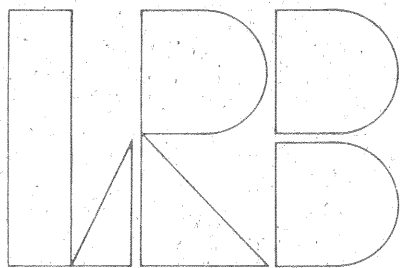


# COMPETITIVE PRACTICES IN HAWAII'S HEALTH CARE INDUSTRY



LEGISLATIVE REFERENCE BUREAU / STATE OF HAWAII / 1996



# 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.

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15. Establishing a format for, and compiling and publishing an index of, rules adopted under the Administrative Procedure Act.

# **COMPETITIVE PRACTICES IN HAWAII'S HEALTH CARE INDUSTRY**

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**Report No. 2, 1996**

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## **FOREWORD**

This is the concluding section of a two-part study examining competition among the organizations that offer prepaid health plans in Hawaii. This section provides an overview and update of material presented in the preceding report, and identifies some of the competitive practices that concern those active in the industry. The perspectives of plan providers, the state agencies charged with regulating providers, and the employers who purchase health plans for their employees are examined.

The final chapter presents findings and recommendations for consideration by the Legislature that address issues raised in both parts of the study. The recommendations are directed toward strengthening state oversight of the financial practices of health plan providers and establishing uniform requirements for the different types of organizations active in the industry.

We extend our sincere appreciation to the following for their assistance and cooperation during this study: the Hawaii State Departments of Health and Labor and Industrial Relations; the State Insurance Commissioner's Office; Hawaii Medical Service Association; Hawaiian Electric Industries, Inc.; Kaiser Permanente, Hawaii Region; Hawaii Association of Health Underwriters; Queen's Health Systems; Small Business Hawaii; and Straub Clinic and Hospital.

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## **CHAPTER 1**

### **INTRODUCTION**

House Resolution No. 200, H.D. 3 (see Appendix A), adopted by the state House of Representatives during the 1994 Regular Session, requested the Legislative Reference Bureau to conduct a two-part study to examine the relationships between health plan administration and health care providers, the competitive environment and practices in the State's health plan market place, and the impact and level of state oversight of the industry.

Part I of the study, *Factors Influencing Competition Among Health Plan Providers*,<sup>1</sup> was completed last year and the interim findings of that report are included in chapter 2. This report constitutes part II of the project and covers the competitive practices and state oversight elements of the study. The part I report is an integral part of this study and readers are urged to consider the findings and recommendations in the context of both the part I and part II reports.

#### **Study Parameters and Approach**

This report updates the significant changes in the material presented in the 1994 study, examines competitive practices, and how those practices are perceived by those involved in or with the industry. It continues use of the "producer-product-consumer" economic model used in the part I report, with emphasis being placed on the consumer element. The concluding chapter presents a suggested perspective from which to consider issues relating to the prepaid health plan industry as well as specific recommendations for legislative consideration. This chapter addresses issues covered in both parts of the study.

Interviews were used extensively in order to identify the views and concerns of those actually involved in the day-to-day operations of health plan providers. While a number of questionable practices were identified and are described in the report, it must be noted that this report does not attempt to confirm whether or to what extent they may, in fact, occur. Because they are perceived to be "real" elements of the competitive environment, the market place acts and re-acts accordingly.

#### **Endnotes**

1. Nell A. Cammack, *Factors Influencing Competition Among Health Plan Providers*, Legislative Reference Bureau, Report No. 11 (Honolulu: 1994).

## Chapter 2

### OVERVIEW OF PART I REPORT

*Factors Influencing Competition Among Health Plan Providers*<sup>1</sup> was the first of a two part study requested by the 1994 regular session of the Legislature in H.R. No. 200, H.D. 3. The resolution requested that the Legislative Reference Bureau examine competition among the organizations that offer group health plans in Hawaii and that the first part of the study address the general environment within which health plan providers operate and the features of that environment that influence competition among plan providers.

Specifically, H.R. No. 200, H.D. 3 (1994), requested 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.

The resolution reflects concerns about the relationships between the organizations that administer health plans and health plan 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 different aspects of the industry.

#### Part I Study Parameters and Approach

Part I of the study examined the issues raised in the context of a simple product-producer-consumer economic model where health plans are "products", the entities that offer plans are "producers", and employers constitute the largest group of "consumers". The product and producer elements of the model were examined, identifying the key state statutory and regulatory provisions that influence the business environment, the characteristics of the health plan marketplace, and the structure of the organizations active in that marketplace. In order to simplify one set of variables in the product-producer-consumer model, the report focused on employer-sponsored prepaid health plans. The approach allowed the issues of competition to be examined in a situation where producers are marketing comparable products. The approach is continued in the current report.

Hawaii's Prepaid Health Care Act<sup>2</sup> (PHCA), chapters 431 and 432 of the Hawaii Insurance Code (Code), and their implementing rules form the basic statutory environment within which health plan providers operate. The PHCA sets minimum coverage requirements, and defines the employees and employers subject to its provisions. It is administered by the Department of Labor and Industrial Relations. The Code regulates the financial practices of



## OVERVIEW OF PART I REPORT

organizations that offer health plans that indemnify insured individuals. Commercial insurers, mutual insurers, mutual benefit societies, and fraternal benefit societies are subject to the Code. (Beginning January 1, 1996, health maintenance organizations (HMOs) are similarly regulated by the Insurance Commissioner.<sup>3</sup>)

A discussion of the indemnity and HMO methods of delivering health plans, and the three basic rate setting methodologies are also covered in the Part I report.

The report describes the market for health plans and the contractors active in that market, including the organizational structure, finances, operations, and rate-setting methodologies of a sampling of health plan providers.

The Part I interim findings are as follows:

### 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 to 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 that 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 addition 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. 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 to employees. PHCA also defines the maximum amount of cost-share with 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 policyholders. 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 of all groups 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.

## OVERVIEW OF PART I REPORT

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.<sup>4</sup> 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.

### Endnotes

1. Nell A. Cammack, *Factors Influencing Competition Among Health Plan Providers*, Legislative Reference Bureau, Report No. 11 (Honolulu: 1994).
2. *Hawaii Rev. Stat.*, chap. 393.
3. Act 179, 1995 Haw. Sess. Laws.
4. Beginning January 1, 1996, HMOs are subject to regulation under the provisions of Act 179, 1995 Hawaii Session Laws.

## Chapter 3

### UPDATE

Part I of this study, entitled *Factors Influencing Competition Among Health Plan Providers*,<sup>1</sup> was completed in late 1994. The following items update the material presented in that report.

#### Chapters 2 and 3--State Law; Health Maintenance Organizations

Chapter 2 examined the exiting state laws that address health plan content and the organizations that offer plans. Chapter 3 described the operational characteristics of health maintenance organization (HMO) plans as distinguished from traditional indemnity coverage.

#### Health Maintenance Organization Act

House Bill No. 1918, H.D. 2, S.D. 1, was passed during the 1995 regular session of the Legislature and enacted as Act 179. This measure established a new chapter of the *Hawaii Revised Statutes* providing for the regulation of health maintenance organizations to become effective January 1, 1996. The measure, as passed, is substantially similar to part 1 of H.B. No. 3430, H.D. 2, S.D. 2, passed during the 1994 regular session but subsequently vetoed by the Governor.<sup>2</sup>

Section 1 of Act 179 defines an HMO as "...any person that undertakes to provide or arrange for the delivery of basic health care services to enrollees on a prepaid basis, except for enrollee responsibility for copayments, deductibles, or both."

The key provisions of Act 179:

- Require all HMOs to obtain a certificate of authority from the Insurance Commissioner.
- Set forth the powers of HMOs.
- Require HMOs to file the same annual reports as are required for commercial insurers.
- Require HMOs to have an initial net worth of \$1.5 million with subsequent upward adjustment of this amount under certain conditions.
- Provide that enrollees shall not be liable to health care providers for sums owed by the HMO.
- Guarantee continued coverage for the enrollees of an insolvent HMO.

- Allow insurers licensed in the state, hospital or medical service corporations or their subsidiaries or affiliates to organize and operate an HMO.
- Authorize the Insurance Commissioner to examine the affairs of HMOs and any providers with whom they have contracts, agreements, or the like.
- Require HMOs to have annual audits conducted by a certified public accountant. The Insurance Commissioner must be given the name and address of the audit firm selected by the HMO and may disapprove the selection within fifteen days of such notification.

As noted in the interim findings of Part I of this study, the financial and organizational elements of HMOs were not subject to state regulation prior to enactment of this measure. By defining HMOs, establishing financial standards, and giving the Insurance Commissioner regulatory authority over their basic financial practices, the new law establishes comparable requirements for all health plan providers regardless of their business structure or method of service delivery.

While the HMO Act takes effect January 1, 1996, administrative rules to implement its provisions have not yet been adopted.

## **Chapter 6—Health Plan Providers**

This chapter described the organization, operations, rate setting methodology, and finances of a sampling of the State's health plan providers. Developments during the past year in this area include the following.

### **Hawaii Medical Service Association (HMSA)**

#### ***Operations***

A new plan, HealthLink, was developed in cooperation with the Hawaii Business Health Council.<sup>3</sup> It is an HMO that includes a "point-of-service" option. This allows members to receive benefits outside the plan's health center, in effect, adding an indemnity type option to the basic HMO service package.<sup>4</sup> HealthLink took effect January 1, 1995 and is currently offered by Outrigger Hotels, four Hawaiian Electric Industries, Inc. subsidiaries, and four other companies.<sup>5</sup>

In April, a cap of 75,000 (with minor exceptions) on the number of QUEST clients that HMSA can enroll for the islands of Oahu, Kauai, and the Big Island, except for Ka'u. This, in effect, froze HMSA's QUEST enrollees at the current level.<sup>6</sup>

### *Finance*

In 1994, HMSA's operating revenues exceeded \$1 billion and its investments were valued at \$354 million. Net investment income dropped from \$30 million in 1993 to \$3 million in 1994.<sup>7</sup> This was the result of changes in the overall market and, according to the Insurance Commissioner, losses from its investments in volatile mortgage-based derivatives. Prior to release of the Commissioner's findings, the HMSA board of directors reviewed and revised its investment policies. Current policy limits investments in these types of securities to twenty-five percent of fixed income investments and prohibits investment in certain types of complex derivatives.<sup>8</sup> It should be noted that although HMSA's 1994 earnings from investments dropped, it still achieved a net gain of \$3 million. The Insurance Commissioner and HMSA's board of directors agree that the organization is financially sound.<sup>9</sup>

HMSA's federal tax liability increased from \$6 million in 1993 to \$9 million in 1994.<sup>10</sup>

### Hawaii Dental Services-Medical (HDS-Medical)

According to the 1994 Report of the Insurance Commissioner of Hawaii, HDS-Medical paid claims of \$10.7 million and wrote direct premiums totalling \$14.8 million as of December 31, 1993. They represent increases over the previous year. The Commissioner's report also indicates a net loss of \$1 million for HDS-Medical for 1993.

HDS-Medical declined requests for interviews for this study.

### Pacific Group Medical Association (PGMA)

PGMA became operational in September 1993. The Insurance Commissioner's 1994 Report reflects that in PGMA's first full year of operation it had assets of \$1 million, premiums written of \$882,000 and benefits paid of \$52,000. PGMA had a net gain for the year of \$60,000.

### Hawaii Management Alliance Association (HMAA)

The Insurance Commissioner's examination of HMAA in 1995 identified potential self-dealing as the result of fees and commissions paid to for-profit corporations controlled by HMAA's directors and officers. As of December 31, 1994, HMAA, a nonprofit mutual benefit society, provided health insurance coverage to approximately 13,000 members through 1,200 employers.<sup>11</sup>

On December 31, 1993, HMAA's financial condition reflected a net loss of \$1 million according to the Insurance Commissioner's 1994 annual report.

HMAA did not respond to the requests for an interview for this study.

## **Kaiser Permanente**

### ***Operations***

Kaiser Permanente's Hawaii operations added two clinics for a total of fourteen and now serves all four counties. It now markets its plans both directly and through agents.<sup>12</sup> Previously Kaiser Permanente did not use agents in its marketing strategy.

In 1994, Kaiser Permanente began a two-year "point-of-service" pilot program for members whose employers belong to Small Business Hawaii. Under the new option, the patient pays for services of non-Kaiser care and is reimbursed by Kaiser for a percentage of the cost.<sup>13</sup> Like HMSA's HealthLink, this is a product that combines HMO and indemnity coverage.

In September 1995, Kaiser Permanente and Queen's Medical Center joined to contract with the Hana Medical Center to provide physician administrative services in Hana, Maui. HMSA and HDS-Medical agreed to honor billings from Kaiser Permanente for services provided under this agreement.<sup>14</sup>

Kaiser Permanente has started issuing annual reports on quality of medical care. The reports compare key indicators of quality of care provided by Kaiser with care provided generally in Hawaii and nationally. Reports of this type are increasingly used on the mainland to help consumers evaluate different health plans.<sup>15</sup>

### ***Finance***

Nationally, Kaiser Permanente's assets exceeded \$10 billion, with cash and marketable securities amounting to \$2 billion and revenues of \$12.3 billion in 1994. These figures all represent increases over those for 1993. Similarly, the Hawaii Region's 1994 revenues of \$367 million, member dues of \$276 million and expenses of \$334 million were all greater than the figures for 1993.<sup>16</sup>

## **Straub Clinic and Hospital**

### ***Operations***

Straub has ten clinics in addition to its main hospital and offers two HMO plans one of which was approved in 1995 and offers lower copayments than that provided under their original HMO plan. Membership in the original plan remains at an estimated 3,500. Straub is a QUEST provider serving some 5,000 members.

### The Queen's Health Systems (QHS)

#### *Operations*

QHS formed a new HMO, Queen's Hawaii Care, to serve Department of Human Services clients under the State's QUEST program. The new HMO has some 29,000 members as of December 1995.<sup>17</sup>

As noted in the preceding discussion of Kaiser Permanente, Queen's and Kaiser have joined to provide medical and administrative services for the Hana Medical Center.

### AlohaCare

AlohaCare is a new Hawaii-based HMO organized to serve QUEST clients. It contracts with 400 participating physicians and has two main service centers in Waimanalo and Waianae. AlohaCare has more than 20,000 members on Oahu, Kauai, and the Big Island.<sup>18</sup>

## **Chapter 7--The Competitive Environment**

This chapter discussed the national and local factors that characterize and help shape today's health plan marketplace.

### National Factors

#### *Insurers and Managed Care*

Hawaii's health plan market place continues to be dominated by HMSA and Kaiser Permanente, both of which are nonprofit organizations. Commercial insurers and for-profit HMOs are not significant factors in the State. This is the reverse of national trends which reflect dominance by commercial insurers and for-profit HMOs, and market consolidation through mergers between the two types of plan providers.

In 1994, the nation's largest HMO organization, United Healthcare Corporation, purchased Metrahealth, a traditional indemnity insurer. The merger created America's largest provider of health plans. (Metrahealth was only one year old having been formed by an earlier merger of health insurance elements from Metropolitan Life and Travelers. It has one plan approved by the Department of Labor and Industrial Relations under the Prepaid Health Care Act.) When combined, the two organizations have revenues of \$2 billion, net income of \$129 million and membership of 14 million. By comparison, at the end of 1994, Cigna and Aetna, which are also large, publicly traded for-profit health plan providers, had 3.3 and 3.0 million members respectively.<sup>19</sup> While these national companies all operate preferred provider networks in Hawaii, their market shares are less than two percent.<sup>20</sup>



## **CHAMPUS**

The Civilian Health and Medical Plan for the Uniformed Services (CHAMPUS) is the federally controlled health plan for some 82,000 military family members in Hawaii. The award, in 1994, of the contract to Aetna Government Health Plans in association with HMSA was challenged by an unsuccessful bidder. The challenge was upheld and the Hawaii subcontract is now with the Queen's Health Systems.<sup>21</sup>

### **Local Factors**

#### ***State Oversight***

Act 179, Session Laws of Hawaii 1995, the Health Maintenance Organization Act is to become fully effective January 1, 1996. The new law will give the Insurance Commissioner regulatory authority over the financial activities of HMOs similar to that currently in effect for commercial insurers and mutual benefit societies.

#### ***Provider Practices***

The distinction between traditional indemnity coverage and the HMO capitated payment system becomes less clear as insurers develop HMO products and HMOs include indemnity coverage in their plans. Some Blue Cross/Blue Shield organizations on the mainland are developing Integrated Delivery Network (IDN) alliances each of which is designed somewhat differently in response to local conditions.<sup>22</sup> The focus of IDNs is the delivery of managed care within a structured network that can offer plan members a broad choice of care providers. Ideally, physicians and other care providers, hospitals, and plan administrators, are all equal players in the system. IDN is a flexible concept and administrative participation for an individual network is reflected in the membership of its board of directors.<sup>23</sup> Locally, the Hawaii Business Health Council, HMSA, and some Honolulu hospitals are currently exploring the possibility of developing IDNs. An organization's affiliation with an IDN is not exclusive and members may participate in several networks.

Kaiser Permanente's new "point-of-service" pilot plan and HMSA's HealthLink are further examples where the once clear line between HMO and indemnity plans is starting to blur.

#### ***Vision 2000<sup>24</sup>***

On September 8, 1995 a conference was held to identify key issues in the area of health, and develop strategies to address those issues. The conference was an initiative of the private sector and was a collaborative effort of the business community and the health care industry. The conference resulted from the work of task forces focusing on efficiency, the medical/legal environment, cost shifting, human resources, consumer education, and

implementation. They had met during the prescribing year to develop reference and recommendations. The Hawaii Health Council was formed as a result of the conference.

### Legislative Proposals

Senate Bill No. 1233, as introduced during the 1995 Regular Session, provided for the regulation of HMOs and also included provisions requiring mutual benefit societies to file either schedules of rate premiums or the rate setting methodology with the Insurance Commissioner. It also gave the Commissioner authority to disapprove the filings if the result would be excessive, inadequate or unfairly discriminatory. The HMO regulation section of the bill was enacted as Act 179, Session Laws of Hawaii 1995. Senate Bill No. 1233, S.D. 2, H.D. 2, was pending conference committee referral at the close of the 1995 Special Session. In that form both the rate and HMO regulation sections had been deleted from the bill, leaving it vehicle for other regulatory items. It may be further amended to re-visit the issues of rate regulation during the 1996 regular session.

The House Committees on Consumer Protection and Judiciary deleted the rate regulation provisions from the Senate bill, noting in House Standing Committee Report No. 1150, dated March 23, 1995, that HMSA had testified that it was not fair to impose these requirements on only one segment of the health plan industry.

### Endnotes

1. *Factor Influencing Competition Among Health Plan Providers*, Legislative Reference Bureau (Honolulu: 1994), Report No. 11.
2. House Bill No. 3430 included a second part that would have regulated mutual benefit societies' premium rate-making procedures. The Governor's veto message stated that the veto was based on the fact that funds were not provided to implement part 2 of the measure.
3. The Hawaii Business Health Council was formed about five years ago by several of the larger employers in Hawaii. Its members include representatives from the major banks, utilities, and visitor industry. The group's primary interest is health care cost containment.
4. *1994 Annual Report and Financial Highlights*, Hawaii Medical Service Association (Honolulu, undated), p. 7.
5. Letter from Stacy Evensen, HMSA, to Nell A. Cammack, November 27, 1995.
6. *Ibid.*, and *Honolulu Star Bulletin*, April 22, 1995.
7. *1994 Annual Report*, HMSA, pp. 12 and 13.
8. *Honolulu Star Bulletin*, July 4, 1995; and memorandum from Stacy Evensen, HMSA, to Nell Cammack, December 14, 1995.
9. Telephone interview with Wayne Metcalf, Hawaii Insurance Commissioner, November 12, 1995; and memorandum from Stacy Evensen, HMSA, to Nell Cammack, December 14, 1995.

UPDATE

10. 1994 Annual Report, HMSA, p. 12.
11. *Honolulu Star Bulletin*, September 19, 1995.
12. Letter from Lauren Toal, Kaiser Permanente, Department of Public Affairs to Nell A. Cammack, November 24, 1995.
13. *Honolulu Star Bulletin*, August 31, 1994.
14. *Honolulu Advertiser*, September 10, 1995.
15. *The Honolulu Advertiser*, September 26, 1995.
16. Toal letter, November 24, 1995.
17. Telephone interview with Richard M. Jackson, President and Chief Executive Officer, The Queen's Health Care Plan, November 15, 1995; letter from Richard M. Jackson to Nell A. Cammack, November 16, 1995.
18. *Honolulu Star Bulletin*, 1995. AlohaCare did not respond to written request for additional information.
19. *New York Times*, National Edition, June 6, 1994.
20. Letter from Richard M. Jackson, President and Chief Executive Officer, The Queen's Health Care Plan, to Nell A. Cammack, December 27, 1995.
21. Telephone interview with Richard M. Jackson, November 15, 1995.
22. Daniel B. Moskowitz, "Blues No Longer Health Care's Back Seat Driver," *Journal of American Health Care*, vol. 4, No. 5. September/October 1994, p. 19.
23. Interview with Stacy Evensen, M.S., Government Relations, Hawaii Medical Service Association, December 16, 1995.
24. "Vision 2000 Health Care Congress, Post-Congress Report," (Honolulu: October 27, 1995).

## Chapter 4

### COMPETITIVE PRACTICES

The standard techniques for marketing health plans include media advertisements, targeted mailings with follow up to employers, and personal presentations (either solicited by a potential client or initiated by the provider) by the providers' marketing or sales staff. Most plan providers also use independent health underwriting agents who develop accounts and are compensated by the provider on commission basis (usually three to seven percent per year of gross premiums<sup>1</sup>). While the State regulates minimum benefits for most employer-sponsored health plans, competition is possible in the areas of costs, coverage, and service delivery.

#### Premium Rates

Businesses consider health plan premiums as one of the most important elements in their selection of health plans. Similarly, steep increases in premium costs are cited as a major reason for changing health plan providers (see Chapter 5). Health plan providers consider their actuarial procedures and data to be proprietary information. Neither premium amounts nor the methodology used to calculate them are regulated by the State. Federally qualified health maintenance organizations (HMOs) must use one of the community rating methodologies set forth in the federal statutes.<sup>2</sup> Kaiser Permanente and HMSA's HMOs are federally qualified. Thus, outside the federal restrictions, rate setting in Hawaii is at the discretion of each plan provider so long as the revenues generated are sufficient to cover benefits and maintain the financial reserves and resources required by the state Insurance Code.

Those interviewed for this study described certain rate setting practices that they viewed as unfair. However, specific situations were not identified. Independent verification would require an extensive analysis of the financial records of plan providers that is beyond the scope of this study. Further, as is noted in the following descriptions, the imputed motive rather than the act alone, appears to be the element that brings some of the practices into question.

- Offering employers unrealistically low premiums for the first year or so to get them to change plan providers. Issues of fairness are raised when these "loss leader" incentives are funded with accumulated reserves, are unfunded, or are covered by actuarially unjustified rates imposed on other clients.
- Using excess reserves or other assets to subsidize rates. Equity is an issue if the clear purpose of a rate subsidy is to drive out competition in certain segments of the market.
- Treating actuarial data as proprietary. Clients cannot independently verify the actuarial basis for rate changes, particularly increases.

## COMPETITIVE PRACTICES

- Setting unreasonably high premiums for high risk or high utilization clients or client groups. The concept of prepaid group health care is based upon cost and risk sharing. "Skimming" or "cherry picking" distorts the distribution of more costly coverage and shifts it to other providers.

### Coverage

Hawaii's Prepaid Health Care Act<sup>3</sup> (PHCA) establishes the basic coverage for employer-sponsored health plans and provides for the Prepaid Health Care Advisory Council to advise the Director of the Department of Labor and Industrial Relations with regard to the comparability of new plans relative to the mandated coverage. In effect, "comparability" refers to Hawaii Medical Service Association (HMSA) Plan 4 and Kaiser Permanente Plan B. Applications for approval of new plans are submitted to the Department of Labor and Industrial Relations, reviewed by departmental staff, and submitted to the Council for its consideration and recommendation for approval or denial. The Director has, in most cases, accepted the Council's recommendation. The Council's seven members are appointed by the Director and represent a cross-section of the interests impacted by PHCA, with strong representation by the plan provider sector. At this writing the members are:

Paul A. Tom, President, Benefit Plans Consultants (Hawaii)

Michael Gold, Senior Vice President, HMSA

Dr. John T. McDonnell, Castle Professional Center

William W. H. Brown, Vice President, Human Resources, Outrigger Hotels

Nolan Namba, Health Plan Manager, Kaiser Permanente

Grace Abe, Personnel Officer, Queen's Medical Center

Shirley C. Wong, Principal Mutual Life Insurance Company<sup>4</sup>

The Council is generally considered to have substantial influence regarding plan approvals. Issues of competition and possible unfair advantage arise when:

- An applicant's request is to be evaluated by a group comprised of their competitor(s).
- Council members are asked to objectively evaluate applications from their own firms.

## Service Delivery

In order to compete successfully in the health plan market place, providers must be able to deliver appropriate services to the ultimate users and pay the care providers for their services. The comparative simplicity of the capitated payment system of the HMO when contrasted with the individual billings and payments required under an indemnity plan probably give the former a competitive edge in terms of lower administrative costs. However, user preference for the wider selection of care providers available under indemnity plans counters the administrative convenience of HMOs. Among indemnity plans, those that provide direct payment to participating care providers have a distinct advantage over those requiring the user to file a claim for reimbursement. This may, in part, account for the fact that commercial health insurers are not major players in Hawaii.

Service delivery does not appear to be a significant competitive factor in today's marketplace. However, should there be a move toward exclusive contracts between plan providers and health care professionals and facilities, this could change dramatically. Exclusive contracts with a single-plan provider could eventually result in a vertically integrated monopoly.

## Endnotes

1. Interview with Arnold Hirotsu, Hawaii Association of Health Underwriters, August 27, 1995.
2. 42 U.S.C.A. §300e.
3. *Hawaii Rev. Stat.*, chap. 393.
4. Membership confirmed by telephone interview with staff of Disability Compensation Division, Department of Labor and Industrial Relations, December 15, 1995.

## Chapter 5

### PERSPECTIVES ON COMPETITION

Opinions about competition in the health plan marketplace reflect the observer's position in the industry. Regulators' concerns center on the ability to enforce existing law and whether the laws adequately protect the public interest. Employers look for value for their premium dollar, an affordable product, and a marketplace that is responsive to their needs. Health plan providers want a "level playing field", the flexibility to design and deliver a product that is responsive to market demands, and a minimum of government regulation.

The characteristics of the marketplace itself also influence these views. As discussed in Part I of this study,<sup>1</sup> they include:

- Coverage for more than half the population is provided by a single plan provider, Hawaii Medical Service Association (HMSA). In addition, HMSA contracts with some other providers to administer their plans including actuarial analysis services. It is the fiscal intermediary for the federal Medicare program in Hawaii.
- More than ninety percent of health plan coverage is provided by or through tax exempt nonprofit entities. These providers are in direct competition with taxable commercial insurers and for-profit health maintenance organizations (HMOs).
- Hawaii's Prepaid Health Care Act (PHCA) requires that virtually all private sector employers provide comprehensive health care coverage for their employees, and defines the maximum amount of cost-sharing with employees.
- State programs offer comprehensive coverage to state and county workers, public assistance recipients, and low income individuals.
- State regulation of the industry is fragmented. Oversight in the area of health plan coverage provisions may be the responsibility of the Department of Labor and Industrial Relations, the Department of Human Services, or the Hawaii Public Employees Health Fund, depending upon the population served. Financial oversight is the responsibility of the state Insurance Commissioner in the case of mutual benefit societies, commercial insurers, and, as of January 1, 1996, health maintenance organizations. Determination of an organization's tax status is made by the Department of Taxation.

#### The Regulators' Perspective

##### Insurance Commissioner<sup>2</sup>

The Insurance Commissioner is charged with licensing and monitoring the financial practices of commercial insurers, nonprofit mutual benefit societies and, as of January 1, 1996, HMOs. Issues raised in interviews with the Commissioner and key staff include:

- HMSA's dominance of the marketplace can be compared to that of a public utility and may justify similar rate review and approval.
- The Insurance Commissioner's authority to monitor financial practices such as investment of reserves, maintenance of adequate reserves and unfair competitive practices varies, based upon whether the plan provider is a commercial insurer, HMO, or mutual benefit society. This authority does not extend to affiliated groups that may, in fact, be essential elements of a health plan provider's administration and service delivery. This limited authority is not sufficient to prevent or respond to possible failure of a plan provider due to poor financial management.
- The Insurance Commissioner has no authority to review rate setting methods or practices of health plan providers. Since health plan premiums are the primary source of providers operating revenues a key element of their financial picture is exempt from state oversight.

#### Department of Labor and Industrial Relations (DLIR)<sup>3</sup>

The federal Employees Retirement Income Security Act of 1974 (ERISA) had the effect of freezing Hawaii's Prepaid Health Care Act in its original form except as to nonsubstantive administrative amendments. This has prevented the State from statutorily updating its provisions. Thus, the Department is limited in its ability to respond to changing conditions. However, DLIR's Prepaid Health Care Advisory Council has supported and the Director has authorized a variety of plans which they have determined are comparable to the coverage set forth in PHCA.

#### **The Health Plan Providers' Perspective**

The perspectives of plan providers, including independent agents, reflect a highly competitive environment that, at the same time, involves affiliations and alliances among competing entities. The following issues were raised by the health plan providers who agreed to be interviewed for this study. Due to the sensitive nature of some of the issues raised, the comments have been consolidated and specific sources are not identified. However, a draft of this material was circulated for comment to all who participated in the study, and this section reflects their comments.

- Some plan providers find it unnecessarily difficult (as they see it) to get new plans approved by DLIR. Some believe that DLIR staff recommendations have an undue influence on the decisions of the Prepaid Health Care Council. There is concern that a provider's membership on the Council gives them an unfair advantage with regard to recommendations for approval or denial of plans.



## PERSPECTIVES ON COMPETITION

- While commercial insurers declined to participate in this study, it was suggested that their small share of the market could be attributed to the fact that they are subject to the state 4.265 percent gross premiums tax and cannot profitably compete in a market dominated by tax-exempt providers. Reluctance to market plans in compliance with PHCA was also mentioned. Neither of these views has been confirmed by a representative of the industry.
- HMSA's large database of clients and service utilization gives it an unfair competitive edge in both rate and product design.
- As administrator for some competing health plans, HMSA has access to proprietary information that could be used unfairly.
- Some health plan providers avoid covering high risk groups in order to limit their exposure to costly claims. Plan providers that are new to the market or cover a small number of clients are more likely to practice this type of "skimming".
- While inadequate reserves could result in a provider being unable to meet its obligations, it is also possible for providers to accumulate excessive reserves and use them to subsidize or underprice their plans in order to drive out competition.

### The Employers' Perspective

#### Small Businesses

In a survey conducted for this study, small businesses were asked about their views regarding state regulation of health plan providers. The number of responses was disappointingly small. Of approximately sixty surveys distributed, only twelve responded (see Appendix B). The respondents were, with one exception, located on Oahu. Most had fewer than ten employees. However, four had more than ten. Three reported having an employee assigned full-time to human resource/personnel management tasks. The type of business of the respondents was quite diverse including manufacturing, retailing, construction, and professional service. None were unionized. The health plan providers serving the respondents were (in alphabetical order) HMAA, HMSA, Kaiser Permanente, PGMA, and Washington National Ins., and two reported that their plans were provided through a parent organization or business affiliation.

Generally, those who responded were satisfied with the level and impact of competition in the health plan marketplace, and they did not support state regulation of the industry. It is impossible to say whether the lack of response by the majority of those surveyed indicates a similar level of satisfaction. It is noteworthy, however, that given an opportunity to express their satisfaction or lack thereof with the health plan marketplace, few felt moved to complain. Specifically, the twelve responses received reflect the following positions.

## COMPETITIVE PRACTICES IN HAWAII'S HEALTH PLAN INDUSTRY

### *Competition*

- Nine believe that they have a good choice of plans and prices under existing conditions, that excessive competition is not a problem, and that competition among health plan providers has increased in the past five years.
- Only two felt that there is not real competition in the area of prices, while five felt that competitive benefit packages are not available.
- Seven supported a suggestion that more health plan providers be encouraged to enter the Hawaii marketplace.

### *State Regulation*

- None believed that health plan premiums should be regulated by the State.
- Only two supported regulation of rate setting methodologies, three were for regulation of plan providers' financial practices, with one respondent indicating a "maybe" on these issues.
- Ten respondents opposed setting a cap on the portion of the labor force that any one provider could cover.
- Eight felt that the State should encourage the formation of health plan purchasing alliances or cooperatives for small businesses and sole proprietorships.
- The respondents were split evenly on the question of the State defining and monitoring unfair competitive practices for health plan providers.

### *Past Experience*

- One-half of those responding had changed plan providers because of unacceptable rate increases and the provider's refusal to negotiate critical issues.
- Four indicated a change influenced by the availability of a competitive package offered by another provider.
- One had had a plan canceled and two changed providers because of poor plan administration.

***Plan Selection Factors***

- The three factors that most respondents considered most important in selecting a health plan were (1) the amount of premium, (2) plan benefits, and (3) the geographic area served.
- The factor of least importance in plan selection was the providers willingness to negotiate, with one respondent noting that providers refuse to negotiate.

**Large Businesses<sup>4</sup>**

Many of Hawaii's large employers have operated in the State for several decades and have long standing relationships with established health plan providers. They find that health plan providers are generally willing to negotiate on key issues. The larger enterprises are more likely to offer a variety of plans administered by different providers as well as a choice of plans from an individual provider. They are more likely to have a unionized labor force and include health benefits among collectively bargained items, and have full-time professional staff to develop and administer their employee benefits programs.

Dramatically rising health plan premiums in the late 1980s and early 1990s prompted formation of the Hawaii Business Health Council to examine the causes and possible solutions to the problem. Most of the State's large employers are represented on the Council. It provides a forum for its members to identify areas of common interest with regard to employee health issues, and to explore innovative options with health plan providers.

The HMSA HealthLink plan was developed in cooperation with the Council. It has also been active in discussions with HMSA and a number of health care providers relating to the possibility of forming Integrated Delivery Networks (see chapter 3). In these activities it functions as a purchasing alliance or cooperative.

The large employers share with their smaller colleagues the positions that:

- Further state regulation of health plan providers is not needed.
- Competition among health plan providers generates a good choice of health plans.
- Competition has increased significantly over the past several years.

They are concerned that:

- The Prepaid Health Care Council may be too conservative in its consideration of proposed new plans and coverage, and that conflicts of interest may occur in some instances.

## COMPETITIVE PRACTICES IN HAWAII'S HEALTH PLAN INDUSTRY

- As employers, they do not have access to sufficient health care utilization data to permit them to evaluate whether their health plan coverage is appropriate to the needs of their labor force. (It should be noted that HMSA will provide detailed peer utilization reports to its large, experience-rated accounts.)<sup>5</sup>

### Endnotes

1. Nell A. Cammack, *Factors Influencing Competition Among Health Plan Providers*, Legislative Reference Bureau, Report No. 11 (Honolulu: 1994).
2. Telephone interviews with Wayne Metcalf, Insurance Commissioner, November 21, 1995; and Paul Yuen, Staff Attorney, Office of the Insurance Commissioner, November 24, 1995 and December 7, 1995.
3. Interview with Gail Hiraishi, TDI Program Specialist, Department of Labor and Industrial Relations, August 11, 1994.
4. Interview with Peter C. Lewis, member, Hawaii Business Health Council and Vice President - Administration, Hawaiian Electric Industries, Inc., and Phyllis Okata, Human Relations Specialist, Hawaiian Electric Industries, Inc., November 28, 1995; and telephone interview with Lewis, November 29, 1995.
5. Interview with Stacy Evensen, M.S., Government Relations, Hawaii Medical Services Association, December 27, 1995.

## **Chapter 6**

### **ORGANIZATIONAL STRUCTURE AND COMPETITION**

The structure of an organization reflects its primary function or purpose, the relative importance the activities in which it is engaged, and the financial and professional assets available to its various enterprises. Its ability to respond to competitive forces in the marketplace is also shaped by its basic structure. Hawaii's health plan providers operate under a variety of organizational structures ranging from Kaiser Permanente's closely held vertically integrated health maintenance organization (HMO) to the multi-state commercial insurers for which Hawaii health plans are just one of a myriad of their financial products.

#### **Internal Organization**

As discussed in the interim findings for this study (see chapter 2), the State's health plan providers are organized as groups of affiliated corporations with the parent corporation being a regulated insurer, mutual benefit society, or hospital-based organization. The focus of the parent corporation, rather than organizational size, appears to be a principal factor in its ability to capture and retain a major share of the health plan market. The corporate focus guides the allocation of resources to support and promote its health plan products. Organizations that are involved in a variety of activities must resolve competing demands within the organization as well as face competition from other providers.

The fact the Hawaii Medical Service Association (HMSA) and Kaiser Permanente continue their historical domination of the market supports this assessment. HMSA's constitution and bylaws provide that it shall operate as a nonprofit medical indemnity and hospital service association and its resources are directed to that end.<sup>1</sup> Kaiser Permanente is organized to support its group practice prepayment system of comprehensive medical and hospital services.<sup>2</sup> In contrast, the Queen's Health System developed from the Queen's Hospital Corporation and the Queen Emma Trust established to support hospital and health care for Hawaiians. Its prepaid health plan and preferred provider network are not principal functions of the organization.<sup>3</sup> Commercial insurers are affiliations of numerous corporate entities organized to generate profits for their stockholders by marketing a variety of financial products. In Hawaii, health plans generally are not priority products for commercial insurers.

#### **Contractual Relationships**

All health plan providers in Hawaii contract with other plans or care providers, or both, for some aspects of their programs. These relationships are shaped by the areas of expertise and corporate focus of each organization and the types of health plan involved.

In general, the commercial insurers and mutual benefit societies' strength is plan administration, billing and account maintenance, marketing and investment activities. Some mutual benefit societies provide administrative and actuarial services to competing

## COMPETITIVE PRACTICES IN HAWAII'S HEALTH PLAN INDUSTRY

organizations and may lease their preferred provider networks (PPNs) to other plan providers. At least one hospital-based provider contracts out for plan administration while also participating in the PPN and HMOs of other health plans.

Only Kaiser Permanente uses exclusive contracts among its plan, hospital and physicians group to support its HMO. It does not administer other plans; the physicians group does not participate in other health plans; and the hospital and clinics serve only Kaiser Permanente members.<sup>4</sup> Its "stand alone" system appears to have a competitive advantage in the HMO market due to the fact that essential information can flow freely within the organization and is not accessible to its competitors. However, vertical integration based on exclusive relationships is costly in that it must support its own service delivery system. The capital investment needed reflects a long term commitment to the program.

Contracting out elements of a plan that are beyond the provider's basic expertise and resources is the more common practice and allows programs to develop and change in response to market conditions.

Hawaii's existing network of changing contractual relationships among plan providers leaves the providers simultaneously cooperating and competing. Tensions exist in this environment where one party may be suspected of looking to its own interests first and its contractual obligations second.

### Tax Status

The taxes imposed upon a plan provider are cost elements of their plans and the ability to take advantage of tax exemptions clearly gives a competitive advantage to an organization. The tax status of plan providers depends upon the statutory provision under which it is formally organized.

- Mutual benefit societies are exempt from all state and county taxes except unemployment compensation if they are organized solely as nonprofit medical indemnity or hospital service associations.<sup>5</sup> (They may also be exempt from federal income tax.<sup>6</sup>)
- Regulated insurers are taxed 4.265 percent of their gross premiums (less returned premiums) procured or received in the State.<sup>7</sup> This tax is in lieu of other state and county taxes.
- Federal law treats insurance companies and for-profit corporations involved in health plans and health care delivery as taxable. However, health care is generally considered a charitable activity and may qualify as an exempt activity under section 501(c)(3) of the Internal Revenue Code. The State generally conforms with federal determinations of tax exempt status.

With the exception of Straub Clinic and Hospital, Hawaii's health plan providers are organized as affiliated groups of both taxable and nontaxable organizations. Hawaii Medical

## ORGANIZATIONAL STRUCTURE AND COMPETITION

Service Association (HMSA) is a state tax-exempt mutual benefit society with taxable subsidiaries. Kaiser Permanente is an affiliation of three corporations one of which is taxable. Queen's Health Systems is a hospital-based system of some twenty taxable and non-taxable privately held corporations associated with the Queen Emma Trust. The Straub Clinic and Hospital is a privately held for-profit corporation. Hawaii Dental Services - Medical, Hawaii Management Alliance Associations, and Pacific Group Medical are mutual benefit societies.<sup>8</sup>

### HMOs and Indemnity Plans

Under the HMO capitated payment system there are direct contractual obligations between the policy holder and the plan, and between the plan and specific health care providers. Efficiencies are possible in the area of administration because a much simpler billing and claims system is possible. Also, under HMO plans, incentives for over utilization of services or facilities are minimized. (Critics of the HMO system claim that its organizational incentive is to provide less care than may be medically appropriate.)

In an effort to realize comparable efficiencies, indemnity plans have developed refinements to the historic system under which the policy holder is reimbursed a set amount for each covered event and the insurer merely confirms that the service was provided. PPNs are a major innovation in this regard. The indemnity plan contracts with networks of care providers and facilities to provide services to policy holders at reduced rates, and encourages its policy holders to use their preferred providers. Usually, preferred providers bill the plan directly for services. This speeds payment processing to the provider and relieves plan members of the responsibility for filing claims. (This also serves as an incentive to care providers to join a plan's provider network.)

Indemnity plan providers are exploring other approaches to better control costs and care utilization. Integrated Delivery Networks (IDNs) (see chapter 3) reflect a growing interest in developing formal organizational relationships among insurers, health care professionals and facilities and plan purchasers. IDNs generally seek to achieve the efficiencies of HMOs without the capitated payment system.

A provider may offer both indemnity and HMO health plans and a variety of either type so long as they are properly licensed by the insurance commissioner. Employer-sponsored plans must be approved by the Hawaii Department of Labor and Industrial Relations pursuant to the Prepaid Health Care Act.

### Regulation of Organizations

Prior the enactment of Act 179, Session Laws of Hawaii 1995, the 1995 HMO Regulation Act, HMOs were not subject to state regulatory oversight with regard to their operations or financial practices. With passage of Act 179, indemnity providers and HMO providers are subject to comparable regulatory oversight by the state Insurance Commissioner under the State Insurance Code (Code).<sup>9</sup> The Code and Act 179 establish

organizational requirements and provide for State oversight of the financial practices of health plan providers.

Under the Code, mutual benefit societies are allowed to invest in the same instruments (or, put another way, have their investments subject to the same restrictions) as commercial insurers.<sup>10</sup> Act 179 requires the state Insurance Commissioner to establish rules for investments by HMOs.<sup>11</sup> The administrative rules implementing Act 179 have not been adopted as of this writing. In addition, annual audits are required of HMOs and commercial insurers<sup>12</sup> while mutual benefit societies need only file certain financial exhibits.<sup>13</sup>

With passage of Act 179, there does not appear to be a significant competitive advantage for one type of provider over another with regard to regulatory matters.

### Endnotes

1. Nell A. Cammack, *Factors Influencing Competition Among Health Plan Providers*, Legislative Reference Bureau, Report No. 11 (Honolulu: 1994), p. 25.
2. *Ibid.*, p. 30.
3. *Ibid.*, p. 35.
4. Kaiser Permanente's facilities and personnel are available on a case-by-case basis to nonmembers, and it contracts with non-Kaiser facilities to serve its neighbor island members.
5. *Hawaii Rev. Stat.*, sec. 432:1-403.
6. HMSA is a mutual benefit society but taxed under the federal law.
7. *Hawaii Rev. Stat.*, sec. 431:7-202.
8. Cammack, chapters 2 and 7.
9. *Ibid.*, chapter 7.
10. *Hawaii Rev. Stat.*, sec. 432:1-402.
11. Act 179, 1995 Haw. Sess. Laws, sec. -7.
12. Act 179, 1995 Haw. Sess. Laws, sec. -5 (HMOs) and *Hawaii Rev. Stat.*, sec. 431:3-302.5 (insurers).
13. *Hawaii Rev. Stat.*, sec. 432:1-404.



## **Chapter 7**

### **FINDINGS AND RECOMMENDATIONS**

House Resolution No. 200, H.D. 3, requests that part II of this study:

- Assess the impact of competitive practices on the price and quality of health care including any that may limit access to health care coverage;
- Assess the impact on competition, quality and costs of the plan providers engaged in both providing and paying for health care services; and
- Recommend guidelines for oversight of health plan providers to protect the public interest and assure access to affordable, quality care in the State.

#### **Access to Health Care Coverage**

Comprehensive health care coverage for most of Hawaii's labor force and their dependents is provided through the State's private and public sector employers. The QUEST program serves low income individuals and those receiving public assistance. This study found no indication that the competitive practices of the State's health plan providers have the effect of limiting access to care or adversely affecting the quality of care. (The cap placed by the federal Health Care Financing Administration on enrollment by QUEST clients in the Hawaii Medical Service Association's (HMSA) plan did limit the choice of plans previously available to this group.)

There are, at present, no generally accepted standardized measures of health care quality, although "report card" summaries of basic services and outcomes similar to those issued by Kaiser Permanente in 1994 and 1995 are prepared by a number of plans on the mainland. However, even if all Hawaii plan providers were to issue similar reports, it is difficult to see how differences could be attributed to competitive practices within the industry.

#### **Plan Providers that Both Provide and Pay for Health Care Services**

Health plans under which the plan provider is also the care provider are health maintenance organizations (HMOs). This system is well established in Hawaii and dates back to the contract physicians employed by many of the plantations. HMOs use a capitated payment system under which care providers are compensated in advance on a per patient basis rather than for each procedure. Critics of the HMO system claim that care providers in HMOs may withhold or delay care for economic rather than medical reasons, and that the capitation payment system provides an economic incentive to underutilize care services and facilities. A statistically valid analysis of utilization data and medical outcomes covering indemnity and HMO plans with demographically comparable memberships would be needed to properly address this issue.

### Recommendations for Guidelines

Prepaid health plans should probably be considered as a type of service contract rather than a conventional insurance product. A typical service contract is a short-term commitment to provide or pay for maintenance or repair of an item in exchange for a set fee paid in advance. There is an underlying assumption that covered services will, in fact, be requested and provided during the term of the contract; and that current payments from contracts will cover current costs for the group as a whole. With service contracts, the contractor must be able to respond to requests for services (or reimbursement for services) on a regular basis for each contract.

Traditional insurance, such as home, auto, liability, or accident insurance, has a different objective and different characteristics. Insurance, like a reimbursement service contract, provides an agreed-to sum of money when a covered event occurs. However, the actions that trigger insurance agreements are rare, and the client's interest is the protection of financial assets rather than the maintenance/repair of an item. The number of claims expected relative to the number of policies outstanding is significantly lower for traditional insurance policies than for service contracts.

This analogy between comprehensive health plans and service contracts is not perfect, and there is not always a clear distinction between service contracts and insurance. However, the differences in emphasis and purpose between the two instruments are useful when examining issues of public interest and government oversight of health plan providers. In summary, for health plans:

- Both the plan provider and the member understand that covered events are likely to occur,
- A plan member's primary interest is access to proper care rather than protection of financial assets,
- Most plan members will, in fact, experience covered events during the term of the agreement, and
- The health plans are basically pay-as-you-go, with current plan rates set to generate revenues sufficient to cover current expenses.

### The State's Interests

The State's interest in the operation and practices of organizations that offer health plans is based on two factors. One is that State law requires private employers and their employees to participate in prepaid health care plans. The State therefore has a responsibility to ensure that:

- the plans offered are qualified under the law,

## FINDINGS AND RECOMMENDATIONS

- the organizations offering plans have the financial and professional resources meet their obligations, and
- appropriate health care services are accessible to all plan members.

The State's second interest lies in the fact that it is also a consumer of health plans on behalf of its own employees, as agent for the counties and their employees, and as the purchaser of plans under the QUEST program.

### Recommendations

The following recommendations are submitted within the context of the preceding discussion.

1. **Chapter 432, Hawaii Revised Statutes, should be amended to require mutual benefit societies to have annual audits conducted by a qualified certified public accounting firm.**

Currently regulated insurers and HMOs must be audited annually.<sup>1</sup> Mutual benefit societies are only required to submit certain annual financial exhibits.<sup>2</sup>

2. **Chapters 431, 432, Hawaii Revised Statutes, and Act 179, Session Laws of Hawaii, 1995, should be amended to require organizations that offer health plans in Hawaii to: (a) adopt and file with the Insurance Commissioner formal investment policies, and (b) include a statement of compliance or noncompliance with the adopted policy in its annual audit.**

The Insurance Commissioner should have sufficient information regarding an organization's investment program to advise against or prevent the inappropriate investment of plan assets rather than react only after the fact. Had such a provision been in place, HMSA's questionable investments in derivatives (see chapter 3) might have been prevented or the losses minimized.

3. **The Insurance Commissioner should be authorized to establish uniform guidelines for allowed investments of health plan providers.**

All providers of health plans should have their investments subject to a uniform set of standards and guidelines applicable to the health insurance aspects of their operations. The investment objectives and need to access capital reserves may differ for conventional insurance products and prepaid health plans. To that end, investments that are appropriate for one may not be appropriate for the other. But to the extent that the operations of any entity, be it a conventional insurer, a mutual benefit society, or an HMO involve providing health plans, the levels of safety and liquidity needed in those investments should be similar.

Currently, mutual benefit societies may invest in the same instruments as regulated insurers,<sup>3</sup> and the Insurance Commissioner has recently been required to adopt rules for permitted investments by HMOs.<sup>4</sup> For reasons of equity, there is no reason to subject investments related to the health plan operations of some providers to standards and guidelines different from those applicable to the health plan operations of other providers. Similarly, investments related to the operations of health plans should not be subject to the same standards and guidelines as those applicable to insurance products having different investment objectives.

4. **Rather than regulating rates per se, the Legislature should consider requiring health plan providers to include in their annual financial statements a break down, by plan or class of plan, of gross claims paid and gross plan premiums received.**

This would help the Insurance Commissioner to assess whether a plan provider is shifting the costs of one plan to the members of another or whether their current rates, overall, are generating revenues that substantially exceed or fall short of the plan's financial requirements. Rate regulation should be considered if the Commissioner determines that significant cost shifting is occurring or plan revenues do not reasonably reflect plan expenditures.

5. **Public policy should discourage the use of exclusive contracts within the health plan industry.**

Hawaii's health plan industry is a complex network of plan administrators, care facilities and care providers. With the exception of the hospital-based organizations like Kaiser Permanente that have exclusive contracts with their physician groups, the various parties contract with each other on a non-exclusive basis. For example, a physician may belong to several preferred provider networks, and a plan administration organization may administer portions of a competitors program. Exclusive contracts would limit the flexibility of the current system and, if allowed to a significant extent, could lead to a situation where the production and distribution of health plans and services are controlled by a single entity.

The Legislature should direct the Insurance Commissioner to monitor the contractual relationships among plan administrators and the care providers that participate in their programs. If a significant increase in the use of exclusive contracts occurs, the Legislature should consider establishing restrictions on the practice.

### Endnotes

1. *Hawaii Rev. Stat.*, sec. 431:3-302.5 (insurers) and Act 179, 1995 Haw. Sess. Laws, sec. -5.
2. *Hawaii Rev. Stat.*, sec. 432:1-404.
3. *Hawaii Rev. Stat.*, sec. 432:1-402.
4. Act 179, 1995 Haw. Sess. Laws.

## Appendix A

HOUSE OF REPRESENTATIVES  
SEVENTEENTH LEGISLATURE, 1994  
STATE OF HAWAII

H.R. NO.

200  
H.D. 3

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# HOUSE RESOLUTION

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

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

5  
6 WHEREAS, despite this achievement, health care costs in  
7 Hawaii continue to rise faster than the cost of most other goods  
8 and services; and

9  
10 WHEREAS, most of Hawaii's residents are enrolled in health  
11 plans or Health Maintenance Organizations (HMO) operated by non-  
12 profit organizations; and

13  
14 WHEREAS, most of Hawaii's physicians and dentists are  
15 participating providers or employees of these organizations; and

16  
17 WHEREAS, some health care providers are contemplating or  
18 actually entering the health insurance business, intending to be  
19 both providers and insurers of health care; and

20  
21 WHEREAS, concerns have been raised about the impact of this  
22 market situation on free competition; and

23  
24 WHEREAS, concerns have also been raised as to the potential  
25 for conflict of interest if an organization both provides and  
26 pays for services; and

27  
28 WHEREAS, concerns have also been raised over the exclusionary  
29 rating and enrollment practices of commercial, for-profit health  
30 insurers; and

31  
32 WHEREAS, concerns have been also raised regarding the  
33 potential negative impact of overly restrictive state regulation  
34 on health care quality, costs, and access; and

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

4  
5 BE IT RESOLVED by the House of Representatives of the  
6 Seventeenth Legislature of the State of Hawaii, Regular Session  
7 of 1994, that the Legislative Reference Bureau is requested to  
8 conduct a study of the competitive practices of health insurers,  
9 mutual benefit societies, health maintenance organizations, and  
10 any other organization providing health care coverage in Hawaii;  
11 and

12  
13 BE IT FURTHER RESOLVED that the study include but not be  
14 limited to:

- 15  
16 (1) A review and description of the administrative  
17 structures and operations of each of these organizations  
18 including persons covered, benefits and services  
19 offered, rates, rate setting practices, financial  
20 condition, administrative costs, and profits;  
21  
22 (2) An assessment of the impact that the size of these  
23 organizations have on competition and the cost of health  
24 care, and differences in their tax classifications;  
25  
26 (3) A determination of the current level of oversight of  
27 these organizations by the Department of Commerce and  
28 Consumer Affairs and other appropriate state agencies,  
29 as well as compliance with federal anti-trust laws and  
30 regulations;  
31  
32 (4) An assessment of the competitive practices of these  
33 organizations and the impact of these practices on the  
34 price and quality of health care in Hawaii, including  
35 those which may limit access to health care coverage or  
36 increase health care costs;  
37  
38 (5) An assessment of the impact on competition, quality, and  
39 cost of health care that the dual role that many of  
40 these organizations carry out may have in both the  
41 provision of health care services and payment for  
42 services delivered; and

1 (6) Recommendations for guidelines (if any) for the  
2 oversight of the practices of these organizations in  
3 order to protect the public interest and assure access  
4 to affordable, quality health care in Hawaii;  
5

6 and  
7

8 BE IT FURTHER RESOLVED that the Office of Consumer  
9 Protection, the Department of Commerce and Consumer Affairs, the  
10 Insurance Commissioner, the State Health Planning and Development  
11 Agency (SHPDA), the Department of Labor and Industrial Relations,  
12 the Department of Health, and other relevant public agencies, and  
13 all private health insurers, HMO's, and other packaged benefit  
14 providers in the private sector, are requested to cooperate with  
15 the Legislative Reference Bureau in conducting this study; and  
16

17 BE IT FURTHER RESOLVED that Phase I of this study involving  
18 subjects 1, 2, and 3 be completed and submitted to the  
19 Legislature no later than twenty days prior to the convening of  
20 the Regular Session of 1995; and  
21

22 BE IT FURTHER RESOLVED that Phase II of the study involving  
23 subjects 4, 5, and 6 be completed and submitted to the  
24 Legislature no later than twenty days prior to the convening of  
25 the Regular Session of 1996; and  
26

27 BE IT FURTHER RESOLVED the Legislative Reference Bureau  
28 conduct this study by using to the extent feasible national  
29 standards of measurement, state experiences, or other data sets;  
30 and  
31

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

## Appendix B

### CONFIDENTIAL OPINION SURVEY EMPLOYER-SPONSORED PREPAID HEALTH PLANS

Please fill in blanks or circle as appropriate.

#### I. ABOUT YOUR FIRM

- A. Number of years in business in Hawaii \_\_\_\_\_
- B. Number of employees participating in your prepaid health plans, by county:  
Honolulu \_\_\_\_\_ Hawaii \_\_\_\_\_ Kauai \_\_\_\_\_ Maui \_\_\_\_\_
- C. Type of business \_\_\_\_\_
- D. Is one or more of your employees assigned to work exclusively in the area of human resource/personnel management? Yes No
- E. Is your work force unionized? Yes No  
If Yes:
1. Is the choice of health plan providers bargained? Yes No
2. Are health plan benefits bargained? Yes No

#### II. ABOUT YOUR GROUP HEALTH PLANS

- A. Number of health plans your firm offers \_\_\_\_\_
- B. Is your health plan coverage provided through a parent organization or business affiliation such as a franchise? \_\_\_\_\_
- C. Names of the organizations (for example, HMSA, Kaiser Permanente, HMAA, etc.) that administer your health plans: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_
- D. In selecting a health plan, are the following factors: 1 very important; 2 important but not a deciding factor on its own; 3 a minor item?
1. Amount of premium \_\_\_\_\_
2. Premium stability \_\_\_\_\_
3. Plan benefits \_\_\_\_\_
4. Geographic area served \_\_\_\_\_
5. Plan preferred by employees \_\_\_\_\_
6. Advise/recommendations of colleagues \_\_\_\_\_
7. Previous experience with plan provider \_\_\_\_\_
8. Willingness of plan provider to negotiate \_\_\_\_\_
- E. Have you ever used an independent agent to help negotiate and select your firm's health plans? Yes No
1. If Yes, were you satisfied with result? Yes No
2. If No, would you consider using an independent agency in the future?  
Yes No



### III. YOUR PAST EXPERIENCE WITH HEALTH PLAN PROVIDERS

- A. During the past 5 years, have you changed health plan providers for any of the following reasons:
1. Unacceptable premium increase. Yes No
  2. Plan administered poorly. Yes No
  3. Competitive premium/coverage package offered by another provider. Yes No
  4. Provider refused to negotiate critical issues or negotiated in bad faith. Yes No
  5. Plan cancelled by provider. Yes No
  6. Other (describe briefly) \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

### IV. YOUR EVALUATION OF COMPETITION AMONG HEALTH PLAN PROVIDERS

- A. From your perspective as a consumer of group health plans, would you say that:
1. The current level of competition among Hawaii's health plan providers gives you a good choice of health plan products and prices. Yes No
  2. There isn't any real competition in the areas:
    - a. Costs Yes No
    - b. Benefits Yes No
  3. Excessive competition is threatening the delivery and quality of care under some plans. Yes No
- B. During the past five years, competition among health plan providers has:
1. Increased. Yes No
  2. Stayed about the same. Yes No
  3. Decreased. Yes No
- C. Should more plan providers be encouraged to enter the Hawaii health plan market place? Yes No

### V. YOUR VIEWS ON STATE REGULATION OF HEALTH PLAN PROVIDERS

- A. Should the State regulate:
1. Health plan premiums? Yes No
  2. Rate setting methods used by plan providers? Yes No
  3. Financial practices of plan providers? Yes No
- B. Should there be a cap on the percentage of the labor force that any one provider can cover? Yes No
- C. Should the State encourage the formation of health plan purchasing cooperatives for small businesses and sole proprietors? Yes No
- D. Should unfair competitive practices for health plan providers be defined and monitored by the State? Yes No

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