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Grassroot Institute of Hawaii Discusses Local and National Policy

policybrief

Hawaii's Prepaid Health Care Act and Far-Reaching Costs

Discussed by Pearl Hahn, Policy Analyst



Due to its low uninsured rate of 9.6 percent, the state of Hawaii is frequently cited as a health care model for the rest of the United

States¹. Health insurance is widely regarded as the key to accessing vital health care services, and those without insurance are regarded as less likely to access timely and necessary care. To that end, in 1974, Hawaii became the first state to mandate employer-provided insurance through the Prepaid Health Care Act (PHCA). PHCA's impact is multi-faceted, increasing health care cost and thereby affecting employment trends and cost of living. It is important to analyze its far-reaching effects and to examine how PHCA is failing to sustain the state's low uninsured rate.

Background: The Prepaid Health Care Act

In 1974, Hawaii became the first state to mandate employer-provided health insurance under the Prepaid Health Care Act (PHCA) (Massachusetts became the only other state to enact an employer mandate in addition to an individual mandate in 2006)². Under PHCA, employers, excluding federal, state, and city government are required to provide Hawaii employees who work 20 hours or more a week for four consecutive weeks with medical coverage³. To fulfill the requirement under the law, employers can purchase one of a handful of pre-approved plans, have a plan of their choice reviewed by the state Department of Labor and Industrial Relations (DLIR) and the PHC Advisory Council, or offer a health care plan funded by the employer with evidence of financial solvency and ability to pay approved by DLIR⁴.

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In this GreenPaper:

- 1] Background: The Prepaid Health Care Act
- 2] The Health Care Market Then: More Choices, Lower Costs
- 3] The Health Care Market Now: Fewer Choices, Higher Cost
- 4] Hawaii's Uninsured Rate On the Rise
- 5] PHCA's Cost to Businesses Contribute to Growing Uninsured Rate
- 6] Recommendations for Policy Change

The Health Care Market Then: More Choices, Lower Costs

Shortly after PHCA was implemented, there were more choices than today for consumers seeking health insurance. According to the Department of Labor and Industrial Relations, in March 1975, there were a total of nine contractors marketing health care plans: Kaiser Foundation Health Plan, Inc., Hawaii Medical Service Association, Republic National Life, Travelers Insurance, Mutual of Omaha, United Benefit Life, Aetna, Bankers Life, and Equitable Life Assurance Society⁵.

In the 1970s, health coverage was also more affordable. In 1974, monthly costs amounted to less than \$20 per individual, and employers were permitted to evenly split the cost with employees as long as the employee's share did not exceed 1.5 percent of the employee's wages⁶. At the time, 1.5% of the state's minimum wage covered about 30% of premiums, which totaled roughly \$16 per month, according to the Hawaii Medical Service Association⁷.

The Health Care Market Now: Fewer Choices, Higher Costs

Currently, there are only six companies with state-approved plans licensed to sell employer group health insurance in Hawaii: Hawaii Management Alliance Association, Hawaii Medical Service Association, Kaiser Permanente., Summerlin Life & Health Insurance Company, United Healthcare Insurance Company, and University Health Alliance⁸. Numerous mandated benefits and DLIR's due approval process discourage additional insurers from entering the market, as DLIR requires all health care plans to provide equal or better benefits offered by the plan with the largest number of subscribers in the state⁹.

Hawaii Medical Service Association (HMSA) is by far the largest provider, with 68 percent of the private market and 701,527 members as of May 2008^{10,11,1}. Kaiser Permanente, the second largest provider in the state, holds 20 percent of the private market¹². Essentially, PHCA necessitates all other insurance companies to offer a plan equivalent to that offered by HMSA, leaving little room

¹ At the time this brief was written, HMSA was the market leader for PPO's, while Kaiser was the leader for HMOs.



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for competition. PHCA protects HMSA's and Kaiser's control of nearly 90 percent of the market.

Requiring all health plans to offer the same services as Hawaii Medical Service Association without regard to consumer preference is a major factor in driving up costs. Licensed companies in the state tout their comprehensive plans that cover a wide variety of health conditions and services, but whether all of them are necessary is questionable. For instance, mandatory benefits include in vitro fertilization and treatment for drug abuse, services that many consumers do not want nor use^{13,14}. In Maryland, the in vitro fertilization requirement has been identified as very costly while low in importance and proposed for elimination¹⁵. Rather than the state requiring insurance plans to cover an array of costly benefits, consumers should be free to choose the benefits they want and to customize their own plans. For example, most consumers would likely prioritize cheaper, preventive services such as cervical and ovarian cancer screening over costly in vitro fertilization, which remains a mandatory service, in their plans¹⁶.

Government-customized health plans are accompanied by high costs. Since PHCA passed, health care costs have risen significantly, with inflation a significant contributor. Hawaii's overall inflation rate, as gleaned from the Consumer Price Index (CPI) for urban Honolulu, was 29.8% over the period 2000 to 2008¹⁷. Hawaii's inflation rate for medical care during the same period was greater at 32.6%¹⁸. Clearly, costs of medical care are outpacing costs of living in other categories.

This larger burden on family budgets is reflected in the increasing price of health insurance premiums. In Hawaii, health insurance premiums for employment-based health insurance skyrocketed for both individuals and families. Between 2000 and 2007, average premiums for individuals rose from \$2,366 to \$3,765 and from \$6,047 to \$10,001 for families¹⁹. Reportedly, high costs have forced employers to cut benefits, reduce wages, and lay off employees²⁰.

Table 8. Number and Percentage of People Without Health Insurance Coverage by State Using 2- and 3-Year Averages: 2004-2005 and 2006-2007

(Numbers in thousands. People as of March of the following year)

State	3-year average (2006-2007) ¹					2-year average, percentage uninsured					Change (2006-2007 average less 2004-2005 ¹ average) ²
	Total	Uninsured				2004-2005 ¹		2006-2007		90-percent confidence interval ³ (±)	
		Number	90-percent confidence interval ³ (±)	Percentage	90-percent confidence interval ³ (±)	Percentage	90-percent confidence interval ³ (±)	Percentage	90-percent confidence interval ³ (±)		
United States.....	296,588	45,822	388	15.4	0.1	15.1	0.1	15.5	0.1	+0.5	
Alabama.....	4,542	632	44	13.9	1.0	13.5	1.1	13.8	1.1	0.1	
Alaska.....	664	115	8	17.3	1.1	16.9	1.3	17.4	1.3	0.5	
Arizona.....	6,220	1,219	64	19.6	1.0	18.1	1.2	19.6	1.2	1.5	
Arkansas.....	2,774	485	30	17.5	1.1	16.8	1.3	17.5	1.3	0.7	
California.....	36,148	6,720	151	18.6	0.4	18.4	0.5	18.5	0.5	0.1	
Colorado.....	4,773	799	52	16.7	1.1	16.3	1.3	16.8	1.3	0.5	
Connecticut.....	3,475	344	30	9.9	0.9	10.9	1.1	9.4	1.0	*-1.5	
Delaware.....	656	101	8	11.8	0.9	12.7	1.2	11.7	1.1	-1.0	
District of Columbia.....	664	64	6	11.4	1.0	12.8	1.3	10.6	1.2	*-2.2	
Florida.....	18,007	3,058	105	20.5	0.6	19.8	0.7	20.7	0.7	0.9	
Georgia.....	9,255	1,658	70	17.8	0.8	17.6	0.9	17.6	0.9	-	
Hawaii.....	1,267	105	10	8.3	0.8	8.5	0.9	8.2	0.9	-0.3	
Idaho.....	1,473	216	15	14.7	1.0	14.7	1.2	14.6	1.2	-	
Illinois.....	12,647	1,735	75	13.7	0.6	13.4	0.7	13.7	0.7	0.3	
Indiana.....	6,247	766	49	12.3	0.8	13.7	1.0	11.6	0.9	*-2.1	
Iowa.....	2,933	274	25	9.4	0.9	8.7	1.0	9.9	1.0	1.2	
Kansas.....	2,713	320	26	11.8	1.0	10.5	1.1	12.5	1.2	*2.0	
Kentucky.....	4,122	569	42	13.8	1.0	13.0	1.2	14.6	1.2	*1.6	
Louisiana.....	4,188	807	48	19.4	1.1	16.9	1.3	20.2	1.4	*3.3	
Maine.....	1,316	125	12	9.5	0.9	9.6	1.1	9.1	1.1	-0.5	
Maryland.....	5,562	761	50	13.6	0.9	13.4	1.0	13.8	1.1	0.4	
Massachusetts.....	6,204	527	41	8.3	0.7	10.3	0.8	7.9	0.7	*-2.4	
Michigan.....	9,960	1,075	59	10.8	0.8	10.7	0.7	11.0	0.7	0.3	
Minnesota.....	5,156	438	38	8.5	0.7	8.2	0.9	8.8	0.9	0.6	
Mississippi.....	2,663	543	32	18.8	1.1	16.8	1.3	19.8	1.3	*3.0	
Missouri.....	5,767	723	49	12.5	0.8	11.8	1.0	12.9	1.0	1.1	
Montana.....	933	150	10	16.1	1.1	16.9	1.3	16.4	1.3	-0.5	
Nebraska.....	1,762	212	17	12.0	1.0	10.5	1.1	12.8	1.2	*2.3	
Nevada.....	2,517	452	29	17.9	1.1	17.7	1.4	16.4	1.4	0.7	
New Hampshire.....	1,308	138	12	10.5	0.9	9.9	1.0	11.0	1.1	1.1	
New Jersey.....	8,647	1,318	65	15.2	0.7	14.2	0.9	15.6	0.9	*1.4	
New Mexico.....	1,943	425	25	21.9	1.3	20.1	1.5	22.7	1.6	*2.6	
New York.....	19,041	2,551	93	13.4	0.5	12.8	0.6	13.6	0.6	*0.8	
North Carolina.....	8,885	1,469	68	16.6	0.8	15.1	0.9	17.2	0.9	*2.1	
North Dakota.....	619	68	6	11.1	0.9	10.5	1.1	11.1	1.1	0.6	
Ohio.....	11,318	1,249	63	11.0	0.6	11.0	0.7	10.9	0.7	-0.1	
Oklahoma.....	3,516	640	40	18.2	1.1	18.5	1.4	16.4	1.3	-0.2	
Oregon.....	3,702	621	42	16.8	1.1	15.9	1.3	17.3	1.3	1.4	
Pennsylvania.....	12,313	1,203	63	9.8	0.5	10.3	0.6	9.8	0.6	-0.6	
Rhode Island.....	1,051	108	10	10.3	0.9	10.9	1.1	9.7	1.1	-1.2	
South Carolina.....	4,264	705	45	16.5	1.1	16.0	1.3	16.2	1.2	0.2	
South Dakota.....	778	87	7	11.2	0.9	11.4	1.0	11.0	1.0	-0.4	
Tennessee.....	5,679	830	51	13.9	0.9	13.3	1.0	14.0	1.0	0.7	
Texas.....	23,253	5,687	136	24.4	0.6	23.9	0.7	24.8	0.7	*0.9	
Utah.....	2,573	399	25	15.6	1.0	14.9	1.1	15.1	1.1	0.3	
Vermont.....	619	68	6	11.0	1.0	11.0	1.2	10.7	1.1	-0.3	
Virginia.....	7,559	1,031	57	13.6	0.7	13.1	0.9	14.1	0.9	1.0	
Washington.....	6,359	770	51	12.1	0.8	12.8	1.0	11.6	0.9	-1.3	
West Virginia.....	1,803	268	17	14.9	1.0	16.5	1.2	13.8	1.1	*-2.7	
Wisconsin.....	5,465	480	40	8.8	0.7	9.7	0.9	8.5	0.9	*-1.2	
Wyoming.....	515	73	6	14.3	1.1	13.7	1.3	14.1	1.3	0.4	

¹ Statistically different from zero at the 90-percent confidence level.
 - Represents or rounds to zero.
² The 2004 and 2005 data were revised in March 2007. See www.census.gov/hhes/www/hltires/usernotes/schedule.html.
³ A 90-percent confidence interval is a measure of an estimate's variability. The larger the confidence interval in relation to the size of the estimate, the less reliable the estimate. For more information, see "Standard Errors and Their Uses" at www.census.gov/hhes/www/p0_226a.pdf.
⁴ Details may not sum to totals because of rounding.
 Source: U.S. Census Bureau, Current Population Survey, 2005 to 2006 Annual Social and Economic Supplements.

In 2008, the US Census Bureau released data on individual states' uninsured populations. Massachusetts and Hawaii had among the lowest uninsured rates, but they were not statistically different from Minnesota (8.5 %), Wisconsin (8.8 %), Iowa (9.4 %), and Maine (9.5 %), all of which do not implement an employer mandate²⁴.

Figure 1: Table of Uninsured Rates across the Nation



Hawaii's Uninsured Rate On the Rise

Following PHCA's passage, Hawaii's uninsured rate dropped from 30 percent in the early 1970s to a low of 5 percent in the 1980s²¹. The drop in the uninsured rate was widely considered a success of PHCA. Today, Hawaii's uninsured rate of 9.6 percent remains among the lowest in the nation. Yet, despite ranking 8th nationally in coverage of citizens, the uninsured rate rose to 10 percent in 2001²².

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PHCA's Cost to Businesses Contribute to Growing Uninsured Rate

The employer mandate contains several exemptions. Workers are not required to be covered if they have been employed less than four consecutive weeks, if they are employed for fewer than 20 hours a week, if their monthly wages are less than 86.67 times the hourly minimum wage, or if they are seasonal, self-employed, commission-only, or government employees²⁵.

Small businesses (firms of 20 or fewer employees) make up an integral part of Hawaii's economy. The state's 25,883 small employers constitute nearly 97 percent of total employers and 56 percent of private sector employment²⁶. Evidence supports the claim that PHCA has encouraged employers to hire workers for less than 20 hours a week to avoid providing insurance and contributed to the increase in the uninsured rate (see Figure 2). Small and large businesses resort to such measures to cut costs.

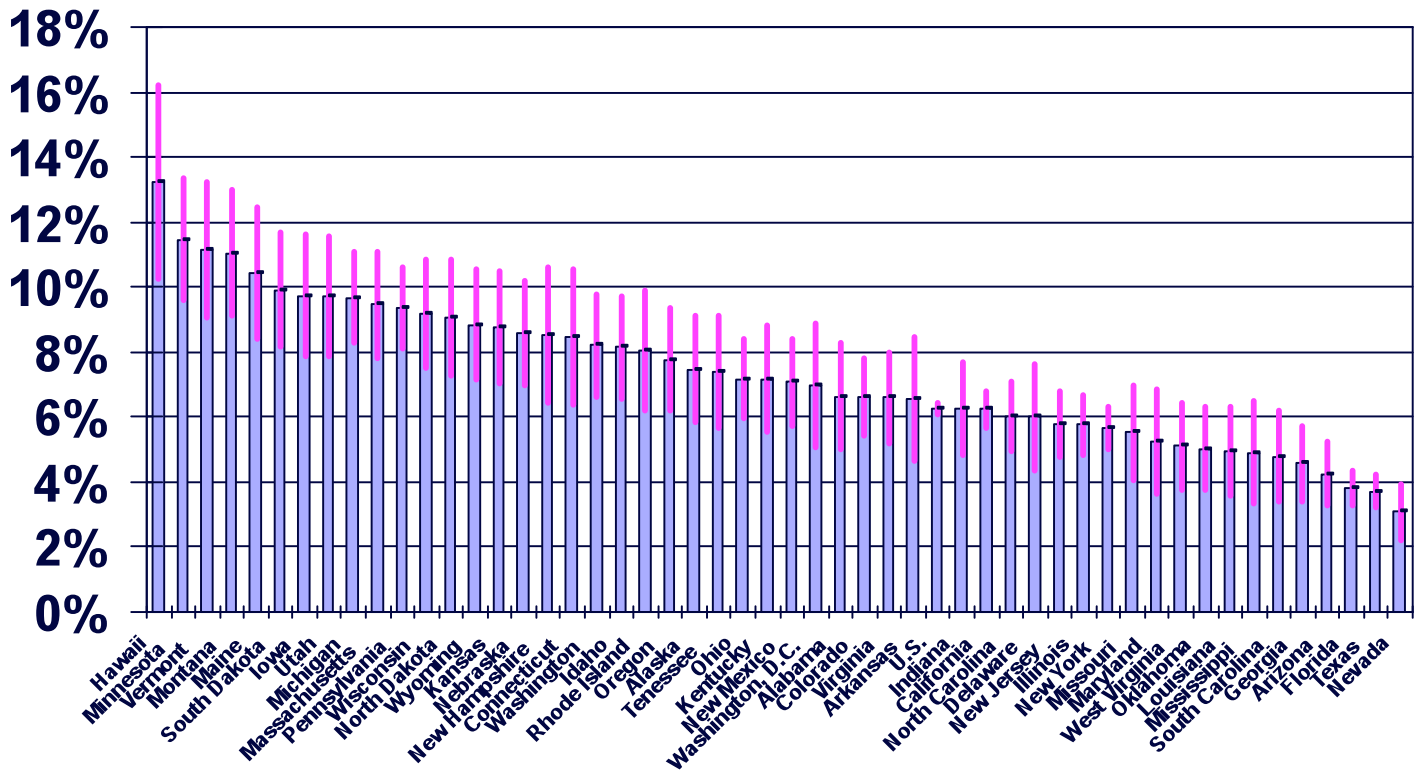
This graph shows the effect of PHCA on the percent of private-sector employees

without employer-sponsored health insurance (ESI) working less than 20 hours a week. Note that Hawaii ranks first of all the states with 13.25 percent of private sector employees with no ESI.

University of Hawaii professor and health economist, Dr. Gerard Russo, found that PHCA impacts labor force utilization in three ways. Firstly, following PHCA, the number of employees working between 20 and 35 hours per week decreased²⁷.

Figure 2: Russo Economics Power Point Presentation

This graph shows the effect of PHCA on the percent of private-sector employees without employer-sponsored health insurance (ESI) working less than 20 hours a week. Note that Hawaii ranks first of all the states with 13.25 percent of private sector employees with no ESI.



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Yet, the proportion of part-time employees working less than 20 hours per week increased, and the utilization of full-time employees working more than 36 hours per week also increased²⁸. The data indicate that the employer mandate encourages employers to hire employees for only part-time hours to save on costs and avoid providing medical coverage²⁹.

Recommendations for Policy Change

As one of two states in the nation with employer-mandated health insurance, Hawaii faces a unique set of problems. The following recommendations seek to increase the purchasing power of health care consumers while lowering the cost of health care.

1. Remove the Department of Labor and Industrial Relations' requirement stipulating that all health care plans provide equal or better benefits offered by the plan with the largest number of subscribers.

This constraint on the market is detrimental to businesses, insurers, and consumers. Following PHCA's passage, the number of insurers decreased in Hawaii, leading to fewer choices and less competition among insurers to lower

their price of coverage. Instead of making coverage affordable, prices have gone up, as insurers are forced to provide all services offered by the leading plan, even if consumers do not plan on using mandated services such as drug and alcohol abuse treatment. Allowing plans to be marketed that do not include such expensive services would reduce costs of coverage, appealing to both employers and consumers.

2 Permit consumers to purchase health insurance from other states

Heavy regulation of health insurance in Hawaii and other states has contributed to the difficulty of insurers to offer, and consumers to purchase, affordable health insurance. People should be able to enjoy the same freedom as when they shop for home or auto insurance across state lines. While an individual health insurance plan in Pennsylvania costs about \$1,500 a year, a similar plan in neighboring New Jersey costs more than double at \$4,000³⁰. Permitting consumers to survey and choose from an array of policies in the country that suits them best restores competition, consumer choice, affordability, and accessibility to the health insurance marketplace.



3 Allow clinicians licensed in other states to practice in Hawaii

Licensing requirements and scope of practice laws unnecessarily restrict access to care and are more often the product of special interests of clinician lobbies rather than concerns for consumer safety³¹.

By recognizing licenses issued by other states, Hawaii could boost affordability and supply of care providers, both of which are badly needed as the number of doctors in the state continues to decline³².

4 Eliminate mandated coverage of benefits

The Department of Labor and Industrial Relations' mandate forces health plans to cover several services and benefits without regard to the wide variety of unique health conditions among the population. Mandated benefits inflate health care costs while doing little to improve the actual health of the population. Mandated benefits may even contribute to Hawaii's growing uninsured rate. The Health Insurance Association of America estimates that as many as one in four are uninsured due to the cost of state health insurance mandates³³. Consumers should be given the option to choose which benefits they want included in their plan.

5 Resist measures to lower 20-hour work requirement of PHCA

Bills have been submitted during session in recent years proposing to lower the

20-hour threshold to only 15 hours.

While such measures intend to increase coverage among the population, as mentioned, the 20 hour requirement has thus far distorted the labor market, raised costs of operating business, and actually contributed to the uninsured rate by boosting the number of part-time employees working less than 20 hours.

New proposals should target regulations that inhibit market competition to lower costs of health coverage overall rather than targeting specific populations.



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The mission of the Grassroot Institute of Hawaii is to promote individual liberty, the free market and limited accountable government. Through research papers, policy briefings, commentaries and conferences, the Institute seeks to educate and inform Hawaii's policymakers, news media and the general public.

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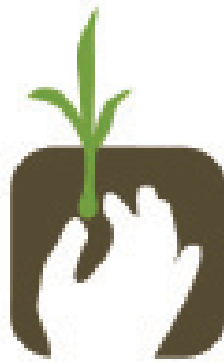
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12

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