility and accountability for medical outcomes of patients enrolled.
- ▶ Competition on the basis of quality and price for a defined set of services.
- ▶ State government changing its role from payer of claims to purchasing agent, possibly through Health Care Purchasing Cooperatives ("HCPC").
- ▶ HCPC contracts with pre-qualified health plans.

2. Health Care Purchasing Cooperatives ("HCPC")

The potential for the HCPC model to provide cost-effective medical, dental, and other health care services at lower costs is due to its ability to utilize "purchasing power" to negotiate and obtain lower capitated rates and fixed maximum annual increases from health plans and health insurers. The use of flat-risk adjusters, such as state-purchased catastrophic reinsurance and risk corridors, reduce the overall risk to the health plan. The use of "carve-outs" for high cost services, such as transplants, also significantly reduces the risk to health plan contractors.

The HCPC must define a procurement strategy. For example, it could limit the number of health plan contracts awarded going to the "low bid," or using "rate ranges" as possible strategies. Assuming these issues can be adequately addressed, the HCPC will benefit by attracting lower capitated rate proposals from plans. The HCPC must also have

a clearly defined benefit package to be successful.

Making "public client purchasing pools" attractive to health plans and developing a purchasing strategy are just the first steps in prudent purchasing. Beyond this initial stage, the HCPC must be able to retain the interest of the health care marketplace in order to help assure that quality health plans stay involved. Nationally, health plans were lured into the Medicaid market by the "economic opportunity" which presented itself.

Although motivations for entering the marketplace vary, no plan expects to operate at a loss. Since the early 1990s, health plans have seen profound changes in the Medicaid market, particularly as programs became mandatory. States have lowered or "refined" rates, or enrolled a broader range of beneficiaries, and demanded more in terms of reporting or administration. This has led to a growing number of commercial health plans dropping out of federal health programs.

Recommendations from health plans to address this issue were offered in a study conducted by Hurley and McCue.¹ They found that tensions between HMOs and Medicaid agencies have been exacerbated by growing requirements for quality and data reporting while margins have continually declined. To avoid health plan "fallout" from the marketplace, they presented the following recommendations:

¹Robert E. Hurley, Ph.D., and Michael A. McCue, D.B.A., "Medicaid and Commercial HMOs: An At-Risk Relationship," Department of Health Administration, Medicaid College of Virginia Commonwealth University, Center for Health Care Strategies, Inc., The Robert Wood Johnson Foundation's Medicaid Managed Care Program, May 1998, pp. 38-39.

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- ▶ Develop clear, consistent qualifications for continued participation in the program;
- ▶ Provide adequate, stable rates;
- ▶ Administrative demands should mirror the commercial managed care environment to the extent possible; and
- ▶ Long term needs can only be served by creating an environment that will lead to long term relationships between purchasers and plans.

Medicaid's experience with health care purchasing should be used as an example for other purchasing pools. The QUEST managed care purchasing model can also be expanded to include state employees or small business purchasing alliances. The National Academy for State Health Policy in a recent report stated the following: "At least among government agencies, there is an opportunity to coordinate, perhaps even consolidate, purchasing requirements and monitoring functions"²

Several states, including California, Florida, Washington, and Minnesota, have created purchasing cooperatives and passed enabling legislation which could eventually lead to coordinated purchasing for multiple populations. However, to be successful in attracting health plans, there must be close coordination and a high degree of uniformity in the development of benefit packages, rate setting methods, as well as quality and administrative requirements between purchasing agencies.

²Robert L. Mollica, "State Employee Health Purchasing Agencies and Managed Care Contracting," National Academy for State Health Policy, January 1998.

3. Medicaid as Good Grantsmanship

Medicaid is the only health care program that provides a federal dollar for every state dollar expended. In some cases, as with systems development and certain services such as family planning, ninety per cent federal matching is available. Clearly, it is in the State's interest to support the State Medicaid agency's efforts to maximize federal Title XIX funds.

The following are four examples of how Hawaii can benefit by taking advantage of federal revenue maximization opportunities.

a. The Federal Drug Rebate Program

OBRA '90 required pharmaceutical manufacturers to enter into rebate agreements with the federal government in order for their products to be eligible for coverage by the Medicaid Program. The rebate program was enacted after federal officials realized that Medicaid was not receiving the price breaks that drug manufacturers were granting to other high-volume purchasers such as hospitals, HMOs and certain drug store chains.

Hawaii's Medicaid fiscal agent tracks pharmaceutical claims in the Medicaid fee-for-service program and prepares and submits invoices to be submitted to these manufacturers. However, if these claims are not fully paid or are disputed by the manufacturer, the State has had difficulty in pursuing these receivables aggressively.

Dedicated staffing, including a bookkeeper to track and monitor these receivables

and a pharmacy consultant to work with the manufacturers on rebate issues, is not available. Currently, the Department is working with the Attorney general's staff to aggressively pursue these claims. However, dedicated resources could assure more prompt action to recoup these payments. The estimated receivable due the State is over \$3 million.

b. Family Planning Waiver and Other New Programs

The Department of Health has proposed the development and implementation of a new section 1115 waiver to provide coverage limited to family planning and related services to uninsured women of reproductive age whose family income is equal to or less than 300% of the federal poverty limit but who are ineligible for Medicaid under the current section 1115 QUEST waiver. This new waiver would provide essential, cost-effective women's health services including clinical exams, screening for sexually transmitted diseases and breast and cervical cancer, along with contraceptive education and the provision of a contraceptive method. The 10% State General Fund match would be provided by the DOH's Office of Family Planning. It is estimated that this new program could bring in approximately \$1 million in additional federal revenue and, in addition, prevent over 3,000 unwanted births for a potential net savings of \$6.1 million per year.

The problem is that the necessary resources are not available to develop any new waiver application, develop and modify eligibility systems, staff the eligibility units to handle the additional application caseloads, etc. Although formal cost-benefit analyses have not

been done, it has been determined that personnel essential to operating the existing QUEST programs would be pulled off-line to work this project thus diminishing QUEST's ability to service existing beneficiaries, monitor quality and fiscal operations of health plans and provider networks, and develop the necessary information technology for the current program.

As an example, recent estimates of the amount of state employee staff hours necessary to develop and implement a new Medicaid managed care information system range from 20,000-30,000 hours. These hours include staff working with software developers and technical consultants to turn business and program policies into software code, end-to-end acceptance testing of the software, end-user interfacing, etc. These are all functions that can only be accomplished by program staff with the domain expertise in Medicaid. This same domain expertise is required to develop new waiver programs such as the family planning waiver.

Because of fiscal constraints and the competition for current resources, the Department has had to prioritize with a focus on improving service capacity for our current beneficiaries.

c. Third Party Liabilities

Similar to the third-party revenue opportunity presented by the federal drug rebate program, additional resources in this area could uncover other payment sources for

beneficiaries and allow us to pursue those players in lieu of having Medicaid pay the claims.

There is no available estimate of this additional revenue at this time.

d. The Private Sector

Although some functions, such as eligibility determination and redetermination, must be performed by state staff from the Medicaid agency, many other revenue generating functions could be put out for competitive bid with the private sector. Currently, the State has a contract with an accounting firm to explore and appropriately exploit federal revenue operations. Although the process of validating Title XIX claims is rigorous, state agencies such as the Department of Health have increased federal funding for services rendered in the adult and child mental health divisions, emergency services as well as early intervention programs. However, this contract is time limited. The State will have to eventually take over this function and currently does not have the resources to aggressively pursue opportunities and maintain ongoing requirements for federal claiming.

4. The Need for Adequate Staffing

The Legislative Auditor pointed out that inadequate staffing at QUEST led to an inability to properly monitor quality as well as QUEST clients' eligibilities. Appropriate investments in systems and staffing could lead to significant benefits and administrative savings in the program as well. For example, adequate staff and systems support in the Med-QUEST Division Eligibility Branch would not only lead to more timely approval of

eligibility for applicants, but also will assure that those individuals no-longer eligible for services are discontinued from coverage in a timely fashion. This will lead to millions of dollars in potential savings allowing the program to provide eligible beneficiaries with health coverage while staying within budget. Other opportunities for savings include:

- ▶ Durable medical equipment management
- ▶ Level of care determination
- ▶ Fraud and abuse detection

Finally, adequate funding could lead to improvements in quality and fiscal monitoring in both the Medicaid and QUEST programs, hopefully leading to further cost-savings.

5. Considerations on Managed Care/Managed Competition in Hawaii

The rationale for managed competition comes from two directions: first, the State can (and has seen) prices ratcheted down by competition amongst the plans to be a successful bidder. This is the basis of the current procurement process. However, it could be argued that the State already has a fair estimate of what the actual costs of services to the population are, and hence further cuts created by this competition will have the possibility of jeopardizing the plans' financial viability and/or their ability to provide services appropriately. The second proposed benefit concerns competition amongst the plans for providing quality services. but this competition depends on the availability of good data on quality measures across plans, which are understandable and useable by the Medicaid

population, something that does not currently exist in our State.

Arguable, the most serious concern about managed care is the financing structure that pays health plans to care for individuals, regardless of the specific services provided. The potential of managed care to slow or even decrease spending creates the most obvious concern for persons (especially disabled persons) enrolled in the managed care plans: will they get the services they need within a system that does not compensate health plans for providing more care to certain persons? Systems that ensure that both at-risk populations and individuals receive necessary services must be in place. Systems that make it attractive to care for such groups are ultimately in the State's best interest. Risk-adjustment, quality assurance mechanisms, accurate statewide MIS data, and the role of patient advocates/ombudsman all need to be a part of this.

Managed care/managed competition increases the administrative costs of health care delivery. The multiplicity of formularies, referral networks and protocols created by the system of managed competition all add up to increased costs of deliverers of care. If a doctor or the doctor's staff spends an extra five minutes per patient processing complex managed care paperwork, that is five minutes less time to spend delivering care. It is important to acknowledge/measure these costs and to find ways minimizing them so that a larger percentage of the Medicaid dollar goes to needed service delivery and not administration.

While managed care allows us to manage or place controls on providers and patients'

behaviors, it does not mean that the motivation for those behaviors will disappear. Even the perfect combination of market forces and incentives may not significantly alter the increasing demand for health care services.

The success of managed care thus far has been in managing money, not care. The future of managed care lies in developing sophisticated information systems that empower both the providers and consumers of care to make intelligent health decisions, while allowing the payors to clearly evaluate whether their money is being well spent.

C. A Clinical Data Repository

To move this effort forward, the Task Force formed a special subcommittee which examined the concept of establishing a clinical data repository ("CDR"). The subcommittee's analysis of this concept is that the potential medical and economic benefits for establishing such a repository are far reaching. The special subcommittee concluded that:

- ▶ **Establishing a statewide CDR is a desirable goal for Hawaii, one shared by several other states. Many issues (financial, political, and technical) need to be resolved, however, to progress to this goal.**
- ▶ **The special subcommittee members are interested in involving the private sector with State government. The State should not develop or implement a CDR by itself. The State's involvement is crucial to create the environment allowing for the development of a CDR and providing incentives for the private sector to being involved.**

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- ▶ The Hawaii Medical Association, through its committee structure, can assist in bringing together several of the interested medical and health community parties to work on this concept.
- ▶ Data should be used to integrate the health care system rather than segregate the various components.
- ▶ The special subcommittee should be able to continue in some form and attempt to gather financial and human resources to further the goal of a CDR in Hawaii.
- ▶ The State should leverage its control of \$1 billion in health care to require a standardization of data from participating plans.
- ▶ Standardization is necessary before a statewide CDR can be implemented.
- ▶ The State needs to hold the appropriate parties accountable for the use of government funds in providing services and for maintaining the quality of care at an acceptable level.

D. While Prudent Purchasing Remains a Goal of the QUEST Program, Prudent Purchasing by Itself May Not Result in Significant Economies.

"Every time you subdivide the main pool, you lose your leverage and become a less prudent purchaser." -- Ms. Katie Kiedrowski.

At the invitation of the Task Force, Ms. Katie Kiedrowski of Community Health Concepts, Arlington, Virginia, made a presentation to the Task Force on November 26, 1998.

It was apparent from her informative presentation that "prudent purchasing" (or "tweaking" the system) may not by itself result in significant economies. Put another way,

there may not be enough money saved from "prudent purchasing" (i.e. "tweaking" the system) to cover the increased population needing to be covered.

Perhaps previously "buried money" (by way of "cost shifting") may have covered the increasing QUEST population in the part. For example, Ms. Kiedrowski pointed out that approximately \$200 million is being spent annually by teaching hospitals and community health centers in "uncompensated care." With health care premiums being ratcheted down by more effective purchasing strategies, the issue of "uncompensated care" in Hawaii will need to be addressed. If medical infrastructure supports such as graduate medical education ("GME"), for example, were previously buried in "uncompensated care," there may no longer be any money left for GME under the current "managed care" model. What then happens to "quality"?

Ms. Kiedrowski made the following pertinent points:

- ▶ **By consolidating purchasing power, you create "leverage" and provide the incentive not to cut benefits out when budget numbers become tight.**
- ▶ **By consolidating purchasing power, you gain the ability to take on policy issues such as the need to support graduate medical education and other issues critical to "quality of care."**
- ▶ **By consolidating purchasing power, you gain the ability to obtain whatever data you need to affect price, or establish standards with which to judge whether quality and access to health care have improved for the population being served.**

E. The Concept of "Consolidating Purchasing Power among All Public Payors": Providing "Leverage" in the Purchase of Health Care Services – Can it Work in Hawaii?

"Doing nothing is not an option." Hawaii's fiscal crisis should be viewed as an "opportunity" to do good and be better. Hawaii must remain committed to providing almost universal access to health care; and that payors, providers, health plans and consumers can create a more rational health care system in your State. -- Mr. Robert

D'Alessio & Mr. Tom Elkin

I. California Public Employees' Retirement System

The Task Force invited two national experts on health care purchasing to make a presentation on the widely-accepted CalPers "success story." On October 23, 1998 Mr. Tom Elkin, former assistant executive director for the California Public Employees' Retirement System ("CalPers"), and now Senior Vice-President with the Institute for Health Futures, a subsidiary of Birch & Davis Health Management Corporation; and Mr. Robert D'Alessio, Senior Vice-President of Birch & Davis, in Aspen, Colorado, provided an eye-opening description of what they was accomplished for CalPers through leverage, aggressive purchasing strategies and the benefits of integration.

With CalPers facing double-digit increases year after year, and cost containment efforts focused on reducing benefits, and with no performance, no quality and little cost data available to them, CalPers was doomed to paying further increases without justification.

What did CalPers do? It consolidated the management of health care; collected data from HMOs; aggressively negotiated premiums; and measured quality and performance. CalPers also standardized its benefit design by eliminating overly complex variations in design; required basic comprehensive services across all plans; and fostered competition among health plans.

Enhanced data collection for CalPers meant requesting cost information for all major benefit categories; requiring performance information for selected procedures such as C-sections, immunizations and mammograms; assessing the effectiveness and efficiency of health care delivery; and establishing risk-adjusted premiums.

CalPers aggressively negotiated premiums by questioning trends; determined value for each premium dollar; and used its enormous purchasing power to force premiums downwards. The Task Force wishes to note that even this may have limits. After the initial success in forcing premium costs downwards, these costs have now begun to increase.

2. The Hawaii Public Employees' Health Fund

Structural changes need to be made in order to bring the Hawaii Public Employees Health Fund in line with current purchasing strategies.

The Task Force, recognizing that our Hawaii Public Employees' Health Fund is smaller than CalPers' and also more complex, invited Health Fund Administrator Mr. Cenric Ho to make a presentation on October 28, 1998.

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Mr. Ho reported that there are approximately 165,000 persons presently covered in the Fund, which administers contracts with seven (7) health insurance carriers to provide health (and life) insurance benefits. The Health Fund has nine (9) plan types and transfers employer contributions to thirteen (13) union plans. As of July 31, 1998, 57.8% (or 28,443) of the public employees and dependents were enrolled in a Union-sponsored plan, up by 5.3% from the previous year, while 99.1% (or 29,182) of the retirees were enrolled in the Public Employees' Health Fund. With the higher cost of retiree health care, as the number of retirees increases, the "unfunded vested liability" for the Health Fund could be staggering.

The Task Force understands that a report is due this legislative session on the calculation of this "unfunded vested liability" to the State.

a. Issues

The Task Force examined the Hawaii Public Employees Health Fund and engaged in a discussion of the following:

1. How efficiencies can be obtained by combining State purchasing power in both the QUEST and Hawaii Public Employees Health Fund; and
2. Ideas and potential cost saving opportunities within the Hawaii Public Employees Health Fund itself.

b. Health Fund

The Health Fund represents employer-sponsored plans on behalf of the State of Hawaii, the four counties, and the Honolulu Board of Water Supply. Coverage is limited

to eligible employee positions that are certified by the various personnel hiring authorities (typically positions that have a duration of 90 + days and also a full time equivalency of 50%). Employees may choose enrollment from employer-sponsored plans, union sponsored plans, or a combination thereof (when available).

Employees who subsequently retire from state/county government service are certified by the Employees Retirement System as eligible for health fund benefits based on years of credited service. Upon retirement, the Health Fund services the retirees, similar to the personnel offices servicing active employees for Health Fund enrollments.

Employer-Sponsored Plans
Actives (Employees)
Retirees

Union-Sponsored Plans
Actives (Employees)
Retirees³

c. **Union Trust**

The Task Force understands the Hawaii Legislature will be reviewing this session the concept of a union-trust type of structure or plan, wherein employees represented by unions would be required to join union-sponsored health plans.

The union trust concept, however, does not appear to directly address excluded employees and retirees, as these members are not exclusively represented by a union collective bargaining agreement. Thus, the justification to consider a HCPC for at least non-

³As of 11/98, approximately 300+ Retirees were in the HGEA Retiree Medical Plan (under age 65/non-Medicare only). Note: Employer-paid premium contributions are, for the majority, at an approximate rate of 60% for employees and 100% for retirees.

union public employees and retirees could be explored. Union employees could also be a part of the HCPC, with the approval of the unions.

A large alliance with public unionized employees members would seem to be an improvement over fractionalized groupings of union members (currently each public employee union has their own set of plans, exclusive to their own membership). A possible scenario is one where all public employees (union and non-union) as well as retirees participate within a large alliance to increase its purchasing power and its leverage.

d. The Employee Retirement System ("ERS")

Many other state, county, and other government jurisdictions offer health insurance plans to their retirees, which are handled by their respective pension offices. In the State of Hawaii, the Employees Retirement System (ERS) is responsible for the servicing pensions for state and county retirees. However the ERS does not administer/service retirees for health insurance. The ERS could take over the responsibility of servicing the retirees, in the event of a union trust, or the dissolution of the Health Fund. However, consideration could also involve an HCPC to service retirees' pension and health insurance needs, especially in light of the possibility that the Health Fund may cease to exist.

e. Ideas for the Hawaii Public Employees Health Fund Plans⁴

The following represents the ideas and suggestions to bring the Health Fund more

⁴Items pre-faced with an * asterisk could be implemented in the short-term (1-3 years). Other areas may take longer to develop.

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in line with current purchasing strategies and allow the Health Fund to get more "bang for the buck."

- *1. That the Health Fund offer multiple tiered rate plans. Charge by the person, up to a set maximum (similar to QUEST).
- *2. That the Health Fund offer bundled or grouped plans: Medical, Drug, Vision, and Dental. This helps to minimize adverse selection in the plans, where members pick and choose only what they need. Administration of enrollments is reduced due to less plan changes and enrollments to the individual plan vs. a bundled group plan. Also, premiums would be lower when a grouped plan is offered vs. ala carte plan offerings.
3. To explore having the Health Fund plans associate with QUEST and/or a HCPC. However, keep adult dental insurance, and encourage QUEST to offer adult dental insurance. Both QUEST and the Health Fund Offer Children's dental.
4. To charge retirees nominally for the cost of health insurance for greater accountability and to offer a free low-cost/lower benefit level plan for retirees. Any additional coverage available for spouse and/or dependents would be charged premiums to the member and/or higher deductibles. The Health Fund currently pays for unreported deceased spouses (dependents) that are enrolled in the retiree plans. As most retirees do not pay premiums, there is little accountability in this matter. Charging retiree spouses/dependents for coverage, even if nominally, would provide a better means for control and accountability.
5. To require all Medicare eligible retiree participants to join Medicare. When a retiree is eligible for Medicare, adjust the Health Fund plan to coordinate with Medicare coverage. Thus Medicare is primary and Health Fund is secondary for retirees. Retirees failing to enroll in Medicare when eligible could be faced with a plan that pays out benefits at a rate that presumes Medicare (whether or not the retiree has actually enrolled in Medicare). Offer those retirees who fail to enroll in Medicare (if eligible) the opportunity to pick up a higher level of coverage, and charge the retiree for any higher premium contributions and/or have higher plan deductibles.

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*6. The Health Fund currently pays a reimbursement of Medicare part B to retirees and their spouses enrolled in the Health Fund Medical plans. Currently the amount is \$3.5 million paid quarterly (over \$14 million annualized). The amount has approximately doubled in 6 years, and it is tied to Medicare rates subject to Health Fund Board approval of rate increases. Consideration should be given to eliminating or placing a limit or "cap" on this reimbursement for retirees, if it means paying for a better overall medical plan. However, the reimbursement has been an incentive to have retirees report their Medicare status (on a voluntarily basis) to the Health Fund, and thus reduces the overall premium that the employer pays to the Health Insurance Carriers (Medicare lesser rate vs. non-Medicare higher rate).

7. Historically, the Health fund has offered the identical employer sponsored plans for retirees and employees. This contrasts to only one union offering a retiree medical plan. HGEA has approximately 300 + retiree medical plan enrollments (medical premiums paid for by employer). Most unions have chosen to not cover any retirees. HGEA retiree medical coverage is limited only to those retirees not eligible for Medicare.

To help reduce higher retiree medical plan costs, the employer should consider offering different plans to retirees than those offered to employees. The employer currently pays for almost all of the retiree plan premiums, versus employees who contribute an average of 40% or more of their premiums. Consider having retiree plan(s) with managed care provisions, required Medicare enrollment for those eligible, and the participation of retirees in an alliance similar to that of the HCPC.

8. Employer Negotiated Contributions for Employees.
As premium costs escalate, an adjustment to coverage and/or an increase of premiums costs passed on to employees and retirees maybe necessary due limited funding.

Public Employers could consider a new formula as it relates to the payment of health fund/union health insurance premium contribution on behalf of Employees (and Retirees).

With respect to employees:

The employer contribution is based on a 60% contribution for single and

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60% of family premiums. The formula is currently based on negotiated contributions which are tied to the Health Fund plans with the highest enrollment by category type as of a specific period. The family rate for the medical plan is over 3 times the single rate (3 :1).

Although this area is tied to negotiations and collective bargaining agreements, consideration to explore a new formula based on the same contribution for employees, regardless of whether there is a self, family (or multiple party plan) enrollment. The employers and unions could resolve whether the new formula will be that of percentages or dollar figures. However the issue of equity in providing the similar amount to employees, regardless of marital or family status would appear to treat employees in a non-discriminatory fashion. In addition the employer could more readily ascertain potential liabilities toward the payments of Health Fund contributions, as the amounts would be similar for employees regardless of single or multi-party enrollments. This helps to forecast employer costs more readily using the formula: contribution amounts negotiated multiplied by the number of employees (enrolled and eligible).

Thus employees seeking additional coverage, higher costing plans, and dependent coverage, in excess of the employer contribution, would be responsible for the payment of any additional premiums.

Note that current eligible government employees (state and county) who are married to each other are limited to employer paid contributions as follows: single employee contribution for each of the two married employees, or one family employee contribution (presuming that both employees are in the same plan together with other dependent(s)).

Government employees are not permitted to have two family plans, each spouse covering the other. The employer will only pay for a maximum of one family plan to cover both married employees. In some bargaining units, the number of government employees married to each other exceeds 20 %.

Using a formula where the employer would pay a contribution per employee, government employees married to each other would receive an equitable contribution as other employees. These married employees in turn could combine the employer contribution to pay for one family plan, or choose to have two single plans or even choose to have two family plans, with the

understanding that the employee(s) will pay for any additional premiums to pay for the plan(s).

Under the old current formula, many government employees feel "penalized" as they are limited to the amounts of employer contribution, as opposed to another co-worker with a spouse in private industry who has two plans, one family plan with the state or county government, and another plan with the spouse's private industry plan.

Many employees like the ability to have more than one health plan coverage. The new formula provides that opportunity for employees, in a non-discriminatory fashion, and also provides single enrollment employees to be treated in the same way as married employees with respect to employer contributions.

With respect to retirees :

The majority (over 95%) of current retirees receive a 100% employer paid contribution. The suggestion to charge retirees some premium has been suggested in the above items.

9. **Drug Plans**

To help reduce the high cost of drugs, drug formularies should be encouraged for all drug plan offerings, for both generic and brand name type of drugs. Brand name prescriptions with a generic equivalent could require the use of the equivalent generic drug, unless designated as brand name drug - no substitutions by the physician.

There is a Hawaii Drug Formulary of Equivalent Drug Product for Generic Drugs, which could be cited as a standard for all plans. The HMSA Drug plan with the Health Fund currently follows this practice.

However with respect to prescription brand name drugs that are without a generic equivalent, there is no brand name drug "closed" formulary in the Health Fund drug plans.

The advent of new drugs, "super drugs," without generic equivalency tend to be very expensive. Many of these drugs are currently processed through a faster FDA approval process (than in previous years), with concerns as to their long term effectiveness and side-effects.

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Currently the Health Fund plans pay for these high cost prescribed drugs, with member co-payment of \$10 for brand name drugs (\$3 for generic). Thus if a physician writes a prescription for an expensive new brand name drug, it will be covered. Standards and limits on these costly items should be incorporated in the plan design, with procedures for exceptions.

Consideration should be made to develop a "closed" formulary of brand name approved drugs, where the effectiveness and benefits of the brand name drugs have been deemed effective and/or acceptable by the plan. The formulary should be timely reviewed for current information to include those medicines deemed beneficial for the treatment of plan members. The drug plan could also consider having higher co-payments to offset higher costs associated with brand name drugs (even those that are off the formulary).

Consideration of contraceptive coverage as a benefit should be included in all drug plans.

Explore a drug purchasing cooperative or similar, possibly with QUEST or an HCPC.

- *10. **Monitoring**
Provisions to independently review claims, utilization, quality of care, and any other areas deemed appropriate, with contracted plan carriers.

- *11. **Health Fund Board**
A review of the mechanism directing the Health Fund, the Board of Trustees. Looking at the makeup and composition to provide for elected representatives by employees (the ERS has employee elected positions on their board), and medical practitioners, health insurance industry representatives, and employer representatives. In addition, another scenario would be to have a professional staff, similar to QUEST reviewing and authorizing plan benefit design and selection in place of the Board.

- *12. **Computer System**
The Health Fund currently operates with an outdated mainframe system which is beyond its capacity and has severe limitations to serve the current needs of the Health Fund. In addition, there is a heavy use of paper based processing and documentation, which is slow, inefficient, and prone to errors.

A new state-of-the-art automated computer system to track enrollment, provide timely processing, capture history, and to provide users with the ability to inquire and obtain enrollment and accounting report data inquiries. Allow all users to connect via any/all means of connectivity with the minimum requirements to be Intranet and Internet capable.

F. A Joint Purchasing Alliance

A coordinated prevention of illnesses at an earlier stage by professionals knowledgeable in the community's lifestyle must be the priority of this State if significant financial savings are to be made in the future.

Even though many individuals take the time and effort in maintaining their own health, this State cannot stand idly by and hope that everyone stays healthy. Newer treatments of advanced illnesses often involves greater expenses which drain scarce finite resources.

Reaching this coordinated level of community care for citizens of our State cannot be achieved by merely addressing one or two issues. Rather, there will have to be a concerted effort by many individuals and programs in different fields to find a workable solution. This process will include people trained in education, health matters, and environmental engineering. Central to this effort, therefore, is the formation of a joint purchasing alliance ("JPA").

The JPA would leverage the \$1 billion spent yearly on health care into the purchase of health-based, as opposed to disease-based, quality-oriented benefits system. The JPA

purchases health services (not insurance coverages) from providers, whether individually or collectively, and makes these services available to the community. Essential to the effectiveness of determining the makeup of these services would be the ongoing collection and dissemination of treatment data. This data should be available in a clinical data repository, with all necessary information safeguards in place, and be accessible only by authorized professionals.

Intervention of the development of serious illnesses by professionals would significantly reduce long-term health costs, thereby freeing needed dollars to be either reinvested in the JPA or applied to other State programs.

G. The State as a Direct Purchaser of Services

I. The Present Situation

Currently, the State of Hawaii has done an excellent job of cost containment in the QUEST program through the introduction of managed competition. However, the State has failed to get the two most costly areas of medical services to the poor under control: the Aged, Blind, and Disabled ("ABD") Program; and Long Term Care ("LTC"). Savings realized through the implementation of QUEST are being devoured by the inability of the State to control costs in the ABD and LTC.

The original risk adjusters to the QUEST participating plans have continued since 1994 and need to be changed. The incentives should be to provide care to the most in need

and those with the highest risks. The State of Minnesota, after extensive study and in support of the premise that those providing care to the highest risk populations should be compensated proportionately, adopted legislation to require payors to reconcile their payments to the risks assumed by the plans. The Task Force recommends that Hawaii should explore a Minnesota-like law.

2. Open and Closed Systems

Presently, there are two predominant types of health care systems that service Hawaii's citizens: "open" and "closed." The State needs to recognize the limitations of "open" systems compared to "closed" systems of care.

A "Kaiser-like" system is referred to as a "closed" system. Kaiser employs all the providers of care and owns the facilities from which care is provided. Kaiser can control the costs within its care system. However, there are parts of the medical care system that Kaiser cannot control, thus costs continue to increase for the same care. These costs include pharmaceuticals, manufactured goods and equipment, the availability of qualified staff at a price Kaiser wants to pay, and the medical services not owned by Kaiser. These latter services include residential nursing care, rehab hospitalization, dental and certain diagnostics and interventions that are not economically feasible to offer the occasional user.

Contrasted to the "closed" system is an "open" system similar to the type used by HMSA. The services provided under an "open" system, whether by institutions or

individuals, are paid for by an open-ended formula of reimbursements. The limits are set on allowable services and percentages of reimbursement per charge. This is a "pure" insurance system. Risks are actuarially determined and prospectively charged to the purchaser. The risk to the plan is inversely proportionate to the accuracy of the actuarial projections and the number of policyholders.

3. A Future Possibility

At \$1 billion per year, the State is the single largest purchaser of health. As a purchaser, the State purchases insurance for its entitled citizens. The State needs to move towards being a purchaser of services, rather than simply a purchaser of insurance.

Prior to 1994, the Medicaid program purchased services from providers for all entitled recipients. The State contracted with a third party administrator ("TPA") to process the billing claims and pay for the services. There was no control over the number and kinds of services (other than prescribed by Medicaid), nor was the collected data used to evaluate the health of the recipients or the appropriateness of the provider.

QUEST introduced the concept of assigning health care services to its recipients through primary care providers ("PCPs") and emphasized managing the care provided. Insurance purchased from the participating plans assumed the risk of providing all the mandated services to entitled recipients. The exceptions were those people covered under the ABD category, the most costly individuals entitled to care.

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The model being proposed here is to restore the State to being the purchaser of care. The State would contract with a TPA to process the claims; assign all entitled recipients to a PCP; gather and evaluate all the data, both service data and socio/demographic data, on all providers and recipients; and to merge QUEST with the ABD and LTC programs and the Health Fund into a single State purchasing alliance. The State would assume total risk for all recipients and would control a single TPA, hired by competitive bid, for the administration of the program.

This program should be controlled like a public utility, recognizing that public health is an entitlement, and not merely a commodity that the State purchases for its citizens. The State needs to take health care out of the marketplace, with the benefits package being determined by the State as purchaser, as opposed to the State purchasing health care insurance coverage from the plans, each with its own package of benefits to offer.

Three very beneficial outcomes would inure to the benefit of the State through this proposal:

1. The State would be the prudent purchaser of care and be able to control the cost, the quality, and the outcomes similar to a "closed" program;
2. The State would have a clinical data repository ("CDR") on utilization and the socio/demographics for approximately 25% of the State's population;
and
3. The State could take major control over the costs of LTC, ABD, and the

These anticipated beneficial outcomes need to be balanced, however, by the reality that this model will require a large, experienced administrative workforce. This will certainly not be possible to establish in this current economic environment.

Hopefully, an improvement in the State's economy will permit this to occur in the future. Additionally, there needs to be sufficient flexibility built in to the administrative structure so that as management needs change, so will the administrative structure be able to change accordingly.

This requires a new management concept for the State, which may necessitate some statutory changes, but primarily a different way of thinking and purchasing when it comes to health care for our State. While it will not be easy or simple to move this model within the system we currently have in place, in the Task Force's view, for the State to fulfill its mission as a "prudent purchaser" of health care for its citizens it requires that we fully commit taking steps in this direction.

IV. RECOMMENDATIONS FOR FUTURE ACTION

The following are three recommendations by the Task Force:

1. Improve QUEST along the lines discussed in Section III.B;
2. Move QUEST towards becoming a part of a joint purchasing alliance as discussed in Sections III. E and F; or
3. Change QUEST so that it becomes a direct purchaser of services as discussed in Section III.G.

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The Task Force was limited by the amount of time given to fully address these very important courses of action. The Task Force hopes that these ideas and recommendations will lead to further discussion and development by the Legislature, the Administration and perhaps a succeeding task force. The need to move from "concept" to "statutory change" and to new "management models" was clear to the members of the Task Force. The individuals and organizations involved in the Task Force stand ready to further assist the Legislature in whatever manner the Legislature deems appropriate.

As a Task Force, we would like to express our appreciation to the Legislature for its passage of H.C.R. 119, H.D. 1, one of the most significant resolutions on the public purchase of health care in our State, particularly during this austere budgetary time. We hope that we have been equal to the task set forth in this important legislative initiative.

Respectfully submitted:

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