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By Dr. Phillip D. Hellreich

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By Dr. Phillip D. Hellreich

As legislative chair of the Hawaii Federation of Physicians and Dentists, I have been for many years actively lobbying our state legislature to preserve the traditional doctor-patient relationship and the right of every individual to select the physician of his or her choice.

It must seem a little bizarre to many that our small state located in the middle of the Pacific ocean would play such a prominent role in the debate over how we should reform our health care system. The reasons are that Dr. John Lewin, our state director of health, has had considerable input into the crafting of the Clinton health care proposals and that many of the ingredients of the Hawaii plan have been incorporated into the President's health care reform package.

Hawaii's Prepaid Health Care Act was enacted in 1974 and went into effect on January 1, 1975. Hawaii thus became the first state to mandate employer-provided medical coverage for employees. In 1974, the Hawaii economy was dominated by the so-called Big Five corporations, and the Prepaid Health Care Act was adopted because of union domination of our legislature. To quote Sam Slom, the head of Small Business Hawaii: strong, paternalistic, centralized control. "From the plantation era (1900-1960) health care was delivered either by the plantation owners (who also provided housing and other basics) or by the government, so Hawaii has always had a high ratio of government employees. Government became the new 'Luna' (or boss) of a current Hawaii plantation. Health care was described as a right of every employee without limit."

Chevron challenged the new law on constitutional grounds, because the Federal ERISA law prohibited employer mandates. The Act was even suspended while it awaited this judicial review. President Nixon intervened and granted Hawaii exemption from ERISA. This is the only exemption ever given to any state in the Union. As in the Clinton plan, it has an employer mandate for all employees who work 20 or more hours a week for a month or longer, but dependents are not covered as they would be in the Clinton health care proposal. In practice, however, most employers do cover their employees, dependents. As in the Clinton plan, we have a standard benefits package. The Prepaid Health Care Act designates that the benefit package must be equivalent to the plans "that have the largest number of subscribers in the State." This in essence means HMSA, which is Hawaii's Blue Cross/Blue Shield, which controls some 70 percent of the market, and the Kaiser-Permanente HMO plan, which covers approximately 20 percent of the population. The benefits package expanded considerably during the 1980s, to even include in-vitro fertilization, costing between $10,000-$15,000 for each attempt. The in-vitro fertilization was added after intense political pressure and lobbying by the small group of physicians who performed that procedure and their very vocal patients. This demonstrates how a stand-

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ard benefits package may be altered by political pressure, thereby favoring certain more politically correct procedures and diseases over others.

As in the Clinton plan, alliances of small and large business groups have been formed to negotiate contracts with Hawaii's health plans in the hope of getting cheaper rates. Similar to Clinton's National Health Board, Hawaii's State Health Planning and Development Agency (SHPDA) has established quasiglobal budgeting and has started to ration care. SHPDA is a state bureaucracy which has the sole authority for permit approval and authorization for any private health care facility or equipment.

In 1990, the state decided to take care of the remaining so-called gap group, that is to say, those people with incomes too high for Medicaid but below 300 percent of the federal poverty level. This group included seasonal workers, dependents of low-income employees who are not covered by employer plans, sales people on commission, and self-employed independent contractors and so-called mom and pop shop-owners. These people are covered under the so-called State Health Insurance Plan, or SHIP.

We in Hawaii have been living with a Clinton-like health care system since 1975. And so a study of what has happened in Hawaii should be a pretty good indication of what the adoption of the Clinton health care proposals will do for, or to, the rest of the nation.

Dr. John Lewin and other proponents of the Hawaii health plan make the following points about Hawaii's Prepaid Health Care Plan and what it has brought to our state.

First, he has gone all over the country and has appeared on national talk shows indicating that our state's uninsured rate is only 2 percent compared to the alleged 37 million Americans who are uninsured nation-wide, or roughly 14 percent of the entire U.S. population.

Proponents of the Hawaii system claim that Hawaii's health care expenditures are lower than those for the nation as a whole and compare very favorably to many other developed Western nations with whom the United States is often compared. For example, it is claimed that in 1988 the percentage of the Hawaii gross state product expended on medical goods and services was 8.1 percent in contrast to 11.1 percent of the U.S. gross national product.

Proponents also claim that, when compared to other industrial countries with supposedly exemplary national health programs, Hawaii's health expenditures as a percentage of the economy are lower than many of these.

They also claim that Hawaii has one of the lowest hospitalization rates in the nation in terms of the number of admissions per thousand population, in which the national average is 130 while for the state of Hawaii it is only 92.

Dr. Lewin also claims that Hawaii has lower hospitalization expenses because we have far fewer hospital beds per thousand population than the nation as a whole. In the United States, for example, the average is 3.9 hospital beds per thousand population, while in Hawaii it is 2.4.

According to Dr. Lewin, in 1990 the monthly premium for an individual in Hawaii's Blue Cross/Blue Shield comprehensive small group policy was $94; for Kaiser's HMO in Hawaii it was $90. By way of contrast, similar Blue Cross/Blue Shield coverage cost about $104 per month in Arizona, California, Georgia, and Iowa, $150 in Illinois and New York, and $220 in Massachusetts, $230 in Delaware, and $280 in Kansas.

Using the above statistics, Jack Lewin and others have convincingly argued that Hawaii's health care delivery system is fantastic and should be transferred to the nation as a whole. But a more careful and rigorous evaluation of what has really transpired in Hawaii might lead you to a completely different conclusion.

As I stated earlier, our Hawaii state health director claims that only 2 percent of Hawaii's population is uninsured, compared to the national average of 14 percent. But this claim is untrue. A 1992 report by the American Public Health Association found that Hawaii's uninsured rate is 11 percent and that Hawaii ranked 15th in the nation in the percentage of its population being uninsured. Additionally, a 1991 AARP study entitled "Health Care in American State Profiles" stated that Hawaii's uninsured rate was 9 percent to 11 percent. According to the U.S. Department of Labor in 1974, which is one year before Hawaii's Prepaid Health Care Act went into effect, the uninsured rate in Hawaii was 10 percent. So in terms of the percentage of Hawaii's population not insured, not much has changed since the enactment of these reforms.

A recent *Newsday* article reported that because of Hawaii's health care system, 51 percent of companies restrict wage increases and raised prices to cover health costs and 38 percent have had to reduce the number of employees because of the effects of this employer mandate. *Newsday* has also found that Hawaii's insurance premium rates are going up an average of 12 percent per year, even though physician fees and hospital rates are significantly lower than in comparable cities on the mainland U.S. According to Sam Slom, the head of Small Business Hawaii, in the September 1993 issue of Hawaii *Citizen*,

> In mid-1993 Hawaii led the nation in bankruptcies, foreclosures, delinquent loans, all areas in which 20 years ago Hawaii was the envy of the United States....Our major industry, tourism, is in serious decline, sugar is ended as a viable employer, there is little manufacturing and economic diversity.... Since government neither listened nor modified the mandated health benefits, many businesses exercised the only option, they moved, to Las Vegas, Tucson, Seattle and elsewhere. Outrigger Hotels moved its reservations offices to Denver, more will leave, others will shut down. Landmark businesses, the Pearl City Tavern, the Willows, have gone, and they cited mandated health costs.

And most telling is that the state of Hawaii has exempted state employees from the Hawaii Prepaid Health Care Act because it is too expensive and would place an excessive burden on the state economy. State employees must pay 40 percent of their health insurance premiums, and the state has hired many so-called temporary hires to avoid this mandate. We wonder why the state assumed that this mandate would not be excessively burdensome to small business as well.

The Families USA Foundation report dated October 1990 revealed that from 1980 to 1990, total health care expenditures in Hawaii increased 191 percent compared to the national average of 163 percent. They also found that the state of Hawaii per capita health expenditures in 1990 were $2,469 as compared to a national average of $2,318.

As I mentioned earlier, the State Health Department has claimed that premium costs in Hawaii are below the national average. But in Hawaii, insurance premium costs to small businesses have escalated geometrically. Small Business Hawaii has formed a purchasing alliance, similar to the Clinton health plan, in which they have negotiated health insurance premiums for their member firms. An HMSA (which is Blue Cross/Blue Shield) small business premium for a single individual was $57.50 in 1987 and was $214.98 in 1993, which is an increase of nearly 375 percent in six years. For a family plan which covered the

employee and dependents, the premium in 1987 was $213.34, whereas in 1993 it had escalated to $597.92. Dr. Theresa Smith of the Hawaii Federation of Physicians and Dentists, compared several plans submitted to Small Business Hawaii and discovered the premium costs are below the national average only for single employee coverage, while premiums for family plans were actually higher in Hawaii than in many other states in the country.

The State Health Insurance Program, the so-called SHIP program enacted in 1990, which as you recall was to cover the gap group whose income was too high for Medicaid but was within 300 percent of the federal poverty level, offers only a bare-bones package limiting outpatient visits to twelve per year, hospitalization for a maximum of five days, and maternity to a maximum of two days, and many elective surgery and tertiary care services are excluded. In order to pay for these services, SHIP enrollees must "spend down" to the point where they qualify for Medicaid. The SHIP package offers very minimal coverage, especially when you compare it to the Standard Benefits Package which the Clinton plan would guarantee to all Americans, and therefore the Clinton plan would be far more expensive than the cost of the SHIP program in the state of Hawaii.

State Health Director John Lewin states that Hawaii's health system is so good "because we've offered, for nearly two decades, basic primary care for almost all of our people, [that] Hawaii has nearly twice as many outpatient visits per capita as the rest of the nation, and fewer than 40 percent of inpatient visits." But Dr. Lewin's contentions are incorrect. Marvin Hall, the Director of HMSA (Hawaii's Blue Cross/Blue Shield), states, "From the best numbers we can find, our people visit the doctor about as often as people anywhere do." So it is incorrect to claim that Hawaii has nearly twice as many outpatient visits per capita as the rest of the nation. Also, to quote *Medical Economics*, February 3, 1992, "Neither are there exceptional numbers of primary care physicians. AMA statistics are represented in Hawaii at about the same proportion as in the rest of the country."

As I mentioned earlier, the proponents of Hawaii's health care system have indicated that Hawaii spends, as a percentage of its gross state product, only 8.1 percent on health care, compared to the national experience of 11.1 percent. But according to the Bank of Hawaii's chief economist, as reported in the *Wall Street Journal* in September of 1993, "the state is leaving out key costs" and the real percentage of the gross state product expended in Hawaii on health care is 11 percent to 13 percent, and so is close to the national average or higher.

The August 5, 1993, issue of the *New England Journal of Medicine* pointed out that Hawaii currently led the nation in terms of hospital expenses and throughout the 1980s it was fourth, behind only New York, Alaska, and Connecticut. The *Journal* article also revealed that Hawaii was fifth in the nation in terms of hospital administrative expenses.

So Hawaii's Prepaid Health Care Act has not worked in terms of decreasing the number of people uninsured in the state, or in terms of controlling increases in health care expenditures as compared to the rest of the nation, even though Hawaii has several features that are unique. To quote *Medical Economics*, "Hawaii's system cannot simply be shipped to the Mainland like pineapple and macadamia nuts." Hawaii appears to have a healthier population than most of the rest of the nation.

In 1988, Hawaii's death rate per 100,000 people due to heart disease was 54 percent of the national average; from cancer, 62 percent of the national average; from stroke, 61 percent of the national average; and from accidents, 73 percent of the national average.

To quote the National Center for Health Statistics report in 1990:

> Asian persons and Pacific Islanders in the United States have the lowest death rates across each age group and for nearly all causes of death compared. Among those under 45 years of age, black persons and American Indians have the highest death rates. Hawaiian citizens are more Asian than Caucasian, 23 percent Japanese, 11 percent Filipino, and 5 percent Chinese, versus 24 percent white; only 2 percent are black; and native Hawaiian and part-Hawaiian comprise 20 percent of the population. Hawaii doesn't have smog, Hawaii doesn't have an urban ghetto with attendant violence and high rates of AIDS, and more than 85 percent of non-agricultural jobs in Hawaii are in sectors such as tourism, trade, government, communications, and finance, rather than the more hazardous occupations of manufacturing and construction.

Despite these advantages present in Hawaii, health insurance premium rates are escalating at a very high rate.

This increase is occurring in spite of the rationing of health care by SHPDA, the State Health Planning and Development Agency, through its certificate of need process. For example, in 1991, the number of MRIs in the state of Hawaii was 1 to 1.1 million population compared to the national average of 1 to 100,000. Without any political pressure, the Hawaii Department of Health seemed to be happy with this arrangement even though many physicians were sending their patients to the mainland for MRIs because the total cost, including hotel and air fare for the patient and companion, was cheaper than getting an MRI in Hawaii. To the Hawaii Federation of Physicians and Dentists, it appeared to be more than mere coincidence that five new MRIs were quickly approved by SHPDA through its CON process just when the Hawaii Plan began to be touted as a model for the rest of the nation. Even with the additional MRIs, the ratio is still only 1 to 400,000 population.

In addition, the CON process, as well as the cost of land and development, has precluded the construction of hospital beds in our state. For example, the national average for acute-care hospital beds per 1,000 population is 4.2 to 4.7, as compared to 2.1 in Hawaii.

This has also resulted in a deficiency in the number of long-term beds available. There are many occasions when all the hospital beds in the state are full and a 48-hour waiting list for admission to a major hospital is not unusual. Additionally, the shortage of long-term nursing beds often requires patients to remain in acute-care beds for several months awaiting placement. And despite this, published SHPDA plans reveal that their goals are to decrease the number of hospital beds per 1,000 even further.

Reports from the islands of Maui and the big island of Hawaii report a greater than 10 percent occupancy rate in their hospitals for three months out of last year, and there have been reports of physicians having to treat patients with critical illnesses at home because no hospital beds could be found. And despite this rationing of health care, the neighbor island and rural hospitals under state control run huge deficits because the state's Medicaid program is the most generous in the country.

In the nation as a whole, the number of nursing beds per 1,000 population for people over the age of 65 is 56, while in Hawaii it is only 18.

Last year the *Medical Tribune* reported that Hawaii had the highest rate of physician exodus and early retirement in the nation.

Another indication that Hawaii's Prepaid Health Care Act has failed to contain costs is the newly instituted Health Quest Program, which was introduced after Hawaii received a waiver from the federal government, in which first the indigent population of Hawaii, and later in Phases II and III most of the rest of the population, will be assigned to a primary care provider and will not be allowed to see any other physician unless that primary care provider agrees. It also states that advanced nurse practitioners have to be included as primary care providers, so we may have a situation in which a patient will be assigned to a Health Maintenance Organization and be unable to see any physician, let alone a specialist, unless that nurse refers the patient.

The Clinton health care proposals contain similar provisions which would expand the role of nurse practitioners in the delivery of health care, so people all over this nation may be confronted with this same situation whereby they can get to see a physician only if the nurse recognizes that they are sick enough to warrant it.

In conclusion, Hawaii has had most of the components of the Clinton health care proposals in effect since the enactment of its Prepaid Health Care Act in 1974. It has failed in its two major goals of 1) decreasing the number of Hawaii's population that were uninsured and 2) curtailing the ever-rising costs of health care delivery. In order to control spiraling health care costs, it has just instituted its Health Quest Program, which will severely ration care and deprive most of the citizens of our state of their right to be treated by the physician of their choice.

In light of this information, the American people and members of Congress should think long and hard before enacting a health care proposal which shares so many features of Hawaii's Prepaid Health Care Act. This is especially important when you consider that most of the statistics about Hawaii's health care delivery system come from three sources: HMSA (Hawaii's Blue Cross/Blue Shield), Kaiser Permanente, and the Hawaii Department of Health. These three would seem to have a vested interest in making the system look good.

We should not base a national health system on data provided from a state which have not been independently verified.

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