

Affordability in a Mandated Environment

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As states across the nation gear up to implement provisions of the Affordable Care Act (ACA), there is an opportunity to reflect on lessons learned from the state of Hawaii's nearly 40 years of experience with an employer mandate. Hawaii's mandate has indeed expanded coverage, and the state continues to have a relatively low proportion of uninsured residents, even as that figure has increased in past years. Furthermore, Hawaii's employer-based health insurance premiums are among the lowest in the country—in spite of requiring coverage of a relatively generous set of benefits with limited employee cost sharing. At the same time, the rate of cost growth observed in the state is no lower than the US average—meaning that Hawaii's residents face the same sustainability issues faced by states without a mandate and signifying that payment and delivery system reform are critical if we are to have a sustainable healthcare system. To gain insights from Hawaii's experience, we reviewed the literature on healthcare costs in Hawaii, analyzed descriptive state level and national data, and conducted a series of interviews with key stakeholders in Hawaii's healthcare system. Interviewees included representatives of the Governor's Office, Hawaii Department of Commerce and Consumer Affairs, Hawaii branch for the National Federation of Independent Businesses, Hawaii Health Connector, Hawaii Health Information Exchange, Hawaii Independent Physicians Association, Hawaii Medical Service Association (HMSA), Hawaii Pacific Health, Hawaii Prepaid Health Care Advisory Council, Hawaii State Senate, Kaiser Foundation Health Plan, The Queen's Medical Center, and University of Hawaii School of Nursing. Interviews lasted 45 to 90 minutes and took place between January and September 2012; 12 were conducted in person and 2 by phone.

Hawaii's Employer Mandate: Overview and Effects

Hawaii's Prepaid Health Care Act (Prepaid), passed in 1974, requires employers to purchase health insurance for their employees (but not dependents); employees are likewise required to accept coverage. The benefits required in statute are quite comprehensive, and employees' share of premium is limited to 50% of the premium or 1.5% of wages.^{1,2}

The most comprehensive study of the effects of Hawaii's mandate on the health insurance and labor markets found that Prepaid expanded coverage among both employees and dependents.³

In 2011, the uninsured rate for Hawaii's nonelderly population was 9%, compared with the US

Objectives: To identify insights gained from Hawaii's experience with healthcare costs in an environment of mandated employer-based coverage and implications for other states as implementation of the Affordable Care Act ramps up.

Study Design: Case analysis.

Methods: We reviewed literature on healthcare costs in Hawaii and analyzed descriptive state-level and national data from a variety of sources, including MEPS and Hawaii's Department of Commerce and Consumer Affairs. In addition, we conducted 14 interviews with 12 stakeholder organizations in Hawaii's healthcare market, including representatives of health plans, delivery systems, physicians, employers, government, the non-profit sector, and academia.

Results: After almost 40 years of mandated employer-based coverage, Hawaii has a lower uninsured rate than other states and lower employer-based premiums. Stakeholders we interviewed attributed lower costs in part to the concentrated insurance market, in which the dominant carrier acts largely like a single payer in the commercial market; stakeholders raised administrative cost efficiencies and negotiating clout as factors contributing to lower employer-based premiums. While premiums are lower than the US average, the rate of growth in costs is not. As a result, Hawaii's healthcare stakeholders are focused on aligning incentives for payers and providers.

Conclusions: Based on interviews with stakeholders and the review of current data, we conclude that mandated coverage will not slow the inexorable rise in healthcare costs or solve the growing affordability issues for health insurance in the United States. To expand access to coverage in a manner that is sustainable over time, healthcare cost growth must be addressed.

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Take-Away Points

The State of Hawaii has mandated employer-based coverage since 1974, offering an opportunity for learning as implementation of the Affordable Care Act ramps up.

- Hawaii's uninsured rate is substantially lower than the US average, with the differential almost entirely associated with employment-based coverage.
- Hawaii features relatively low employer-based premiums, explained in part by a concentrated insurance market that yields lower administrative costs.
- The mandate has had little effect on the growth rate in the cost of coverage, which mirrors the rest of the United States. Hawaii's stakeholders are focused on delivery and reimbursement approaches that maintain quality while reducing costs.

rate of 18%; the 9-point differential was almost entirely due to Hawaii's higher rate of employer-based coverage among the population under 65 years of age, which was 66% compared with 58% in the United States.⁴

In addition to broader coverage than most mainland states, employer-based premiums in Hawaii are among the lowest in the United States. In 2010, premiums for employer-based insurance averaged \$4940 for single coverage (employee-only) in the United States as a whole, compared with \$4294 in Hawaii.⁵ Given that prices in Hawaii tend to be higher than on the mainland, this differential is effectively even larger.

This ranking cannot be attributed to "thin" benefits (significant cost sharing at the point of service). Hawaii's actuarial value for employer-based coverage was 84.4% in 2002 (US average, 83.4%), meaning insurance covered 84.4% of enrollees' health expenses.⁶ Only 9 states had higher actuarial values. After adjusting for actuarial value, Hawaii had the lowest employee-only premium in the nation. Further, persons in Hawaii with medical expenses below the median paid less out of pocket than similar people in other states. One explanation is the lower deductibles and more comprehensive coverage for primary and preventive care in Hawaii compared with other states. Data on cost as a barrier to care provide further support for the relative generosity of benefits under Hawaii's mandate: in 2010, only 7.5% of Hawaii residents reported that they could not see a doctor due to cost in 2010, compared with 14.6% for the United States overall; only North Dakota and Massachusetts reported lower figures.⁷

Employer-Based Premiums in Hawaii: Why So Low?

Given mandated coverage, a generous benefit package, and generally high costs in Hawaii, what accounts for the lower premiums? Many factors contribute to premium cost, including extent of coverage and associated need for uncompensated care, population demographics and health status, as well as utilization. Indeed, Hawaii's population shows better health status compared with the US population on key indicators like child mortality, obesity, cancer incidence, smoking

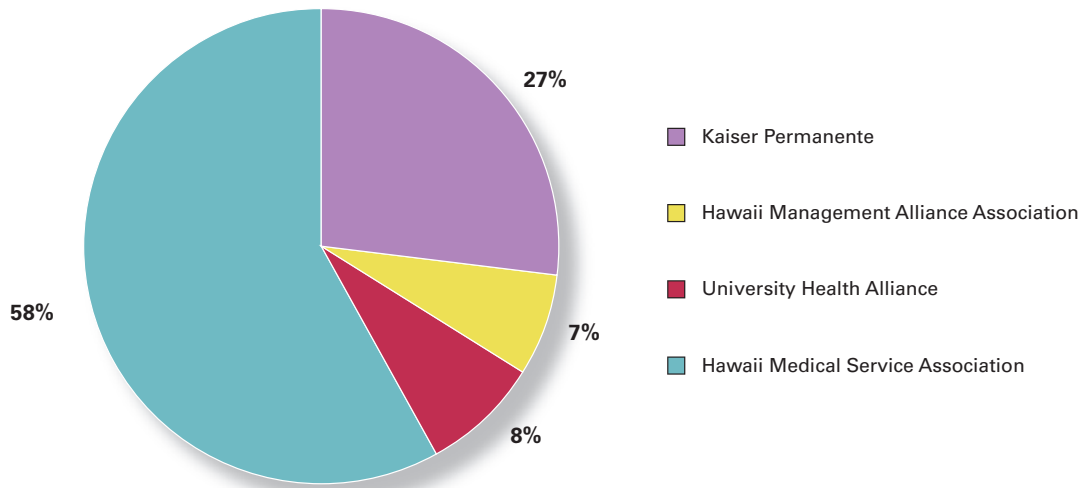
status, and violent crimes.^{8,9} Utilization of emergency departments and inpatient admissions are lower in Hawaii compared with the United States as a whole as well.^{10,11} However, the main explanations raised by the stakeholders we interviewed focused on the concentration and geographic isolation of the health insurance market and implications—both positive and negative.

The largest insurer, by a large margin, is HMSA, the Blue Cross Blue Shield affiliate for the state of Hawaii. HMSA has approximately 58% of the employer-based market, followed by Kaiser Foundation Health Plan with approximately 26%. Other players in the employer-based market comprise approximately 15% collectively as shown in **Figure 1**. The concentration extends to delivery systems—the dominant private systems in the state are Hawaii Pacific Health (HPH), a 4-hospital system with 49 clinics and service sites; The Queen's Medical Center, a 500-bed hospital featuring a broad array of tertiary services; and Kaiser Permanente, with a 275-bed hospital and 18 clinics. Given that Kaiser's health plan and provider network have an exclusive contract, the primary negotiations between insurers and delivery systems in the state occur between HMSA on the carrier side and HPH and Queens on the delivery side.

The concentrated market, according to several interviewees, contributes to lower administrative costs due to the economies of scale in administration and reduced costs associated with marketing. Data from the Hawaii Department of Commerce and Consumer Affairs indicate that the ratio of administrative to total expenses ranged from 8% to 10% at HMSA and from 2% to 4% at Kaiser between 2004 and 2011. These estimates bring Hawaii well within the medical loss ratio (MLR) requirements of the ACA, which are set at a maximum of 80% for individual and small group and 85% for large group plans. Plans that do not meet those requirements must provide rebates to enrollees, beginning with the 2011 contract year. Recent analyses show that Hawaii had the fifth lowest rebate rate in the country at an average of \$15 per family compared with \$151 for the United States.¹² Another factor contributing to lower administrative costs in Hawaii may be that most of the health plans—including all those listed in **Figure 1**—and all the hospitals in the state are not-for-profit.

A number of stakeholders also pointed to the negotiating clout held by what amounts to a "single payer" on the commercial side, HMSA, and suggested that purchasing power may be holding down provider reimbursement rates and contributing to physician shortages—particularly beyond the

■ **Figure 1.** Market Share, Employer-Based Health Insurance in Hawaii, 2011



Data Source: Hawaii Department of Commerce and Consumer Affairs, Health Branch, Insurance Division.

O’ahu market on the more rural neighbor islands. The proprietary nature of plan-provider contracts makes it difficult to obtain data that illuminate questions related to adequacy and comparability of provider compensation, but downward pressure on rates seems plausible. Whether the cost pressure on providers was viewed as positive or negative depended, not surprisingly, on the perspective and organizational affiliation of the interviewee. Providers tended to perceive unfair market power, while other stakeholders were more likely to see the benefits of a strong health plan negotiator.

Interviewees raised one additional explanation for Hawaii’s relatively low premiums: lower intensity in the “medical arms race” that can cause costs to spiral in markets with many competing delivery systems, each of which acquires its own costly medical technology to attract specialists (and their patients). The state has a certificate of need process, which resulted in rejection of a proposed second hospital on the island of Maui in recent years. In addition, stakeholders suggested that advanced imaging equipment (eg, PET scanners, MRIs) is less prevalent than it is in other communities of similar size.

Cost Growth in a Mandated Environment

While premiums for employer-based coverage in Hawaii have historically been lower than they are in the United States, they are increasing at a similar rate. **Figure 2** shows the employee-only premiums between 1996 and 2010 for the “prevalent” health maintenance organization (HMO) and preferred provider organization (PPO) plan in Hawaii (the plan of each type with the largest enrollment). The prevalent plans are offered by the 2 dominant health insurers, both

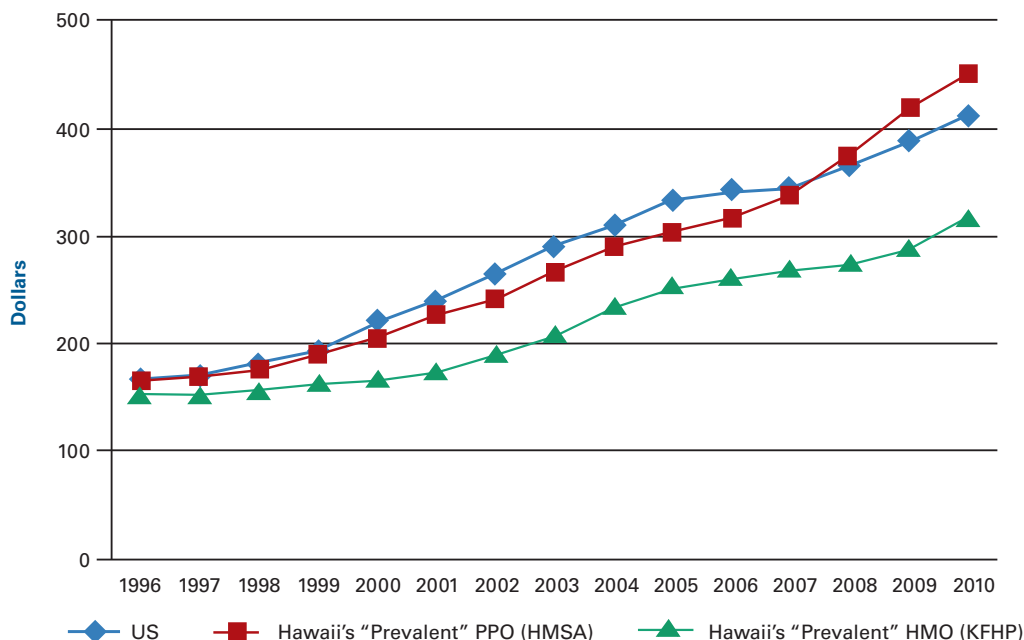
of which are non-profit: Hawaii Medical Service Association ([HMSA], a Blue Cross Blue Shield state affiliate) offers the prevalent PPO, and Kaiser Foundation Health Plan offers the prevalent HMO. Of note, HMSA’s premium trend line for the prevalent PPO product crosses the national premium trend line around 2008, reflecting acceleration of premium increases in recent years. Kaiser’s prevalent HMO plan continues to trend below the national average.

The rate of increase in premiums has far outstripped growth in wages, in both Hawaii and the United States. Insurance premiums in Hawaii increased by over 100% between 1996 to 2010, while wages increased only 37% between 1999 and 2009.¹³ Due to the statutory maximum employee contribution to premium—set at the lower of 50% of employee-only premium or 1.5% of wages—employers are required by law to bear a substantial and growing share of the premium in Hawaii. While there has been discussion over the years regarding increasing the employee’s share of premium to acknowledge the growth in premiums relative to wages, Hawaii is not allowed to make changes to the Prepaid Act without compromising its Congressional exemption from the Employee Retirement Income Security Act (ERISA).¹⁴ While Hawaii’s employers do raise concerns about the increasing costs,^{15,16} the coverage mandate is widely accepted after almost 40 years, and Hawaii’s employees have come to expect generous benefits at relatively low out-of-pocket costs.

Efforts to “Bend the Trend”

Virtually all stakeholders we interviewed in Hawaii’s health-care system struck a similar chord on alignment of incentives

■ **Figure 2.** Employer-Based Premiums (Monthly Employee-Only), Hawaii and the United States, 1996 to 2010



HMSA indicates Hawaii Medical Service Association; KFHP, Kaiser Foundation Health Plan. Data Sources: Hawaii Department of Commerce and Consumer Affairs, Health Branch, Insurance Division; Agency for Healthcare Research and Quality, Medical Expenditure Panel Survey Insurance Component Tables, Table I.C.1: Average total single premium (in dollars) per enrolled employee at private-sector establishments that offer health insurance by firm size and selected characteristics, years 1996-2011. Generated using MEPSnet/IC (www.meps.gov/mepsweb/data_stats/MEPSnetIC.jsp, (August 29, 2012).

for payers and providers toward the “triple aim,” the framework developed by the Institute for Healthcare Improvement that targets better patient experience of care, improved population health, and lower healthcare costs. This focus reflects the national policy context set by the passage of the ACA, with its emphasis on a National Quality Strategy and investment in developing and testing new models of payment and delivery. HMSA, which has a legacy of leadership in pay-for-quality for physicians,¹⁷ has launched initiatives with both hospitals and physicians aimed at shifting payment from volume to value.

Current HMSA contracts with hospitals, both public and private, tie up to 15% of hospital payments to performance on metrics such as hospital readmission.¹⁸ The contracts include participation in the Premier network, an alliance of healthcare providers across the country aimed at improving care delivery and efficiency, to ensure that hospitals are able to participate in the collection and sharing of clinical and cost data that support performance-based reimbursement. HMSA and Hawaii Pacific Health recently announced the next phase in their performance-based contract: a 5-year agreement starting in January 2014 based on shared savings and loss. While not formally defined as an accountable care organization, the new agreement clearly moves in that direction.

On the physician side, HMSA has 2 initiatives under way that include a component of performance-based reimbursement. Pay for Quality (P4Q) began in 2011 and rewards primary care providers for improvement in 16 specific metrics that include screening for breast and colorectal cancer, diabetes care, and childhood immunizations. A related patient-centered medical home initiative shifts a proportion of physician revenue from fee-for-service to per-month payments that are tied to the same clinical indicators used by the P4Q program.^{19,20} Aggregated across the 2 programs, financial rewards tied to quality metrics comprised 5% of physician payment in 2010, 11% in 2011, and were projected to reach 19% in 2012. Next steps for these programs include expanding to specialists, expanding from private employers to Hawaii’s Quest (Medicaid) program, and adding a shared savings component.

States and health systems anticipating changes arising from implementation of the ACA can look to Hawaii and its 40-year experience with an employer mandate for guidance. While uninsurance rates for the population are likely to decrease, states and health systems will need to continue efforts to improve efficiency in order to keep premiums low; mandating coverage will not be sufficient to curb the rate of growth in

costs. As in many areas of the United States, Hawaii's largest systems are now implementing performance-based payment programs intended to align incentives among payers and providers. Evaluation of these programs will enable us to determine their effects over the coming years.

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