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A series of recent innovations in Hawaii are intended to broaden access to care and create a health care environment that supports health promotion and disease prevention. Innovations have focused on meeting challenges within the conventional health care system (consisting primarily of medical care problems) and expanding the boundaries of health care to include matters of broader environmental concern.

Beginning in 1974 with the passage of the Prepaid Health Care Act (Prepaid), the state moved significantly in the direction of providing universal coverage for its population. In 1989 the creation of the State Health Insurance Program of Hawaii (SHIP) moved the state a step closer to universal coverage. In 1990 the state legislature created a Blue-Ribbon Panel to investigate the dynamics of the health care system in Hawaii and to propose steps for controlling rising health care costs. In mid-April 1993 the state announced an ambitious reform of its Medicaid program, “Hawaii’s Health Quest,” intended to accomplish a broad range of objectives: to enhance quality of care while providing universal access, to encourage efficient use of services while stabilizing costs, and to transform public assistance health care into a more privatized mode while promoting both effectiveness and efficiency through managed care.

The setting. Hawaii’s quest to become a health environment began with the election of John Waihee as governor in November 1986. Many ingredients were already in place, perhaps most importantly the fact that Hawaii is a healthy place. The fortunes of geography and climate have spared it many of the indignities of industrial and postindustrial development. Its three major industries-tourism, government employment, and agriculture-are clean when compared with smokestack environments.

Furthermore, the population of Hawaii is remarkably healthy overall, judging from conventional indicators-with the distinct and notable exception of Polynesians, who fare badly as a group on all major health indicators; the longevity of other major ethnic groups exceeds that of their mainland counterparts. Hawaii has also become an extremely attractive place in which to practice medicine. The ratio of physicians to population is among the highest in the nation (and the world), albeit highly concentrated. Fully 80 percent of Hawaii’s 4,600 physicians and surgeons are specialists. Local economic predictions hold that health care will be the primary industry in the state, exceeding tourism, by 2010.

According to Hawaii’s director of health, John Lewin, the state has much to teach the rest of the nation. First, experience shows that emphasis on primary care produces a healthy population at decreased cost. Hawaii residents have among the lowest mortality and utilization indicators, which may be explained by ready access to effective care at reasonable costs and by the fact that Hawaii’s doctors emphasize outpatient care. Second, mandated employer coverage can be an effective tool for universal access. It is notable that in Hawaii the majority of insurance is provided by private, nonprofit providers. One fear at the time of Prepaid’s passage-namely, that the law would result in
in a distinctive antibusiness climate and that small businesses in particular would suffer—has not materialized, Lewin argues.4

Third, strong insurance reforms must accompany an employer mandate. The key reform is community rating, a necessary prerequisite to affordable insurance rates. Hawaii, in part because of the existence of its two nonprofit carriers and the guaranteed market provided by prepaid coverage, has enjoyed a voluntary rating system that has helped to keep rates low. Finally, costs can be controlled. Hawaii’s health costs are significantly less than those of the rest of the United States—about 8.1 percent of gross domestic product, compared with close to 14 percent nationally. Again, approximations to universal access are the key, as the availability of early, inexpensive treatment tends to eliminate later, more expensive care. Hawaii also retains its certificate-of-need (CON) process, which is credited with the fact that the state does not struggle to accommodate excess capacity (and use) of hospital facilities. Managed care, when extended to a significant portion of the population, further reduces costs. And finally, when competition exists within clearly structured ground rules, it forces insurers and providers to hold down costs.

**Prepaid Health Insurance**

In the current national climate favoring universal coverage, Hawaii’s SHIP provides the state with its claim to be ahead of the curve of health care reform. SHIP built on the state’s experience with the Prepaid Health Care Act of 1974. The law mandates employer-based health insurance for all employees not covered by collective bargaining. It operates through the existing insurance system, which is dominated by two major providers accounting for 80 percent of existing insurance coverage: (1) the Hawaii Medical Service Association (HMSA)-Hawaii’s “Blues” organization—which covers 60 percent of all insured persons; and (2) Kaiser Permanente—the dominant health maintenance organization (HMO).6 The law stipulates that “the plan must provide health care benefits equal to or medically substitutable for benefits provided by plans having the largest number of subscribers in the state,” thereby guaranteeing this relationship to the primary providers and ensuring that employees covered under Prepaid do not receive a lesser form of coverage. The current benefit package includes medical, surgical, and maternity coverage; up to 120 days of hospitalization; outpatient benefits provided by a physician, psychiatrist, or psychologist; and diagnostic laboratory services, x-ray, and radiotherapeutic services. A separate act permits the legislature to “mandate options” into the basic benefit package, making them eligible for third-party reimbursement. An impact assessment must be provided by the legislative auditor prior to such authorization. Examples of mandated options currently in the package include well-baby checkups, mammography, in vitro fertilization, and coverage for alcohol and substance abuse treatment.

Financing is shared equally by employees and employers, with the exception that the employee in no case contributes more than 1.5 percent of total wages; employers must pay at least half of the remaining cost. Employees are not permitted to decline coverage, and coverage is universal for nonunionized employees (unions having their own plans). Government employees (who have their own plan), approved seasonal agricultural employees, family members in family-owned businesses, certain persons paid on commission, and part-time employees are exempt from coverage.

Prepaid was the product of plantation culture and a broadly based health agenda sponsored by the state’s unions, especially the International Longshore Workers Union. The plantations had provided primary care for their own workers and instilled a sense of employer obligation for health care. The prolabor bias of the law can be seen in the fact that it is administered (with very low overhead) by the Department of Labor, not the Department of Health.

The 1974 law was the concluding piece to a 1967 legislative request for studies of temporary disability insurance and a universal employer-based system of health care.
The 1967 act was largely the product of Nadao Yoshinaga, a powerful state senator from Oahu and a primary spokesperson for a Hawaiian style of social welfare liberalism. Stefan A. Riesenfeld, a law professor at the University of California, Berkeley, was selected to write both reports. Ironically, part of Riesenfeld’s argument for Prepaid lay within the broader political context of the Nixon administration’s intention to develop employer-based mandates on a national level, which at the time seemed a logical extension to the enactment of Medicare and Medicaid in 1965.8

Both Riesenfeld and Prepaid’s legislative sponsors targeted coverage for those unable to afford medical insurance and yet unqualified for Medicaid. Estimates of the size of this “gap group” ran between 11.5 percent and 17 percent of the population, depending on whether physician and hospital coverage were combined or treated separately.9

Employer-mandated coverage was particularly important to this generation of legislators, still close to the plantation experience, who realized that plantation agriculture was on the wane. Ideologically and politically they were also part of that group that led the Democratic party to majority status in 1954. They were also primarily Japanese Americans who had returned from World War II with the dual aims of achieving political power and effecting social justice.

As a vehicle for universal coverage, Prepaid was hamstrung from the beginning, as Riesenfeld admitted in his report to the legislature. Marvin Hall, current president of the HMSA, estimates that subsequent to passage the number of insured workers did not increase by more than 5,000. As Emily Friedman interprets Prepaid’s impact, the major effect was not to provide a massive extension of coverage, but rather to define a basic benefit package, “thus setting a standard that all coverage had to meet.”10

Compared with situations in other states, Hawaii’s law has had the effect of constraining the growth of the gap group. Prepaid was challenged in 1981 by the claim that its authority had been exempted by the Employee Retirement Income Security Act (ERISA) of 1974, which prohibits states from mandating health benefits. Having lost in the courts in its appeal for exemption, the state was able in 1983 to gain a federal exemption through Congress; it is now the only such state to possess this right. While pleased that federal action recognized that Prepaid was antecedent to ERISA, the state has been bound, nonetheless, by the restriction in the exemption that any modification of Prepaid must be in the context of a further federal exemption.

State Health Insurance Program

The creation of SHIP in 1989 was a self-conscious step to further shrink the gap group while providing comprehensive care and attention to prevention. The latter is, in the opinion of John Lewin, the critical element, the point at which health insurance itself can operate as a lever for social change. Lewin argues that providing health insurance must be conjoined to an active concept of promoting public health by, first, convincing people to choose healthy lifestyles; second, selling health values to business as a solid economic investment; and third, moving to the broader social agenda of creating a healthy society.

Like Prepaid, the political strength of SHIP lay in its use of existing provider organizations, thereby being institutionally positioned among market forces that could act to control costs. A major selling point of the program was its presumed ability to affect overall utilization patterns, especially the common tendency of uninsured persons to use emergency rooms in lieu of readily available primary care. An attraction to providers was the prospect of reducing the bad debt/uncollectables pool.

The enabling legislation, adopted in April 1989 and signed into law in June that year, provided $4 million for the first sixteen months of operation and $10 million for the second full year. State spokespersons have been careful to bill SHIP as “a partnership between government, individuals and families, and the private sector. Government subsidizes insurance coverage for those unable to pay. Insurance companies provide
the coverage, and the already existing health care providers deliver direct care."

SHIP still does not provide universal coverage. Rather, it is targeted to those "who have been uninsured by public or private health care coverage programs and who are at a low enough income level where they cannot access current health care coverage." At the time of SHIP's passage, the size of this group was estimated at 30,000 to 35,000. This "residual gap group," officially estimated at 5 percent of the population, is made up primarily of the unemployed (30 percent of the uninsured); dependents of low-income workers, particularly children; part-time workers; off-Oahu residents; immigrants; seasonal workers; and students.

Initially, only Hawaii residents without health insurance in the three months before application were eligible for the program. SHIP establishes a sliding fee schedule. Under 100 percent of poverty, individuals pay nothing. Self-payments rise with income. Between 251 percent and 300 percent of the federal poverty level, adults pay the entire cost of insurance, while health care for children is still subsidized. Only those below 300 percent of the federal poverty standard are eligible; for Hawaii in 1989 that amounted to $41,759 for a family of four." To be eligible for SHIP the applicant would need to prove ineligibility for Medicare, Medicaid, and other federal benefits. To be eligible for SHIP the applicant would need to prove ineligibility for Medicare, Medicaid, and other federal benefits.

The logic underlying SHIP makes one important assumption: It is a temporary service, a "hand up" for those in need, "most of whom will be fitting into the Prepaid Health Care system soon." The eventual emphasis in SHIP will be on preventive and primary care. To accomplish the latter, SHIP focuses on services delivered through the HMSA such as health appraisals, typically including well-baby and child care, age-appropriate health screening, and a package of basic primary care services. Higher-cost items are deemphasized within the program and shifted where possible onto Medicaid if spend-downs render a person eligible for Medicaid. Hospitalization is limited to five days, with a dollar limit of $2,500. Two inpatient days are allowed for maternity care. Elective surgery and high-cost tertiary care are not covered.

In SHIP's first full year of operation, $1.7 million of revenue was obtained from individual payments. The first-year projection of total coverage was 150,000 enrollment months and a year-end enrollment of 20,000 persons. Contracts for the first year's service were signed by Kaiser (limited to 1,000 Oahu residents) and the HMSA.

Implementation of SHIP was designed to identify and enroll people unaccustomed to participation in a medical insurance scheme or put off by bureaucratic mechanisms—people who are often viewed as "outside the system." Statewide implementation, which began 16 April 1990, was organized to eliminate barriers to entry. Forms were shortened to collect only the most basic information. Certain persons, such as those dropping off Medicaid rolls, have instant access to the program, as do children and pregnant women. A broadly based community outreach program assisted by over 200 volunteers trained to help applicants fill out the necessary forms also has been developed.

Evaluating SHIP. SHIP's initial evaluation was completed in December 1991. With only a year and a half of real experience as a baseline, the evaluation study understandably focused more on operational aspects of the program than on achievement of its broader goals. It is still unclear how well SHIP can reach a relatively high-risk population with a disease prevention and health promotion strategy that will significantly reduce health care use while achieving acceptable health outcomes.

SHIP's initial enrollment goals fell short of expectations, which points out the difficulties involved in reaching this population. From 1 June 1990 to 30 July 1991, 12,000 people were enrolled: about 11,000 in the HMSA managed fee-for-service plan and more than 1,200 in Kaiser Permanente. Disproportionate numbers of enrollees are low-income subscribers: 63 percent are from families with incomes below the federal poverty level, and one-fifth report no income at all. With 90 percent of enrollees reporting incomes of less than 200 percent of federal poverty, this population emerges as only slightly better off than Medicaid recipients.
Enrollment grew to more than 17,000 members (13,300 in the HMSA statewide and 3,500 in Kaiser Oahu), with 22,000 being served by early 1993.

The initial evaluation did not examine SHIP's ability to provide a minimal basic benefit package while controlling costs. However, utilization rates indicate higher usage (about 85 percent higher) in the Kaiser Permanente hospital plan, which permits unlimited hospital days. A similar finding holds for ambulatory care. The larger proportionate enrollment of poorer families with young children in Kaiser may account for these differences.17

Interestingly, enrollees prefer SHIP to Medicaid. More than 60 percent of enrollees have incomes below 100 percent of poverty, rendering some significant portion of this group Medicaid eligible. Apparently the relative ease of entry into SHIP is a distinct advantage for some, as is the absence of Medicaid's welfare identification and the marketing of SHIP as private insurance.18

The evaluation gives SHIP sound overall marks. However, at the time of the initial evaluation, it was clear to many key policy-makers that SHIP was inadequate on a number of dimensions. Lewin, for one, saw SHIP as a patch in a still fragmented system that does not address the need for increasing funding to public health and community-based prevention. Nevertheless, SHIP in some form permits Hawaii to lodge its claim of being the only state with a workable answer to eliminating the gap group.

Jim Shon, SHIP's legislative sponsor in the House, has focused on SHIP's inability to meet what he sees as “the real needs of the community.” In his view, SHIP gained legislative approval at a time of significant revenue surpluses and at the expense of competing and ultimately more expensive programs such as long-term care, which are still struggling to gain political support. He also believes that SHIP's administration has quickly fallen victim to the bureaucratic malaise of the Department of Health, which has been unaffected by Lewin's fervor for reform. In place of the enthusiasm of the early enrollment period, applicants now encounter a skeptical bureaucracy concerned with controlling "cheating" on self-payment fees. In Shon's view, the administration of SHIP chose the narrowest construction of the program to assure that costs could be controlled. This trades off against SHIP's potential to have provided universal coverage. He points to the preamble of the bill he drafted, which called for the legislature to use innovative means to assure coverage for all residents "regardless of age, income, employment status, or any other factor . . . necessary to sustain a healthy life."19

Shon and others also question SHIP's actual achievements in coverage. The evaluation report focuses on the continued difficulties of identifying precisely how many people lack coverage and enrolling these people when found. The report estimates a current gap of 3 to 7 percent, significantly above the official 2 percent level. To Lewin and Waihee, in their intense desire to mark Hawaii as the first state to achieve universal coverage, these numbers represent "just the last increment" to complete coverage. Other commentators believe that the uninsured figure could be much higher, noting that the tendency within the state is to estimate the gap group as the residual from total policies in force, a practice that underestimates the percentage of the population with family double coverage. Splitting the difference in estimates, one may be left with the reality of 50,000 uninsured persons in the state and the policy embarrassment of having to deal with the cost of uncompensated care they represent.

Governor's Blue-Ribbon Panel

Concern for the lack of integration among the various components and key participants in Hawaii's overall health care environment produced the Governor's Blue-Ribbon Panel on Health Care. The panel was instructed to develop a more comprehensive understanding of the health care system through widespread community consultation and to help facilitate more effective cost control. The creation of the panel underscored problems that the legislation had not yet addressed, including the bur-
The panel, comprising “a cross section of Hawaii’s economic and social leaders including representatives of business, insurance providers, unions, academia, consumers, government agencies, and health care providers,” met almost biweekly for more than fifteen months.21 In July 1992 the panel made thirty-six recommendations directed at controlling costs in five areas: administrative costs, medical malpractice, consumer expectations, health care resources, and cost shifting. These five areas were chosen after months of hearing the views of a broad spectrum of the health care community and are significant in part for what they did not include. Long-term care, certainly a major factor in the overall cost environment, was not addressed because the Governor’s Office on Aging was concurrently preparing its own recommendations. Specific areas for attention included insurance rate regulation, health care facility costs, and common purchasing agreements. The first two were rejected after considerable discussion as more the result of cost factors than their cause. Joint purchase was seen as already a routine administrative practice. In extending the panel’s one-year authorization, the legislature suggested that mental health issues were also a matter of concern, but the final report makes no mention of them.

The panel designated eight of its thirty-six recommendations as “key change” proposals because of their presumed centrality to the overall pattern of reform being advocated by the panel. These called for (1) reform of administrative procedures, including electronic claims processing, automated record keeping, and a universal claims form; (2) reform of the regulatory system to lessen the costs of regulatory compliance; (3) reform of insurance access through revised community rating; (4) development of a no-fault medical malpractice system; (5) better strategic planning to address shortages in health-related human services; (6) encouragement of more efficient and effective utilization practices, establishment of a universal basic benefit package, and more effective use of primary care as first access to the system; and (7) full funding of public support programs that cover all public benefit packages, to eliminate cost shifting.22

The eighth key change recommendation grew out of the panel’s concern that its work result in actual changes in the current system. It called for the creation of an “entity” to implement the panel’s recommendations, which explicitly combined private- and public-sector players in an extensive range of activities, including the gathering, analysis, and dissemination of systemwide data (to make better judgments about cost issues); implementation of panel recommendations; redesign and monitoring of the basic benefit package; and periodic legislative recommendations on other health care matters.

The panel believed this to be its most important recommendation and spent the most time on its deliberation. For some panel members, this entity could only arise from the already good working relations between the key public- and private-sector players, particularly the insurance industry (the coalition that produced both Prepaid and SHIP). For them, the entity signaled a further commitment to “partnership” in the development of quasi-cooperative/quasi-regulatory approaches to further health care system development and cost control. Others on the panel were less sanguine, citing

growing elderly population, a growing shortage of certain types of health care professionals, acute and long-term care bed shortages, and rising health care costs.

Two important items were excluded from this agenda of concerns: a deficient mental health care system and the persistent health problems of native Hawaiians, which stand in stark contrast to the generally good health of the rest of the population. The reasons for this poor health profile are numerous and subject to considerable and contentious differences of emphasis and interpretation. Where many see the issue as one of improving access to care, others see the issue in the broader perspective of cultural conflict between Hawaiian and “modern” lifestyles. These issues have been addressed in part through the Native Hawaiian Health Care Act passed by Congress in 1988. The law is currently in the early stages of implementation; it is still too early to assess its likely impact on overall Hawaiian health.20

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the entity's nature as neither "fish nor fowl" and predicting that it would either be dominated by insurers and providers or be merely ineffective. Business interests on the panel predictably were reluctant to embrace "yet another" increment of public-sector regulation. Labor interests argued that without strong governmental authority and backing, such an entity would not be taken seriously.

The two most important panel recommendations—community rating and the creation of the entity—were proposed as legislation by the Department of Health; both failed to get out of committee in both the House and the Senate. A "face-saving" Senate resolution was gained on the community rating issue, which requests the Legislative Reference Bureau to study the feasibility of requiring community rating of all small-group health service plans that provide coverage in Hawaii. Some administrative supporters hope that this mechanism will prove to be a vehicle for developing the data-gathering/policy-analysis elements of the proposed entity, thereby keeping Hawaii even with other states that have appointed health care commissions.

The failure to act legislatively resulted from a breakdown in the political coalition that supported both SHIP and the panel. Shon lost his committee chairmanship to a wide-sweeping reorganization of the House just prior to the 1993 legislative session. The new committee chair, Rep. Julie Duldulao, has been either unwilling or unable to forge a new coalition to support health reform. Lewin, increasingly out of state and involved with the Clinton health care task force, has loosed the leadership ties that had brought other players on board in support of administrative proposals. Some observers of the process, Shon foremost among them, have been pointed in their criticism of the state's relative loss of position vis-a-vis other states on health care reform.

### Project QUEST

Throughout the health care reform process of the previous three years, costs have continued to increase for private insurers and government. Both the HMSA and Kaiser have raised insurance rates in the 14-18 percent range over the past several years, increases that belie Hawaii's generally favorable cost experience. Medicaid expenditures also have continued to rise, this year requiring the legislature to appropriate an additional $35.3 million to continue funding through June and to impose a 4 percent provider tax on hospitals and nursing homes. QUEST develops an insurance purchasing pool for Medicaid and SHIP, folding most recipients under a single insurance coverage plan. The state hopes to contain its costs through the promotion of managed competition for all publicly funded coverage, development of a comprehensive purchasing cooperative to be located with the Department of Human Services, and development of a basic benefit package common to Medicaid and SHIP recipients.

QUEST anticipates managed competition as a major feature of the Clinton health care initiatives and hopes to develop it in Hawaii first. The broad underlying assumption is that Hawaii's ERISA exemption will be extended and modified to permit these changes. Current proposals to modify the exemption and Prepaid to complement the changes in QUEST include providing dependent coverage, changing the employer/employee share ratio (without hurting lower-income employees), and, of course, changing aspects of the benefit package. Throughout the discussion of national health care reform over the past two years, Hawaii's political leaders have been concerned that the state not lose the leverage it has gained, which may happen if it is forced to conform to national proposals that would reduce coverage. In this sense, QUEST can be seen as both preemptive and as an extension of the rationale to pursue universal coverage while controlling costs and continuing to provide a desirable basic benefit package.

The key to cost control within QUEST is the substitution of conventional insurance coverage for the open-ended payment scheme of Medicaid. The common benefit package would be generous by current SHIP standards but would reduce the overall "richness" of the Medicaid package—long a
concern to many local health care professionals and business representatives, who see it as overly generous. Additionally, the primary care and prevention bias of SHIP would be extended to Medicaid.

The benefit package includes (1) inpatient medical, surgical, and rehabilitation with a $25 copayment per medical/surgical admission and no copayment for rehabilitation or for children’s services; (2) fifteen days of inpatient psychiatric care per year with no copayment; (3) five days of inpatient detoxification per year with no copayment; and (4) inpatient maternity and subacute care with no copayment. Early Periodic Screening, Diagnosis, and Treatment (EPSDT) services are covered with no copayment, as are other preventive services (including physical examinations, well-baby care, immunizations, family planning, and Medicaid options for mothers and infants). Laboratory and home health services are included with no copayment. Patients pay $5 per physician office visit and have no copayment for visits with a nonphysician provider. Mental health, dental, and catastrophic health benefits (other than those listed above) will be dealt with in separate plans, which are still to be released. The state would share catastrophic health costs up to $100,000 with the insurer and develop a sliding cost-sharing scale beyond that.

Representatives of the provider industry-hospitals in particular—are enthusiastic about QUEST because they see it as ending cost shifting. Small-business owners look for the program to relieve the HMSA and Kaiser of the need to raise rates to spread the shortfall over other subscribers.²⁴

To date, only a few physicians have been vocal in their opposition to QUEST, seeing in it an extension to managed care, which prevents individuals from choosing their own physicians. Philip Hellreich, legislative chair of the Hawaii Federation of Physicians and Dentists, the state’s most politically conservative health professional interest group, has gone so far as to predict that if managed care programs become the norm, many of Hawaii’s “finest physicians will leave the state.” But this is a decidedly minority view. The current president of the Hawaii Medical Association, Jeanette Chang, provides a more prosaic judgment: “We need some kind of reform, because Medicaid has gone down the tubes.”²⁵

Where Hawaii Is Now

Hawaii’s health reform efforts are lodged somewhere in midstream. Just how wide that stream might be and the nature of its direction are matters for speculation and of some dispute. Until two years ago Hawaii unquestionably led the nation in developing near-universal coverage while keeping health care costs under control. The health care environment in the state was remarkable for the amount of cooperation between the private and public sectors and the seemingly broad consensus on the major dimensions of health care reform. The outcomes of the Blue-Ribbon Panel signaled the possibility of yet another step forward toward this productive partnership.

As of this writing, the situation appears somewhat less clear. On the one hand, Project QUEST promises to be a vehicle for resolving existing weaknesses in both SHIP and Medicaid. Modeled after managed competition and managed care, these programs seem to be at the cutting edge of health care reform. Yet, on the other hand, some element of purpose and vision seems to have dropped out of the picture. The entity proposed by the Blue-Ribbon Panel was to be a grand experiment, a vehicle for developing yet a new measure of private and public-sector cooperation. Efforts throughout the fall of 1992 to carry forth the energy of the panel and to develop a broader consensus for an entity focused primarily on broad data gathering to inform future public policy choices faltered. Failure to gain legislative endorsement for both the health commission and revised community-rating bills-outcomes that have emerged in various other states (for example, Minnesota and New York)—signals to some in Hawaii that at the very least the familiar coalition responsible for past health care reforms may itself be in the process of reformation. Attention is now focused on Project QUEST.
and its proposed implementation date of January 1994. If QUEST succeeds as designed, Hawaii may move once again to the acknowledged forefront as a state able to transform its health care system in response to the pattern of changing demands.

The author thanks Robert Grossman, John Lewin, and James Shon for providing valuable information and insights for this paper.

NOTES


2. This analysis is taken directly from a document John Lewin has developed to provide a thumbnail sketch of Hawaii’s health care system. J.C. Lewin, “Briefing on Hawaii’s Health Care System” (Hawaii State Department of Health).

3. An additional advantage has been the HMSA’s historic record of controlled administrative costs. The HMSA argues that ninety-four cents of every client dollar goes to care reimbursement, which certainly compares very favorably with mainland Blues plans and may in fact be the lowest administrative overhead factor in the United States.

4. This assertion is hotly contested by small business and its lobbying agents, who see Lewin’s effort to reform Prepaid to cover all employers, no matter how small, as harming them. The news reports the day after Lewin presented “Seamless” to the Blue-Ribbon Panel chose to emphasize his proposal for extending Prepaid to include part-time employees, most of whom work for small businesses. The outcry was considerable and overshadowed any other positive press that the plan might have received from the broader community.

5. The Blue-Ribbon Panel had a difficult time settling on a recommendation covering community rating. Kaiser and the HMSA argue for the concept of voluntary rating, which Lewin promotes for the purposes noted. Others, however, believe that a significant erosion has occurred in the concept, which works significantly to the disadvantage of small businesses—which are in effect small risk pools. The rating has nine “hands” that can be assigned applicants, with a fully 45 percent difference between the most and least favorable. In the eyes of many, this undermines the effect community rating is meant to produce.


12. Ibid.

13. There is no discernible compelling logic for this figure. Apparently Lewin and his Health Department colleagues felt that that level would both sell politically and was a realistic assessment of living costs in Hawaii, which typically has the highest cost of living in the nation.


15. Kaiser offers a more benefit-rich package than the HMSA and thus has continued to restrict enrollment as a protection against excessive exposure.

16. The State Health Insurance Program of Hawaii: From Legislative Priority to Reality (Prepared by Center for Health Research, Kaiser Permanente, Portland, Oregon; School of Public Health, University of Hawaii; and Hawaii Medical Service Association, December 1991), 7.

17. Ibid., 8.

18. Ibid., 19.


20. For a recounting of the process leading to the passage of the Native Hawaiian Health Care Act and a statement of the broader cultural argument, see K. Blaisdell, “Historical and Cultural Aspects of Native Hawaiian Health,” in Social Process in Hawaii 23 (University of Hawaii, 1989).


23. The plan would exclude approximately 25,000 aged and disabled persons, who would continue to be served by Medicaid in a traditional manner. The rationale is that these persons have needs that stand outside the requirements of the basic benefit package.

24. Ibid.