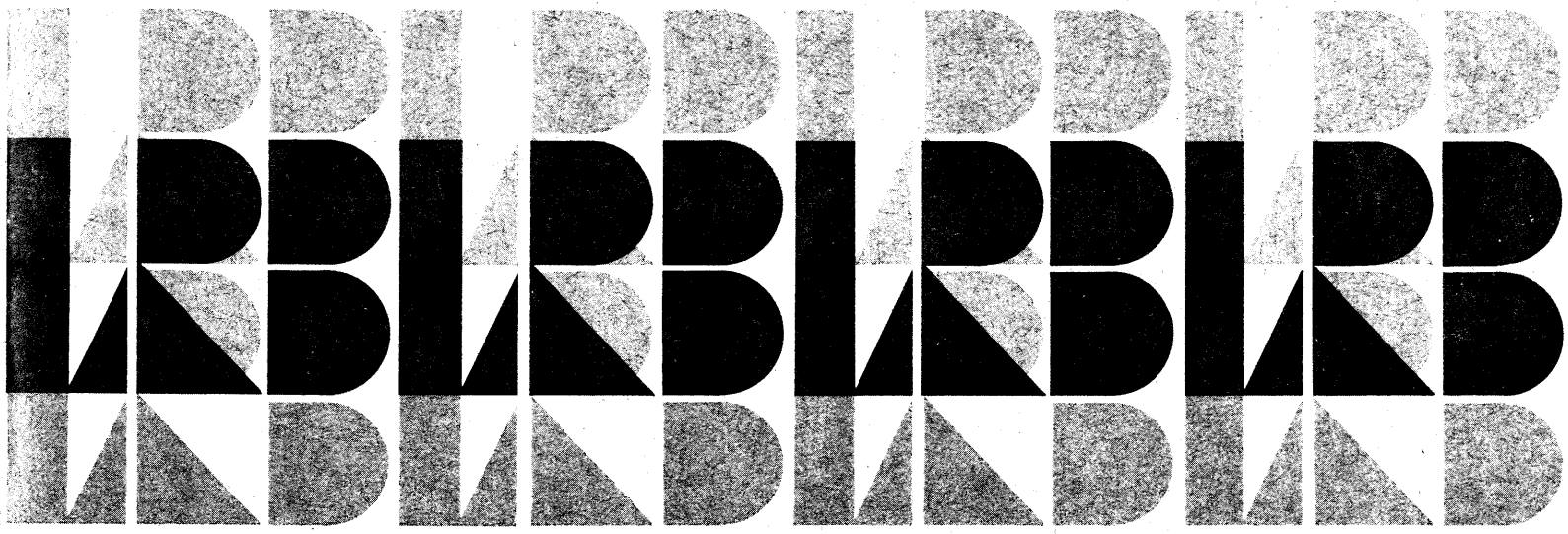
FACTORS INFLUENCING COMPETITION AMONG HEALTH PLAN PROVIDERS



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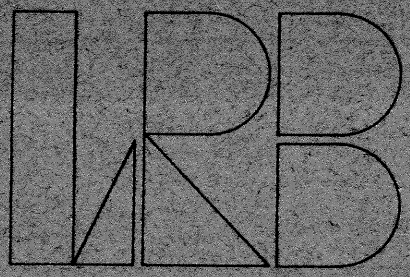

THE OFFICE OF THE LEGISLATIVE REFERENCE BUREAU

The present Office of the Legislative Reference Bureau resulted from Act 171, Session Laws of Hawaii 1972, which transferred, as of July 1, 1972, the former Legislative Reference Bureau out of the jurisdiction of the executive branch of government to the legislative branch of government. In addition, the Office of the Revisor of Statutes, formerly under the Judiciary, was placed within the Bureau for administrative purposes only. In 1977, Act 8 of the First Special Session, completed the integration process by making the functions performed by the revisor additional responsibilities of the Bureau. The end result of this legislation is to centralize under the Legislature the functions of bill drafting and bill publication as well as research and reference services supportive of the Legislature. The new Bureau is one of three legislative support agencies directly under the Legislature.

As a governmental institution, however, the Legislative Reference Bureau has its origins in Act 91, Session Laws of Hawaii 1943, when the Territorial Legislature established the organization as an integral part of the University of Hawaii.

Services performed by the Bureau cover a wide range from major report writing to bill drafting for the Legislature to answering telephone requests for information. Briefly, these services include:

1. Maintaining a reference library.
2. Preparing studies and reports and drafting of legislative measures in response to legislative requests.
3. Providing service to legislative committees, including interim committees.
4. Publishing standard reports.
5. Compiling and exchanging information with similar legislative service agencies in other states and with national organizations.
6. Providing information to legislators.
7. Conducting and coordinating pre-session seminars for members of the Legislature and for their legislative staffs.
8. Serving as a member of governmental boards and commissions when Bureau representation is specified.
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10. Controlling and maintaining the operations of any legislative data processing program as may be established.
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13. Publishing the session laws and supplements to, and replacement volumes of, the revised statutes.
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15. Establishing a format for, and compiling and publishing an index of, rules adopted under the Administrative Procedure Act.

FACTORS INFLUENCING COMPETITION AMONG HEALTH PLAN PROVIDERS

NELL CAMMACK
Researcher

Report No. 11, 1994

Legislative Reference Bureau
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FOREWORD

This report is the first part of a two part study that examines the competitive environment and practices of organizations that offer employer-sponsored health plans in Hawaii. This section of the study provides an overview of the current health plan system (Chapter 1) and the state laws that impact health plan providers (Chapter 2). Chapter 3 provides a brief description of Health Maintenance Organizations, and Chapter 4 discusses the basic methodologies used to set group health plan rates. Chapter 5 provides an overall picture of the health plan market.

A substantial portion of the report (Chapter 6) is devoted to outlining the organizational structure, operations, rate-setting practices and financial aspects of specific health plan providers. Not all providers are included in this section. However, the major plan providers (Hawaii Medical Services Association and Kaiser Permanente) and a reasonably representative selection of other health plan organizations are included. Representatives of the organizations were interviewed except as noted in the report, and they reviewed the material relating to their organization for accuracy and completeness.

Chapter 7 examines some of the national and local governmental factors that shape the competitive environment within which health plan providers operate. The interim findings of this part of the study are presented in Chapter 8.

All individuals and agencies noted in House Resolution No. 200, H.D. 3, as well as others who were interviewed were given an opportunity to review and comment on a working draft of the entire report with the exception of the final chapter. We extend our sincere appreciation to all for their assistance, in particular: the Hawaii State Departments of Health, Commerce and Consumer Affairs, and Labor and Industrial Relations; Kaiser Permanente, Hawaii Region; Hawaii Medical Service Association; The Queen's Health Systems; Straub Clinic and Hospital; and the Hawaii Association of Health Underwriters.

Samuel B. K. Chang
Director

December 1994

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Chapter 1
INTRODUCTION

House Resolution No. 200, H.D. 3 (see Appendix 1), adopted by the state House of Representatives during the 1994 Regular Session, notes that while near universal health coverage has been achieved in Hawaii, with costs of coverage remaining among the lowest in the nation, health care costs in the State are rising faster than those of most other goods and services. The Resolution reflects concerns about the relationships between health plan administration and health care providers, the competitive environment and practices of the organizations and businesses that offer health plans, and the impact and level of state oversight of the industry.

The Resolution requests the Legislative Reference Bureau to conduct a two-part study, to be conducted over a two-year period, to examine these issues and develop recommendations for the oversight of the organizations that comprise Hawaii's health plan industry. This report represents the first part of the study. It describes the overall environment in which the industry operates, and the types of businesses and organizations that offer health plans. The types of plans offered, rate setting policies and financial practices are also reviewed. In this part of the study the relationship between organizational "size" and cost competition, the variations in tax-status among the types of plan providers, and existing oversight responsibilities of the State are reviewed.[1] Part II of the study will focus on competition among health plan providers and its impact on costs and quality of health care in the State. The study's recommendations will be presented in the Part II report.

Study Parameters and Approach

This report discusses the major factors that influence the types and costs of health plans offered in Hawaii. These factors include key state statutory and regulatory provisions and the general business environment they have created, as well as the business practices of those operating within this environment. The impact of potential federal health care legislation is beyond the scope of this report.

The issues raised in H.R. No. 200, H.D. 3 are examined using a producer-product-consumer model under which the entities that offer health plans are the "producers", health plans are the "products", and employers make up the major group of "consumers".

Employer-sponsored health plans dominate the health plan market in Hawaii. For this reason, and in order to explore the issues of industry competition in a context where all producers are marketing products that are comparable, the report focuses on this type of health care coverage. Primary emphases is placed on plans subject to the 1974 Hawaii Prepaid Health Care Act (PHCA).

Background[2]

In Hawaii, access to health care coverage through employers can be traced back to the 1800's when the early plantations developed a system of guaranteed access to care for plantation workers using salaried or contract physicians, including plantation-owned hospitals in some areas.[3] The system that developed established some of the basic characteristics of the State's current health care system. They include, (1) employer responsibility for providing health care to employees and their dependents, (2) acceptance by physicians of group practices and payment by employers under contract or direct salary, and (3) acceptance by the labor force of access to health care coverage as a condition of employment.

During the 1940's, there was a shift from employer-provided health care to a system of employer-provided health insurance. This change was supported by organized labor. However, the key principles of the plantation system carried over. Since then, the activist role of organized labor and subsequent state legislation has firmly established health care coverage as a labor relations issue.

The State's Role

Consumer

The State has long been a major consumer of health care plans. Under state law, individual and family plans with broad coverage are offered to all state and county employees who work for three months or more in positions that are half-time or greater, state and county retirees, elected officials, and the surviving spouse and children under age 19 of an employee killed in the line of duty.[4] The Public Employees' Health Fund was established by Act 146, Session Laws of Hawaii 1961, and pre-dates both collective bargaining for public employees (Act 171, Session Laws of Hawaii 1970) and enactment of the 1974 Hawaii Prepaid Health Care Act (PHCA). Currently, the trustees of the Public Employees' Health Fund determine the benefit package for public employees while the employer/employee cost shares are negotiable cost items under the collective bargaining law.[5] Government employers are not subject to the PHCA.

Regulator

In terms of the producer-product-consumer model, the State is not only a consumer but also is involved in certain oversight or regulatory aspects of both the producer and product components of the model.

The basis for product regulation is the minimum coverage standards established for prepaid health care plans and accident and sickness insurance contracts under state law. The PHCA establishes minimum coverage requirements that must be offered in employer-sponsored health plans. Under PHCA, the state Department of Labor and Industrial Relations (DLIR) is responsible for determining the plans to be used as the standards by which all others are to be evaluated, and for certifying that the coverage complies with the law's requirements. All employer-sponsored plans that are not exempt from PHCA must be reviewed by the Prepaid Health Care Advisory Council and approved by DLIR.[6]

The state insurance laws also include certain coverage requirements for accident and sickness insurance contracts offered by regulated insurers and benefit contracts offered by fraternal and mutual benefit societies. Oversight responsibility for these provisions rests with the state Insurance Commissioner.[7]

Producer regulation varies depending upon the type of business engaged in offering a health plan. Regulated insurance companies, nonprofit mutual benefit societies, and fraternal benefit societies must be licensed by the Insurance Commissioner and are subject to review regarding certain business practices including financial practices. Other types of profit and nonprofit businesses providing direct medical care can offer health care plans. They must qualify under the general requirements for doing business in the State, and register with the Department of Commerce and Consumer Affairs.

The System Today

The State has established minimum standards for employer-sponsored health plans and requires that most private sector employers offer them to their employees. The State as an employer also represents a sizeable market for similar plans that are offered to state and county employees and retirees. The resulting market for health plans is large, stable, and well established. A market with these characteristics is attractive to business, and sharp competition is to be expected.

As of May, 1994, there were fourteen organizations offering DLIR approved health care plans. (See Appendix 2.) However, the industry is dominated by two providers: (1) the Hawaii Medical Service Association (HMSA) with 623,726 individuals covered under an HMSA plan in 1993;[8] and (2) Kaiser Permanente which reported 190,680 Hawaii members for the same year.[9] These totals include individuals covered under employer-sponsored, individual, and special senior citizen plans. Kaiser's data do not break out employer-sponsored plan membership. HMSA's regular and health maintenance organization (HMO) employer plans cover 571,671 individuals. An overall view of the market shows Kaiser and HMSA providing coverage to some 75 percent of the civilian population and commercial insurers 8 percent, leaving a remainder of 17 percent being shared by the other providers or having no coverage.[10] (Public plans (SHIP, QUEST, medicaid) all excluded from these figures.)

PHCA identifies two types of health plans that may be offered. One is the Health Maintenance Organization plan under which the organization offering the coverage also directly provides the covered benefits. Kaiser Permanente operates as an HMO. The second is the third-party reimbursement plan where the plan reimburses plan members for all or a

portion of the costs of covered benefits provided by health care providers. This is the traditional indemnity insurance-type plan.[11] So long as a plan offers benefits determined by DLIR to be comparable to those under either of the two most widely used plans, it is not required to deliver benefits exclusively by one or the other of these systems.[12] Thus, while the law establishes a minimum benefits package, it allows plan providers flexibility in the delivery of those benefits. Additionally, an organization can offer a variety of plans and include benefits that exceed or are in addition to those established under PHCA.

Plan costs are not controlled under PHCA or the related insurance laws. However, PHCA provides that:

> Unless an applicable collective bargaining agreement specifies differently, every employer shall contribute at least one-half of the premium for the coverage required by this chapter and the employee shall contribute the balance; provided that in no case shall the employee contribute more than 1.5 percent of his wages; and provided that if the amount of the employee's contribution is less than one-half of the premium, the employer shall be liable for the whole remaining portion of the premium.[13]

Employer cost-sharing is not required with respect to optional additional benefits. Employer cost-sharing for an employee's dependents under an employer-sponsored plan is required for plans that provide aggregate benefits that are more limited than those of the plans having the largest number of subscribers.[14]

In summary, health plans and particularly employer-sponsored health plans are an attractive market in Hawaii and it is reasonable to expect strong competition among plan providers for a share of that market. While the State regulates minimum benefits for plans subject to PHCA, competition within that segment of the market is possible in the areas of costs, coverage, and service delivery. While currently some fourteen organizations offer PHCA qualified health plans, the market is dominated by HMSA and Kaiser Permanente.

Endnotes

1. The second part of the study, as directed by the Resolution will be presented in a separate report prior to the convening of the 1996 regular session of the Legislature.

2. Emily Friedman, The Aloha Way: Health Care Structure and Finance in Hawaii (Hawaii Medical Service Association Foundation, 1993), pp. viii-ix.

3. It is generally accepted that economics rather than altruism was the driving force behind this policy. In a labor-intensive enterprise it is simply good business to keep your labor force healthy and working.

4. Hawaii Public Employees Health Fund, Benefit Plans, Spring 1993, p. 3.

5. Hawaii Rev. Stat., sec. 87-2, to determine plan benefits; sec. 89-2, plan costs are "cost items" for collective bargaining purposes; and sec. 89-9(d), health plan benefits are not negotiable .

6. Employers that are foreign, federal, state, or county governments are exempt, Hawaii Rev. Stat., sec. 393-3(3).

7. Hawaii Rev. Stat., chaps. 431 and 432.

8. 1993 Annual Report and Financial Highlights, Hawaii Medical Service Association (undated), p. 1.

9. Kaiser Permanente 1993 Annual Report (undated), p. 20.

10. Friedman, p. 86.

11. Hawaii Rev. Stat., sec. 393-12.

12. Hawaii Rev. Stat., sec. 393-7(a).

13. Hawaii Rev. Stat., sec. 393-13.

14. Hawaii Rev. Stat., sec. 393-7(b).

Chapter 2

STATE LAW

State law establishes certain conditions for health plans. The Prepaid Health Care Act (PHCA) requires most private sector employers to offer plans to their employees and identifies minimum coverage requirements for those plans. State insurance laws focus on operational and financial requirements for organizations offering health plan coverage in the State and oversight of these organizations. Certain benefits are also required under the insurance laws. Together, these laws form the basic legal framework for health plan content, administration, and state oversight.

The Hawaii Prepaid Health Care Act[1]

The 1974 Regular Session of the State Legislature enacted Act 210, The Hawaii Prepaid Health Care Act. The law required that private sector employers offer health plan coverage to their regular employees and share the premium costs. When the law was enacted, a great many of Hawaii's workers already had access to broad health care coverage through collective bargaining agreements, voluntary employer-sponsored plans, and as public employees. It is estimated that passage of PHCA extended coverage to no more than 5,000 additional workers. However, the statutorily defined benefit package improved coverage for up to 30,000 individuals.[2] The key provisions of PHCA are as follows with appropriate citations to relevant provisions of the *Hawaii Revised Statutes* in parentheses:

- "Employer" is defined to include all individuals and organizations with one or more regular employees. However, federal, foreign, state, and local governments are excluded, as are certain services (§393-(3)(3)).

- "Regular employee" includes anyone employed for 20 or more hours per week excluding seasonal workers (principally agricultural workers as determined by administrative rule) (§393-3(8)). Certain categories of employees who work solely on a commission basis (insurance solicitor/agent, real estate salesperson/broker) are excluded (§§393-4 and 393-5).

- "Prepaid Health Plan" means an agreement where the plan contractor agrees to: (1) provide the required health care (HMO-type service), or (2) defray or reimburse all or a portion of the costs of such services (§393-3(6)).

- "Prepaid Health Plan Contractor" means; (1) *any medical group or organization* that undertakes under a health plan to provide health care, (2) any *nonprofit organization* that undertakes to defray or reimburse all or a portion of the expenses of health care, or (3) any *insurer* that undertakes to defray or reimburse all or a portion of such expenses (§393-3(7)).

- The benefits must: (1) be comparable to those offered by the HMO or reimbursement plans having the largest number of subscribers in the State (HMSA Plan 4 and Kaiser Plan B), or (2) be approved under the provisions coverage specified in PHCA (§393-7(b)).

- Employers are responsible for selecting the plan contractor(s) and plan(s) to be offered to their employees, and must pay at least one-half of the premium costs. (Employee contributions are limited to the lesser of 1.5 percent of their monthly wage or one-half of premium costs (§393-13).

- While employers are required to offer prepaid health plans to their regular employees, an employee may be exempt or waive the right to participate (§§393-17 and 393-2). A form must be filed stating the reason for the exemption or the substitute plan for a waiver.

- The Department of Labor and Industrial Relations administers the PHCA. The director appoints a seven-member Prepaid Health Care Advisory Council which is responsible for reviewing proposed plans for comparability and compliance with required coverage and cost-sharing (§393-7(a) through (d)).

Insurance Laws

The Hawaii Insurance Code (Code), chapters 431 and 432, *Hawaii Revised Statutes*, regulates most of the various types of insurance, sets forth basic requirements for the operation of those offering insurance, and places responsibility for their regulation with the state Insurance Commissioner. The Code also requires that insurance general agents, subagents, solicitors, and adjustors be licensed by the Insurance Commissioner (§431:9-101 through 240).

Insurance Code

The Insurance Code (Code) provides that "insurer" means every person engaging in the business of making contracts of insurance (§431:1-202) and that, "insurance is a contract whereby one undertakes to indemnify another or pay a specified amount upon determinable contingencies" (§431:1-201(a)).

Indemnification is the system where a third-party (the insurer) reimburses the policy holder or insured for all or a portion of costs or losses incurred as stated in the policy. Regular premiums are paid for such coverage. PHCA allows employers to provide indemnity-type health plans offered by insurance carriers. Insurance carriers may also offer health policies outside the provisions of PHCA so long as the requirements of the Insurance Code are met. These policies may be offered to individuals and associations but not as employer-sponsored plans.

For-profit (Commercial) Insurers[3]

The Code applies to insurers that operate on a for-profit basis of which two types are recognized.

Stock insurers are those that obtain their capital from the issuance of stock. Shares of these stocks may be freely traded and no connection between policy holders and stock holders is required. Premium income may be used to pay stock dividends so long as adequate reserves are retained. (§431:4-201 through 214)

Mutual insurers are owned by the policy holders and issue no stock separate from their policies. They may issue dividends as cash or premium rebates. The policy holders are the members and owners of a mutual insurer. (§431:4-301 through 326)

Both domestic (based in Hawaii) and foreign (based out-of-state) insurers may offer policies to Hawaii residents and are subject to regulation by the Insurance Commissioner. Regulation consists of requirements for reserves adequate to meet the risks covered, restrictions on investment of reserves, annual financial reporting requirements, and authority for the Insurance Commissioner to inspect financial records and other activities of the insurer as deemed necessary. Article 13 of the Code prohibits certain unfair methods of competition and unfair or deceptive practices, and establishes procedures for imposing penalties for any violation of prohibited practices. (§431:13-101 through 204)

For-profit insurers are taxed at the rate of 4.265 percent of their gross premiums (less returned premiums) on premiums written, procured or received in the State (§431:7-202). This tax is in lieu of other state and local taxes.

Nonprofit Insurers[4]

Chapter 432, *Hawaii Revised Statutes*, defines and exempts certain nonprofit benefit societies that offer sickness, disability, or death benefits to their members from the provisions of the Code. Chapter 432 establishes specific requirements for benefit societies with regard to their organization, administration, financial reserves, licensing and reporting. Except as specifically stated, these societies are exempt from the Insurance Code.

Mutual Benefit Societies. Chapter 432 defines a mutual benefit society as any corporation, unincorporated association, society, or entity that is:

- Organized, not for profit, for the benefit of its members and their beneficiaries to provide sickness, disability, death or other benefits the payment of which is derived from assessments collected from the members;

- Organized for any purpose requiring regular assessments from members for the payment of benefits; or

- Organized for purposes determined by the Insurance Commissioner to be substantially similar to the above. (§432:1-104)

These societies must have a constitution and bylaws that provide for the selection of officers who are residents of the State, and grant to these officers certain powers and authority. They must file copies of the organizational documents with the Insurance Commissioner who is authorized to issue a certificate of registration upon finding that the society's purposes are lawful. (§432:1-301)

They may not use more than twenty-five percent of assessments received, up to $100,000, and seven percent of the assessment in excess of $100,000 for operating expenses other than taxes. Societies organized solely as nonprofit medical indemnity or hospital service associations may use up to thirty-five percent of assessments received to meet operating costs. (§432:1-305)

Chapter 432 specifies the reserves that must be maintained and authorizes the Insurance Commissioner to make any examination necessary to ensure compliance with the law. It provides that a society's assets may be invested in the same manner as is allowed for insurers under the Insurance Code, and grants the Insurance Commissioner the same powers, duties and authority respecting examinations as are allowed under the Code.

Mutual benefit societies organized solely as nonprofit medical indemnity or hospital service associations are exempt from state and county taxes, except unemployment compensation. (§432:1-403)

Fraternal Benefit Societies. A fraternal benefit society is "any incorporated society, order or supreme lodge, without capital stock,...conducted solely for the benefit of its members and their beneficiaries and not for profit, operated on a lodge system with ritualistic form of work, having a representative form of government..." (§432:2-104)

A lodge system is one with a supreme governing body and subordinate lodges into which members are admitted in accordance with the organization's rules. (§432:2-105)

A representative form of governance is one under which the supreme governing body is either an assembly with at least two-thirds of the delegates elected by lodge members, or

board composed of persons elected by the members either directly or by representatives in intermediate assemblies. Only benefit members may be eligible for election to any position, and each member shall have one vote. (§432:2-106)

Fraternal benefit societies that meet these requirements may offer hospital, medical or nursing contractual benefits to lodge members (§432:2-401). Lodges must operate both to provide specific member benefits and for other "lawful social, intellectual, educational, charitable, benevolent, moral, fraternal patriotic or religious purposes which may be extended beyond the membership. (§432:2-107)

Fraternal benefit societies may invest their assets in the same manner allowed under the Code for life insurers (§432:2-501). All societies organized or licensed under *Hawaii Revised Statutes*, Chapter 432 Article 2 are exempt from all State and county taxes, except real property and unemployment compensation taxes (§432:2-503).

Societies must be licensed by the Insurance Commissioner with licenses renewed annually (§432:2-603). The Insurance Commissioner's authority to examine fraternal benefit societies is the same as for regulated insurers (§432:2-604), and their agents are subject to the licensing requirements for insurance agents (§4342:2-609). The Code provisions relating to unfair methods of competition and unfair practices also apply (§432:2-610).

The law covering fraternal benefit societies does not establish any specific requirements with regard to the hospital, medical or nursing benefits comparable to those applicable to mutual benefit societies and regulated insurers. Rather the statute focuses on death and annuity benefit requirements.

The ERISA Factor

Three months after PHCA was enacted by the State Legislature, Congress enacted the Employees Retirement Income Security Act of 1974 (ERISA) which prohibited state regulation of self-insured employers. Following years of litigation and efforts to exempt PHCA from this provision of ERISA, a waiver was enacted by Congress in 1982. However, it specifically prohibited implementation of any amendments to PHCA made after September 2, 1974, except for nonsubstantive administrative matters. This effectively froze PHCA in its original

form as a matter of federal law. In order to enact modifications to the PHCA mandated benefits package for health plans, the Legislature has amended the Insurance Code and the companion provisions for mutual benefit societies by requiring that indemnity health policies issued under these laws include certain benefits. Among the benefits mandated in this manner are coverage for mental health, alcoholism and substance abuse, newborn children, child health supervision, newborn adoptees, in vitro fertilization, and mammogram screening. Thus, *all* indemnity-type plans covered by the Code, including those subject to PHCA must include the benefits mandated by the Code.

Summary

State laws establish minimum benefits for employer-sponsored plans in the private sector, and mandates that certain benefits be included in all third-party reimbursement plans. It further identifies the types of organizations that may offer employer-sponsored plans and places responsibility for regulating those using the third-party reimbursement system with the state Insurance Commissioner. The tax status of the regulated organizations offering health plans varies depending upon whether they are organized on a profit or nonprofit basis and, for nonprofits, whether they are mutual or fraternal benefit associations.

Absent from the statutes are provisions relating to:

- The manner in which rates or premiums are to be established;
- State review or approval of rate changes; and
- Operational requirements and regulatory oversight of HMO-type plan providers not subject to the State's insurance laws.

Endnotes

1. Hawaii Rev. Stat., chap. 393.
2. Emily Friedman, The Aloha Way: Health Care Structure and Finance in Hawaii (Hawaii Medical Service Association Foundation, 1993), pp. 63-64.
3. Hawaii Rev. Stat., chap. 431.

4. Hawaii Rev. Stat., chap. 432.

Chapter 3

HEALTH MAINTENANCE ORGANIZATIONS

Under the traditional fee-for-service system of health care delivery, care providers and facilities charge the individual each time service is provided. Health insurance indemnifies policy holders by reimbursing all or a portion of these charges. Under this system the contractual responsibility for paying the care provider and paying the insurance premium rests with the patient/policy holder. The responsibility for reimbursing the patient rests with the insurer. Some insurers utilize preferred provider organizations (PPOs) which are contractual agreements with certain providers and facilities that allow for direct payment to the provider and are tied to an agreement to limit or discount the care providers' usual fees. However, it is still a system where the care provider is only paid for services actually rendered and the insurer's basic responsibility is indemnifying the policy holder with regard to those fees.

The distinguishing characteristic of health maintenance organizations (HMOs) is that care providers are compensated directly by the plan as salaried employees or under fixed contracts. Similarly, hospitals and clinics operated under an HMO program are prepaid on a capitated basis rather than by a fee-for-service revenue flow that depends on utilization of the facility. Under the HMO approach there is no need to indemnify policy holders since payment of premiums fulfills the financial obligation for both plan coverage and payment to their care providers. (HMO's may impose co-payments for certain services which introduces an element of fee-for-service financing into their operations.)

Hawaii state law does not address HMO's directly although the Prepaid Health Care Act (PHCA) acknowledges this method of health care delivery generically by including in the definition of prepaid health care contractor, "any medical group or organization which undertakes under a prepaid health care plan to provide health care."[1] Since indemnification of the health plan member is not involved, the state insurance laws do not apply. State laws regarding licensing of medical professionals and hospitals apply equally to HMO's and non-HMO's, and the general requirements for doing business in the State also apply.

Federal law defines and imposes certain requirements on HMO's.[2] (See Appendix 3.) These conditions include the use of a community rating system, maintenance of adequate reserves and provision against the risk of insolvency, enrollment of persons broadly representative of the population in the area served, and arrangements for an ongoing quality

assurance program. (Community rating is discussed in Chapter 4.) HMSA's Health Plan Hawaii and Kaiser Permanente are federally qualified HMOs. Other HMO programs available in Hawaii, such as those offered by Straub and Queens Health Services are not federally qualified. Qualification under the federal provisions establishes eligibility for certain federal loans and loan guarantees, technical assistance and the HMO Intern Program for administrators and managers of HMO's. It also assures clients of the standards and oversight established in the law.

Endnotes

1. Hawaii Rev. Stat., sec. 393-3(7)(A).
2. 42 U.S.C.A. §300e.

Chapter 4

RATES

Virtually all health plan administrative and benefit costs are derived from premiums or dues, whether the organization offering the plan is a regulated insurer, a mutual or fraternal benefit society, or an HMO. Another feature common to all plans is that they strive to operate on a pay-as-you-go basis as opposed to one under which resources are accumulated and invested over a long period to meet a possible future need. While reserves or earnings from the investment of reserves can be used if expenses exceed premium income, the basic goal is for premiums to generate revenues sufficient to cover the costs of plan administration and benefits over the short-term. To achieve this, plan administrators monitor expenditures on an ongoing basis, and premiums are subject to adjustment annually or biennially.

There are three basic approaches to setting rates, *community rating, experience rating, and demographic rates*. The approach chosen determines how costs and risks are shared among plan participants and between participants and the plan provider. The approaches are not mutually exclusive and are often blended in unique combinations.

Experience Rating[1]

Under a pure experience rating system each covered group is evaluated and a premium set based on factors that are considered to be indicators for potential use of health services (underwriting standards) by the group. Within the group, costs are shared equally. That is, if a group member is a "high risk" individual, that will be factored into the group's premium but the cost will be shared equally among all members of the group. With a "pure" experience rating system, costs are not shared or spread among separate groups.

Another feature that may be found in experience rating is a periodic resolution of actual benefit costs incurred versus premiums paid.

Thus, under pure experience rating:

- Cost sharing generally occurs only within the specific group not among groups; and

- The group rather than the plan realizes cost savings if benefits are under utilized and assumes the risk for over utilization of covered benefits. The plan provider, in effect, "advances" payments for unanticipated costs but does not assume the risk. This is balanced by the group's opportunity to realize savings when claims are less than anticipated.

In practice, pure experience rating is generally used by insurers only for their largest accounts and amounts to self-insurance. Small groups are, to varying extents, pooled in order to spread the costs of high risk coverage over as large a group as possible. This is a limited use of community rating as discussed below.

Community Rating[2]

Under a pure community rating system the claims experience of all groups participating in a plan is used to project future benefit costs on a per-person or per-family basis. In effect, for rate setting purposes, there is only one group comprised of all plan participants. Group premiums are determined by multiplying the base rate by the number persons in the group without regard to the risk factors of the individuals that make up each group. Community rating does not usually provide for a reconciliation of actual benefits costs with premiums paid. The Federal HMO law allows a nominal differential in community rates to reflect differences in marketing and administrative expenses for individuals, small groups, and large groups. Differentials may also reflect systematic compositing of rates to accommodate group purchasing practices of employers.

The distinguishing features of community rating are:

- Cost sharing is spread among all plan participants as opposed to among group members with different rates for different groups;

- During the contract period, the plan assumes the risk for benefit costs that exceed projections and retains the excess when costs are less than anticipated.

Community Rating By Class[3]

The federal HMO provisions also allow HMO's to use a community rating by class system where rates may vary among groups. Under this system a basic pure community rate is determined by classifying all members into classes based on factors that have been found to predict utilization. Then the revenue requirements for each class are computed. Each groups' rate must reflect the groups' composite of the HMO's revenue requirements for providing services to them as members of the classes used for predicting utilization.

Adjusted Community Rating[4]

Alternatively, the federal requirements provide that rates may reflect the costs of providing services to the group so long as rates for groups of less than one hundred members do not exceed 110 percent of the rate that would apply using either a pure community rating or rating by class methodology.

Demographic Rating

Demographic rating uses certain indicators that are broadly predictive of service utilization including age, sex, and industry. Under this system, a group's demographics determines its rate.[5] This is similar to Community Rating by Class.

Endnotes

1. Compiled from: telephone interview with Arnold Hirotsu, Past President, Hawaii Association of Health Underwriters, November 14, 1994; unpublished material provided by Stacy Evensen, HMSA; and "Adjusted Community Rating in the Kaiser Permanente Medical Care Program" (Undated).

2. P.L. 100-517, §1302(8), as amended, and "Adjusted Community Rating In The Kaiser Permanente Medical Care Program" (undated).

3. Ibid.

4. Ibid.

5. Laudra E. Eber, President, Hawaii Association of Health Underwriters letter and enclosure to Samuel B.K. Chang, dated December 7, 1994.

Chapter 5

THE HEALTH PLAN MARKET

Characteristics of the Health Plan Market

In 1990, there were some 30,000 private sector establishments in Hawaii reporting at least one employee. These establishments employed 445,000 employees.[1] State and county government accounted for another 76,700 employees in the same reporting period. There were slightly fewer than 42,000 self-employed workers. While the components of these broad categories shift in response to changes in the economy (most notably a drop in sugar, pineapple and food processing), State and county government employment consistently represents about 14 percent of civilian employment, the federal government[2] and self-employed another 6 percent each, and the private sector around 74 percent.[3]

Six hundred, or 2 percent, of the 30,000 private sector employers each employ 100 or more workers and account for some 38 percent of the 445,000 private sector employees. The comparable percentages for private sector employers with 50 or more employees are 5 percent of the employers employing 53 percent of the employees.[4]

Thus, state, county and large private employers (100 or more employees) account for 47 percent of employment in the State while representing some 2 percent of the employing establishments. If employers with 50 or more employees are considered, the figures increase to 60 percent of workers being employed by 5 percent of employing establishments.

In order to offer employer-sponsored health plans to the entire market, a provider must be able to serve the few large employers as well as the numerous smaller establishments. While some 29,000 employers in the State have fewer than 100 employees and 28,000 have fewer than 50; respectively, they account for only 50 percent and 40 percent respectively of total private sector employees.

Multi-State Employers

Multi-state employers such as national retailers and banks, major hotel chains, and airlines may:

- Self-insure;
- For reasons of administrative efficiency require a health plan provider who can serve their employees on a national basis; or
- Have collectively bargained health coverage that can only be provided by a multi-state plan.

These factors may effectively remove such employers from the market place for health plan providers that operate solely within the State.

Health Plan Providers

Two organizations provide health plan coverage for an estimated 75 percent of Hawaii's resident civilian population.[5] However, there are a surprising number of providers serving the remaining 25 percent. A recent listing of those approved under the Prepaid Health Care Act (PHCA) shows twelve providers other than HMSA and Kaiser Permanente.

Commercial insurers on the list, with the number of plans offered in parentheses, are: Aetna (5), Nippon Life of America (1), Principal Mutual Life (formerly Bankers Life of Des Moines, Iowa) (14), and The Travelers (11).[6] Commercial insurers market their plans through agents who must be licensed for disability by the Department of Commerce and Consumer Affairs. At June 30, 1992, there were 10,000 agents, subagents, insurance solicitors, surplus lines and insurance adjustors licensed to market and serve *all* types insurance accounts in Hawaii.

In addition to HMSA, mutual benefit societies offering health plans include: Hawaii Management Alliance Association (HMAA) (2), Hawaii Dental Service - Medical (HDS) (3), and Pacific Group Medical Association (1). Mutual benefit societies may market their health plans

directly or through licensed agents. They may offer indemnity or HMO-type plans, or both, as is the case with HMSA (9).

Other organizations with PHCA qualified HMO-type plans are: Kaiser Permanente (4), BestCare (2), Health Plan Hawaii (1), Island Care (5), Pacific Health Care (1), and Straub Clinic and Hospital (1).

In addition, a Kaiser plan, HMSA's indemnity plan, and HMSA's HMO plan are available to state and county employees and retirees.

Market Shares[7]

Of the estimated 955,000 persons with health plan coverage in 1992, HMSA accounted for 64 percent: Kaiser Permanente, 19 percent; commercial carriers (insurers), 6 percent; Queen's Plan, 5 percent, HDS-Medical, 4 percent; and Island Care, 2 percent. Excluded from these data are persons with coverage under government programs such as Quest, CHAMPUS, Medicare and Medicaid.[8] These figures include both individual and group plan coverage.

HEALTH PLAN	MEMBERS	% OF TOTAL
HMSA	606,835	64
Kaiser Permanente	183,115	19
Commercial Carriers	55,000	6
Queen's Plan	45,000	5
HDS-Medical	44,000	4
Island Care	21,000	2

Health plan providers usually revise rate-benefit packages and renegotiate contracts annually or every two years. Also, an open enrollment period is provided to the 76,700 state and county employees each year. These factors provide an opportunity for employers and a number of employees to change their health plan, making the market somewhat volatile. As a result, the market share for specific plan providers can change significantly from year to year.

Finances

The Insurance Commissioner reports that in 1992 commercial insurers wrote premiums totaling $147 million for all accident and health policies while incurring losses and paying benefits of $78 million. Group accident and health policies accounted for $97 million (premiums) and $63 million (losses/benefits) of these totals. For the same year mutual benefit societies collected membership dues of $866 million while paying claims of $771 million for all types of health and disability coverage they offer. HMSA's $852 million in dues with $762 million in benefits dominated the other two mutual benefit societies (HMAA and HDS-Medical.[9]

Comparable data are not compiled for organizations that are not under the Insurance Commissioner's jurisdiction. However, for 1993, Kaiser Permanente reported revenues of $340 million ($254 of which is from dues) and benefit costs of $306 million for the Hawaii region.[10]

Endnotes

1. Hawaii, Department of Business, Economic Development, and Tourism, The State of Hawaii Data Book 1992 (Honolulu: March 1993), p. 330.

2. Federal government employment is generally excluded from this discussion because its employee benefit policies are outside the control and jurisdiction of the State.

3. Tax Foundation of Hawaii, Government in Hawaii 1993 (Honolulu, 1994), p. 11.

4. Data Book, p. 330.

5. Hawaii Medical Services Association Foundation, Health Trends in Hawaii (Honolulu: Hawaii, 1994), pp. 91-92. Based on 1992 data that excludes special coverage programs such as SHIP (State Health Insurance Program), CHAMPUS (for military dependents). Medicare, and Medicaid. The report estimates that uninsured individuals at 48,000 or 4 percent of resident civilian population of 1.1 million.

6. Some of these plans may no longer be offered since plan providers are not required to report cancellation of plans to the Department of Labor and Industrial Relations (DLIR).

7. Many employers offer health plans that cover not only the employee but also their dependents. Plan providers report the numbers of persons they cover and so data for persons covered by employer-sponsored plans is not comparable to data on employment alone.

8. Hawaii Medial Service Association Foundation, Health Trends in Hawai'i, First Edition (Honolulu: 1994), p. 90.

9. Hawaii, Department of Commerce and Consumer Affairs, Insurance Commissioner, Report of the Insurance Commissioner of Hawaii, 1993 (Honolulu: (Undated)), pp. 6, 7, and 41.

10. Kaiser Permanente, Kaiser Foundation Health Plan Inc., "Planning for Health", Spring 1994, Honolulu, Hawaii, p. 7.

Chapter 6

HEALTH PLAN PROVIDERS

This chapter discusses some of the organizations that are involved in the major aspects of group health plans in Hawaii. While it is not a comprehensive listing, it illustrates the variety of organizational structures and contractual relationships among those involved in the health plan industry.

Mutual Benefit Societies

Hawaii Medical Service Association (HMSA)[1]

In 1935 a Territorial Conference of Social Workers found that there was a need for accessible, affordable health care for many of Hawaii's citizens. HMSA was established after the Territorial Legislature, in 1938, enacted legislation that allowed the group to charter a nonprofit, member-owned association to provide health care benefits to its members and their families. When the Blue Shield Association of medical service plans was formed in 1946, HMSA was among the first independent programs to join. The HMSA Constitution provides that the objects and purposes of the Association are:

> To function exclusively for the benefit of the community for the promotion of social welfare, including but not limited to the furnishing of medical, nursing, hospital and health care and other services and benefits for its members and their families. . .; to operate as a nonprofit medical indemnity and hospital service association. . .[2]

It is licensed by the Hawaii Insurance Commissioner as a mutual benefit society under the provisions of chapter 432, *Hawaii Revised Statutes*.

Organization

HMSA, operates under the direction of twenty-seven member board of directors. The directors serve three-year terms without compensation. The board is organized into eleven

committees, ten of which oversee specific areas of operations. These subject-area committees report to a decision making executive committee.

Vacancies on the board of directors are filled by election at the annual membership meeting. The chairman of the board appoints a nominating committee that submits nominations sufficient to fill any vacancies. Nominations may also be made from the floor at the annual meeting. Association members present at the annual meeting and not delinquent in membership dues are entitled to vote. All individuals whose applications have been approved by HMSA are considered members of the Association.

In addition to the parent HMSA organization, one affiliate and three subsidiary groups have been formed, each with its own board of directors.

Health Plan Hawaii, an HMSA affiliate, is a nonprofit, federally qualified HMO established in 1982. It currently has 23,000 members. It contracts with HMSA to provide or arrange all benefits and administrative services.

Integrated Services, Inc. is a for-profit subsidiary divided into two nonprofit taxable subsidiaries. Hawaii Family Medical Centers owns and operates three clinics and manages another two. These clinics provide specialty care and support services not generally available in certain areas of Oahu, the Big Island, and Kauai. Hawaii Family Dental Centers is a dental HMO with ten centers on the four major islands serving 19,200 members.

HMSA Foundation is an HMSA subsidiary established in 1986 to support and conduct research to develop cost-effective responses to major health care issues.

Benefit Services of Hawaii, Inc. is also a subsidiary of HMSA. It offers employers assistance in developing comprehensive employee benefit packages. The general focus of Benefit Services is assisting small employers provide supplemental employee benefit packages such as cafeteria plans, 401(k) plan administration, and flexible spending accounts.

Operations

Day-to-day operations are performed by a staff of more than 1,400 employees under a president and chief executive officer who is hired by the board.

A broad spectrum of health care services are available through HMSA. However, the services provided directly by HMSA employees are administrative, focusing on plan design and administration, benefit and claims processing, and financial management. This is reflected in the subject-area committees of the board of directors (Exhibit 1). a total of some 20,000 employer groups (including sole proprietors) were served by an HMSA medical, drug or vision plan in 1993.

HMSA does not own, operate, or manage hospitals and, in general the health professionals that provide health services under HMSA plans are not HMSA employees. Its relationship with health care providers consists of an extensive system of contractual agreements for the delivery of health plan benefits. The largest element of this contractual network is the Preferred Provider Organization (PPO). Some 3,300 health care providers participate in the PPO through which they agree to accept HMSA's eligible charges for a wide range of medical procedures and services as payment in full when serving HMSA members. Incentives such as lower co-payments encourage members to use participating providers, and providers can bill HMSA directly for eligible charges which helps ensure timely payment for services.

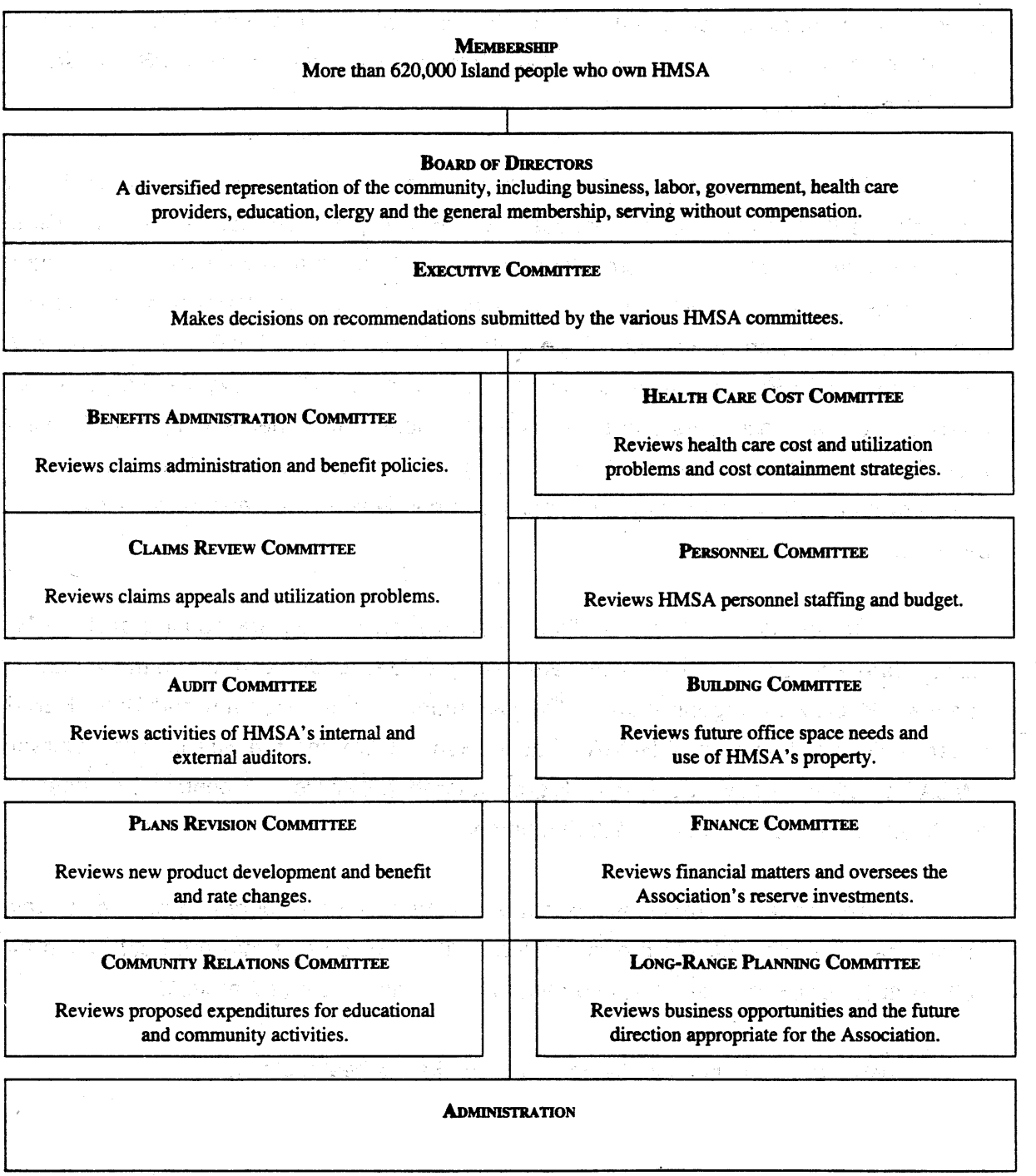
HMOs, in addition to the affiliated Health Plan Hawaii, are administered by HMSA. Health care services in these plans are also provided under contract with various health centers and provider organizations. The Community Health Program and HMO Hawaii are separate lines of business of HMSA. Pacific Health Care and the Straub Plan contract with HMSA for administrative services. Eight hundred providers are contracted under HMSA HMOs and serve approximately 52,000 members.

These contractual relationships not only establish the amount and manner of payment for services, but may include provisions that utilize elements of managed care such as pre-authorization for certain services, and certain cost-containment procedures.

HMSA does not use outside agents to market its health plans.

Exhibit 1

How HMSA Functions



Source: HMSA 1991 Annual Report, p. 17.

Rating-Setting Methodology

HMSA bases its rates primarily on experience and adds an amount (usually a percentage of dues) to cover administrative expenses. Community rating, merit or credibility rating, and experience rating are used depending, generally, upon the size of an employee group.

Community rating is used for groups of 100 or fewer subscribers with adjustments of up to plus or minus 20 percent of the base rate based upon underwriting guidelines and previous experience. Merit or credibility rating is used for groups of 100 or more. The rating pool is made up of all merit-rated accounts with rates of overall experience blended. The degree to which each account's own experience is used is based on its size and calculated using a standard credibility table developed by HMSA's consulting actuary. Experience rating is used only for very large accounts. Only the individual account's actual experience is used with a monthly or annual reconciliation.

Finance

With 1993 operating revenues of $931 million and investments valued at nearly $200 million, HMSA is a billion dollar operation. As a nonprofit mutual benefit society, it is not limited as to the amount of revenues that may be generated from member dues and earnings, but is required to use all revenues for program administration, benefits, and maintenance of reserves. Ninety percent of the 1993 dues went for benefit costs, 7 percent for administration, and 3 percent was applied to the reserves account.

HMSA may invest earnings (some $50 million in 1993) and reserves in the same instruments as are allowed for regulated insurance company including securities and mortgages and real property. Under the state insurance law and as a Blue Cross Bule Shield affiliate, HMSA is obligated to maintain reserves to protect its members. Earnings from investments in 1993 totalled $30.5 million and were used to reduce product costs.

As a nonprofit mutual benefit society, HMSA is exempt from Hawaii income, excise and real property taxes. In 1989 Congress enacted legislation to tax nonprofit, non-HMO health insurance companies.[3] HMSA's federal tax payments under this legislation were

nearly $6 million in 1993. The tax status of the health care providers and facilities that serve HMSA members varies depending upon the manner in which they are organized.

Other Mutual Benefit Societies

Hawaii Dental Services - Medical (HDS-Medical), Hawaii Management Alliance Association (HMAA), and Pacific Group Medical Association are registered mutual benefit societies that offer PHCA approved health plans. HDS-Medical and HMAA declined requests for interviews for this study.

According to the 1993 Report of the Insurance Commissioner of Hawaii, HDS-Medical was first registered in 1988 and reported assets of $4 million, direct premiums written of $9 million and claims paid of $6.5 million as of December 31, 1992. It offers three DLIR approved indemnity health plans two of which utilize a preferred provider organization with 2,300 participants. HDS-Medical also offers a prescription drug plan, group life policies, and HDS Flex Plan.[4] In 1994, HDS-Medical became HMAA's third party administrator.

HMAA was registered in 1990. Its annual report for 1993 on file with the Insurance Commissioner reflects assets of $3 million, direct premiums earned of $10.1 million and claims incurred of $7 million. The report indicates that, in 1992, HMAA purchased third party administration services from Queen's Health Plan. This arrangement ended in December 1993.[5] An HMAA newspaper advertisement claimed participation by more than 1,800 employers and a preferred provider organization of 2,200 health care professionals.[6]

The Pacific Group Medical Association became operational in September 1993 and so is not included in the reporting period covered in the Insurance Commissioner's 1993 report.

Hospital-Based Plan Providers

Kaiser Permanente[7]

Kaiser Permanente Medical Care Program is a group practice prepayment plan for comprehensive medical and hospital services. It is the largest group practice prepayment plan in the United States and the largest nongovernmental program in the world. Kaiser

Permanente is geographically organized into twelve separate regions serving some 6.5 million members in sixteen states. It developed during the 1930's and 1940's as industrial health programs for construction and shipyard workers in the Kaiser industrial companies. The programs were opened to pubic enrollment in 1945. The Hawaii Region was established by Henry J. Kaiser in 1958 and was the fourth of the present twelve regions. All Kaiser Permanente programs are federally qualified HMO's.

Organization

Kaiser Permanente operates within a decentralized but closely coordinated structure consisting of; (1) the Kaiser Foundation Health Plan, Inc. (Health Plan), a California nonprofit organization, (2) Kaiser Foundation Hospitals, Inc. (Hospitals), also nonprofit and based in California, and in Hawaii, (3) the Hawaii Permanente Medical Group, Inc., a Hawaii for-profit professional corporation (see Exhibit 2).

The Health Plan and Hospitals organizations, while registered as separate organizations are administered by a common board of directors that sets overall policy for the design and administration of health plans and the Kaiser Permanente hospitals and clinics in all twelve regions. (Hawaii is one of four regions that own and operate their own hospitals. The other regions contract with various local facilities for in-patient care.) The formal relationship between the central health plan and hospital organizations is contractual. The Hawaii Permanente Medical group is one of twelve group practices that contract with Health Plan, Inc. to provide health services to Kaiser Permanente plan members in Hawaii.

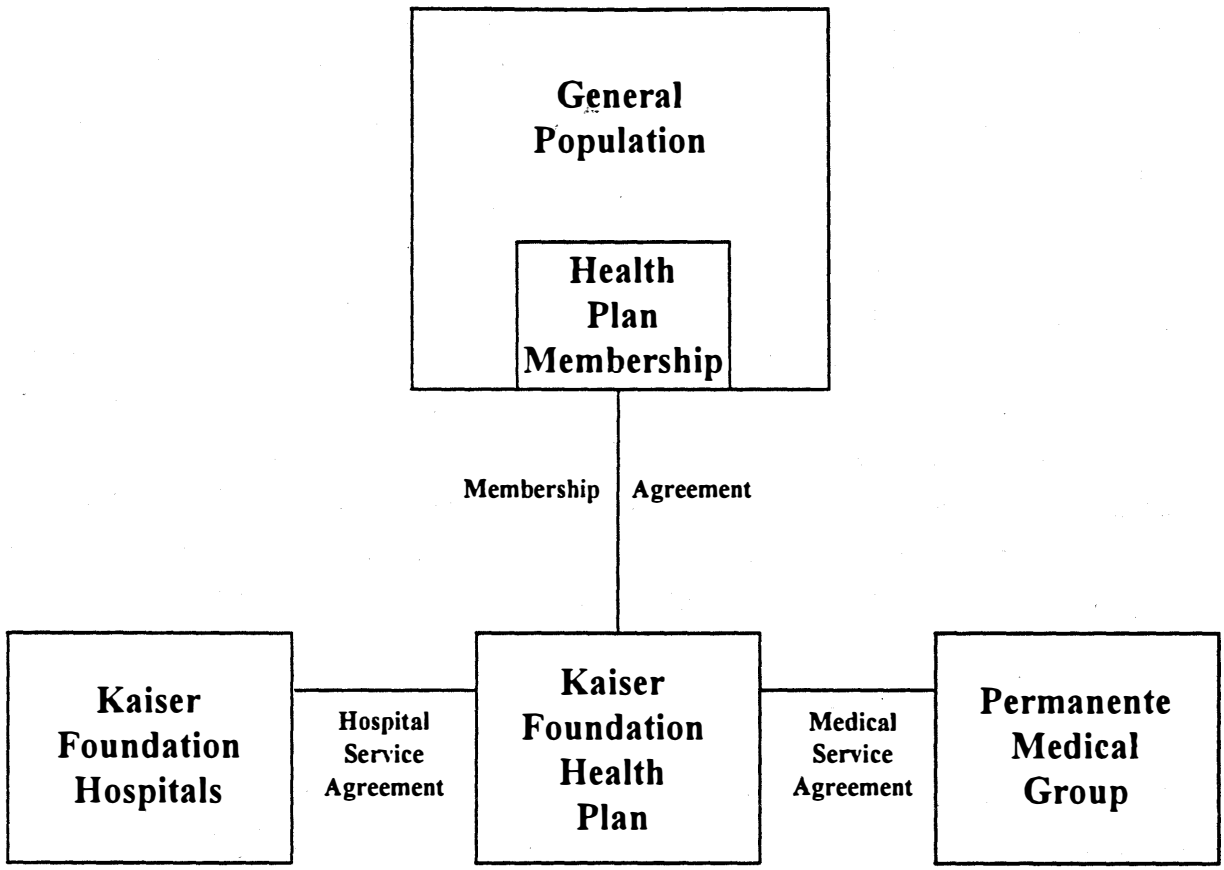
Operations

Under the policy-level direction of the central Health Plan and Hospital organizations, the Hawaii region personnel, under a Senior Vice President and Regional Manager, are responsible for basic operations within the region. Health plan employees based in Hawaii serve the local accounts, market Kaiser Permanente plans and oversee the general administration of the organization. The Kaiser Permanente Medical Center in Moanalua and its twelve clinics are similarly the responsibility of Hawaii-based employees. Unlike the Health Plan and Hospitals groups, the Permanente Medical Group is a Hawaii corporation under contract with the Health Plan to provide the professional and support staff to serve plan members. These individuals are employees of the Hawaii Permanente Medical Group.

Exhibit 2

Kaiser Permanente
Medical Care Program

Regional Structure



Source: Provided by Kaiser Permanente, Hawaii Region.

Today, Kaiser Permanente's Hawaii operations involve 3,500 employees including 290 physicians, one full-service medical center that includes a 202 bed hospital and a 55 bed skilled nursing facility, and twelve clinics on Oahu, Maui and west Hawaii.

While the twelve regions of the Kaiser Permanente system are relatively decentralized, the resources of its Program Office in Oakland, California, can be made available when appropriate. This can be of significant assistance if, for example, a region needs financial assistance with regard to a major investment such as a new hospital or costly high-tech equipment. Each region is also bound by the basic policies established by the Program Office which include the policy that any group offering a Kaiser Permanente plan must also offer an alternative plan. In Hawaii, Kaiser Permanente does not use outside agents to market its plans.

Rate-Setting Methodology

As a federally qualified HMO Kaiser Permanente has elected to use an adjusted community rating system in Hawaii. This system is described in Chapter 4.

Finance

Nationally, Kaiser Permanente's 1993 annual report reflects total assets of nearly $10 billion. More than one-half of the value of these assets represents real property and equipment which is to be expected considering the fact that Kaiser Permanente owns and operates a number of hospitals and clinics across the nation. Current assets including cash and marketable securities amounted to $1.7 billion. Revenues for the period totalled $1.8 billion.

The Hawaii Region reported total revenues of $340 million of which $254 million represented member dues. Total expenses for the year came to $316 million. As nonprofit organizations, the Health Plan and Hospitals organizations are exempt from federal, state and local taxes. The Hawaii Permanente Medical Group is a taxable Hawaii corporation.

Straub Clinic and Hospital[8]

Straub Clinic and Hospital, established in 1921, is a Hawaii for-profit corporation offering comprehensive hospital, home health, physician, and outpatient services. The main hospital and clinic is located in Honolulu with additional clinics in the central business district, Hawaii Kai, Kailua, Kaneohe, Mililani, Aiea, Lanai, and Kailua-Kona. While a member of various professional organizations, Straub is not affiliated for operating or financial purposes with a national or parent organization. The Straub Foundation, a nonprofit organization, supports medical research for Straub's programs.

Straub participates as a fully capitated network provider in HMSA's HMO products, and as a preferred provider in network-based products such as HMSA's Preferred Provider Plan and the CHAMPUS (Civilian Health and Medical Plan for the Uniformed Services) Tricare Plan.

Operations

Straub offers both fee-for-service and managed HMO programs. The Straub Plan currently has nearly 3,500 members and is available through 40 employer groups the largest of which is Straub itself with 2,600 members.

The management and operation of the plan, provision of most medical and hospital services, and marketing of the Plan are the responsibility of Straub. Rate-setting, financial administration and underwriting services are provided by HMSA which is co-guarantor for The Straub Plan. The Straub HMO is not federally qualified.

Rate-Setting Methodology

HMSA uses the same rate-setting and underwriting criteria for The Straub Plan as are used for the HMSA HMO plans, subject to review and possible revision by Straub. (See preceding discussion of rate-setting under the HMSA section of this chapter.)

Finances

Straub is unusual in that it is a for-profit, privately held corporation. As such it is taxable and its owners may realize profits from its operations. As a privately held entity Straub does not file public financial reports. However, a recent "Report to the Community" includes the following summary of 1993 financial activities, (in millions):

1993 Profit	$ 2.9
Net Worth	15.6
Salaries Paid	85.5
State/Federal Taxes	12.5
Charity Care Provided	8.7

An estimated 10 percent of total Straub revenues are generated by its health plans.

The Queen's Health Systems (QHS)[9]

The Queen's Health Systems is a system of some twenty privately held corporations involved in various aspects of health care delivery and administration. In addition to the Queen's Medical Center, a preferred provider organization, an HMO (not federally qualified) for employer sponsored health plans, and an HMO serving QUEST clients are among the health services offered through QHS.

QHS developed from the original Queen's Hospital Corporation (known today as the Queen's Medical Center) established in 1859 and the Queen Emma Trust which is a private land trust established in 1885 to support the hospital and health care for Hawaiians. The Trust's holdings include 10,000 acres on the island of Hawaii, 2,300 acres in central and leeward Oahu, and 18.5 acres in Waikiki. These holdings are the real estate asset base for QHS. The Medical Center is the System's principal cash flow generator.

Organization

The Queen Emma Foundation, a private, nonprofit foundation, manages the Queen Emma Trust lands the earnings from which help support health care provided through QHS.

Long-term leases on Trust lands which are due for renegotiation or expiration over the next twenty years are the major income sources for the Foundation.

The Queen's Medical Center is a private, nonprofit hospital with 530 acute care beds and 30 sub-acute beds. It has 3,600 employees and 1,000 physicians, and participates in both the HMSA and QHS preferred provider organizations.

Molokai General Hospital is a 30-bed hospital and medical center which was acquired by QHS in 1987. It is the major acute care provider on the island of Molokai.

Comprehensive Home Care and Comprehensive Home Services of Hawaii (certified home health agencies), Mid-Pacific Rehabilitation Center, Inc., and Pacific Radiopharmacy, Ltd. are separate corporate entities within the QHS group of hospital-related activities.

Queen's Development Corporation is a for-profit organization that manages a number of diverse profit and non-profit entities with the QHS. It manages the *Queen's Health Care Plan, Inc.*, which is a for-profit preferred provider organization (PPO) of some 750 medical professionals and 15 hospitals throughout the State. A number of regulated insurance companies contract with the Plan to utilize the PPO for their health plans. An estimated 39,000 individuals are served through this PPO. *Island Care* (formerly Best Care) is a nonprofit HMO also managed by the Queens Development Corporation. It provides health plan coverage to some 500 employer-sponsored groups serving an estimated 16,000 employees and their dependents. Both independent agents and in-house staff market Island Care health plans.

Other entities under the Development Corporation's umbrella are:

- *Queen's Hawaii Care, Inc.* - an HMO serving 20,000 QUEST members;
- *Queen's Health Care Centers* - providing walk-in primary care and clinic-based services in Hawaii Kai and Waikiki;
- *Managed Care Management, Inc.*

- *Queen's Health Technologies, Inc.* - involved in several functions relating to high tech services; and

- *Diagnostic Laboratory Services, Inc. - offers laboratory support such as blood and urine testing.*

Rate-Setting Methodology

Island Care uses an adjusted community rating system (see Chapter 4) with adjustments to reflect age and sex factors that are predictive of care utilization.

Finance

QHS and its affiliates reported 1993 assets of $501 million. This figure does not include the market value of certain lands managed by the Queen Emma Foundation. Total revenues for the period were $394 million ($85 million from managed care programs) with total expenses of $382 million.

Regulated (Commercial) Insurance Companies

Insurance companies offering DLIR approved health coverage for purposes of PHCA include: Aetna Life, Nippon Life Insurance Company of America, Principal Mutual Life, and The Travelers Insurance. Requests for interviews with the local offices of Travelers and Principal Mutual were declined.

Principal Mutual's 1993 annual report on file with the Insurance Commissioner reflects total corporate assets of the parent company and its affiliates of $32 billion and liabilities of $31 billion. Premium income from all group accident and health policies for the reporting period totalled nearly $3 billion with incurred claims of $2.3 billion. Twenty-six million was returned as dividends to policy holders and $196 million was paid in commissions. Investment earnings were $2.4 billion. These figures reflect Principal Mutual's financial condition on a national basis. Data in the report do not separate Hawaii health and accident policies. According to the Insurance Commissioner's Annual Report for 1993, Principal

Mutual's Hawaii business generated premium income from all policies other than life and annuities at $1.8 million and claims paid of $1.3 million.[10]

A number of the plans offered by insurance companies use the Queen's Health Care Plan, Inc. preferred provider organization. The rates and rate-setting methodologies are determined by the insurers, not the PPO.

Insurance Agents[11]

With the notable exceptions of HMSA and Kaiser Permanente, most health plan providers market their products both in-house and through agents who generally work on a commission basis. The Hawaii Association of Health Underwriters, with some fifty members, is the professional association for health insurers and agents. These agents work with individual employers and often function as brokers for available plans. For smaller employers who do not have in-house human resource personnel, agents may fill this need and develop employee benefit packages that include benefits other than health plans such as retirement plans, temporary and long term disability insurance coverage, and group life policies.

Benefit plan consultants may also assist employers develop self-funded health plans approved for PHCA purposes under which financial responsibility for plan benefits rests with the employer rather than the plan provider. An insurance product (excess risk policy) may be an integral element of a self-funded plan.[12]

Endnotes

1. The information in this section of this chapter is compiled from a number of sources. It has been reviewed for accuracy by HMSA. The primary sources are as follows.

   (1) Constitution of Hawaii Medical Service Association (HMSA) as amended April 6, 1973.

   (2) Bylaws of Hawaii Medical Service Association (HMSA) as amended as of May 7, 1993.

   (3) Annual Report and Financial Highlights, Hawaii Medical Service Association, 1991, 1992, and 1993 editions.

   (4) Interview with Stacy Evensen, Manager, Government Relations, HMSA and Gene Fujii, July 25, 1994, and subsequent correspondence.

(5) HMSA testimony before Senate Committee on Consumer Protection on SB 2384, dated February 24, 1994.

2. Constitution of Hawaii Medical Service Association (HMSA), as amended as of April 6, 1976, Item No. 1.

3. Internal Revenue Code, sec. 501(m).

4. HDS-Medical, "Focus on the Facts, Plan 400, Plan 600, and Plan 700(A) Benefit Highlights" (Honolulu: Undated Brochure).

5. Interview with Richard M. Jackson, President and Chief Executive Officer, The Queen's Health Care Plan, November 1, 1994.

6. Honolulu Star Bulletin, November 14, 1994.

7. The material in this section is compiled from a number of sources. It has been reviewed for accuracy by Kaiser Permanente. Primary sources are as follows:

   (1) The 1992 and 1993 Kaiser Permanente Annual Reports.

   (2) Kaiser Permanente, Hawaii Region, "Planning for Health", Spring 1994, p. 7.

   (3) Interview with Christopher G. Pablo, Manager, Public, Government and Community Affairs, Kaiser Permanente, and Francie Boland, August 1, 1994, and subsequent correspondence.

8. The information in this section is based primarily upon an interview with Karen Lennox, Manager, Straub HMO services, on October 20, 1994, and supplementary materials provided at the interview. Straub has reviewed this section for accuracy.

9. The information in this section is based upon an interview and material provided by Richard M. Jackson, President and Chief Executive Officer, The Queen's Health Care Plan, November 1, 1994. It has been reviewed for accuracy by The Queen's Health Systems.

10. Telephone message from Lucia Riddle. Principal Mutual Life Ins. Co., Des Moines, Iowa office, November 4, 1994, stated that they provide plans for 57 employers in Hawaii covering 241 individuals.

11. This section is based upon an interview with Arnold Hirotsu, past President of the Hawaii Association of Health Underwriters, August 3, 1994.

12. Telephone interview with Gail Hiraishi, TDI Program Specialist, Department of Labor and Industrial Relations, October 28, 1994.

Chapter 7

THE COMPETITIVE ENVIRONMENT

National Factors

McCarran-Ferguson Act of 1945

The McCarran-Ferguson Act of 1945[1] exempts insurance companies from the federal antitrust laws that apply to other organizations involved in the health care industry. Proposals to repeal the exemption and the alternative of extending it to other elements of the industry such as hospitals and professional medical practices have been suggested.[2] This exemption applies to insurers that offer indemnity policies. Activities of mutual benefit societies may be classified as "the business of insurance" for the purposes of the McCarran-Ferguson federal antitrust exemption.[3]

Insurers and Managed Care

The nation's five largest health insurers are no longer members of the Health Insurance Association of America. This has positioned them to shift from their traditional focus as indemnity insurers toward becoming managed care companies. Such a change could have a significant impact at the national level and cause these groups to re-examine their level of involvement in Hawaii. The big five insurers are Aetna Life and Casualty Co., Cigna Corp., MetLife, Prudential, and Travelers Corp. Each has an extensive marketing network through their existing agents, and may have sufficient capital and experience to develop and administer integrated plans. They appear to have the potential to significantly expand their market shares and role in the health care industry.[4]

Both Aetna and Travelers offer PHCA qualified health plans in Hawaii. Aetna's consolidated statement showed $90 billion in total assets for 1993. Travelers' statement for the same period reflects assets of $101 billion. These figures represent assets of all activities of the parent and subsidiaries of these corporations, and both are engaged in a number of activities other than health insurance.[5]

Principal Mutual Life, a mutual insurer active in Hawaii offering PHCA qualified plans, already has several mainland subsidiaries that are HMOs. Principal Mutual reported total

assets of $32 billion[6] which is significantly greater than those reported by Hawaii's two major health plan providers. HMSA and Kaiser Permanente reported total assets in 1993 of $480 million and just under $10 billion, respectively.[7] The Kaiser Permanente figures reflect the assets of all twelve regions. Thus, should the major insurance companies decide to move into managed care in Hawaii, they have the financial potential to become major providers.

CHAMPUS

The Civilian Health and Medical Plan for the Uniformed Services (CHAMPUS) is federally controlled and not subject to the PHCA. This is the health plan for some 82,000 military family members and retirees (7 percent of all covered lives in the State). The CHAMPUS contract is scheduled for re-bid every five years with an annual review and re-negotiation. It represents a significant portion of the health plan market and is aggressively sought by plan providers in Hawaii. HMSA held the contract for a number of years. Then The Queen's Health Systems was awarded the contract. Currently, HMSA holds the subcontract for CHAMPUS managed care services in Hawaii in conjunction with the national contractor for this region.[8]

Federal Taxation

Under the Internal Revenue Code (IRC), insurance companies[9] and for-profit corporations involved in health plans and health care delivery are taxable corporations (HMSA is taxable under federal law (IRC section 501(m)). However, health care is generally considered a charitable activity, and nonprofit organizations that provide health care and health plan coverage may qualify for an exemption under section 501(c)(3) of the IRC. Exempt status is also available to cooperative hospital service organizations that perform services such as data processing, purchasing, or clinical services for two or more tax-exempt hospitals (IRC section 501(e)).[10]

Local Factors

Hawaii Prepaid Health Care Act

PHCA treats employer-sponsored health plans as a labor-relations issue placing emphasis on plan benefits, making plans available through the work place, and employer-employee cost sharing. Reflecting this approach, responsibility for regulation and enforcement of PHCA is placed with the Department of Labor and Industrial Relations (DLIR) rather than with the Department of Health or the Insurance Commissioner. The Prepaid Health Care Advisory Council (Council), which advises the DLIR director regarding health plans submitted for approval, plays a key role in the department's implementation of PHCA. The seven-member Council is appointed by the director and serves without compensation.[11] The Disability Compensation Division of DLIR administers PHCA and provides staff assistance to the Council. As of this writing Council members are:

Paul A. Tom, Benefit Plans Consultants (Hawaii)
Michael Gold, HMSA, Vice President, Underwriting
Dr. John T. McDonnell, Castle Professional Center
William W. H. Brown, Outrigger Hotels, Vice President, Human Resources
Nolan Namba, Kaiser Permanente, Health Plan Manager
Grace Abe, Queen's Medical Center, Personnel Officer
Shirley C. Wong, Principal Mutual Life Ins. Co.[12]

PHCA provides that health plans must either meet the specifications set forth in PHCA or provide, "...benefits equal to, or medically reasonably substitutable for, the benefits provided by prepaid health plans of the same type,... which have the largest number of subscribers in the State."[13] Judgments as to whether benefits are "equal" or "medically reasonably substitutable" may be disputed. The director of DLIR usually accepts the recommendations of the Council in these matters, making it a major factor both in implementation of PHCA and in the competitive environment relating to PHCA qualified plans. The composition of the Council is of interest and concern among some plan providers.

State Oversight

Financial oversight for indemnity-type health plans is the responsibility of the Insurance Commissioner. Mutual benefit societies, mutual insurers and for-profit insurers submit annual financial reports to the Commissioner and are subject to audit at least every three years. Those offering indemnity plans must meet the requirements for adequate reserves and the restrictions on investment of earnings that are established in the Insurance Code.

PHCA also allows employers to self-insure their health plans. DLIR reviews the financial capacity of these employers annually to determine whether their financial resources are sufficient to cover the anticipated costs of their plans.[14]

Hospital-based HMO plan providers such as Kaiser Permanente and Straub Hospital and Clinic are not subject to state financial oversight with regard to their health plans. They submit annual statements to the Department of Taxation to verify their tax status. Kaiser Permanente and HMSA's federally qualified HMO must submit financial and program reports to the *federal* government as determined by the U.S. Secretary of Health and Human Services (see Chapter 3).

Taxes

The state tax status of an organization that offers group health plans depends upon the statutory provisions under which it is organized as well as the product or services it provides. When plan providers are organized as affiliations of corporate entities, the taxability of each entity is determined independently of the others. As a result the taxes associated with otherwise identical plans can differ and, to the extent the tax is passed on, may be reflected as differing premiums.

Regulated insurers organized under chapter 431, *Hawaii Revised Statutes*, pay taxes of 4.265 percent of their gross premiums while being exempt from general excise and state income tax.[15]

Nonprofit mutual benefit societies organized as medical indemnity or hospital service associations under chapter 432, *Hawaii Revised Statutes*, are exempt from all state and county taxes except unemployment compensation tax.[16]

For-profit corporations organized under chapter 415, *Hawaii Revised Statutes*, are subject to all state and county taxes, the major taxes being the state corporate income tax imposed on net income,[17] general excise tax levied on the gross proceeds of all business activities,[18] and county real property taxes based on the assessed value of land and improvements.[19]

Foreign (out-of-state) and domestic nonprofit corporations are also taxable unless specifically exempted. (Nonprofit status is generally a requirement for the specific exemptions.)

Nonprofit hospitals and infirmaries are exempt from county real property taxes[20] and, if eligible under IRC sec. 501(3), from state income and general excise taxes. The excise tax exemption applies only to gross income directly attributable to exempt activities.[21]

Insurance solicitors are subject to the state personal income tax and the general excise tax at a special rate of 0.15 percent.[22]

State corporate income tax rates range from 4.4 percent on net income up to $25,000 to 6.4 percent on amounts over $100,000. General excise rates are 0.5 percent on intermediary services and 4 percent on retail sales of goods and services. County property tax rates are set annually and vary among the four counties.[23]

Provider Practices

With the exception of Kaiser Permanente which is organized to provide comprehensive support for its health plans, from plan development and administration to service delivery, with very limited use of entities outside the Kaiser corporations, most health plan providers in Hawaii either utilize or serve other providers with respect to some aspects of their operations. Thus, while competing for market shares, they are, at the same time, using the services of competitors or providing services to them.

In contrast, regulated insurers and mutual benefit societies have little overlap and are in direct competition with similar products and services, offering plan administration and indemnity-type plans. Some mutual benefit societies, such as HMSA and Hawaii Dental Service, are agents for group life policies and offer flexible benefit services. These activities are in direct competition with products and services provided by insurance companies and agents. The state tax exempt status of the mutual benefit societies is seen by insurers and the agents marketing insurance products as an unfair competitive advantage for the mutuals.

Legislative Proposals

During the 1994 Regular Session, the state Legislature entertained several proposals relating to group health plans.

S.B. No. 3058 and H.B. No. 3436 would have required all licensed insurers, prepaid hospital and medical service plans, HMOs, mutual benefit societies, and other providers of health insurance to use a community rating system, and imposed a civil penalty of not more the $10,000 for violations.

S.B. No. 2384 would have prohibited mutual benefit societies, their affiliates and subsidiaries from, (1) operating clinics except in areas determined by federal standards to be medically underserved, and (2) engaging in any line of insurance other than that for medical and hospital benefits. The bill also required annual reporting of a society's expenses relating to expansion of services to be separated from those for maintenance of current services.

H.B. No. 3430, H.D. 2, S.D. 2, was passed during the 1994 Regular Session of the Legislature but vetoed by the Governor because funds were not provided for implementation of part 2 of the legislation.[24] Part 2 would have regulated mutual benefit societies' premium rate-making procedures. Part one of the bill would have regulated HMO's by requiring them to submit applications for certificates of authority to operate, established reporting requirements for HMOs similar to those imposed on regulated insurers and mutual benefit societies, and established financial reserve requirements for HMOs. The measure placed administrative responsibility with the Office of the Insurance Commissioner.

Endnotes

1. 15 U.S.C. sec. 1101-15.

2. Howard Metzenbaum, U.S. Senator (D), Ohio, "Antitrust Enforcement: Putting The Consumer First," Health, vol. 2, no. 3 (Bethesda, MD: Fall 1993), pp. 137-139.

3. Telephone interview with Stacy Evensen, Manager, Government Relations, HMSA, November 7, 1994.

4. Julie Kosterlitz, "Monopoly Medicine?", National Journal, vol. 25, no. 28, July 10, 1993, pp. 1749.

5. Summary data provided by Rodney A. Chang, Assistant Branch Manager, Dean Witter Reynolds, Inc.

6. Annual Statement of Principal Mutual Life, Co. of Des Moines, Iowa, to the Insurance Division, Department of Commerce and Consumer Affairs, State of Hawaii, for the Year Ended December 30, 1993. On file with the Hawaii Insurance Commissioner.

7. 1993 Annual Report and Financial Highlights, Hawaii Medical Services Association (Honolulu: Undated), p. 4. Kaiser Permanente 1993 Annual Report (Oakland: Undated), p. 34.

8. Interview with Richard M. Jackson, President and Chief Executive Officer, The Queen's Health Care Plan, November 1, 1994.

9. US Master Tax Guide, Commerce Clearing House, Inc. (Chicago: 1992), p. 32.

10. Ibid., pp. 174 and 177.

11. Hawaii Rev. Stat., sec. 393-7(d).

12. Membership list provided by Disability Compensation Division, Department of Labor and Industrial Relations.

13. Hawaii Rev. Stat., sec. 393-7(a).

14. Telephone interview with Gail Hiraishi, TDI Program Specialist, Department of Labor and Industrial Relations, November 7, 1994.

15. Hawaii Rev. Stat., sec. 431:7-202 and -204.

16. Hawaii Rev. Stat., sec. 432:1-403; Revised Ordinances of Honolulu, sec. 8-10.9; Hawaii County Code, sec. 19-76; Maui County Code, sec. 3.48.490; and Kauai County Code, sec. 5A-11.9.

17. Hawaii Rev. Stat., chap. 235.

18. Hawaii Rev. Stat., chap. 237.

19. Revised Ordinances of Honolulu, chap. 8; Hawaii County Code, chap. 19; Maui County Code, sec. 3.48; and Kauai County Code, chap. 5A.

20. Honolulu Revised ordinances, sec. 8-10.10; Hawaii County Code, sec. 19-77; Maui County Code, sec. 3.48.495; and Kauai County Code, sec. 5A-11.10.

21. Hawaii Rev. Stat., sec. 237-23.

22. Government in Hawaii 1993, Tax Foundation of Hawaii (Honolulu), p. 34.

23. Ibid.

24. "Statement of Objections to House Bill No. 3430," John Waihee, Governor, June 22, 1994.

Chapter 8

INTERIM FINDINGS

This report is the first part of a two phase study to examine competition among the organizations that offer group health plans in Hawaii. It focuses on the general environment within which health plan providers operate and the features of that environment that influence competition among plan providers. Part II will address the competitive practices of plan providers and the impact on costs and quality of health care in Hawaii. Recommendations for guidelines and oversight of health plan providers will be presented in Part II.

H.R. No. 200, H.D. 3, requests that Part I:

(1) Review the organizational structure, benefits offered, rates, and finances of health plan providers;

(2) Assess the impact of size and tax classification on competition among providers; and

(3) Identify the level of state oversight of the industry.

Organizational Structure

Most health plan providers are organized as groups of affiliated corporations with the parent corporation being: (1) a regulated commercial insurance company, (2) a nonprofit mutual benefit society, or (3) a hospital-based profit or nonprofit corporation. The importance of health plans relative to other activities of the organization is reflected in the way the affiliated group is structured. For example, Kaiser Permanente's activities center on administering and operating its health maintenance organization (HMO) health plans. Two of the three corporations that comprise Kaiser Permanente share the same board of directors and the third contracts exclusively with the Health Plan organization to provide the professional health care services its members.

At the other extreme, the commercial insurance companies are generally affiliations of numerous corporate entities that offer a variety of financial products. Their health plans are

only one of those products and, in Hawaii, do not represent a major segment of their financial base.

It is not uncommon for a health plan provider to contract with another for certain services which are outside its area of expertise. The Queen's Health Services' preferred provider organization is used by several regulated insurers, and Straub Hospital and Clinic's plan is administered by the Hawaii Medical Service Association (HMSA). At the same time, both Queen's and Straub are among the hospitals that are participating providers for a number of health plans in additional to those offered by their parent organizations. Tension both within an organization and among the plan providers may arise in this type of environment.

Health Plan Benefits and Coverage

For the purposes of this study, the health plan industry is examined using a simple producer-product-consumer economic model. Under this model, a standardized or uniform product facilitates identification of the competitive factors at play by eliminating one set of variables. The study, therefore, focuses on health plan benefits required under Hawaii's Prepaid Health Care Act (PHCA). This is a comprehensive package of health care and hospitalization benefits offered as an employee benefit to most private sector employees. Employers are required to offer PHCA qualified plans and share the cost of coverage with their employees.

In 1992, an estimated 955,000 persons in Hawaii were covered by a health plan, in most cases, through an employer as active workers or retirees, or the immediate members of their families. Kaiser Permanente and HMSA accounted for some seventy-five percent of this coverage. Commercial carriers, The Queen's Plan, HDS-Medical, and Hawaii Management Alliance Association (HMAA) each cover under ten percent of the total.

Financial Requirements and Taxes

Mutual benefit societies and commercial insurers must, by state law, maintain reserves to protect their members and policy holders. Reserve provisions do not apply to other types of organizations. For-profit organizations are taxed at both the state and federal levels, and also strive to generate acceptable profits for their owners and stockholders. Tax-

exempt groups must return all revenues to the activities for which the exemption is granted. For plan providers that are organized as affiliations of more than one corporate entity, the tax status of each corporate unit is determined independently. Thus, it is not uncommon for a health plan provider to have both taxable and exempt components.

Rates

Providers not subject to the federal rate-setting provisions for HMOs generally blend experience, demographic, and community rating methodologies. Under experience rating a group's previous and projected claims experience is used to establish its rates for the contract period and different groups may have different rates. With community rating, the experience and projected requirements all group covered by the provider are combined and the same rates apply to all groups. Adjusted community rating allows some variation among groups based on group size and costs of administration. Demographic rating uses key characteristics such as age, sex, and industry for each group to determine its rate.

In order to be competitive, health plan providers must offer rates and benefits that compare favorably with Kaiser Permanente, which follows the federally established methodology, and HMSA, which uses different methodologies depending upon the size of the group and the type of plan involved.

Size of Provider Organizations

There appears to be little, if any, correlation between the organizational size of health plan providers and the size of their operations in Hawaii. Organizationally and financially, the regulated commercial insurers are the largest entities offering health plans in the State. However, they currently provide coverage for less than ten percent of the civilian population. Factors other than gross financial resources that characterize Hawaii's two major plan providers are:

(1) A corporate focus on health plan operation and administration.

(2) An administrative structure that allocates corporate resources and decision-making authority in a manner that allows plan administrators to concentrate on their Hawaii operations.

(3) A history of successful operation in Hawaii over a number of years.

State Oversight

Oversight of the financial and operational aspects of health plans in Hawaii is not centralized or uniform. The Insurance Commissioner monitors certain financial elements of regulated insurers and mutual benefit societies. However, HMOs are not subject to financial examination by the State. Neither the amounts of health plan rates nor the methods used to develop them are regulated by the State. (Federally qualified HMOs must comply with certain requirements regarding their finances, rate-setting practices and plan benefits.)

The Department of Labor and Industrial Relations (DLIR) administers the Hawaii Prepaid Health Care Act which mandates the benefits package that must be offered to most private sector employees. Plans covering the self-employed and government workers are not subject to PHCA. Oversight of the financial capacity of self-insured employers is the responsibility of DLIR.

HOUSE OF REPRESENTATIVES
SEVENTEENTH LEGISLATURE, 1994
STATE OF HAWAII

H.R. NO. 200 H.D. 3

HOUSE RESOLUTION

REQUESTING THE LEGISLATIVE REFERENCE BUREAU TO STUDY AND REPORT ON COMPETITIVE PRACTICES OF HEALTH INSURERS, MUTUAL BENEFIT SOCIETIES, AND HEALTH MAINTENANCE ORGANIZATIONS.

WHEREAS, through a coordinated set of public-private partnership programs Hawaii has achieved near universal access to health insurance coverage for its people, with costs among the lowest in the nation; and

WHEREAS, despite this achievement, health care costs in Hawaii continue to rise faster than the cost of most other goods and services; and

WHEREAS, most of Hawaii's residents are enrolled in health plans or Health Maintenance Organizations (HMO) operated by non-profit organizations; and

WHEREAS, most of Hawaii's physicians and dentists are participating providers or employees of these organizations; and

WHEREAS, some health care providers are contemplating or actually entering the health insurance business, intending to be both providers and insurers of health care; and

WHEREAS, concerns have been raised about the impact of this market situation on free competition; and

WHEREAS, concerns have also been raised as to the potential for conflict of interest if an organization both provides and pays for services; and

WHEREAS, concerns have also been raised over the exclusionary rating and enrollment practices of commercial, for-profit health insurers; and

WHEREAS, concerns have been also raised regarding the potential negative impact of overly restrictive state regulation on health care quality, costs, and access; and

WHEREAS, the State has a vital interest in ensuring that its residents have adequate access to affordable and quality health care services; now, therefore,

BE IT RESOLVED by the House of Representatives of the Seventeenth Legislature of the State of Hawaii, Regular Session of 1994, that the Legislative Reference Bureau is requested to conduct a study of the competitive practices of health insurers, mutual benefit societies, health maintenance organizations, and any other organization providing health care coverage in Hawaii; and

BE IT FURTHER RESOLVED that the study include but not be limited to:

(1) A review and description of the administrative structures and operations of each of these organizations including persons covered, benefits and services offered, rates, rate setting practices, financial condition, administrative costs, and profits;

(2) An assessment of the impact that the size of these organizations have on competition and the cost of health care, and differences in their tax classifications;

(3) A determination of the current level of oversight of these organizations by the Department of Commerce and Consumer Affairs and other appropriate state agencies, as well as compliance with federal anti-trust laws and regulations;

(4) An assessment of the competitive practices of these organizations and the impact of these practices on the price and quality of health care in Hawaii, including those which may limit access to health care coverage or increase health care costs;

(5) An assessment of the impact on competition, quality, and cost of health care that the dual role that many of these organizations carry out may have in both the provision of health care services and payment for services delivered; and

(6) Recommendations for guidelines (if any) for the oversight of the practices of these organizations in order to protect the public interest and assure access to affordable, quality health care in Hawaii;

and

BE IT FURTHER RESOLVED that the Office of Consumer Protection, the Department of Commerce and Consumer Affairs, the Insurance Commissioner, the State Health Planning and Development Agency (SHPDA), the Department of Labor and Industrial Relations, the Department of Health, and other relevant public agencies, and all private health insurers, HMO's, and other packaged benefit providers in the private sector, are requested to cooperate with the Legislative Reference Bureau in conducting this study; and

BE IT FURTHER RESOLVED that Phase I of this study involving subjects 1, 2, and 3 be completed and submitted to the Legislature no later than twenty days prior to the convening of the Regular Session of 1995; and

BE IT FURTHER RESOLVED that Phase II of the study involving subjects 4, 5, and 6 be completed and submitted to the Legislature no later than twenty days prior to the convening of the Regular Session of 1996; and

BE IT FURTHER RESOLVED the Legislative Reference Bureau conduct this study by using to the extent feasible national standards of measurement, state experiences, or other data sets; and

BE IT FURTHER RESOLVED that certified copies of this Resolution be transmitted to the Director of the Legislative Reference Bureau, the Hawaii Medical Service Association, the Kaiser Foundation Health Plan, the Director of the Office of Consumer Protection, the Director of Commerce and Consumer Affairs, the Insurance Commissioner, the Director of Labor and Industrial Relations, the Director of Health, the Hawaii Association of Health Underwriters, and the Administrator of SHPDA.

Appendix 2

LAHCC/LISTS 5/6/94

APPROVED HEALTH CARE PLANS

Contractor	Plan(s)	Type
Aetna Life Insurance Company	Plan 1	(7a)
	Plan 2	(7a)
	Plan 3	(7a)
	AEcono-Med-A	(7a)
	Plan MCP-150	(7b)
BestCare	Plan A	(7a)
	Share Plan T-1	(7b)
Hawaii Medical Service Association (HMSA)	Plan 4/01	(7a)
	Plan A	(7a)
	Plan 9	(7b)
	Plan 7*	(7a)
	Plan 3	(7a)
	HMO Hawaii	(7b)
	Plan Med 1	(7b)
	Preferred Provider Plan A	(7a)
	Preferred Provider Plan C	(7b)
Hawaii Management Alliance Association	Option Plus	(7a)
	Exclusive Provider Option	(7b)
HDS Medical	Plan 400	(7a)
	Plan 700(A)	(7a)
	Plan 600	(7a)
Health Plan Hawaii	Conversion Plan (Plan 5/Basic)	(7b)
Island Care	HI Option	(7a)
	Health Plan 1	(7a)
	Health Plan 2	(7b)
	K2	(7b)
	K3	(7a)

*union

Contractor	Plan(s)	Type
Kaiser Foundation Health Plan, Inc.	Plan B	(7a)
	Plan A	(7b)
	Plan C	(7a)
	Plan G	(7b)
Nippon Life Insurance Company of America	NLIA Plan I	(7a)
Pacific Group Medical Association	Platinum Plan	(7a)
Pacific Health Care	Pacific Health Care Plan	(7b)
Principal Mutual Life Ins. Co. (Bankers Life Company)	Plan PAT 500	(7a)
	Comprehensive	(7a)
	PEP Plan	(7b)
	Comprehensive Plan Plan 150CC	(7b)
	Comprehensive Plan 100-7A	(7a)
	Comprehensive Plan 100-EL	(7b)
	Comprehensive Plan CM200	(7b)
	UMEG-CC50 A	(7a)
	UMEG-CC50 B	(7b)
	UMEG-100A	(7a)
	UMEG-100B	(7b)
	UMEG-200	(7b)
	IEA 100-Option 500A	(7a)
	-Option 500B	(7b)
	-Option 750	(7b)
	-Option 1250	(7b)
	IEA 150	(7b)
Straub Clinic & Hospital	Straub Health Plan	(7b)
The Travelers Insurance Co.	Plan 11	(7b)
	Plan XIX	(7a)
	Plan XX	(7a)
	Plan XXI	(7b)
	Plan XXIII	(7a)
	Plan Q-1	(7a)
	Plan Q-2	(7a)
	Plan M-1	(7a)
	Plan M-2	(7b)
	Plan N-1	(7b)
	Plan N-2	(7b)

Appendix 3

SUBCHAPTER XI--HEALTH MAINTENANCE ORGANIZATIONS

CROSS REFERENCES

Guarantee of principal and interest on mortgages as function of National Mortgage Association, see 12 USCA § 1721.

Qualified health maintenance organization defined for purposes of state plans for medical assistance, see 42 USCA § 1396a.

§300e. Requirements of health maintenance organizations

(a) "Health maintenance organization" defined

For purposes of this subchapter, the term "health maintenance organization" means a public or private entity which is organized under the laws of any State and which (1) provides basic and supplemental health services to its members in the manner prescribed by subsection (b) of this section, and (2) is organized and operated in the manner prescribed by subsection (c) of this section.

(b) Manner of supplying basic and supplemental health services to members

A health maintenance organization shall provide, without limitations as to time or cost other than those prescribed by or under this subchapter, basic and supplemental health services to its members in the following manner:

(1) Each member is to be provided basic health services for a basic health services payment which (A) is to be paid on a periodic basis without regard to the dates health services (within the basic health services) are provided; (B) is fixed without regard to the frequency, extent, or kind of health service (within the basic health services) actually furnished; (C) except in the case of basic health services provided a member who is a full-time student (as defined by the Secretary) at an accredited institution of higher education, is fixed under a community rating system; and (D) may be supplemented by additional nominal payments which may be required for the provision of specific services (within the basic health services), except that such payments may not be required where or in such a manner that they serve (as determined under regulations of the Secretary) as a barrier to the delivery of health services. Such additional nominal payments shall be fixed in accordance with the regulations of the Secretary. If a health maintenance organization offers to its members the opportunity to obtain basic health services through a physician not described in subsection (b)(3)(A) of this section, the organization may require, in addition to payments described in clause (D) of this paragraph, a reasonable deductible to be paid by a member when obtaining a basic health service from such a physician. A health maintenance organization may include a health service, defined as a supplemental health service by section 300e-1(2) of this title, in the basic health services provided its members for a basic health services payment described in the first sentence. In the case of an entity which before it became a qualified health maintenance organization

(within the meaning of section 300e-9(d) of this title) provided comprehensive health services on a prepaid basis, the requirement of clause (C) shall not apply to such entity until the expiration of the forty-eight month period beginning with the month following the month in which the entity became such a qualified health organization. The requirements of this paragraph respecting the basic health services payment shall not apply to the provision of basic health services to a member for an illness or injury for which the member is entitled to benefits under a workmen's compensation law or an insurance policy but only to the extent such benefits apply to such services. For the provision of such services for an illness or injury for which a member is entitled to benefits under such a law, the health maintenance organization may, if authorized by such law, charge or authorize the provider of such services to charge, in accordance with the charges allowed under such law, the insurance carrier, employer, or other entity which under such law is to pay for the provision of such services or, to the extent that such member has been paid under such law for such services, such member. For the provision of such services for an illness or injury for which a member is entitled to benefits under an insurance policy, a health maintenance organization may charge or authorize the provider of such services to charge the insurance carrier under such policy or, to the extent that such member has been paid under such policy for such services, such member.

(2) For such payment or payments (hereinafter in this subchapter referred to as "supplemental health services payments") as the health maintenance organization may require in addition to the basic health services payment, the organization may provide to each of its members any of the health services which are included in supplemental health services (as defined in section 300e-1(2) of this title). Supplemental health services payments which are fixed on a prepayment basis shall be fixed under a community rating system unless the supplemental health services payment is for a supplemental health service provided a member who is a full-time student (as defined by the Secretary) at an accredited institution of higher education, except that, in the case of an entity which before it became a qualified health maintenance organization (within the meaning of section 300e-9(d) of this title) provided comprehensive health services on a prepaid basis, the requirement of this sentence shall not apply to such entity during the forty-eight month period beginning with the month following the month in which the entity became such a qualified health maintenance organization.

(3)(A) Except as provided in subparagraph (B), at least 90 percent of the services of a physician which are provided as basic health services shall be provided through--

(i) members of the staff of the health maintenance organization,

(ii) a medical group (or groups),

(iii) an individual practice association (or associations),

(iv) physicians or other health professionals who have contracted with the health maintenance organization for the provision of such services, or

(v) any combination of such staff, medical group (or groups), individual practice association (or associations) or physicians or other health professionals under contract with the organization.

(B) Subparagraph (A) does not apply to the provision of the services of a physician--

(i) which the health maintenance organization determines, in conformity with regulations of the Secretary, are unusual or infrequently used, or

(ii) which are provided a member of the organization in a manner other than that prescribed by subparagraph (A) because of an emergency which made it medically necessary that the service be provided to the member before it could be provided in a manner prescribed by subparagraph (A).

(C) Contracts between a health maintenance organization and health professionals for the provision of basic and supplemental health services shall include such provisions as the Secretary may require, but only to the extent that such requirements are designed to insure the delivery of quality health care services and sound fiscal management.

(D) For purposes of this paragraph the term "health professional" means physicians, dentists, nurses, podiatrists, optometrists, and such other individuals engaged in the delivery of health services as the Secretary may by regulation designate.

(4) Basic health services (and only such supplemental health services as members have contracted for) shall within the area served by the health maintenance organization be available and accessible to each of its members with reasonable promptness and in a manner which assures continuity, and when medically necessary be available and accessible twenty-four hours a day and seven days a week, except that a health maintenance organization which has a service area located wholly in a nonmetropolitan area may make a basic health service available outside its service area if that basic health service is not a primary care or emergency health care service and if there is an insufficient number of providers of that basic health service within the service area who will provide such service to members of the health maintenance organization. A member of a health maintenance organization shall be reimbursed by the organization for his expenses in securing basic and supplemental health services other than through the organization if the services were medically necessary and immediately required because of an unforeseen illness, injury, or condition.

(5) To the extent that a natural disaster, war, riot, civil insurrection, or any other similar event not within the control of a health maintenance organization (as determined under regulations of the Secretary) results in the facilities, personnel, or financial resources of a health maintenance organization not being available to provide or arrange for the provision of a basic or supplemental health service in accordance with the requirements of paragraphs (1) through (4) of this subsection, such requirements only require the organization to make a good-faith effort to provide or arrange for the provision of such service within such limitation on its facilities, personnel, or resources.

(c) Organizational requirements

Each health maintenance organization shall--

(1)(A) have--

(i) a fiscally sound operation, and

(ii) adequate provision against the risk of insolvency,

which is satisfactory to the Secretary, and (B) have administrative and managerial arrangements satisfactory to the Secretary;

(2) assume full financial risk on a prospective basis for the provision of basic health services, except that a health maintenance organization may (A) obtain insurance or make other arrangements for the cost of providing to any member basic health services the aggregate value of which exceeds $5,000 in any year, (B) obtain insurance or make other arrangements for the cost of basic health services provided to its members other than through the organization because medical necessity required their provision before they could be secured through the organization, (C) obtain insurance or make other arrangements for not more than 90 per centum of the amount by which its costs for any of its fiscal years exceed 115 per centum of its income for such fiscal year, and (D) make arrangements with physicians or other health professionals, health care institutions, or any combination of such individuals or institutions to assume all or part of the financial risk on a prospective basis for the provision of basic health services by the physicians or other health professionals or through the institutions;

(3)(A) enroll persons who are broadly representative of the various age, social, and income groups within the area it serves, except that in the case of a health maintenance organization which has a medically underserved population located (in whole or in part) in the area it serves, not more than 75 per centum of the members of that organization may be enrolled from the medically underserved population unless the area in which such population resides is also a rural area (as designated by the Secretary), and (B) carry out enrollment of members who are entitled to medical assistance under a State plan approved under Title XIX of the Social Security Act [42 U.S.C.A. § 1396 et seq.] in accordance with procedures approved under regulations promulgated by the Secretary;

(4) not expel or refuse to re-enroll any member because of his health status or his requirements for health services;

(5) be organized in such a manner that provides meaningful procedures for hearing and resolving grievances between the health maintenance organization (including the medical group or groups and other health delivery entities providing health services for the organization) and the members of the organization;

(6) have organizational arrangements, established in accordance with regulations of the Secretary, for an ongoing quality assurance program for its health services which program (A) stresses health outcomes, and (B) provides review by physicians and other health professionals of the process followed in the provision of health services;

(7) adopt at least one of the following arrangements to protect its members from incurring liability for payment of any fees which are the legal obligation of such organization--

(A) a contractual arrangement with any hospital that is regularly used by the members of such organization prohibiting such hospital from holding any such member liable for payment of any fees which are the legal obligation of such organization;

(B) insolvency insurance, acceptable to the Secretary;

(C) adequate financial reserve, acceptable to the Secretary; and

(D) other arrangements, acceptable to the Secretary, to protect members,

except that the requirements of this paragraph shall not apply to a health maintenance organization if applicable State law provides the members of such organization with protection from liability for payment of any fees which are the legal obligation of such organization; and

(8) provide, in accordance with regulations of the Secretary (including safeguards concerning the confidentiality of the doctor-patient relationship), an effective procedure for developing, compiling, evaluating, and reporting to the Secretary, statistics and other information (which the Secretary shall publish and disseminate on an annual basis and which the health maintenance organization shall disclose, in a manner acceptable to the Secretary, to its members and the general public) relating to (A) the cost of its operations, (B) the patterns of utilization of its services, (C) the availability, accessibility, and acceptability of its services, (D) to the extent practical, developments in the health status of its members, and (E) such other matters as the Secretary may require.

The Secretary shall issue regulations stating the circumstances under which the Secretary, in administering paragraph (1)(A), will consider the resources of an organization which owns or controls a health maintenance organization. Such regulations shall require as a condition to consideration of resources that an organization which owns or controls a health maintenance organization shall provide satisfactory assurances that it will assume the financial obligations of the heath maintenance organization.

(July 1, 1944, c. 373, Title XIII, § 1301, as added Dec. 29, 1973, Pub.L. 93-222, § 2, 87 Stat. 914, and amended Oct. 8, 1976, Pub.L. 94-460, Title I, §§ 101, 102(a), 103, 105(a), 90 Stat. 1945-1947; Nov. 1, 1978, Pub.L. 95-559, §§ 9(b), 10, 11(a)-(d), 92 Stat. 2137-2139; July 10, 1979, Pub.L. 96-32, § 2(b), 93 Stat. 82; Aug. 13, 1981, Pub.L. 97-35, Title IX, § 942(a)(1), (2), (b)-(e), 95 Stat. 573, 574; Oct. 24, 1988, Pub.L. 100-517, §§ 2-3, 4(a), 5(a)(1), (2), (b), 102 Stat. 2578, 2579.)

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