# 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, now 3
  - 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)
- Private sector participation declining drastically

## 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 offered better benefits, provider pay, or policies, it would 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 current 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.
  - Care coordination is undermined by competition.
  - Adverse selection and competition for risk pools incentivize plans to deny or avoid covering care for sicker, more complex patients.
  - 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.
- Cost-effective care: physician stewards beat managed care

## 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 Roadmap

- Goal is a universal single-payer system
- Transitional strategy of 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
  - cooperation and collaboration, not competition, to improve cost-effectiveness of care
  - comprehensive responsibility for population and bringing as many as possible into appropriate care
  - increased Medicaid fees tied to shared savings
  - whole system is one big integrated "ACO" – only one for each island or region

## 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 Federal waiver or 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 (not RBRVS and E&M) system that is task-neutral (eliminating incentive to game documentation)
  - 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.
- 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
- the priority must be on ensuring access to appropriate, quality care for everyone - both individual patients and population health.

## 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)