

RECORD, Volume 24, No. 2*

Maui II Spring Meeting
June 22–24, 1998

Session 49CS

Health Care Reform Around the World

Track: Health
Key words: International

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Summary: Around the world, many countries are reforming their health care financing and delivery systems. Their objectives are to improve access to health care providers, contain escalating costs, and improve quality of care.

This session first provides a birds-eye view of main reform ideas and programs around the world. Major reform programs for Taiwan, Hawaii, and South America are then discussed in detail.

Finally, a summary of health care reform in an international context is presented.

Mr. Chiu-Cheng Chang: I will be your moderator and one of the panelists. Other than me, there are two other panelists. Josh Bank is an actuary with 23 years of experience in design, implementation, funding, and accounting for domestic and international pension, insurance, and post-retirement medical programs. He grew up in Mexico, speaks four languages, and travels frequently to South America for pension reform and privatization. Josh will present some elementary information on the structure of health care systems in three major South American countries.

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California, San Francisco, and the School of Law at UCLA. After nearly two decades in Washington, D.C., involving national health policy issues principally for the U.S. Congress' Office of Technology Assessment, he returned to Hawaii in 1989. He's professor of Family Practice and Community Health at the John Burns School of Medicine at the University of Hawaii, and was previously medical director of the state Quest Medicaid/Medicare program.

I have worked in six countries. My first employer was Mutual of Omaha, and I worked for Mutual of Omaha's Canadian and Japanese operations, including, of course, the U.S. domestic operation, altogether for ten years. For that reason, I'm also a Fellow of the Canadian Institute of Actuaries (FCIA), because by Canadian law, only an FCIA is considered an actuary. Internationally I have worked as a consulting actuary for a number of multinational insurance and reinsurance companies in their Asian operations. I also work as a consulting actuary and advisor to both the governments of Singapore and Taiwan. Currently I'm a professor, chairman, and director for Tonkin University in Taiwan. Just two or three months ago I was appointed to review Taiwan's national health insurance program.

Our topic is a huge topic—health care reform around the world. There have been many books written on this subject. There are even many more academic and professional articles and papers written on this subject, so it is almost impossible to cover this subject in 90 minutes. In order to utilize this time effectively, this is our plan. I will spend just a few minutes giving a birds-eye view of health care reform around the world. Then Josh will cover health care reform in South America in detail. Following Josh will be Dr. Miike who is going to cover Hawaii's health care system in detail. Finally, I will cover Taiwan's national health insurance program and my suggestion to the government on how to reform that program, which has been in operation for three years. I presented a related paper two weeks ago in Birmingham, U.K. to the International Actuary Association. Without further delay I will present to you briefly my view of health care reform around the world.

All countries have their health care systems. In Session 87, Health Care Financing Systems Around the World, I will give detailed descriptions of all the major systems, their advantages, disadvantages, and how they operate. Basically, when I say all countries have their health care systems, I mean all the systems are different mixtures of all those major systems I will be describing in Session 87. All these models or systems are based on combinations of financial sources and the payment systems. Sometimes regulatory systems, regulators, and also delivery systems have some bearing on the formation of such a model. Consequently, all the models are some kind of mixture of what I call major systems, whether one aspect of a major

system is emphasized over the other, all depending on that country's social, cultural, and political considerations.

All systems have their objective, of course, which is access to health care services; that is adequacy and equity in access to some minimum of health care. Another objective is macroeconomic efficiency. That means that the health care cost should not exceed some percentage of GNP. Another objective is microeconomic efficiency; that is, health outcome and consumer satisfaction. These two goals must be achieved at the minimum cost. This is what we know widely as cost containment. Finally, freedom of choice for consumers.

Why reform? Well, generally speaking, the reason for reform is that no single system can achieve all the objectives, and this is understandable; tension exists between all objectives. All the objectives I mentioned are partially or internally conflicting or maybe overlapping. Because of this internal inconsistency, systems are designed, operated, or updated to make progress in achieving more objectives and also to make progress in achieving each objective more completely.

More specifically, the reason for reform is rapid aging of the population. We have been hearing this for quite a number of years. This, together with declining birth rates and a decreasing tax base, have raised health care costs, escalating at a much faster pace than CVI or RPI in the case of British Commonwealth countries, and this is a specific reason. Another reason is the technological imperative on health care. This is what we know all about, the advance of cost-increasing medical technology. For example, my parent company, which is the largest multinational conglomerate from Taiwan, owns the largest hospital chain system in Taiwan. They just bought a huge cancer treatment facility that is so big that it takes three stories to accommodate such large equipment. This is a technological imperative. Because of that you need to consider reform in order to improve quality and access and to control cost. Another is the well-known supply-induced demand. Physicians have the financial incentive to increase demand. Last, higher consumer expectations. This will become more and more so, especially in those newly industrialized countries and in those newly democratic societies.

There are basically two types of reform. I classify them according to a number of commentators. One is evolutionary reform. Another is structural reform. Structural reform is far more radical than evolutionary reform. I will define evolutionary reform by concentrating on four important items: equity, cost containment, microefficiency, and consumer choice. When you see this evolutionary reform you will notice that, indeed, this has been around for some time, except that we may not consider it as reform because it is evolutionary. For equity, of course, you extend

the coverage to make equitable access a possibility for most of the population of a society. This is evolutionary reform. Similarly, you expand your geographic coverage. We call it geographic equity. You also have the evolutionary reform. For evolutionary reform, whether geographically or increasing the coverage of population, we use generally so-called population-based formulas as criteria to determine what is the equitable extension of coverage. Similarly, when we talk about coverage we also have to talk about outcome. Equity of outcome is an important evolutionary reform. Also, you may have seen and heard in the case you are allowed to be contracting out of a main insurance system. This is also considered a kind of reform. Finally, income-related charges, or contribution premiums based on income, income-based contribution, and extra billing when you use more expensive health care service than allowed.

Cost containment is the most fundamental concept of insurance, and this is, of course, one kind of reform. Tight hospital budgets control cost. The trend towards case-related payment systems is also an attempt to contain cost. All the other systems are designed to contain costs in this system of paying hospitals because hospitals are always one of the most expensive items among all health care services. Rationalizing hospital and medical equipment is another one, which is an alternative to hospital care. Hospital care is expensive. So, all substitutes for hospital care should be considered an attempt at evolutionary reform to contain cost.

We also know a number of mixed payment systems for doctors from fee-for-services to capitation, to case payment, and diagnostic-related groups (DRG). All of the mixtures are considered attempts to contain cost and improve fee-for-service payment systems. Positive and negative lists of drugs and price controls are other evolutionary reform ideas. The reference price systems for drugs are another reform attempt. The education and training of physicians, I think, is probably most fundamental, but I know of no country which has been successful in asking physicians to come up with the most cost-effective way of doing their job.

From the Floor: What do you mean by reference price systems?

Mr. Chang: Oh, reference price systems. For example, in many countries the government comes up with a set of price guidelines so that the reinforcement will be according to the price guideline. So, for example, in Taiwan, the government has a long list of reference prices. The government pays providers according to the price list.

Micro-efficiency. These are incentives to encourage hospital efficiency and to reduce waiting list problems. As far as I know, the most notorious example is the U.K.'s national health program where the waiting list is quite long, so much so that the private health insurance market is growing simply because those who can pay don't like to wait. Those who can afford will spend money to save time versus those, maybe a majority of people, who like to spend time to save money. There is an attempt to improve efficiency in virtually every aspect of the health care industry. New incentive systems, the expansion of primary care services—again, to reduce the more expensive services by using specialists—and, finally, quality assurance are also attempts to improve microefficiency. Consumer choice includes the choice of primary care doctors and referrals in the case of HMOs and PPOs. Access to hospitals is another consumer choice.

Structural reform has far more radical changes than evolutionary reform. I will only cite a few examples. The details come from a number of publications, particularly those from Organization for Economic Cooperation and Development (OECD) countries. OECD countries have periodical publications summarizing in great detail OECD countries' health care reform program appraisals, performance evaluations, monitoring, and recommendations for change. New Zealand transformed their regulated health care market to a competitive one. I think this is very significant. I am personally interested in this. I believe eventually all the health care problems will not be solved unless some kind of free market can work in the health care industry, and, as far as I know, New Zealand is a very interesting example. I consider that example exciting.

Another one is Sweden. Sweden has achieved productivity increases and, at the same time, cost reduction through many changes. It's quite complex to describe all the changes. The detailed description can be found in OECD's published book. I believe the title is something like "The Health Care Reform for OECD Countries," up to probably 17 or 20 countries, and I got this out of that book. Turkey has begun an extensive transformation of health care institutions and practices. Again, all the details can be found there. I consider this structural reform. If they are successful, other countries will follow suit in some way, taking into consideration their own cultural characteristics and, of course, their tradition and political considerations.

Finally, there are structural reforms in the U.S. national health insurance proposal. Most of you are probably very familiar with this. Howard Bolnick, our SOA President-elect, about three years ago gave a presentation on this when I organized an international conference in Singapore on affordable health care. This is what I have observed. I don't claim that these are all the movements toward market competition, but we can detect that movement converging to what I call market

competition, and here are a few examples. One is the fund-holding general practitioner.

In some countries, such as the U.K., general practitioners now can hold part of a hospital's budget so that they are in the position to buy hospital services on behalf of their patients. Because of this newly acquired purchasing power they are in the position to negotiate with hospitals for better quality hospital services for their patients. This is the beginning of what I call market competition. We cannot expect a totally free market from health care immediately, but I consider this a very, very good practice or at least a good starting point. Competing insurers within national health care systems. Many national health care systems are what I call monopolies. Only one insurance company insures government workers; for example, Taiwan's national health insurance.

Competition is important within some guidelines. The third movement toward market competition is separation of purchaser and provider. A very important problem or critical problem for health care industry executives is that providers are also one of the biggest purchasers of health care services. They are clearly in the conflict of interest position. So, if you have someone who is a provider who is also a big purchaser of health care services, you cannot expect to have a very good free competition market. Finally, those well-managed public hospitals, becoming so-called self-governing hospitals, are also an important step towards market competition.

The most remarkable feature as I have observed in so many countries is that the degree of emerging convergence seems to be increasing. I believe this emerging convergence will become more intensified, and that is good for the health care industry globally. That reform follows in the general direction of those pioneers earlier. This is to be expected, human beings being human beings. We certainly cannot create something. We follow what those pioneers have started, but I think the pace will be faster and be more intensified. There are movements in seemingly contrary directions due to countries in different reform stages. Contrary directions may be due to the fact that different countries are in different reform stages.

Finally, my favorite subject, outcome measurement and management, I think will become a major issue. Let me use an example for your reference. My parent company is a hospital, the largest hospital system in Taiwan. To start an outcome measurement system and a management system, how do I convince the superintendent of the hospital system who is a very powerful man, an internationally well-known medical doctor, of my argument? I say that as a medical doctor, you don't start your outcome measurement system. As a consulting actuary,

I can collaborate with this insurance industry, and I can help the industry utilize their data to come out with a model to measure the outcome of all physicians. I call it the outcome profile of each and every physician, and I can do similarly for hospitals in terms of mortality, morbidity, and so on. I'm very confident I can be very successful in this regard. If your medical doctor doesn't come up with your own outcome measurement system, then this model say owned by an insurance industry or a consulting company, will be replacing your legitimate position because they will be in the position to say Doctor A is this good, Doctor B is this bad, and so on according to their outcome. This is my main argument, and, because of this, the largest hospital system in Taiwan is very much interested in setting up outcome measurement. This meeting's keynote speaker also gave me a very positive answer to my question, and I feel very strongly that this is the way to go. No medical doctor can be immune from being measured. We should be in the position to measure medical doctors' performance.

Mr. Joshua David Bank: I've learned some great things at this meeting so far. There's one thing that really stuck in my mind, and that was the idea from the general session regarding that low earnings may not be a direct cause of higher mortality and that it actually may go the other way. That just has been bothering me all day. I don't understand it. How much can a dead person earn anyway? Maybe they're right about that. I mean death really impacts earnings instead of earnings impacting mortality.

I want to give thanks to the sources in particular for the paltry material that I was able to collect on South America. One of them is Inez Torres, who addressed you in a session a couple years ago in Colorado Springs from the Argentinean health care system, much more thoroughly and comprehensively than what I'm going to be able to give you, but some of the material I got was from her. Also, Ronald Poon-Affat, who's currently our SOA ambassador to Brazil. He's a reinsurance actuary I think at Swiss Re in Sao Paulo. Finally, to the SOA International Section Council and Mike Gabon, without whose encouragement this session would not have been possible. Finally, the *Economist* and the Canadian Institute of Actuaries which has a pretty good database on the Internet that has all kinds of demographic and economic information. I had a lot of fun comparing the economist data and the CIA data and laughing over how different they are, and I found this as a recurring theme throughout all my research. It's just really hard to get information on some of these places. I did the best I could, and hopefully you'll be confused enough that you'll want to do some of your own research on this stuff.

Latin America. What I'll try to go through is some demographic profiles and economic profiles. The demographics and economics really have a lot to do with

everything. Then I'll talk a little bit about Argentina, Brazil, and Chile. Part of that is because it's on actuarial benefits consulting (ABC) and I work for the ABC group in Deloitte & Touche, so I have some good credit for that, and also those are three of the four countries that I'm most interested in.

Let's look at some demographics. There are some things that I found interesting. First of all, look at the percent urban in Table 1. We think the U.S. is so advanced and so urbanized, but at least of these four countries, it's the lowest in urban population. All the other numbers are probably about where you'd expect them to be, at least on a relative basis. You look at this theme that we've heard over the last day of distribution of age groups. You have a lot of young people in South America and a lot fewer older people. In some of these countries you're going to see that change substantially. Life expectancies aren't really that different. Probably if you looked back a few years, you'd see a lot more difference there, but they're converging, and I think some of the information provided over the last day is showing that it's going to converge even more.

TABLE 1
DEMOGRAPHIC PROFILES

	U. S.	Argentina	Brazil	Chile
Total Population	267.1m	34.8m	159.0m	14.2m
Pct. Urban	75.2%	87.4%	79.1%	87.3%
Pct. Under 15	22.0%	28.9%	31.6%	29.4%
Pct. Over 65	12.6%	9.4%	4.8%	6.6%
Life Expectancy (m)	73.4	69.6	63.4	72.3
Life Expectancy (f)	80.1	76.8	71.2	78.3
Human Development Index	94.0	88.5	79.6	88.2
Crude Birth Rate per 1,000	13.8	19.9	19.6	19.9

The human development index is something that I don't understand, but I thought it was an interesting number. You'd expect it to be lower in certain countries than in others. It must be some kind of logarithmic scale because when I look at U.S. versus Brazil, you expect Brazil maybe to be in the 40s, or some countries to be in the 40s, but I looked through the entire book that contained this measure. It's actually a measure either created or modified by the World Bank using some United Nations information, and it has so many governmental and economic factors in it that I could probably do research just on what that index means, but that's just a directional thing.

Birth rates are a little bit higher in these three countries, but when you switch to some of the—I wouldn't say less developed countries—but at least ones that are maybe a little bit behind or have gone through some potholes in the road toward development, the urban factor now starts to change a little bit for Columbia,

Mexico, and Peru in Table 2. Particularly Peru is quite unurbanized. This has a lot to do with the ability to provide health care because in some of the countries the programs really differ between urban areas and rural areas, or at least the ability to provide certain kinds of programs in the rural areas degrades pretty strongly.

TABLE 2
DEMOGRAPHIC PROFILES

	U.S.	Colombia	Mexico	Peru	Venezuela
Total Population	267.1m	35.8m	91.1m	23.5m	21.8m
Pct. Urban	75.2%	74.5%	74.9%	70.5%	94.9%
Pct. Under 15	22.0%	34.3%	35.5%	35.9%	36.8%
Pct. Over 65	12.6%	4.4%	4.3%	4.4%	4.1%
Life Expectancy (m)	73.4	68.2	69.5	65.9	70.0
Life Expectancy (f)	80.1	73.7	75.5	70.9	75.7
Human Development Index	94.0	84.0	84.5	69.4	85.9
Crude Birth Rate per 1,000	13.8	23.4	24.6	24.9	24.9

Look at Venezuela. Everybody lives in the cities. Here, the people under 15 and over 65 are somewhat similar to the prior group. For life expectancy, as you would expect, Peru is not in great shape. Peru is having a lot more problems than just health care or staying healthy. Columbia also has some problems, primarily a lot of violence and deaths from accidental causes. The human development index is 69.4. Peru is really the one that sticks out. I'm not sure why. There must be some heavy weighting to the form of government or something like that. I think some people would say that Peru is still a dictatorship and may be the only one of the meaningful countries in South America. The birth rates are a lot higher here. I don't know why that is.

I won't get into economics too much. (Table 3) Purchasing power/parity is again something I don't fully understand, but at least it seems consistent in that in Brazil, for instance, if you only earn \$3,600 a year, it's not like you earn \$3,600 in the U.S. Things are cheaper, and maybe demands are lower for certain things. In Argentina there's not a whole lot of difference between the actual and the purchasing power/parity. I'm a little bit surprised at how low that number is because the times I've been down there it seems like a very progressive country, but they have a lot of unemployed people. The economy is hot, growing like crazy, but there is 20% unemployment. There's just a lot of recurrent problems there. Some of you probably know Argentina claims to have the lowest inflation in the world, and it's hard to get much lower than that, so you go into deflation, but when you look at the average, the averages are somewhat deceptive because particularly in Brazil you had 8,000% inflation in 1991 or 1992. That means you had to pay 80 times as much at the end of the year as you did in the beginning. From one day to the next people were manipulating a lot of stuff.

TABLE 3
ECONOMIC PROFILES

	U. S.	Argentina	Brazil	Chile
GDP Per Capita (U.S.\$)	\$26,580	\$8,008	\$3,646	\$4,163
Purchasing Power/Parity	\$26,580	\$8,600	\$6,300	\$8,400
CPI (Inflation) 1996	2.98%	0.28%	15.58%	7.48%
Avg. Inflation 1989–1995	3.6%	173.3%	746%	14.8%
Unemployment Rate (1996)	5.4%	17.3%	5.2%	6.5%
Avg. Unempl. 1990–1995	6.4%	10.4%	6.1%	5%

Inflation has a lot to do indirectly with insurance and health care because of the payment patterns. If you can delay paying a bill for 3 weeks and inflation's 1,000%, you can really manipulate things like that. Health care and insurance systems in these countries, at least the private portions, are having trouble learning how to make money the old-fashioned way by efficiency and actually having a good product because they used to make money just on the float. Venezuela's the one that just has had a little bit of trouble getting reset. There has been constantly high inflation for several years. I'm convinced they will come out of it. They have a highly educated population, which may be a little sleepy at the present time, but they're going to be waking up.

Let's actually move on to health care for a minute. I have to warn you there is a bug in this material. I'm not going to tell you exactly where it is because I want you to actually look through it carefully. Some of these numbers don't make sense. It wasn't a typo. I don't think it was an error. It was just very difficult to interpret some of the materials that I was looking at. I did a lot of research, and I spoke to people down there. I'm convinced that many people in Argentina don't understand their own health care system either, so I'm just going to try to put a little bit of perspective on what the basic structure's like.

In Argentina basically you have a tradition of socialized medicine, and there's still a lot of that left over. I'm distinguishing between private, which is people who are trying to make money; privatized, which is previously government-run systems that they want out of, that they just really didn't think that they can handle right; and then public, which is just what's left over, primarily for unemployed people or the disenfranchised, and I think you'll see that in most countries. The private system is really quite small. It's made up by these prepay systems that they like to compare to HMOs, PPOs, and point-of-service plans, but there's really very little or no managed care character to these systems, and that's pretty universal throughout South America. Mexico is starting to actually get into managed care, but they're prepaid. They're group programs, so they're not fully insured. There's actually very little of a private insurance market down in Argentina.

The obras sociales are traditionally closed groups by union or by employer, and they're basically setups where a company or a union owns its own hospitals, owns its own clinics, and hires its own doctors. If you work for a certain carpenter's union or cement worker's union, then you go to these obras. There is very little or no competition. I've heard that the service is relatively bad, sometimes nonexistent, and it's open to a lot of fraud and inefficiencies. There are some obras sociales for executives that popped up from people who had previously worked with these obras or people who had been covered in some other system. For a little extra on the side they can get into these obras and get their families into them, so there's an advantage there.

They've now privatized the retiree medical throughout the country. It's a very large system, and it is very complex, but it's also riddled with a lot of fraud and inefficiencies. I've done some studies regarding the PAMI trying to help the people down there use sampling to root out corruption. They were spending a lot of money doing full audits. We're talking something like 4 or 5 million claims a month, and they were going through 40% of them to try to compare the prescription to the drug that was being out and the treatment and all this, and it was a disaster. So, it was pretty easy actually to find the fraud once we taught them how to sample things. Not a whole lot of money is being spent on health care. I think it runs somewhere around 7% of gross domestic product, and that has been kind of steady for the last four or five years anyway. That would be low compared to us but much higher than, I think, any other country in South America. There are 2.2 million people, and these are sometimes affiliated with U.S. companies, who want to give a shot to doing some health care investment in Argentina. My philosophy about South America and health care is there's not a whole lot of opportunity for U.S., North American, or First World countries to make money in Argentina in health care. There's not a big insurance industry down there in the first place, much less a health insurance industry. The way to go probably is to buy into or to give some capital to some of these companies as things get less fraudulent and more efficient to try to maybe take back some of that money that is being stolen now, but philosophically, I don't like the idea of us going down there and bringing money back that could otherwise be used to provide more health care.

The premiums are pretty low, and the average for the entire thing is lower than almost any of the other top eight. That's because some of these just provide an absolute minimum of coverage. I think there was a law that was passed recently that set some minimum coverage for these private health plans, and I think the cost of that minimum coverage is \$17 a month. I think all they have to do is give you a blood pressure test or something like that. It's nothing meaningful. But they're

building their way up, and they're going to actually have some meaningful minimums.

Brazil is interesting. It has a pretty easy to understand system. It's basically private. In a lot of ways Brazil is similar to the U.S. Its social security system is still defined benefit, and they're saying that it's going to stay that way, although there are bills in Congress like there are here talking about privatizing it, in other words, breaking it up and going to a defined contribution. Seguros-Saúde is more or less as close as you can come to a real insured product, and there's a fair number of people there. Planos de Saúde are kind of like organizations between several employers, and it's not an insured product but more like a self-insured. Medicina de Grupo is a big group insurance plan. Some of these could be prepay, and some of them come very close to looking like private insurance. Auto-gestô is purely self-insured. These would usually be very large companies that can really afford to do that kind of thing. And then there is the biggie, Sistema Unico de Saúde, which is their old government system. That still covers most of the people out in the boonies, of which there are many people. That's the vast majority.

The current thinking is that all of these others are going to grow in size, particularly the very private one at the top, and there is a good opportunity, but I don't feel that strongly about Brazil because it's in really bad shape. It needs our expertise, and I think they should be willing to pay us for it. Table 4 shows private health insurers in Brazil. You can see that there's a fair amount of outside investment and partnerships, and these top 7 account for roughly 87% of the market: Aetna, Prudential, CIGNA, and Hong Kong Shanghai Bank. They're going crazy throughout Latin America buying up banks and insurance companies.

TABLE 4
PRIVATE HEALTH INSURERS
SEGURO-SAÚDE IN BRAZIL

Company	Partner	Premium	Percentage of Market
Sul America	Aetna	R\$1.341b	34%
Bradesco	Prudential	1.053b	26
Golden Cross	CIGNA	0.535b	13
Maritima		0.191b	5
Bamerindus	HSBC	0.188b	5
Porto Seguro		0.173b	4
Other		0.494b	13
Total		R\$3.975b	

Chile has always been pretty obscure to me. This is somewhat of a joke. If you want to ever try to understand it, good luck. But this is the way I kind of drilled it down. The public system is funded by a 7% payroll deduction, but it's also

subsidized by the government and by the employer for maternity and certain kinds of benefits. The SCEH is for the unemployed disenfranchised, like the public hospitals, the very bottom, worst care, but there's a lot of people in it, and it's funded solely by general revenues. There are three brands of ISAPREs: (1) the basic one; (2) the supplemental where you can buy better coverage over the basic coverage that's provided by the ISAPRE; and (3) executive retirees are allowed to come into this system because otherwise I think they'd be stuck in SCEH, and they don't want to be there. Regular retirees get stuck with the bad stuff, but executives for a little extra, say 7% of your pension plus whatever you can negotiate your way in, can enter a one-on-one type of negotiation to take advantage of the ISAPRE.

From the Floor: Is ISAPRE a company?

Mr. Bank: ISAPRE is just a large network of hospitals, clinics, and doctors under a big umbrella. I do not believe that it's very free market. Chile is a strange place. They've been through reform for so long, and they're not real open with their information.

It used to be public, but now it's privatized. Privatized in my definition is not private, but it's a previously government-run system that they wanted to push off into the private sector so that they wouldn't have responsibility such as what they're doing with pensions.

Dr. Lawrence Miike: The introductory overview is very relevant to Hawaii and I think in any state that tries to do things. The only real big difference between us and other states is that we're the only state allowed to mandate health insurance through the employment side. Anybody working 20 hours a week or more must be provided health insurance, and the way that is done is the incentive is for the employers to basically focus on the employee and not the family because they have a choice. Just because of inflation they basically pay just about all the low-paid employees' premium, but if they cover employees' families, they must pay 50% of the premium, even though they can offer a less generous beneficiary package, but the incentive is not to do that.

What we'll find as I go through my presentation is that when we look at the uninsured we have many uninsured children who are of employed families, but overall, if one looks at the U.S. versus Hawaii, in the U.S. the majority of the uninsured are employed, whereas in Hawaii it's the opposite. They're unemployed basically because of prepaid health care. You have all of these things. I just wanted to give you some examples of the kinds of things that make Hawaii the number one state. Hawaii has the longest life expectancy, but I always thought it

was basically because of our various populations, the Asian populations. I took a look at the caucasian rate, and we're in the top three: North Dakota, Minnesota, Hawaii. I figure in North Dakota and Minnesota it takes a while to find people in the cold, so it may be two or three years later they declare them dead, whereas in Hawaii the people that know they're going to live a long time go to some good place and live. That's my explanation of that difference.

Also in Hawaii when you look at the characteristics of Hawaii's health care system, employment-based health insurance is key. We have a patchwork of private and government health insurance coverage, just as you'll see in many other countries or in the U.S. On the uninsured side the people in the private sector who could be covered by private insurance do not consider it affordable or a high financial priority, such as young people and students who think they're not going to get sick. When we look at for the government side, they may be eligible, but they're not aware that they're eligible or they haven't applied for it even if they know that they're eligible. Filling in the gaps will create incentives to join for those who already have insurance. If you make a benefit package liberal enough, and you make the cost low, who wouldn't want to say why should I pay insurance on this side when I can join this program? You'll see that had happened to us when we tried to get into gap-group insurance. Because of my current position as medical director, this area drives me nuts. For those of you who know medical health insurance there's always the issue about what is medically necessary in terms of being covered. When we get into areas such as in my department we have wonderful early intervention services. My people who are advocates for early childhood intervention say Medicaid should pay for this service, and Medicaid people say that's not a medically necessary service. It may be socially wise and very good for a preventive, etc., but it's not a medical service. We end up arguing with the Department of Human Services, which in this state happens to run Medicaid, and that is not in my department. We have the providers. They have the insurers. What we try to do is ask, do you know that when you contract with managed care organizations to provide those pieces of early intervention services that fall within the definition of medically necessary, they will try not to provide them? Let us carve that out and give that to the department so I can use my general revenues, combined with Medicaid funds, to provide the whole early intervention package, but if you're on the other side, it's eroding into your financial base for health care.

The other side is that I'm currently under two lawsuits; that is, two federal court actions. The Individuals with Disability Education Act that said any child in need of education and special services must be provided those services. Those services are defined in an individual education plan that is not medically controlled but

controlled by parents, teachers, psychologists, psychiatrists, etc., and when that is defined it must be provided. My psychiatrists cannot say we don't think that service is necessary. The parents can come in and say it's in the education plan. You better provide that service. Those are the kinds of things that also affect medical dollars.

The other part here is that there is a great incentive to find every bit of money that states provide and see whether you can shoehorn that into some credible program like Medicaid because you're going to get a federal match, so that if I'm spending a dollar on a service of state money, if I can define that as a Medicaid benefit, I will get two dollars to spend on that service. That erodes again into these issues.

Government as provider as well as payer. On this island, all state community hospitals are trying to maximize revenues at the same time as another arm of government is trying to reduce cost. We have the same kinds of urban and rural differences as anyplace else. You notice our distances are separated by water. Once you get out of any kind of urban center such as this, this is a very, very rural state. There are professional incentives to seek independent licensure and direct billing for increased fees. I will not say anything more about politics, unions, and the ability to change but, to give you an example, three years ago we managed to turn, through the legislature, our community hospitals, from a direct control under my jurisdiction, to a nonprofit, private corporation, which is what's going on all across the country. The legislature finally allowed us to do that, but they said you cannot contract out. You're stuck with collective bargaining agreements. Any changes you make, you have to come back to the legislature for permission. An example of that is 65% of our costs in the hospital system is labor. The average in the private sector is between 50% and 58%. If we could get that down to the private sector, the 3 hospitals out of the 12 that make money could subsidize the remainder, but those are the realities of the political situation in Hawaii.

Like everywhere else moving toward managed care, all of the large providers now offer managed care health plans, and we are going in fits and starts toward managed care for worker's compensation and what's called 24-hour coverage. As many of you know, what does that mean? You buy health insurance. You pay automobile premiums, which have a medical component to that. Employers pay for worker's compensation. Why can't we combine all of that in some way and make it a more efficient system? The question is who covers the cost? That's what always stops that.

Characteristics of the uninsured. As I say, nationally it's 70% who are employed. In Hawaii it's about 66% unemployed. There's sort of a reverse going on over here.

The progression from the 1930s, from a plantation economy, came from the insurance situation in Hawaii, the rise of HMSA, which is the local Blue Cross/Blue Shield Association coming out of the 1950s, moving on toward the federal side, the state side, for insurance for government employees. In the 1960s they thought about the prepay health care plan, which would protect every regular employee with a prepaid plan. The level of benefits should conform to community standards. There should be free choice provided by any existing prepayment plan, and the scheme should not interfere with collective bargaining processes. In the 1970s, under Nixon, they talked about national health insurance, and Hawaii did the same thing, but Hawaii moved on to the Prepaid Health Care Act (PHCA). Hawaii passed the act in June 1974. ERISA was passed in September 1974. A federal/state battle occurred. The people didn't want to provide mandatory insurance, saying that it was a federal override of ERISA. The Supreme Court found that to be so. Our congressional delegation went back to Congress and got an exemption in 1981 or so. We're the only state expressly exempted from ERISA. That's why we have our PHCA.

Following that, there still remained concerns for an estimated 3–5% of the population without health insurance, what many people call the gap group, so the state health insurance program was enacted in 1989. I'll go a little bit into that. In the 1990s, just like everywhere else, every year we have to go back to the legislature for emergency appropriations for Medicaid because the costs keep on escalating on our fee-for-service. We moved toward managed care, but at the same time the decision was made to combine this gap group insurance program with Medicaid and liberalize the eligibility standards on the Medicaid to match the gap group eligibility standards. The gap group eligibility standards were up to 300% of federal poverty level, no assets test. However, as on the Medicaid, the assets test is \$2,000 an individual, \$3,000 a couple, and \$250 for every additional family member. So, if you have a halfway decent car, you're not going to be eligible, and that's why we tried to move to that. That caused a lot of problems when we expanded.

What were the express goals of the State Health Insurance Program (SHIP)? Subsidize for gap groups, encourage uninsured to participate in existing plans, discourage people from seeking benefits under the gap group, cost-sharing, and affordability. These were the options. One of the options was to expand the Medicaid program, but remember it was a fee-for-service program. It was felt that the cost would be too high, so this was not adopted, but it was later adopted. This was the choice pick, a subsidized health insurance plan based on income and family size and a special benefits package. I don't want to again get into details, but the state legislature basically provided \$10 million a year, and the state designed a

benefit package around how much money was available. It was decided that we would spend about \$500 per person per year on a benefits package. HMSA, for example, looked at that and said let's design a program of a benefits package worth \$200 a month, and then scale that down. Once you define that, contract it down to get a benefits package of \$60 a month. That would be the package that they offer. Initially, the benefits were 5 hospital days, 2 inpatient maternal days, and 12 physician office visits. We were worried about this, but we figured that people were providing uninsured and uncompensated care anyway, and that they would at least be getting payment for five hospital days. In the four or five years of the program, before it got merged into Medicaid, the insurers made money on this. They never averaged five days. As a matter of fact, at the end when we consolidated and moved SHIP over and we looked back in terms of audits, the insurance gave us back \$3.7 million of unspent money besides what they were able to make.

What happened when we merged Quest and SHIP? When we moved toward managed care, moved SHIP in, and raised the eligibility to 300% of federal poverty level, no assets test, these are the kinds of things that happened. Anecdotally, we had a millionaire apply because somehow his or her investments did not count as income. The University of Hawaii, whose school negotiated with parents to buy a bare-bones benefits package looked at the Quest program and let the students know that they were all qualified for Quest, and they did not have to have their parents buy their insurance. We had to change the eligibility to say that any student in college up to age 21 was not eligible for the program, but the death knell of our original program was as follows. We had moved, as many states had, the aid to families with dependent children and the general assistance population into managed care because they're basically healthy.

The aged, blind, and disabled who were very ill and deal with lots of nursing costs and high expenses we kept in the fee-for-service program while we moved. Eventually we're trying to move that over, except that the aged, blind, and disabled still had an assets test and a very different income test. If you were in the Quest program and you got a stroke and got disabled, you were disenrolled from it. If you had assets, you would not qualify for the ABD. So, that suit was filed. They won. We had to have even eligibility. We could not liberalize the eligibility for the aged, the blind, and disabled, so we had to scale back the eligibility for the Quest program. When we did that we also had to deal with the people who were not going to be eligible under the revived eligibility criteria, so something called Quest Net was developed for people falling out of that. We are actually worse off than when we started. This is before we merged Medicaid and SHIP. The peak of the combined program was about 118,000. There were about 150–160,000 here.

We're back down to about a 133,000. So, maybe 20–30,000 people who used to have insurance under these programs do not have insurance anymore in the state.

When you average them all out, the current uninsured rate in Hawaii now is about 10%. It used to be 3–5% about 5–7 years ago. Even with employment-based mandatory insurance, we're at about 10%. If you look at the percentage of uninsured children in households, of all the uninsured kids, 41% are in households with the head of the household being employed. That's because of the disincentive to cover dependents. In addition to that, there are uninsured children by selected age categories and poverty level. If you look at children under one, for example, most of them are in age groups that would be eligible for Medicaid because under age 1 the eligibility in Hawaii is 185% of poverty level or less. One to 6, it's under 133%. And up through 18 it's 100%. If you look at the number of uninsured children below Medicaid, 89% of kids under 1 actually qualified for Medicaid. If you could go and find them and put them in the program, they would be eligible. So, our uninsured are people in employed households who are not getting coverage under employment-based insurance, and people who are eligible for Medicaid.

This is what the state is currently about to do. With the Federal Child Health Insurance Program, the Balanced Budget Act of 1997, Hawaii has about \$13 million. How to spend it. Hawaii will phase in an expanded health insurance coverage for uninsured children. We're going to go to coverage of children between ages 1–6 and raise the federal poverty level from 133% to 185%. Then we're going to take this age group and increase it by two-year increments so that they all come under there. Right now we have a very fractionated system: pregnant mothers and kids under 1 year of age eligible to 185% of federal poverty level, kids from 1–6 eligible to 133% of federal poverty level, ages 7–18 at 100%. We're going to try to get them all up to 185%.

That's where we are. We have some good things here. We have some bad things. With the state being 50th in the nation in terms of its economic situation it has really exacerbated the number of uninsured. There are lots of incentives for employers in the state to give part-time jobs at 19 hours a week so they don't have to provide coverage. There is one last thing I want to mention as sort of an aside. Last year the state passed a same-sex marriage bill. It wasn't really a same-sex marriage bill, but it was a political alternative to same-sex marriage. They provided a reciprocal beneficiary relationship bill. It started on the Senate side as providing benefits for same-sex couples. The House turned it on its head and defined that as any two people who could not legally get married. That meant a father and a son, a father and a daughter, a mother and a sister, any two people who could not legally get married. The whole point was to provide them with the economic benefits of

marriage without the sanctity of marriage. I don't want to get into politics of it all, but there was a big to-do about it. All the television people came down to my department the day we were supposed to institute that, and only 19 people showed up that day to get that certificate. After all that, even among the employers who are against same-sex marriage because of the problems, some of them have offered the attorney general to read the law narrowly and say that there was a flaw in it, that companies did not provide benefits to reciprocal beneficiary relationships, but the numbers are so small that the companies that were resisting said they'll give it anyway. It's good employee relationships. They have gone on with that.