

**Statement for the Record of the Hearing of the
House Ways and Means Committee
Subcommittee on Health
On
“State Coverage Initiatives: Lessons For the Nation”**

**Testimony of John C. Lewin, CEO, American College of Cardiology
Former Director of Health in Hawaii
Former CEO, California Medical Association**

**On
Lessons Learned from Advancing State-Based
Access to Care Reforms in Hawaii and California**

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As CEO of the 36,000 member American College of Cardiology here in Washington, DC, I am honored to have the opportunity to testify to the Subcommittee today on a most important health policy topic — the pressing need to advance access to care in this nation. The perspectives I share and lessons gleaned from them are based on my previous direct career experience in advancing state-based access to care reforms in both Hawaii and California.

I was Director of Health in Hawaii from late 1985 until late 1994, serving as a member of the governor’s cabinet and overseeing 6,500 employees and a \$1 billion statewide health department and hospital system. As such, I oversaw much of the implementation of Hawaii’s universal employer health insurance mandate, and also designed and implemented the supplemental State Health Insurance Plan (SHIP). The state subsidized SHIP program successfully covered the vast majority of remaining uninsured persons who were unemployed, self-employed, part-time employed, or otherwise ineligible for employer coverage.

The landmark Hawaii Prepaid Health Care Act actually passed the legislature in 1974, modeled after what the young state presumed would be the national access to care policy model fostered by then-President Richard Nixon. Interestingly, ERISA, which strictly limited state actions of this kind, was passed by Congress just a few months after Hawaii’s legislature acted. The new Hawaiian law required health coverage for ALL employed persons working more than 19 hours per week, with benefits approximating the prevailing average employer plan coverage in the state. HMSA (the statewide Blue Cross and Blue Shield plan in Hawaii) and Kaiser Permanente dominated health insurance coverage in the state, which gave the plan a high degree of portability with job changes. The Prepaid Health Care Act’s goal was to require a 50-50 cost split between the employer and the employee overall, based on estimates at the time that an employee’s health insurance globally averaged about 3% of wages or salary. The employee’s required contribution was not therefore to exceed 1.5% of wages, which targeted the 50-

50 split of premium goal, and also ensured lower income employees could afford their share of the costs.

While billed as an “employer mandate,” this law was actually also an employee mandate. The employer share for low income or minimum wage employees was understood to be greater than 50% of costs, but for the majority of workers whose wages exceeded about \$50,000, the split approximated 50-50. Public employee unions negotiated a special cost split provision in the law for their beneficiaries of 60% employer/ 40% employee. No businesses were exempted, including those with only one employee. The law required that dependents be offered the same guaranteed coverage, but the employer-employee cost split for family coverage was not specified — in practice, the 50-50 cost split was typical there as well. Unemployed, self-employed, and part-time under 19 hours-per-week persons were not covered. The law did not cover medications, dental, institutional mental health, or long-term care benefits, but had generous outpatient, inpatient, emergency room, laboratory and diagnostic services coverage through private health insurers (basically HMSA and Kaiser Permanente). There were no real cost-cutting or quality of care provisions in these programs.

Once passed, while many employers voluntarily implemented the law, the Prepaid Health Care Act faced a decade of legal challenges from employers extending all the way into the early 1980s, culminating in a Supreme Court decision that it violated ERISA and could not be implemented. Hawaii then proceeded to Congress to get a narrowly-passed, controversial exemption from ERISA to implement the law. A major problem with this solution was that the law could not be amended as costs increased and the environment changed: the provisions in the law that made sense in the 1970s and early 1980s were frozen without returning to Congress for amendments, and returning to Congress could easily have resulted in an unintended consequence of eliminating the exemption and the law altogether! As a result, it has never been amended, and a number of factors have weakened the law’s acceptability over time:

- As costs have increased and the average cost of health insurance far exceeds 3% of wages or salary, the 1.5% maximum deduction for the employee has shifted most of the costs onto the employer;
- Rising costs have made some employers shift much more than 50% of family coverage costs onto the employee — and some employees feel they cannot afford even 50% of the family premium — putting dependent coverage at risk;
- While an increase in part-time employment (to avoid coverage costs) was not a problem for the first 20 years of implementation, it appears to be increasing now as costs continue to escalate in Hawaii as everywhere else.
- The basic benefits program for the unemployed and self employed — the SHIP — was folded into a Medicaid waiver in 1995, which caused the premiums to triple with the required additional Medicaid benefits. Many of the beneficiaries could no longer afford their share of the premiums and dis-enrolled. In addition, the changed enrollment processes proved much more cumbersome for many of

these beneficiaries. The resulting reductions in coverage further taxed the Prepaid Health Care Act by the cost-shifting associated with having the previously insured SHIP beneficiaries return to the ranks of the uninsured, and to emergency rooms for primary care.

Hawaii's achievements with the full implementation of the Prepaid Health Care Act, and later with the addition of the state-subsidized supplemental SHIP program, were stunning. By 1990, Hawaii had achieved near-universal coverage of approximately 96% of the population. It also had in place an excellent safety net and system of community clinics to address the needs of homeless, mentally ill, non-citizens, and other "uninsurable" persons and those with special health needs.

But, because there has been no parallel federal access to care action, because of rising costs, and because we had no ability to modify the Prepaid Health Care Act, these accomplishments have eroded. In 2007, according to the US Census Bureau, Hawaii had dropped to covering less 91% of the population. While every full-time worker in Hawaii still has coverage — and that is no small thing — increasing numbers of dependents are not covered. The unemployed, self-employed, and part-time employed have the same difficulties getting coverage now as anywhere else in America. Hawaii's accomplishments will further unravel in the absence of national reforms.

I was also the CEO of the California Medical Association from 1995 through 2006 until moving to Washington to assume the role of CEO of the ACC. California has more than 7 million uninsured persons, in addition to perhaps 3 million undocumented residents without coverage. While in California, the CMA led multiple legislative efforts to pass access to care reform legislation. Working with AFL-CIO, in 2002 we proposed an auspicious bill, SB2, roughly based on Hawaii's Prepaid Health Care Act, which was passed by the Legislature and signed into law by then Governor Gray Davis. SB2 exempted businesses with less than 50 employees (a significant compromise), and had a fixed 80%-20% split in premium costs between employers and employees. The bill was to be implemented through competition of private insurers. The thought was to incrementally bring in smaller businesses over time after the bill passed. Public polls showed considerable support for SB2, but before its actual implementation the new Governor Arnold Schwarzenegger led an effort to repeal it through a public ballot initiative, which subsequently passed by a very narrow margin of 50.5%. The arguments against SB2 were fear tactics, designed to convince insured persons that if it passed, their own employer coverage would be destabilized toward a government system, which was clearly antithetical to the intent of SB2.

Following the repeal of SB2 we then worked with Governor Schwarzenegger to attempt to craft a new proposal that considered state-subsidized individual coverage for uninsured workers. This proposal, despite its attempt to avoid employer opposition, failed to pass the legislature.

In summary, there are several lessons learned through these noble experiments at the state level in California and Hawaii that pertain to the agendas before Congress now:

1. State access to care reforms are important and worthy of national support. They have covered more people and have provided lawmakers information on what works, and as importantly what does not work. However, these initiatives are unstable for a number of reasons, such as state budgets. **We need national access to care minimum requirements and policies to ensure that all Americans have coverage that is transportable and consistent across states.** States may still play important roles in a necessary national strategy.
2. Employer coverage, while measurably in apparent gradual decline in America, still affords numerous advantages in efficiently covering most employed Americans, and in possessing administrative advantages in the collection and management of premiums. That acknowledged, employer coverage very often offers little or no choice of plan options, is too often based on inefficient and sometimes unethical experience rating of beneficiaries, and is not portable from job to job. Rather than taking the fiscal risks of shifting what is currently private to public health insurance by phasing out employer coverage as some pundits suggest, we should explore improving employer coverage by promoting state or regional insurance collaboratives that function like the FEHBP to enable the benefits of portability, community rating, and expanded employee choice of coverage options to employer coverage that lacks such attributes today. As we expand access to care for the currently uninsured, let's also preserve coverage that works fairly well for the majority of Americans who have employer-based insurance before we move to a universally different system that is yet untested.
3. Measurable and transparently reportable evidence of quality improvement and cost effectiveness, based on valid data and science-based practices, have not yet been central priorities in the state-based access to care reforms implemented thus far. They have done a lot of "putting together commissions" with little action. Improving quality and patient outcomes must be central to all future efforts if they are to succeed.
4. While neither California's nor Hawaii's efforts in access to care reform focused on electronic or e-health innovation, any state or national effort needs to strongly incentivize electronic medical records, e-prescribing, and quality of care registries that measure quality of care based on established scientific guidelines, performance measures, and appropriate uses of technology. However, standards for interoperability must be national to be effective.
5. Finally, any serious reform effort must realign the perverse incentives of the current payment systems for doctors, health professionals, hospitals, and insurers to instead promote quality, cost-effectiveness, prevention, and patient-centered outcomes improvements.

References

1. *Health Affairs* (Lewin, JC and Sybinsky, PA). Implications of National Health Expenditure Estimates on State Policy: Concerns from a Small State, Vol. 13, Winter 1994.
2. *American Journal of Surgery*, Reflections on National Health Care Reform Based on Hawaii's Experience, February 1994.
3. *Journal of American Medical Association* (Lewin, JC and Sybinsky, PA), Hawaii's Employer Mandate and its Contribution to Universal Access, Vol. 269, No. 19, May 19, 1993.
4. The United States Congress, *Hearing before the Committee on Finance*, S.3180 B The State Health Care Act of 1992, September 9, 1992.
5. *Business and Health*, A Blueprint for Health Care Reform, mid-September 1992.
6. Chapter in: Brecher, C. ed., *Implementation Issues and National Health Care Reform*, Macy Foundation, The Implementation of Health Care Reform: Lessons from Hawaii. New York City: Josiah Macy Jr. Foundation, June 1992.
7. *Journal of Health Care Benefits*, Health Care in the State of Hawaii, May/June 1992.