

HAWAII: TRANSITIONING AND MOVING BEYOND ACA

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HRS 322H: The Hawaii Health Authority

- The HHA "shall be responsible for overall health planning for the state and shall be responsible for determining future capacity needs for health providers, facilities, equipment, and support services."
- "The authority shall develop a comprehensive health plan that includes:
 - 1) Establishment of eligibility for inclusion in a health plan for all individuals;
 - 2) Determination of all reimbursable services to be paid by the authority;
 - 3) Determination of all approved providers of services in a health plan for all individuals;
 - 4) Evaluation of health care and cost effectiveness of all aspects of a health plan for all individuals; and
 - 5) Establishment of a budget for a health plan for all individuals in the state.

The Big Problems with U.S. Healthcare

- Cost – Unsustainable escalation
- Access to Care
 - Uninsured
 - Underinsured
 - Unacceptably insured (doctors won't accept it)
 - Insurance that obstructs care
 - Worst for Medicaid, increasingly for Medicare and private insurance
- Neither is effectively addressed in ACA

Medicaid Managed Care in Hawaii

- Mid-1990's
 - Managed care for GA and AFDC
 - Local, non-profit plans – initially 5 plans
 - 2 smaller plans dropped out, 3 survivors
 - More limited provider participation than FFS Medicaid
 - Plans generally "reasonable"
- January 2009
 - Aged, Blind, Disabled (ABD) population turned over to 2 national for-profit managed care plans – Ohana (WellCare) and Evercare (United Health)

Medicaid Managed Care in Hawaii

- Medicaid managed care plans offered by major national health insurance companies:
 - Promise to control costs for States while improving quality, but lack effective means to do so
 - Much higher administrative overhead than State-run Medicaid, including marketing, lobbying, and profit
 - Use central managed care strategies – denial of care
 - Restrict benefits and access to care
 - Restrict necessary care more than unnecessary care
 - Deterioration in access and quality of care
 - Private sector doctors fleeing Medicaid

Competition Rewards Bad Plans

- Medicaid managed care is an individual market
- Adverse selection – patients and their MDs know health risk when they choose plan
- If a plan offers better benefits, provider pay, or policies, it will attract sicker population
- Worst plan gets patients who see doctors the least – healthiest risk pool
- Result is “race to the bottom”

Hawaii's Prepaid Health Care Act

- ERISA exemption, employer mandate (if 20+ hr/week), broad benefits, 80%-90% coverage
- Has ensured broader risk pooling, better benefits, and lower costs than other States
- BUT,
 - does not cover individual market, self-employed, part-time workers, or unemployed
 - Employers increasingly using “independent contractors,” part-time workers (<19 hr/wk), and dropping family benefits from plans they do offer

Health Transformation Initiative

- Focused on implementation of ACA in Hawaii
- Triple Aims: improve quality, improve health, increase value
- Delivery System: PCMH's, Community Care Networks, “ACO-like” organizations
- Payment Reforms: P4P, shared savings, bundled payments (despite rejection by committee)
- BUT,
 - Added onto existing system of competing health plans
 - Adds administrative complexity and cost
 - No attempt to address dysfunction in Medicaid

The HHA Vision

- Instead of starting with what we have and asking, “How can we make it better (while trying to keep all existing stakeholders happy)?”,
- The HHA vision starts with defining what a truly cost-effective system would look like, and then asks, “How can we get there from here?”

Lessons from Systems that Work

- Universal systems & full access enable large savings.
- Competition in health care financing is always detrimental to cost-effective delivery of care.
 - Cooperation and coordination are “where the money is.”
 - They are undermined by competition.
 - Known risk, adverse selection, and competition for risk pools are strong incentives for plans to deny or avoid covering care for sicker, more complex patients, and to avoid offering better plans.
 - Competition adds cost without value.
- Fee-for-service is not the problem.
- Pay-for-outcomes, bundled payments, and capitation (shifting insurance risk onto providers to counter FFS) all introduce perverse incentives to avoid caring for sicker, more complex patients. No proven value.

Principles for Cost-Effective Health Care Redesign

1. Universal (single risk pool)
2. Standardized benefits - all medically necessary care
3. Simplify administration
4. Promote professionalism in health care
5. System-wide continuous quality improvement
6. Ensure adequate professional workforce (primary care)
7. Accountability to health needs of the population
8. Separate, sustainable funding for health care

HHA Strategy

- HRS 322H is broad, but
 - It does clearly require universality – covering all individuals in Hawaii
 - It is expected to be comprehensive
 - It must coordinate all aspects of health care and health promotion for the State

HHA Roadmap

- Goal is a unified delivery system (“All-Payer”)
 - everyone has same benefits,
 - same provider network, and
 - providers are paid the same regardless of the source of funding for any individual patient.

HHA Roadmap

Replace Medicaid managed care program with Medicaid Primary Care Case Management

- Unified program with single plan administrator
- Kaiser and CHC's as integrated sub-systems
- Include all hospitals and as many doctors as possible
- Comprehensive benefits adequate for all medically necessary care
- Patient Centered Medical Homes
- Community care teams as extenders of PCMH's
- Much cheaper to administer, much better physician buy-in, and much better access to care for patients than Medicaid managed care

HHA Roadmap

- Care managed by delivery system, not health plans
 - Physician-led CQI instead of P4P, bundled payments, and competing ACO's
 - Whole system is one big integrated “ACO” – one for each island or region
 - Instead of competition, a unified regional health care system relies on cooperation and collaboration to improve cost-effectiveness of care

HHA Roadmap

“All-Payer” Insurance Exchange/Connector

- Use same integrated delivery system as for Medicaid
- Eliminates disruptions in care when patients move between Exchange and Medicaid
- Leverage Federal funds under ACA for Exchange and for delivery system reform

HHA Roadmap

- Expand this integrated system to State and County employees and retirees
- Use Medicare Advantage to bring Medicare beneficiaries into this integrated system
- Offer delivery system directly to employers. No need for competing plans to manage care.

HHA Roadmap

- Once this system gains enough market share, start paying hospitals and integrated sub-systems with global budgets, saving billing costs (up to 20% of hospital costs)
- Physicians could be paid either:
 - On salary (if employed by hospitals and integrated sub-systems), or
 - FFS using fee-for-time system that is incentive neutral.
 - Pay-for quality incentives okay, but limited to what is accurately and meaningfully measurable

HHA Roadmap

- Health IT refocused on patient care and quality improvement, instead of reimbursement – eliminates incentive to game documentation to increase pay.
- Rely on CQI and professionalism, not primarily on financial incentives, to keep care cost-effective.
- Focus of reform should be on ensuring appropriate care for those who need it, and not on satisfying the interests of health plans.
- Hospitals and doctors are obviously essential, so it has to work for them, but their needs must be subsidiary to enhancing quality of care and access for patients.

HHA Proposal: Cost Implications

- Direct insurance administrative savings (**10-15%** of total health spending, including elimination of most managed care costs counted as “health care” in “Medical Loss Ratio”)
- Global budgets and no uncompensated care would save 20% of hospital costs (**10%** of total health spending)
- Single financing system would save 10% of doctor’s practice costs (**3%** of total health spending)
- Bulk purchasing of drugs and durable medical equipment (would save ~5% of total health spending)
- Increased access to out-patient and primary care and professionally directed quality improvement would reduce ER and hospital costs, unnecessary and inappropriate care (~**10%** of total health spending)