Can Hawaii health care plan work for U.S.?

Ex-justice says 20 years ago many felt it would fail here

By Stu Glauberman
Advertiser Staff Writer

Experts who say health care laws like Hawaii's won't work on the Mainland are saying the same thing opponents said when the idea was debated here 20 years ago.

First lady Hillary Rodham Clinton focuses her campaign for national health care reform on Honolulu today with a forum on Hawaii's care system. A cornerstone of the system, which is often held up as a model for the nation, is the 1974 Prepaid Health Insurance Act.


Nakamura

Edward Nakamura, 70, now a retired Hawaii Supreme Court justice, says Hawaii became the first state to mandate prepaid health care partly because politically powerful unions and their allies believed that universal coverage was the right thing to do.

Hawaii's liberal Democrats, heavily influenced by the labor movement, came to see prepaid health care as a natural outgrowth of other social welfare legislation.

Nakamura said then-state Sen. Nadao Yoshinaga, who got the ball rolling in 1969, and Big Island state Rep. Yoshito Takamine, the Labor Committee chairman who got the bill through the House, were the key figures in passing the landmark legislation in 1974.

At the time, Nakamura was a labor lawyer lobbying for the International Longshoremen's & Warehousemen's Union.

Nakamura recalls that he and Takamine "used to talk about a complete program ... We figured if we had unemployment insurance, worker's

See Nakamura, Page A2

Health insurance law

Key points of Hawaii's 1974 Prepaid Health Care Act.

- Requires companies to provide health insurance coverage for employees who work more than 20 hours a week.
- Sets minimum benefits all companies must offer their employees.
- Prohibits employers from charging workers more than 1.5 percent of gross wages for minimum health insurance.

The Honolulu Advertiser 7-13-93

Nakamura: How Isle health plan passed

FROM PAGE ONE

comp and TDI (temporary disability insurance), then prepaid health would complete the social welfare package for the worker."

As it turned out, University of California professor Stefan Riesenfeld's proposal, which was to become the basis for Hawaii's Prepaid Health Care Act, also proved to be good for insurance companies. That, according to Nakamura, "saved a lot grief."

"A lot of people in the Legislature were insurance agents," he recalled, including Kauai Sen. George Toyofuku, who headed the Human Resources Committee.

Like TDI benefits, prepaid health care bumped up against considerable opposition from businesses as well as doctors, health insurers and even some labor leaders who saw it as a lost chip in collective bargaining. The debate even raged although most of Hawaii's workers — many represented by unions — were already covered by employer-sponsored plans.

Despite a tradition of plantation hospitals and health care packages for plantation workers, sugar and pineapple growers opposed state-mandated health care on principle. Small businesses, who feared it would ruin them, gained the ear of many House members.

The Hawaii Medical Service Association initially opposed the legislation as "socialized medicine," but later embraced it as inevitable.

Doctors led by the Hawaii Medical Association argued the federal government would soon come up with national health insurance — something, of course, yet to happen.

Reflecting the doctors' concern, lawmakers added a drop-dead clause that would repeal the Hawaii act when a federal voluntary prepaid health-care program went into effect.

Still, Nakamura was elated at having pushed prepaid health through in five years. "We couldn't believe it."

Now as Mrs. Clinton and the President's Health Care Task Force wrestle with national health care reform, about 90 percent of Hawaii workers have coverage through their employers.

Nakamura recommends that Mainland employers who frown on the idea of mandated prepaid health care think again.

"If you make it compulsory for everybody to be covered as an employee, that way, everybody competes and nobody has a competitive edge. It's good for employees. It improves their morale — they're going to be better employees."

The Honolulu Advertiser 7-13-93

Nancy - 395-4619

Sheldon Hochuen
508-693-0467

Tamara
~~224-9842~~

Judy L 986-2647

JOHN WAIHEE
GOVERNOR OF HAWAII

JOHN C. LEWIN, M.D.
DIRECTOR OF HEALTH

STATE OF HAWAII
DEPARTMENT OF HEALTH
P. O. BOX 3378
HONOLULU, HAWAII 96801

In reply, please refer to:
File: DDHRA

June 23, 1993

Mr. John Hart
Deputy Assistant to the President and
Deputy Director for Intergovernmental Affairs
Executive Office of the President
The White House Office
1600 Pennsylvania Avenue, N.W.
Washington, D.C. 20500

Dear Mr. Hart:

Communications Issues and An Employer Mandate

Thank you for the opportunity to present Hawaii's Health Care System to you and your staff. Leo Young and I have discussed the "poor" public image of the employer mandate and would like to submit that in fact a positive picture of an employer mandate is warranted. While Hawaii may have only limited data of our system and its effect, the available data solidly support the proposition that an employer mandate plan should result in basically positive effects if adopted as a major financing element for a national health reform program.

We frequently hear that Hawaii's economic infrastructure is different from that faced by the mainland; therefore, the Hawaii system may not be applicable nationwide. It is true that the infrastructure is different -- the majority of our businesses consist of small business ventures but that many factors are comparable. We submit the appropriate conclusion is that since the Hawaii plan has been successful for the small business enterprises here, it can likewise be effective on a national scale.

Thus far, only studies emphasizing potential negative effects have been done. No work has been done measuring any positive results of an employer mandate plan. Such groundwork could be developed in the following areas:

A. A mandate will positively affect the economy due to the reduction of uncompensated care costs currently being borne by businesses who do insure their workers.

Most big businesses and approximately 2/3 of small businesses currently cover their employees. Basically, the cost of health care for all employed persons, including costs for employees without any coverage by their respective employers, is carried by these employers. Employers who don't provide coverage are given a free ride under the present American system. We submit a true allocation of health care costs to all responsible employers, in and by itself, might well decrease the cost of health care.

Since uncompensated care costs are shifted to insurance, the elimination of the large portion of costs "shifted" from the uninsured businesses to those already insured should produce lower insurance rates for the businesses already providing coverage. These reduced costs should stimulate business, resulting in job creation or other forms of investment, depending on various factors (such as size of business, relation to insurance reform). This stimulus could have significant direct benefit in job growth as well as indirect benefit in areas as foreign trade.

Since the Department of Labor funded a "downside" study of the mandate's impact on jobs, it would seem appropriate that the same organization could support an "upside" study of the same nature.

B. Economic aspects of a mandate on employers not currently covering their employees need not be overwhelmingly negative, and will likely act differentially or businesses due to various factors.

Economic analyses have focussed on business size and have suggested that the greatest impact of a mandate would be on job loss in the smallest businesses. However, these studies have not included several dimensions which could affect a business' ability to continue:

1) Can an industry "pass on costs" to the consumer? If so, hamburgers could cost $1.04 instead of $1.00 without job loss in an industry. This is essentially true when the whole industry is required to adhere to the same health care cost requirement. A relatively small increase in price for a good or service could have minimal market impact and allow for job retention and yet pay for the added health costs for those not currently provided services.

2) Can employee wages be retained at a lower level to give the employee health care instead of an increase in future wages? While health care might not be as popular with low-income employees, it would enhance a benefit package and avert job loss. In fact, since a worker may have the advantage of obtaining fringe benefits at a lower cost through a group, rather than an individual plan, this would result in greater benefits than though receiving higher wages.

3) In an industry where some employers provide health benefits and others do not, a competitive advantage is currently enjoyed by those "not doing the socially responsible thing." Requiring health benefits to be provided here would merely be "leveling the playing field" and bringing fairness to an unfair situation. While this is not a quantitative issue, it is an argument based on equity. A few blatant examples of disparity could go a long way, communications wise, to show unfairness.

4) The health care industry, better than most sectors of the economy should be able to deal with "downsizing." Since many professions are already in shortage, the reductions of jobs should not have overwhelming negative benefits or impact on health care services, system wide.

5) Universal coverage and an emphasis on primary care should reduce the "down time" due to illness, both for the employee inflicted with a particular illness and for fellow employees who could be exposed. The whole area of sick leave utilization may show this indirect benefit might result in greater productivity.

C. <u>Some indirect effects of an employer mandate are also likely to be positive (as would any proposal to bring about universal access)</u>.

1) A reduction of uncompensated care in the health care industry should eliminate the need for practices which relate to the need to cost shift, such as higher charges than costs for many procedures and "unbundling" charges into discrete units (administratively more complex, although more remunerative). This should result in lower cost, more efficient health care, particularly in the hospital industry.

2) Because the currently uninsured will be able to get to care at an earlier stage (they won't "put off" care because they can't pay), the costs of care (and indeed the entire structure of health care) should shift toward lower cost preventive and primary care. A 10% reduction of inpatient costs

related to early diagnosis of cancer, for example, would constitute a significant reduction in health care costs. An across the board analysis of this shift in emphasis in health care would demonstrate this positive cost-saving effect.

3) Because the uninsured will be able in many circumstances to have a family provider, the use of the emergency room as a medical home should greatly decrease. Since emergency room costs are roughly three times greater than physician office visits, a significant reduction here will also cut health care costs and burden upon the employer. Again, an estimate of this benefit needs to be quantified.

We enjoyed the interaction with your staff and will be glad to assist in further defining these areas outlined. Please call me if you have any questions or desire further information at (808) 586-4433, or through Phil Shimer or Rocky Finseth at our Washington Office at (202) 508-3830.

Very truly yours,

PETER A. SYBINSKY, Ph.D.
Deputy Director for Health Resources
PAS:csa

c: Phil Shimer, State of Hawaii - D.C. Office
Norma Wong, Office of State Planning
Dr. John Lewin, Director of Health
Kanani Holt, Deputy Director for Labor & Industrial Relations
Leo Young, Deputy Attorney General

PS, I hear you might be getting to Hawaii this summer. If so, could we schedule some time while you are here? Thanks

EXECUTIVE OFFICE OF THE PRESIDENT
OFFICE OF MANAGEMENT AND BUDGET
WASHINGTON, D.C. 20503

CLOSE HOLD

July 1, 1993

MEMORANDUM FOR BILL GALSTON

FROM: Nancy-Ann Min

SUBJECT: Q's and A's to VA on Senator Rockefeller's Women's Health Bill

You should have received the attached note from our Legislative Referral Division with the VA's draft response to a question submitted by Senator Murkowski regarding coverage of abortion in Senator Rockefeller's women's health bill. The deadline given to you for our response is incorrect. It turns out that the markup on Senator Rockefeller's bill has been postponed until July 15th; therefore, we have until July 12th to get the response up to the Senate. It is our understanding from talking to the VA that Senator Rockefeller does want our response to this question before the markup of his bill. (I have not checked with his office to determine whether or not he is really pressing for this.)

The draft response from VA needs lots of help. Bob Boorstin suggested that we get together with Melanne (and whomever else should be involved from the health care reform perspective) to come up with something better. I assume that this question will begin to come up with increasing frequency given the Hyde vote, the fact that the Senate Appropriations process is now beginning, and the heightened interest in the services to be included in the standard benefits package.

Attachment

cc: Melanne Verveer
Bob Boorstin

EXECUTIVE OFFICE OF THE PRESIDENT
OFFICE OF MANAGEMENT AND BUDGET
WASHINGTON, D.C. 20503

URGENT

July 1, 1993

LEGISLATIVE REFERRAL MEMORANDUM

TO: Legislative Liaison Officer

See Below

SUBJECT: VA response to Senator Murkowski's questions regarding the Administration's abortion policy.

The Office of Management and Budget requests the views of your agency on the above subject before advising on its relationship to the program of the President, in accordance with OMB Circular A-19.

A response to this request for your views is needed no later than Noon tomorrow, July 2, 1993.

Questions should be referred to Bob Pellicci (395-4871), the legislative analyst in this office.

Janet Rice Forsgren for
Assistant Director for
Legislative Reference

Enclosures

cc: Nancy-Ann Min
Bill Galston
Barbara Selfridge
Todd Grams
Nicole Sanderson
Janet Forsgren

Nancy-Ann

VA's response comes across as: (1) they don't know what abortion services are part of "appropriate services" or (2) they don't want abortion services to be included and will include them only if dicked to.

I think the VA response is terrible.

Bob P.

Nancy
5178

VA Answer to Question 3 Submitted by Senator Frank H. Murkowski in Followup to the June 23, 1993, SVAC Hearing on Legislation Concerning VA Health Care Programs

Question: Chairman Rockefeller's women's health bill would create a number of new programs, including "reproductive health services." If the bill were to include abortion as one of the services defined under these so-called reproductive health services, would the Administration support or oppose the bill, and why? Should Congress fail to define the term "reproductive health," would the VA or the Administration define it to include or exclude abortion, and why?

Answer: Absent Congressional direction, we are not prepared at this time to conclude that the term "reproductive health" should or should not include abortions.

Adds to Vets affairs reproductive comprehensive services

15 m mark up or vets

Separate issue presidential pro

N

Equal Opportunity at the Depart-nt of Housing and Urban Develop-nt, there have been many comments garding the need to expedite this ocess. Some Members of this body ve stated that a lengthy discussion Ms. Achtenberg's background is un-cessary. I would argue we are just ow learning some disturbing things bout her background, character, and mperament—all of which will influ-nce her activities as Assistant Sec-etary for Fair Housing.

The debate over this nomination has ocused on Ms. Achtenberg's involve-ent in efforts to cut off United Way nding for the Boy Scouts in the bay rea. We have taken a closer look at ctions she took as a member of the an Francisco Board of Supervisors to unish the Bank of America for revers-ng its earlier decision to eliminate unding for the Scouts. We have had an opportunity to consider statements she has made regarding the Scouts' mis-sion—"Do we want children learning the values of an organization that * * * provides character building exclusively for straight, God-fearing male chil-dren?" As a result of this discussion, the Senate had gained a clear under-standing of Roberta Achtenberg's atti-tudes and the actions she is willing to take against those who do not share her agenda.

The Assistant Secretary for Fair Housing and Equal Opportunity is re-sponsible for Federal monitoring of State and local fair housing law en-forcement agencies. In addition, the re-sponsibilities of this post include di-recting affirmative action compliance within the Department of Housing and Urban Development [HUD], evaluating HUD's Equal Employment Opportunity Program, implementing and developing HUD's Fair Housing and Equal Oppor-tunity programs, and conducting inves-tigations of compliance with Depart-ment rules. This is not a minor post that merely implements the law. It helps shape the law.

Given Roberta Achtenberg's apparent intolerance for individuals and organi-zations, such as the Boy Scouts, who do not comply with her political agenda, I am concerned that she will be unable to exercise impartiality in a post that demands it. Her personal crusade against the Boy Scouts is an example of a radical agenda that is outside the mainstream of civil rights, and there is no set of outstanding qualifications that outweigh these concerns.

It is for these reasons that I will op-pose the nomination of Roberta Achtenberg.

THE BOY SCOUTS 1992 VOTE LAST YEAR

Mr. HELMS. Mr. President, on Sep-tember 22, 1992, the Senate defeated 49-49, an amendment to strike from the Combined Federal Campaign—the Fed-eral Government's charity drive among Federal employees—any charity that used its funds to intimidate the Boy Scouts to accept homosexual Scout leaders and to drop their oath of alle-giance to God.

Inasmuch as the Senate will vote today on the nomination of the leader of this campaign against the Boy Scouts, I ask unanimous consent that last year's vote be printed in the RECORD.

There being no objection, the vote was ordered to be printed in the RECORD, as follows:

SENATE RECORD VOTE ANALYSIS—VOTE NO. 227, 102D CONGRESS, SEPTEMBER 22, 1992

DOD APPROPRIATIONS/BOY SCOUTS, HOMOSEXUALS, ATHEISTS

Subject: Department of Defense Appropriations Bill for fiscal year 1993 . . . H.R. 5504. Helms amendment No. 3118 to the committee amendment beginning on page 142, line 1.

Action: Amendment rejected, 49-49.

YEAS (49)

Republicans (31 or 72%)

Bond, Brown, Burns, Coats, Cochran, Craig, Danforth, Dole, Domenici, Garn, Gorton, Gramm, Grassley, Hatch, Helms, Kasten, Lott, Lugar, Mack, McCain, McConnell, Murkowski, Nickles, Pressler, Roth, Simpson, Smith, Stevens, Symms, Thurmond, Wallop.

Democrats (18 or 33%)

Bentsen, Breaux, Bryan, Bumpers, Byrd, Conrad, Daschle, Dixon, Ford, Fowler, Heflin, Hollings, Johnston, Nunn, Pryor, Reid, Sanford, Shelby.

NAYS (49)

Republicans (12 or 28%)

Chafee, Cohen, D'Amato, Durenberger, Hatfield, Jeffords, Kassebaum, Packwood, Rudman, Seymour, Specter, Warner.

Democrats (37 or 67%)

Adams, Akaka, Baucus, Biden, Bingaman, Boren, Bradley, Burdick, Jocelyn, Cranston, DeConcini, Dodd, Exon, Glenn, Graham, Harkin, Inouye, Kennedy, Kerrey, Kerry, Kohl, Lautenberg, Leahy, Levin, Lieberman, Metzenbaum, Mikulski, Mitchell, Moynihan, Pell, Riegle, Robb, Rockefeller, Sarbanes, Sasser, Simon, Wellstone, Wofford.

NOT VOTING (2)

Republicans (0)

Democrats (2)

Gore—2, Wirth—2.

Explanation of Absence:
1—Official Business.
2—Necessarily Absent.
3—Illness.
4—Other.

Symbols:
AY—Announced Yea.
AN—Announced Nay.
PY—Paired Yea.
PN—Paired Nay.

The PRESIDING OFFICER. The Chair advises the Senator that 51 sec-onds remain.

Mr. HELMS. Mr. President, I think we ought to have the rollcall.

The PRESIDING OFFICER. Is there objection?

The question is on the confirmation of Roberta Achtenberg of California to be an Assistant Secretary of Housing and Urban Development.

The clerk will call the roll.

The legislative clerk called the roll.

Mr. EXON. Mr. President, it is my in-tention to vote "no" on this nomina-tion. However, Senator KRUEGER, who is absent, if he were present, would vote "aye." Therefore, I withhold my vote.

Mr. FORD. I announce that the Sen-ator from Oklahoma [Mr. BOREN], the Senator from New Jersey [Mr. BRAD-LEY], the Senator from Arizona [Mr. DECONCINI], the Senator from Alabama [Mr. HEFLIN], and the Senator from Massachusetts [Mr. KENNEDY] are nec-essarily absent.

I further announce that, if present and voting, the Senator from Arizona [Mr. DECONCINI] and the Senator from Massachusetts [Mr. KENNEDY] would each vote "aye."

On this vote, the Senator from Texas [Mr. KRUEGER] is paired with the Sen-ator from Nebraska [Mr. EXON]. If present and voting, the Senator from Texas would vote "aye" and the Sen-ator from Nebraska would vote "nay."

Mr. DOLE. I announce that the Sen-ator from Missouri [Mr. DANFORTH], the Senator from Vermont [Mr. JEF-FORDS], the Senator from Arizona [Mr. MCCAIN], and the Senator from Wyo-ming [Mr. SIMPSON] are necessarily ab-sent.

I further announce that, if present and voting, the Senator from Wyoming [Mr. SIMPSON] would vote "nay."

The PRESIDING OFFICER (Mr. ROCKEFELLER). Are there any other Senators in the Chamber desiring to vote?

The result was announced—yeas 58, nays 31, as follows:

[Rollcall Vote No. 122 Ex.]

YEAS—58

Akaka	Feingold	Mitchell
Baucus	Feinstein	Moseley-Braun
Bennett	Ford	Moynihan
Biden	Glenn	Murray
Bingaman	Graham	Nunn
Bond	Gregg	Packwood
Boxer	Harkin	Pell
Breaux	Hatfield	Pryor
Bryan	Inouye	Reid
Bumpers	Johnston	Riegle
Campbell	Kassebaum	Robb
Chafee	Kerrey	Rockefeller
Cohen	Kerry	Roth
Conrad	Kohl	Sarbanes
D'Amato	Lautenberg	Simon
Daschle	Leahy	Specter
Dodd	Levin	Wellstone
Domenici	Lieberman	Wofford
Dorgan	Metzenbaum	
Durenberger	Mikulski	

NAYS—31

Brown	Grassley	Nickles
Burns	Hatch	Pressler
Byrd	Helms	Sasser
Coats	Hollings	Shelby
Cochran	Kempthorne	Smith
Coverdell	Lott	Stevens
Craig	Lugar	Thurmond
Dole	Mack	Wallop
Faircloth	Mathews	Warner
Gorton	McConnell	
Gramm	Murkowski	

PRESENT AND GIVING A LIVE PAIR, AS PREVIOUSLY RECORDED—1

Exon, against

NOT VOTING—10

Boren	Heflin	McCain
Bradley	Jeffords	Simpson
Danforth	Kennedy	
DeConcini	Krueger	

So the nomination was confirmed.

Mr. RIEGLE. Mr. President, I move to reconsider the vote.

Mr. MITCHELL. I move to lay that motion on the table.

The motion to lay on the table was agreed to.

The PRESIDING OFFICER. Under the previous order, the President of the

^bc-hawaii-health-system 06-30

American Medical Association Urges President Clinton to Examine Hawaii Health System

To: National Desk, Health Writer

Contact: Dan Maier of the American Medical Association, 312-464-5382

SAN FRANCISCO, June 30 /U.S. Newswire/ -- President Clinton should take a close look at the Hawaii health system next week while returning from the economic summit in Japan, said James S. Todd, M.D., executive vice president of the American Medical Association (AMA), in a speech today before the Healthcare Financial Management Association here.

The 300,000 members of the AMA point to the Hawaii system of health care as the ``best working example'' of industry and government working together in the free market to provide quality care to all citizens while keeping costs down, Todd said.

``The Hawaii plan is real, it's working and it's doing what the AMA and everyone on the mainland wants to do, too -- help our patients, help our people,'' he noted.

The AMA has been promoting its own health reform package, Health Access America. It calls for insurance reform, Medicaid and Medicare reforms, cost-containment strategies, professional liability reforms and mandated-employer health coverage. Many aspects of Health Access America have been integrated into the White House Task Force plan, Todd said.

``We all know President Clinton is about to embark on a trip to Japan,'' Todd told the group. ``And on the way home, he's going to stop off for a Hawaii vacation...Mr. President, when you stop off in Hawaii, take a look at how health care works there. Take a look at Health Access America in action. You might find Hawaii already has a prescription for what ails the rest of the country.''

President Clinton's willingness to ``take on the untamed tiger'' of health system reform was applauded by Todd. However, the AMA executive withheld judgment on the Clinton plan until details are made public.

In February, the White House Task Force was criticized for its decision to deny physicians ``a seat at the table'' of health care reform. Todd quoted former presidential candidate Paul Tsongas' advice to President Clinton that not having physicians on board for reform will ``be like having termites in your system.''

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/U.S. Newswire 202-347-2770/

JOHN WAIHEE
GOVERNOR OF HAWAII

JOHN C. LEWIN, M.D.
DIRECTOR OF HEALTH

STATE OF HAWAII
DEPARTMENT OF HEALTH
P. O. BOX 3378
HONOLULU, HAWAII 96801

In reply, please refer to:
File:

June 30, 1993

Ms. Hillary Rodham Clinton
Chairperson, President's Health Care Task Force
Executive Office of the President
1600 Pennsylvania Avenue, N.W.
Washington, DC 20500

Dear Ms. Clinton:

We are very excited about your willingness to take a few hours out of your vacation time in Hawaii to discuss National Health Care Reform issues.

As I trust you recognize, the Governor and I are vigorous advocates of the forthcoming Clinton Plan and look forward to helping promote it to Congress, the States, and the Nation.

I am informed that you desire to use the opportunity of your visit to utilize our 20-year success with an employer mandate to gain support from nervous national constituencies about the similar approach which will be a significant part of the forthcoming Clinton Plan. We can definitely help in this area! Further, we could then arrange an "unannounced" visit to a small business to discuss with the employer and employees the effects of the law in the "real world." This could be a 30-minute short stop.

Therefore, as requested, I am proposing the following three-hour agenda for your review and editing.

1. First, we would like you to participate with a group of approximately 25 community representatives and leaders representing consumer groups, labor, small and large businesses, government, and health care providers, in a discussion of the successes, strengths, and shortcomings of Hawaii's 20-year health insurance employer mandate. Other issues, such as Hawaii's community insurance rating for small business, could also be discussed.

2. We propose a brief small business site visit to an establishment that didn't insure their workers before the passage of the mandate.

Your office indicated a hollow square set up for the participants with room at the perimeter for media. We will arrange it this way.

Other media exposure could be arranged at your discretion; however, we are going to continue to bill your visit as a vacation-only stopover in order to minimize or eliminate expectations of an admiring public.

The most opportune time to schedule this three-hour visitation appears to be on Tuesday, July 13, 1993, from 9:00-12:00 in the morning, at a time when the President is tentatively scheduled for recreation time. However, the afternoon of Tuesday, July 13th or the morning of July 14th would also be suitable, depending, of course, upon the schedule and preference of the President and yourself.

I am ready to assist your staff in defining and developing arrangements for this proposed meeting and join with Governor and Mrs. Waihee in looking forward to your upcoming visit.

Very truly yours,

aloha,

JOHN C. LEWIN, M.D.
Director of Health

c: Melanne Verveer, Office of the First Lady
Patti Solis, Office of the First Lady
Phil Shimer, Hawaii State Washington DC Office Director
Norma Wong, Office of Governor John Waihee

Enclosure (1)

PROPOSED AGENDA FOR MEETING

- Eight-minute overview on how Hawaii's system works - including recent Kaiser Family Foundation survey - 70% of Hawaii's small business is supportive.
- Big Business perspective - 10 minutes
- Small Business perspective - 10 minutes
    - .. concerns
    - .. problems of hiring part time workers
- Labor perspective - 10 minutes
- Provider perspective - 10 minutes

Leaves at least one full hour for specific questions and answers.

We'll provide names and areas of expertise and concerns for each participant.

Twenty-five maximun Hawaii participants.

UNITED STATES DEPARTMENT OF COMMERCE
Economics and Statistics Administration
Washington, D.C. 20230

R + follow up

MEMORANDUM FOR THE FIRST LADY

FROM EV EHRLICH
UNDER SECRETARY FOR ECONOMIC AFFAIRS-DESIGNATE

SUBJECT HEALTH CARE-RELATED CENSUS DATA

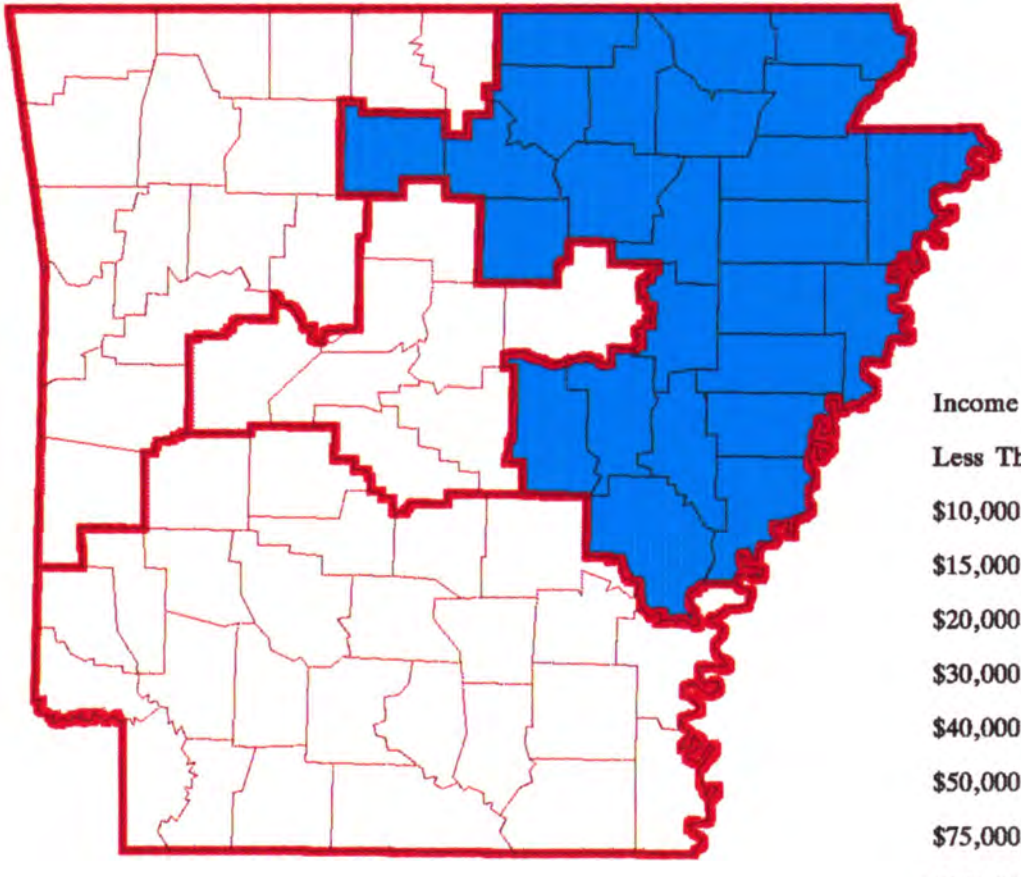
The attached charts demonstrate the Census Bureau's ability to provide the White House Task Force on Health Care Reform with information from the 1990 census.

The information is developed from the Census Bureau's TIGER files, a computerized mapping system that allows information to be categorized by Congressional District or State. As you can see, the data can be presented to personalize the need for health care reform for individual representatives.

Would this information assist you in future meetings with Senators and Members of Congress? yes John Edgell, the Commerce Department's health care liaison, has consulted with Ira Magaziner on this project, and we have developed a prototype using the State of Arkansas. The charts are based on 1990 census data for household income, senior citizen population, nursing home population, and number of uninsured. We are preparing data on small businesses and health care coverage by state. good

I would appreciate your comments and guidance on this project.

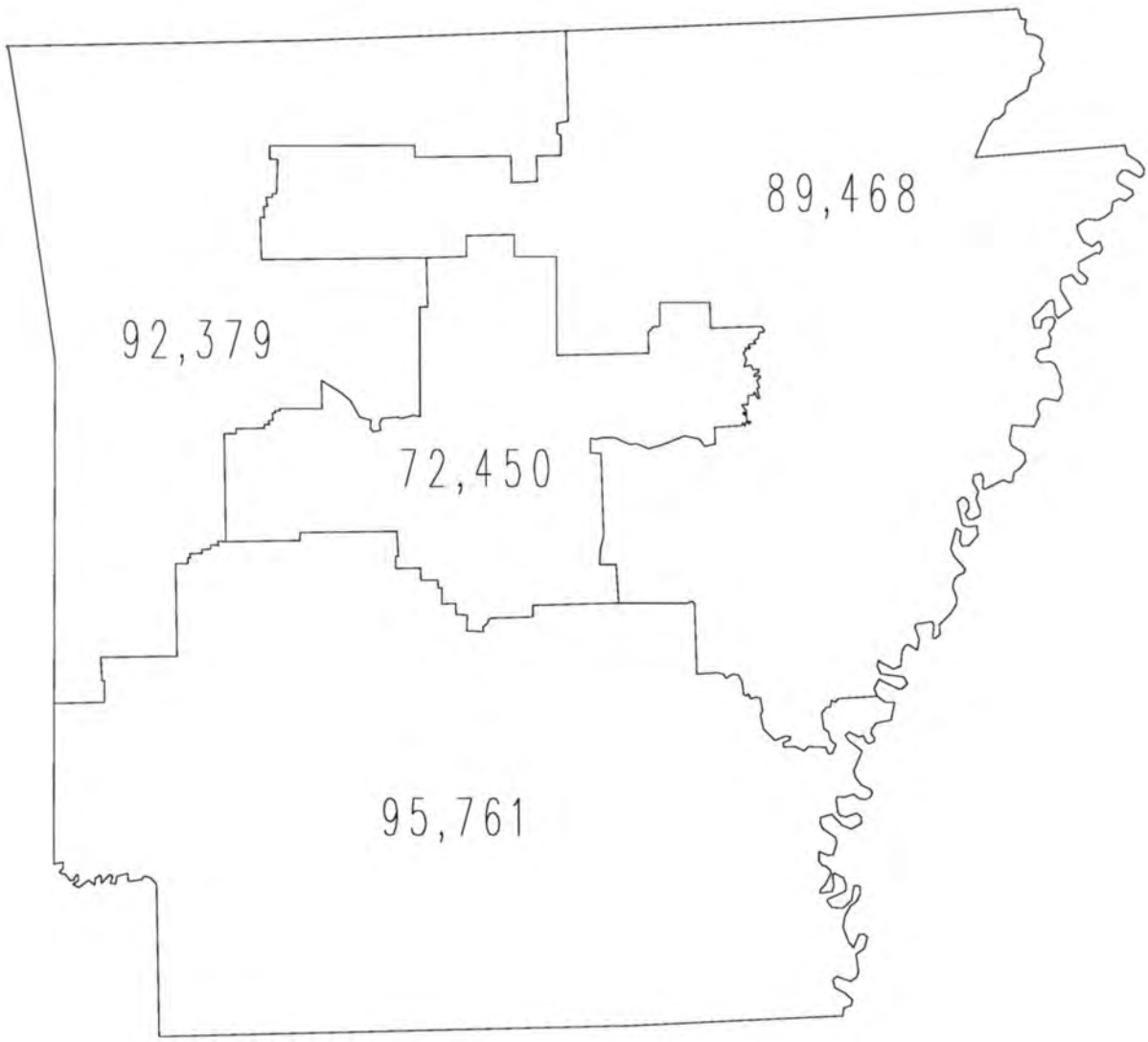
138,317 Families in Arkansas Congressional District 1 Will Pay Less Under White House Health Plan



Income	Current Premium	Payroll Premium	Change	Families
Less Than $10,000	$352	$89	-$262	28,846
$10,000 To $14,999	$570	$248	-$321	19,185
$15,000 to $19,999	$566	$349	-$217	17,841
$20,000 to $29,999	$645	$502	-$143	32,235
$30,000 to $39,999	$808	$677	-$131	24,134
$40,000 to $49,999	$974	$871	-$104	16,076
$50,000 to $74,999	$1,055	$1,206	+$151	16,430
$75,000 to $99,999	$1,059	$1,776	+$716	3,503
$100,000 or More	$1,209	$2,543	+$1,334	2,769

Map Prepared by NCEC Services, Inc.

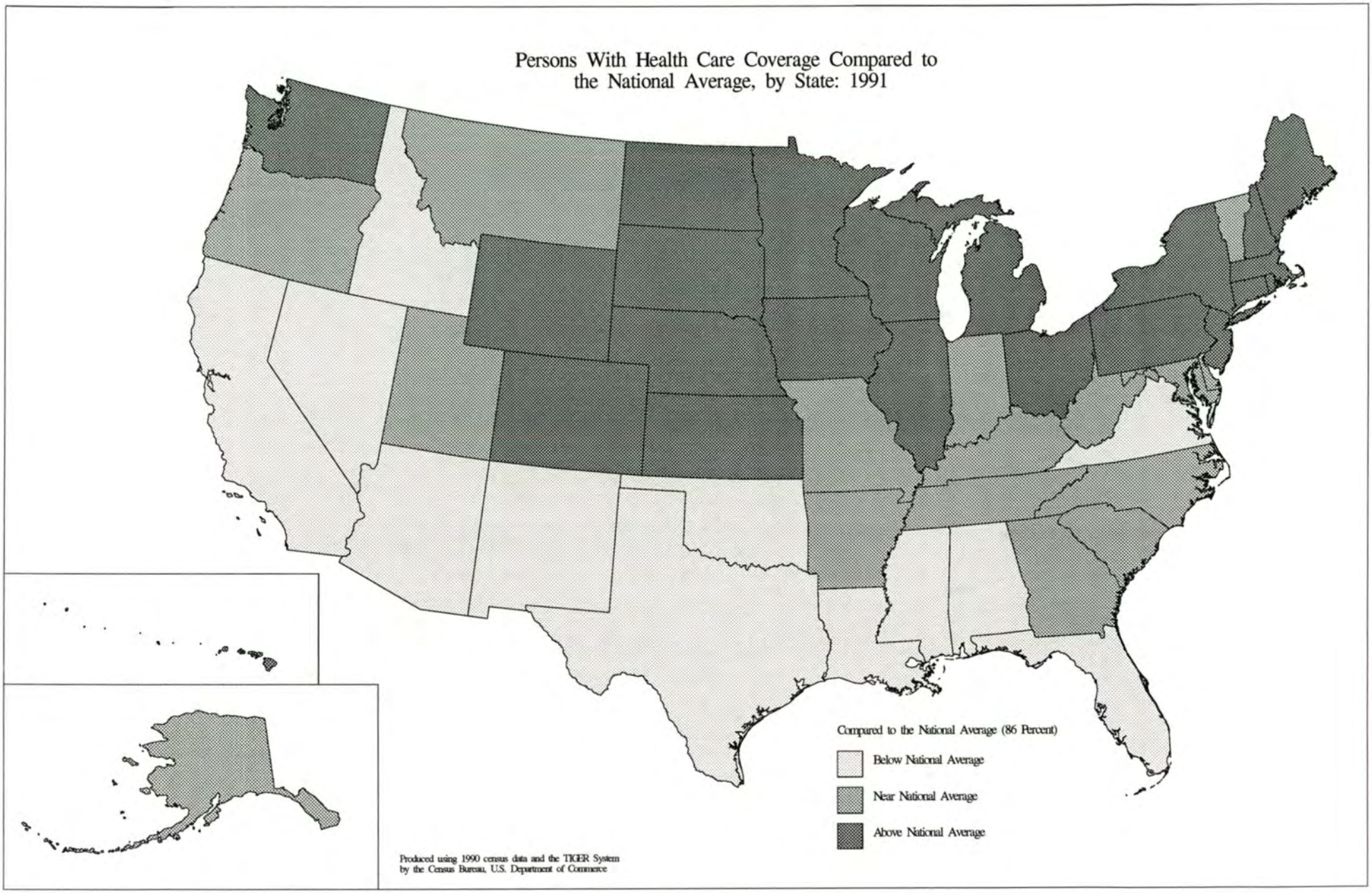
Persons in Arkansas 65 Years of Age and Over by Congressional District: 1990



Total Persons 65 Years of Age and Over: 350,058

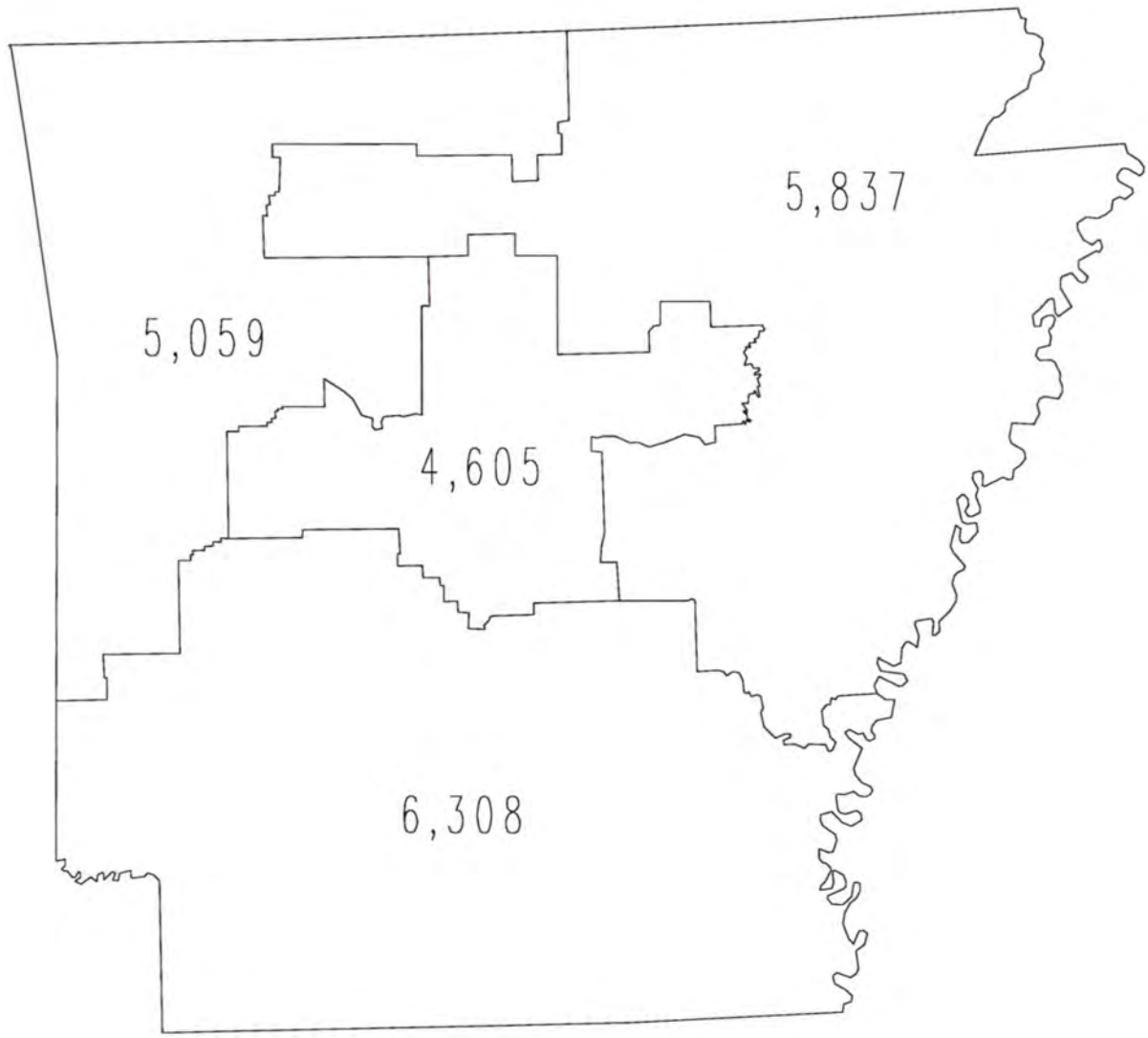
Produced using 1990 census data and the TIGER System
by the Census Bureau, U.S. Department of Commerce

Persons With Health Care Coverage Compared to the National Average, by State: 1991



Produced using 1990 census data and the TIGER System
by the Census Bureau, U.S. Department of Commerce

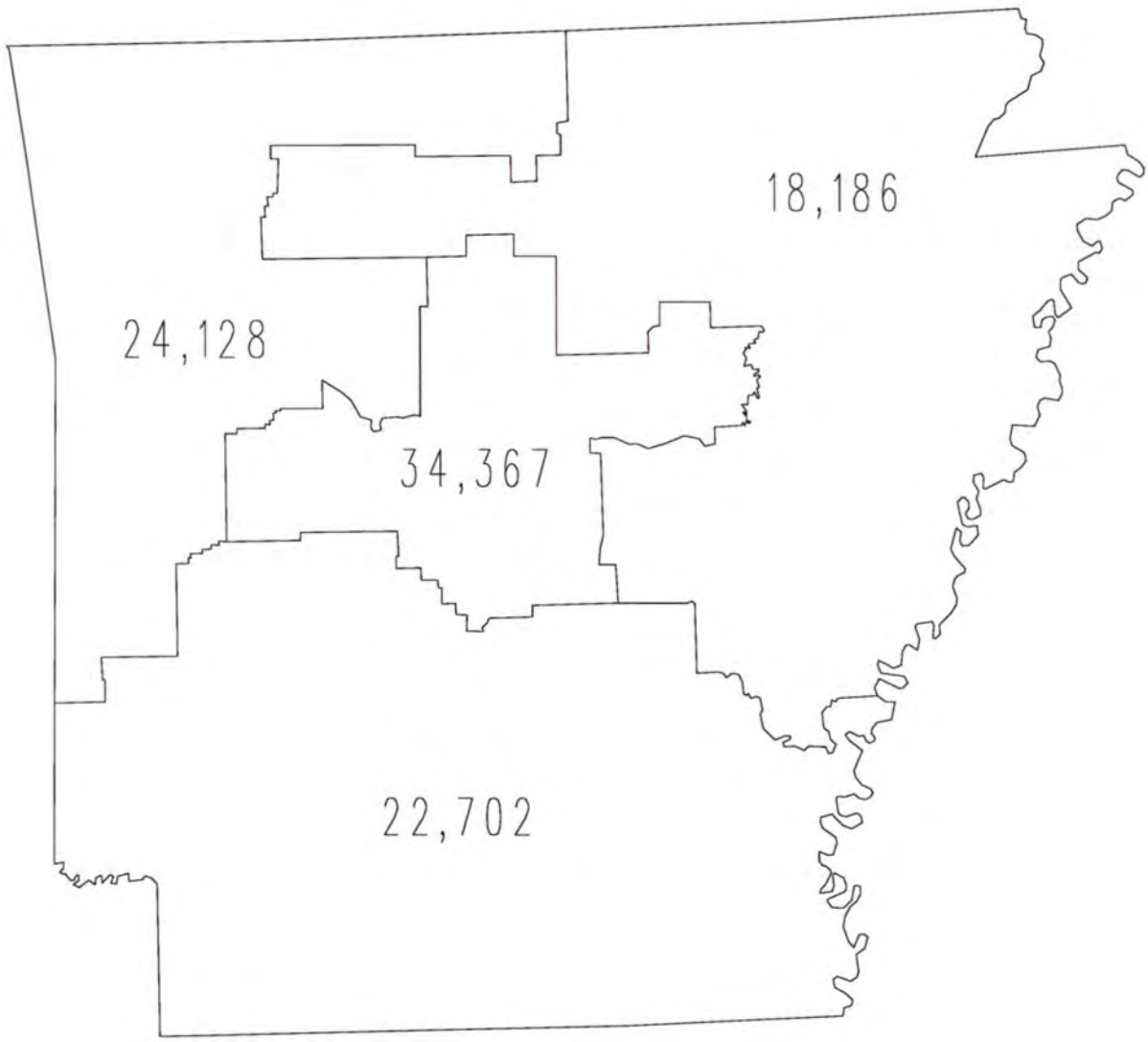
Persons in Arkansas Living in Nursing Homes, by Congressional District: 1990



Total Persons in Nursing Homes: 21,809

Produced using 1990 census data and the TIGER System
by the Census Bureau, U.S. Department of Commerce

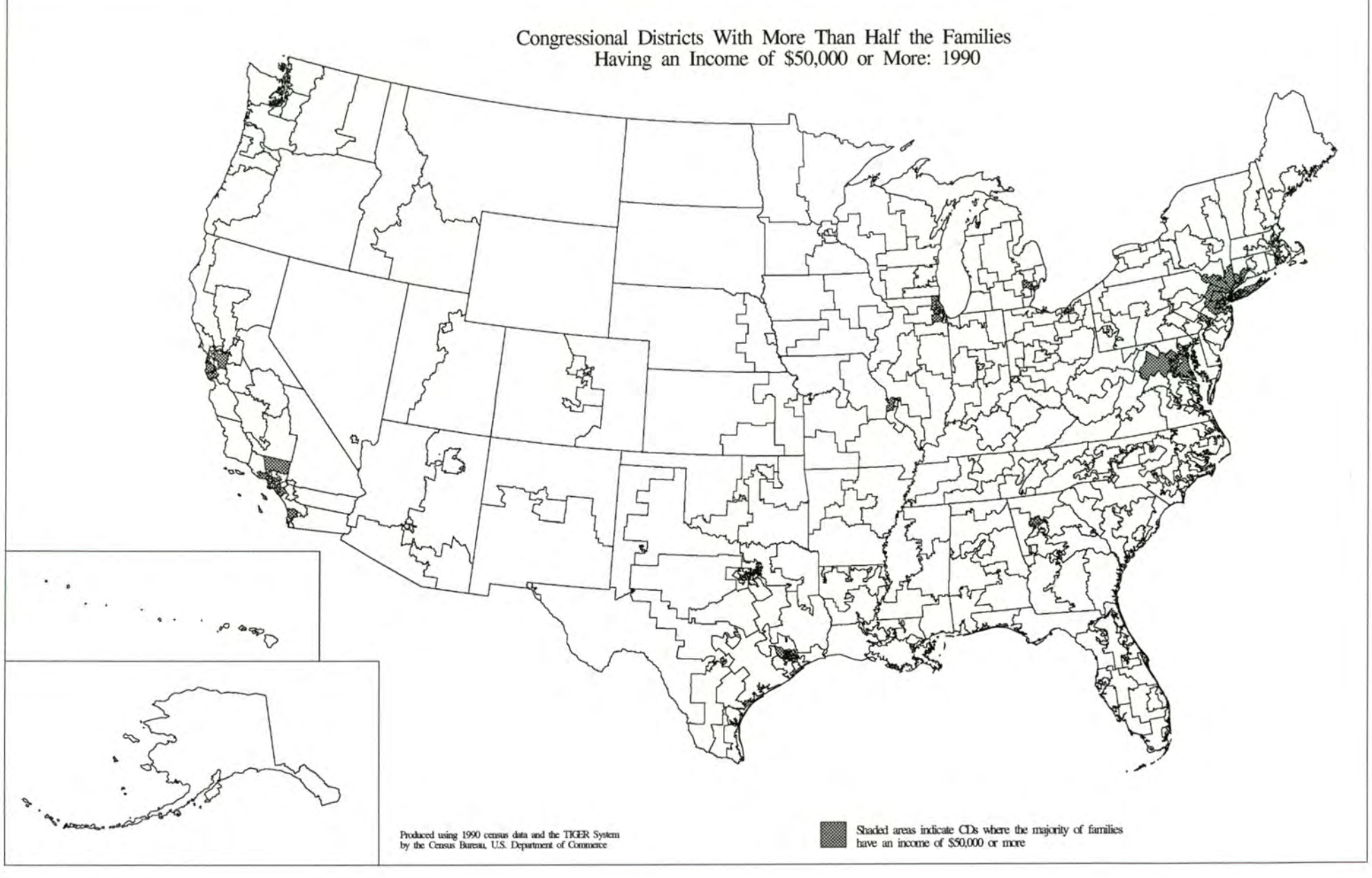
Number of Families in Arkansas Having an Income of $50,000 or More, by Congressional District: 1990



Total Families Earning $50,000 or More: 99,383

Produced using 1990 census data and the TIGER System
by the Census Bureau, U.S. Department of Commerce

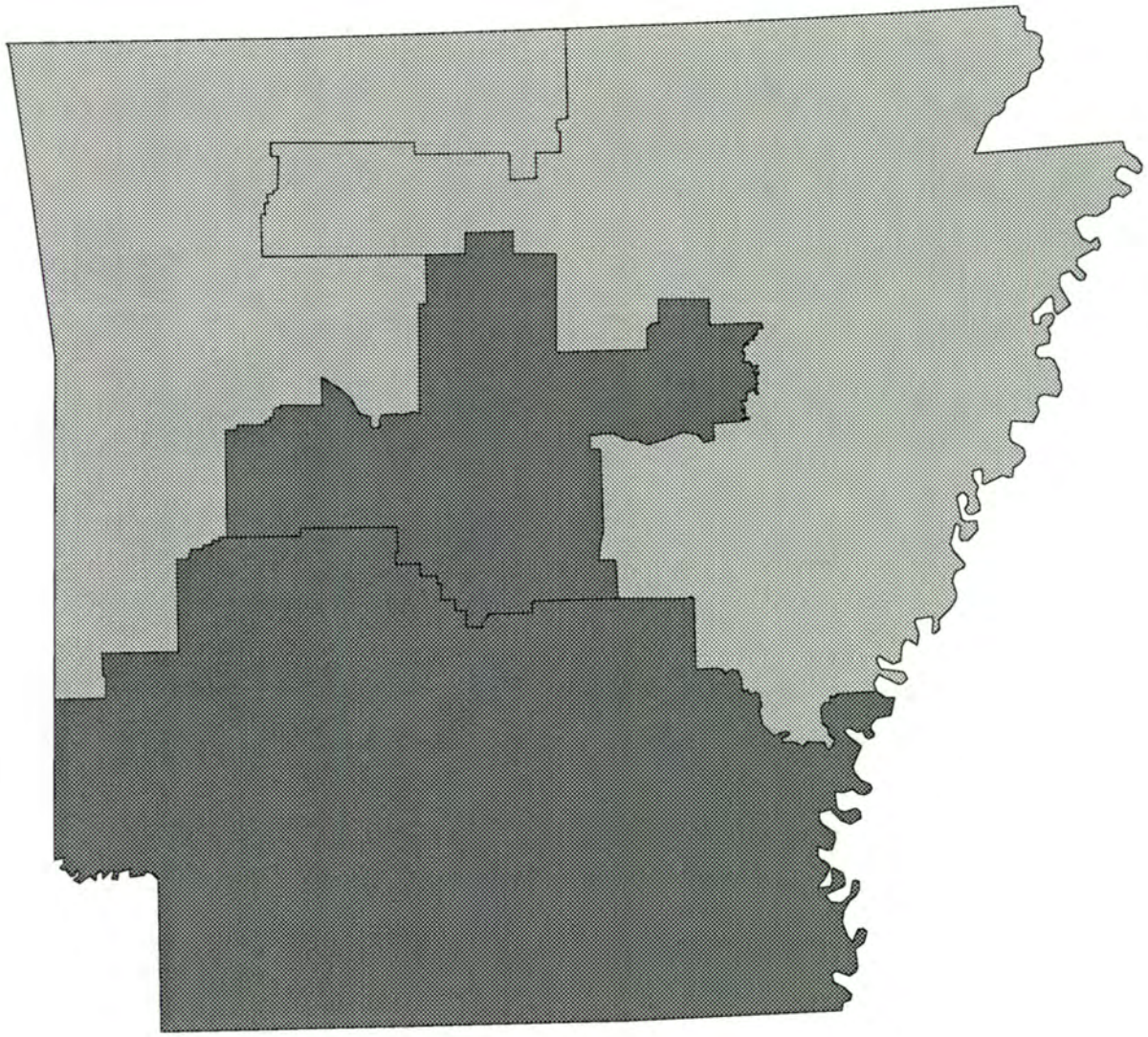
Congressional Districts With More Than Half the Families Having an Income of $50,000 or More: 1990



Produced using 1990 census data and the TIGER System
by the Census Bureau, U.S. Department of Commerce

Shaded areas indicate CDs where the majority of families have an income of $50,000 or more

Percent of Arkansas Population 65 Years of Age and Over, by Congressional District: 1990

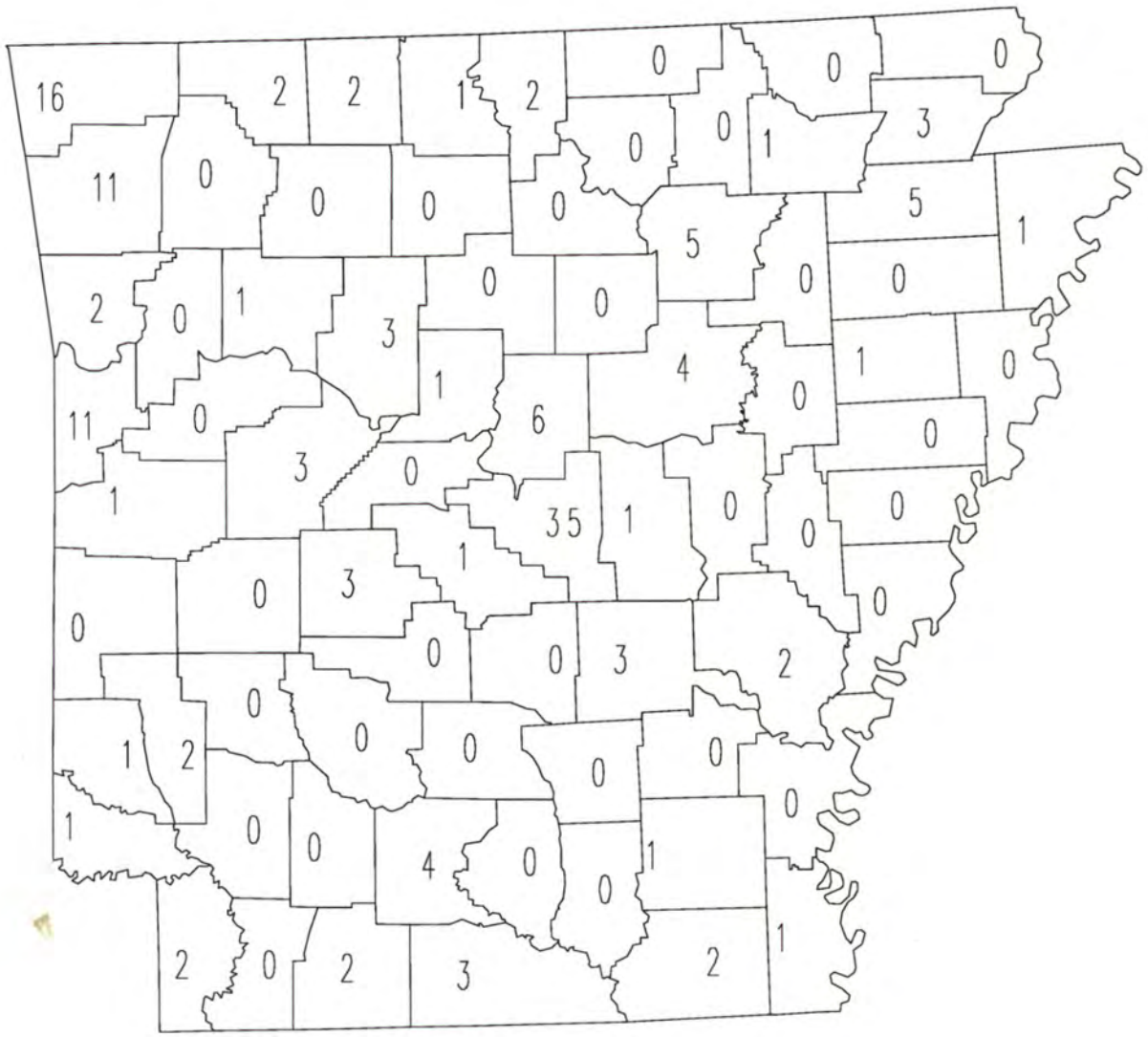


0 to 15 percent

16 to 20 percent

Produced using 1990 census data and the TIGER System
by the Census Bureau, U.S. Department of Commerce

Number of Companies in Arkansas With Payroll of 500 or More, by County: 1990



Produced using 1990 census data and the TIGER System
by the Census Bureau, U.S. Department of Commerce

Hawaii's Employer Mandate and Its Contribution to Universal Access

John C. Lewin, MD, Peter A. Sybinsky, PhD

Much national debate centers around national models in which an employer mandate plays an important role in providing for health care coverage for all Americans. Hawaii has had the nation's only health insurance employer mandate for almost 20 years, yet little is known nationally about the mandate itself or Hawaii's experience with it. This article describes the long-term effects of Hawaii's employer mandate on health care access and costs, and offers reflections on the potentials of national health care reform based on Hawaii's experience.

(*JAMA*. 1993;269:2538-2543)

AT LEAST since the early 1970s, employer mandates have been a part of the policy debate on how to provide cost-effective, high-quality health care coverage for all Americans. During that decade, several administrations prepared employer mandates that, for one reason or another, were eventually rejected. However, in 1974, Hawaii enacted the Prepaid Health Care Act (PPHCA), a remarkably successful law that remains the nation's only employer mandate for health care coverage. Except for a brief period in the early 1980s, employers in Hawaii have been required to cover their employees with a standard, state-established package of health care benefits. This article describes the relationship of the PPHCA to Hawaii's overall system and outlines some health costs and outcomes that the authors believe recommend this policy to other states and the nation.

HAWAII'S PPHCA

The keystone of Hawaii's health care reform efforts is its employer mandate, Chapter 393, Hawaii Revised Statutes, better known as the PPHCA. By significantly reducing the number of uninsured, this measure allowed Hawaii to implement a system of universal access to health care coverage in the late 1980s, making it the only state in the nation to offer such a guarantee to its people.

After 6 years of study and policy development, the PPHCA was adopted in 1974 to provide health care coverage for virtually all employees in the state. The PPHCA, enforced by Hawaii's Department of Labor and Industrial Relations, directs businesses to provide a prescribed standard and comprehensive benefits package for employees throughout the private sector. While not enthusiastically supported by the business community, the measure did have a great deal of support among unions and consumers. The PPHCA was supported by an environment already strong in employment-based health care coverage for comprehensive medical care through prepaid health plans. The major reasons for the PPHCA's passage were to protect the employees in the state from an erosion of health care coverage due to spiraling costs, evident even 18 years ago, and to add to the insured rolls those workers without coverage or with inadequate coverage.[1]

In this, the nation's first and only state-mandated benefits plan, costs are shared between the employer and the employee. The employee may be required to pay as much as 1.5% of monthly wages, up to half the premium cost. The employer pays the balance, but in all cases, at least 50% of the cost. Dependent coverage, while optional, has become the almost universal standard practice, the cost of which may be fully borne by the employer. Any employee who works more than 20 hours a week and makes at least 86.67 times the minimum hourly wage per month is eligible for prepaid health care.

Under the law, employers must provide as a minimum the basic services defined in Section 393-7 (Table 1). Coverage alternatives include both a fee-for-service plan and a health maintenance plan. The fee-for-service plan is the most used in Hawaii and provides a good package of diagnostic and treatment services, using copayments (usually 20%) to reduce overutilization. The health maintenance organization (HMO) model provides a generous package of benefits based on services included for a federally qualified HMO. The prescribed coverage may be purchased from any insurance provider licensed in Hawaii or provided on a self-insured basis by the employers themselves. An alternate package with fewer benefits, deductibles, and higher copayments may be substituted for the two basic plans, but then dependent coverage is required. Most employers, however, have not chosen the alternate plan.

No large state bureaucracy is needed to administer prepaid health care. A PPHCA Premium Supplementation Fund assists small employers (those with eight employees or less) who, because of economic limitations, cannot provide the required insurance, and covers employees whose employers have gone out of business or who are not in compliance with the law. During the 17 years of the program, this fund has had minimal use (a total of $85 000 has been tapped). The PPHCA is enforced by monetary penalties and a provision that the employer is responsible for all the employee's health care expenses in the event the employee is not covered by the employer, as required by law.

There are exclusions to the PPHCA. All government employees (who have their own plans or other coverage alternatives), seasonal agricultural workers (there are relatively few, and a seasonal employer must obtain a specific waiver from the state), real estate and insurance agents working on commission, family members in small family businesses, and government assistance program recipients are not covered by the PPHCA. People with coverage as a dependent under another employer's coverage are excused from being covered by their employer.

From the Department of Health, State of Hawaii, Honolulu.

Reprint requests to the Department of Health, State of Hawaii, 1250 Punchbowl St, Honolulu, HI 96813 (Dr Lewin).

Table 1.—Prepaid Health Care Benefits Based on Section 393-7, Hawaii Revised Statutes

Hospital
Inpatient (120 d)
Outpatient
Emergency department
Surgical
Physician
After care
Anesthesiologist
Medical
Necessary home, office, and hospital physician visits
Medical/surgical consultations
Medical care while hospitalized
Laboratory and radiology services necessary for diagnosis or treatment
Maternity benefits (9-mo waiting period)

Table 2.—Market Share of Health Insurance Providers in Hawaii*

Provider	Market Share, %
Hawaii Medical Service Association	56.4
Kaiser Family Foundation	18.0
Other Hawaii	8.2
Commercials	7.9
Other	9.5
Total	**100.0**

*Data derived from Friedman.[3(p68)]

Table 3.—Comparative Health Maintenance Organization Family Rates, 1992*†

Organization and State	Monthly Rate, $
Kaiser,‡ Hawaii	288
Kaiser,‡ Northern California	327
Kaiser,‡ Oregon, Washington	313
Kaiser,‡ Southern California	362
Kaiser,‡ Colorado	324
Kaiser,‡ Ohio	377
Kaiser,‡ Washington, DC	386
Group Health, Minnesota, Wisconsin	449
Harvard Community Health Plan, Massachusetts	465
Columbia Free State, Maryland	574

*Comparison subject to a number of factors including potentially different benefits and varying market situations.

†Data derived from *Consumer Reports*, August 1992.[4]

‡Kaiser Foundation Health Plan.

The prepaid health care program does not provide specifically for cost containment. However, the PPHCA has created the context required for cost containment by the health care system. The PPHCA's irreducible and broad standard benefits package, the inability under the PPHCA of insurers to reject any employed person, and the PPHCA's indirect coercion of the insurers to more effectively treat patients with chronic disease rather than reject them, and thus to use community rating, all result in a more cost-efficient system. Also, since very little bureaucracy is needed to administer the PPHCA and reporting is minimal, administrative costs created by the mandate are minimal. The healthy competition the PPHCA has fostered among the major companies for the market not only has tended to limit costs, but positions Hawaii for further marketplace competition opportunities as national health reform proceeds. Finally, the state's health planning certificate of need process administered by the State Health Planning and Development Agency has limited unnecessary construction, preventing the problems of overbuilding and overcapacity, which have driven up costs in many jurisdictions.

Overall health care costs in Hawaii remain well below the rest of the nation, but they still cause significant concern, increasing at double-digit rates for much of the 1980s. Nonetheless, a recent study comparing health care costs (including government expenditures such as Medicare and Medicaid) in Hawaii with those in the United States and other nations indicated that Hawaii's overall costs are lower than not only the rest of the nation (7.8% of gross state product compared with the US figure of 11.2% of gross domestic product), but also Canada (8.6%), Sweden (9.0%), the Netherlands (8.5%), and Germany (8.2%).[2]

ERISA AND PREPAID HEALTH CARE

The PPHCA was passed just months before the federal government passed the Employee Retirement Income Security Act (ERISA). While it focuses on pension plans, ERISA also contains language that preempts state employer health coverage mandates. Standard Oil Co, California, challenged the PPHCA in 1976 (*Standard Oil v Agsalud*), after the Hawaii state legislature passed a bill adding mental health and substance abuse coverage to the basic provisions of the 1974 PPHCA. The basis for this suit was ERISA preemption of the PPHCA. In 1981, the Supreme Court declined to review the lower court decisions and the PPHCA was overturned. It took special federal legislation in 1983 to allow the mandate to be reinstated by exempting Hawaii from the ERISA provision. The exemption was based on the 1974 law, which was enacted before the mental health and substance abuse amendment. While it has been reinstated, the PPHCA cannot be modified without congressional action.[3] Because of this limitation, the state cannot amend the PPHCA to reflect the changes in Hawaii's health care system since 1974. Amendments to the 18-year-old law would make sense in areas such as requiring mandatory coverage of dependents of workers, affording periodic and equitable cost-share adjustments between employers and employees, and modifying benefits to reflect improvements in clinical preventive services.

COMMUNITY RATING FOR HEALTH INSURANCE

Community rating spreads risk across an entire population. Commercial insurance practices often focus on trying to find and sell insurance to "low risk" businesses, leaving the "high risks," or those without the ability to pay high rates, without insurance. Without community rating, then, an insurance market is fragmented.

Because Hawaii has such a high level of persons with health care coverage due to its employer mandate, major health care insurers (the Hawaii Medical Service Association, Honolulu, and Kaiser Permanente Medical Programs, Honolulu, Hawaii) can use community rating for coverage for small employers. These rates are comparable to those enjoyed by large employers. Since Hawaii's major health insurers (both of which are nonprofit) voluntarily use modified community rating for small businesses and have such a significant market share (Table 2), rates are affordable for small business in Hawaii. Other factors, such as low inpatient utilization, contribute to the lower costs as well. As a result, fee-for-service and HMO coverage (Table 3) are well below the cost of comparable plans elsewhere in the United States.

Small businesses can purchase insurance at reasonable rates and can comply with the employer mandate without undue burden. Insurance companies cut administrative costs and can market to a large pool of businesses. Costs are low, in part because everyone must play and the young and healthy must pay into the pool along with those who are in greater need of services. The requirements of the PPHCA and responsible voluntary insurance practices have provided a uniformly level field for competition.

SYSTEM'S EFFECTS

While detailed analyses on the effects of Hawaii's system have not been undertaken, observation and preliminary data suggest that the policies established in Hawaii's system and supported by medical practice patterns in Hawaii have resulted in good health outcomes and little overall negative effects. These are evident in Hawaii's health status and its successful implementation and operation of an employer mandate and a supportive insurance system.

Effects on Health Care Coverage

The effects of an employer mandate are apparent. In 1971, 11.7% of the state's population was without hospital coverage and 17.2% was without physician coverage.[5] The PPHCA dramatically reduced those figures. Numbers of people who became insured owing to the passage of the new law were not directly

Table 4.—Reporting Units and Employment by Size of Firm, December 1990*

Size of Firm	No. of Reporting Units	% of Total	No. of Employees	% of Total
1 to 49 employees	25 768	94	173 277	38
1 to 99 employees	26 578	97	228 927	51
All employers	27 271	100	444 871	100

*Unpublished information from the Hawaii State Department of Labor and Industrial Relations.

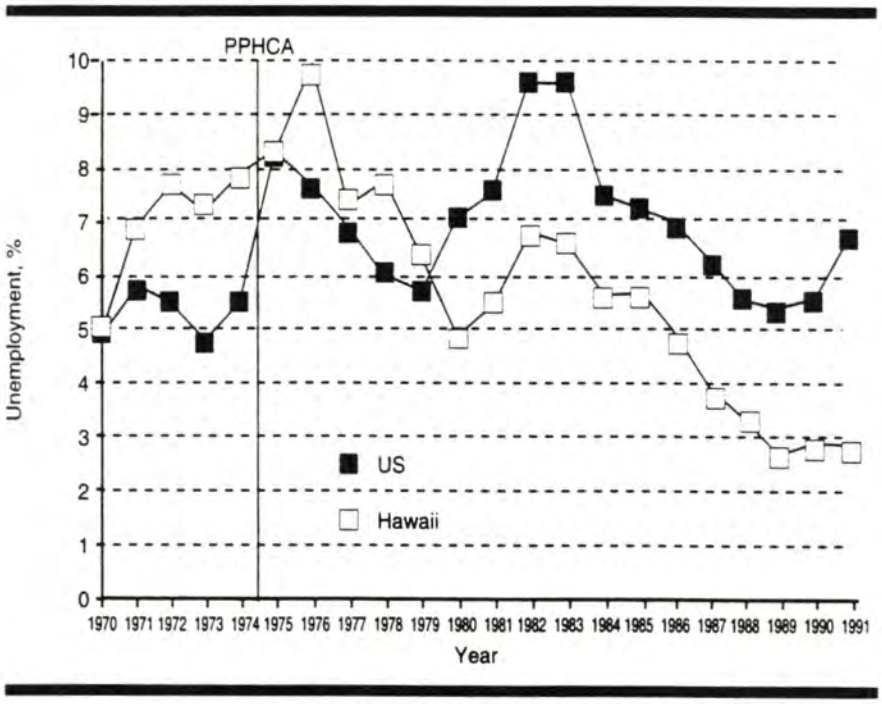


Fig 1.—Unemployment percentages for the United States and Hawaii, 1970 through 1991. PPHCA indicates effective date of the Prepaid Health Care Act. Data from unpublished information from the Hawaii State Department of Labor and Industrial Relations.

measured. One observer estimated that at least 46 000 people were immediately covered.[6] The Department of Health estimates that many more, mostly employees of small businesses, were brought on board, and a Department of Health study indicated that the overall state rate of uninsured was approximately 3.9% after the implementation of the PPHCA.[7] As the Medicaid caseload decreased in the early 1980s, the number in the gap group (those without health care coverage) grew to approximately 5% by 1987.[8]

Some of the remaining uninsured, such as professionals or people with high commission incomes, were able to purchase health services. Others, however, could not. In 1989, the Department of Health estimated the gap group in financial need or "medical indigence" to be about 3.5% of the population, about 35 000 people. Populations at risk in the gap group were the unemployed, some dependents of low-income parents, unemployed dependents, and part-time workers. While a few seasonal agricultural workers and other groups also remained outside the provisions of the PPHCA, their numbers were small. Neighbor island residents (those residing on islands other than Oahu) and immigrants were in the excluded groups in higher numbers, although they are not formally excluded from employer-based coverage.[9] With the remaining in-need population less than 5% of the population, a program of universal access was deemed feasible for the state.

This strategy took two forms. The first was expansion of Medicaid, largely by utilizing the options allowed in the various Omnibus Budget Reconciliation Act measures passed by Congress in the late 1980s and early 1990s. Medicaid was expanded to include pregnant women and infants, young children, elderly persons, and disabled persons. With these additions, and with significant growth in Hawaii/Medicaid's Aid to Families With Dependent Children caseload, Hawaii's Medicaid program grew to more than 96 000 persons by February 1993.[10]

A second option was "gap group insurance." The State Health Insurance Program (SHIP) (Chapter 431N, Hawaii Revised Statutes) was developed for those ineligible for Medicaid. This program provides a basic benefits package, rich in prevention and primary care but limited in catastrophic benefits (under the assumption that the SHIP member can use Medicaid "spend-down" for truly catastrophic events). By February 1993, the SHIP had just under 2% of the state's population enrolled, 86% of whom are under 150% of poverty. Forty percent of the SHIP clientele are children.

Together, the SHIP and Medicaid expansions have provided more than 40 000 recently uninsured people with health care coverage. The state's unemployment rate, while increasing in 1992, remains one of the lowest in the nation. The state conducted a survey on the uninsured from January through September 1991 and reported that those who identified themselves as being uninsured totaled 3.75%.[11] This remaining group may be difficult to insure owing to mental illness, severe substance abuse, or sociocultural reasons such as immigrant status. However, it is critical to point out that once these people present to a medical facility, they receive care.

Mandated health care coverage does not eliminate all barriers to health care. By and large, Hawaii has adequate health care services for its population. However, there are provider shortages in certain areas in Hawaii (four areas on Oahu and two areas on the island of Hawaii have been designated as a "medically underserved area" or "medically underserved population" by the federal government and six other areas are in the process of obtaining federal designation). Community health centers currently serve the Oahu areas and plans are under way to provide for the needs of the others.

Despite these delivery system problems, the PPHCA has been directly responsible for reducing the overall size of the gap group in Hawaii, which has permitted the state to provide cost-effectively coverage for the rest. Hawaii can claim universal access to health care coverage for all of its citizens.

Effects on Business

One of the principal objections to an employer mandate has been an alleged negative effect on business, particularly small business. Hawaii is a "small business" state. Table 4 shows that 97% of Hawaii's businesses employ fewer than 100 persons and account for 51% of the jobs in the state; 94% employ fewer than 50. We note that the available data do not demonstrate that the PPHCA has an adverse effect on business in Hawaii. In fact, some indirect indicators suggest that the effect may be positive.

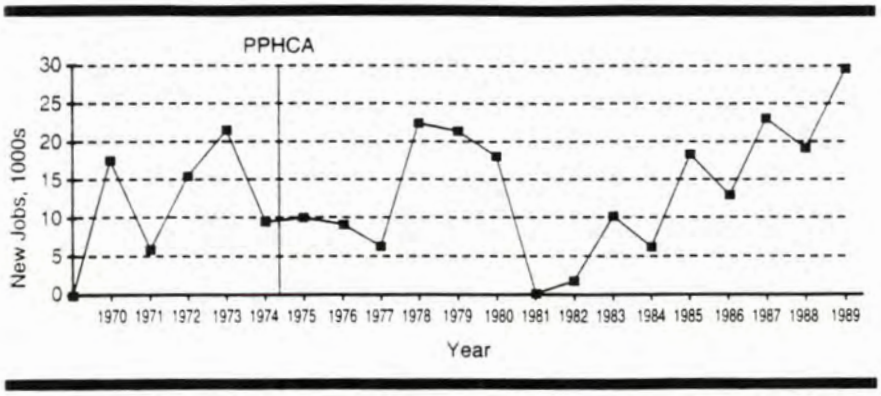


Fig 2.—Change in employment in Hawaii, 1970 through 1989. PPHCA indicates effective date of the Prepaid Health Care Act. Data from unpublished information from the Hawaii State Department of Labor and Industrial Relations.

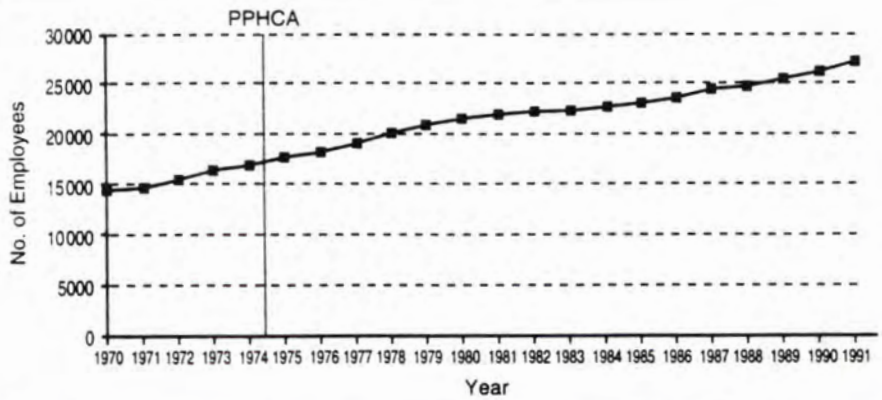


Fig 3.—Growth in employers in Hawaii, 1970 through 1991. PPHCA indicates effective date of the Prepaid Health Care Act. Data from unpublished information from the Hawaii State Department of Labor and Industrial Relations.

From a small-business standpoint, the typical argument against mandated benefits is that, as business costs increase with the burden of required health insurance, marginal businesses will fail and the growth of others will be slower. In either case, a higher than average proportion of businesses would fail and jobs would be lost. Hawaii's statistics do not bear this out. Hawaii's unemployment rate, high when the PPHCA was enacted in 1974 and throughout most of the 1970s, has shown a downward trend since 1977 (Fig 1). While unemployment did reach a high point in the year following the PPHCA's effective date, an evaluation at the time concluded that the PPHCA had no appreciable effect on business.[6] Many factors contributed to the downward unemployment trend in the two decades following the mandate, but it is clear that the PPHCA did not have the devastating economic effect predicted. In fact, viewing job creation as another indicator, Fig 2 shows that in all but 1 year since the PPHCA's effective date more jobs have been created than have been lost. Throughout this period, Hawaii has enjoyed a general growth in employers (Fig 3) and in jobs. In 1990, it was third highest in the nation in the per capita start-up of new businesses and about average with respect to business failures.[12]

One can actually argue that the employer mandate has been good for small businesses. Because its provisions set the basis for the continued voluntary community rating by Hawaii's major insurers, costs of health insurance for Hawaii's small businesses are relatively low. And, unlike other states, since all small businesses are part of the insurance pool, small businesses covering their workers are not paying for the uncompensated care costs of the small employers who don't. Finally, the PPHCA Premium Supplementation Fund rarely has been used. This would suggest that little negative impact has been felt by small businesses eligible for the supplement.

Effects on Health Status

Considering that health outcomes ought to be the key objective of a health care system, Hawaii fares very well, if not the best of all states, in terms of longevity, low infant mortality, and very low premature morbidity and mortality rates for cardiovascular and pulmonary disease and cancer.[13] Two recent national analyses of the comparative health status of all 50 states, one by Northwest Life Insurance Company, Milwaukee, Wis,[14] and another by the American Public Health Association, Washington, DC,[15] have rated Hawaii first among all states. We believe a considerable amount of this success is attributable to direct and indirect effects of Hawaii's employer mandate over the past two decades. Historically, Hawaii's physicians and agricultural plantations emphasized outpatient care over hospitalization, an orientation that continues to the present in Hawaii's medical practice patterns. While no study of health status was undertaken over the effective period of the PPHCA, data available now support our contention.

Table 5.—Years of Productive Life Lost (YPLL) per 100 000 due to Premature Mortality, Age Adjusted*

	Hawaii	US Population
Cancer	684	871
Heart disease	523	699
Index of YPLL, 1987	2345.3	3126.6

*Robert Worth, MD, written communication, March 1991, based on 1990 data from the Centers for Disease Control and Prevention.

Table 6.—Utilization of Community Hospitals, 1991*

	Nation	Hawaii	% of US Rate
Beds per 1000 population	3.7	2.6	70
Patient days per 1000 population	884	792	89.6
Surgery per 1000 population	87.4	52.9	60.5
Emergency departments per 1000 population	351.1	168.9	48.1

*Data derived from the *Universal Healthcare Almanac*.[16]

The state's continued emphasis on ensuring access to primary care for nearly all its citizens has been a major factor in better health outcomes and improved health status for Hawaii's people. This is true despite risk populations and risk factors consistent with other urban and rural areas of the nation. On an age-adjusted basis, Hawaii has many fewer years of productive life lost owing to premature mortality due to cancer, heart disease, and overall causes (Table 5). Early access to primary care also shows up in health utilization statistics. Table 6 shows that Hawaii has 70% of the national rate of acute hospital beds per 1000 population, 90% of the national average for acute hospital utilization, 61% of the national average for surgeries, and 48% of the national rate of emer-

Table 7.—Years of Productive Life Lost due to All Causes, 1990*†

By Ethnicity	Rate per 100 000 Population
Caucasians	4894
Japanese	6025
Filipinos	5689
Hawaiians	10 297

*Age adjusted.
†Robert Worth, MD, written communication, March 1991, based on data from the Centers for Disease Control and Prevention.

Table 8.—Health Risk Behaviors for Hawaii and 45 States, 1990*

Risk Behavior	% of Population	
	Hawaii	Median of 45 States
No leisure activity	31.6	28.7
Sedentary life-style	62.4	58.5
Smoking	21.1	22.7
Overweight	17.7	22.7
Binge alcohol	19.4	15.2
Drink and drive	3.9	2.9
No seat belt	4.9	25.9

*Data derived from Siegel et al.[17]

gency department utilization. There is no rationing, and Hawaii has the same commitment to tertiary care and new technologies as other states. We believe the economies of lower inpatient utilization are a major source of Hawaii's lower costs.

Other hypotheses for the state's better outcomes abound. Because of a high proportion of Asian–Pacific Islanders in its population, Hawaii is purported to have a healthier "genetic stock"; in national data, Asian–Pacific Islanders appear to have better health status in all states. If this is so, the Asian–Pacific Islanders in Hawaii's population presumably would have better health status than Caucasians. However, analysis of recent data belies this hypothesis. As can been seen in Table 7, when age-adjusted populations of Japanese, Filipinos, Caucasians, and Hawaiians are compared (together these four groups make up 85% of Hawaii's population), Japanese, Filipinos, and Caucasians have similar status in terms of years of productive life lost per 100 000 people, with Caucasians coming out the best overall. The only group at variance from this profile are the native Hawaiians, representing 20% of the population, but with about twice the rate of productive years lost. These data suggest no major ethnic component to Hawaii's improved health status, and reveal that the category of Asian–Pacific Islander used in reporting national health statistics appears to mask the poor health status of Pacific Island peoples in Hawaii and might also be hidden in national statistics as well.

Another frequently stated hypothesis about Hawaii's good outcomes and lower health costs presumes that superior life-style choices and climate are responsible. However, Hawaii's data are not particularly noteworthy in this regard. Compared with the other states surveyed by the Centers for Disease Control and Prevention, Hawaii actually ranks above the median for 45 states on four of seven indications of "unhealthy" life-style: lack of leisure-time activity, sedentary lifestyle, binge alcohol drinking, and percentage of population drinking and driving (Table 8). The incidence of essential hypertension and hypercholesterolemia is higher than national averages. Life-style factors reflect Hawaii as an above-average state perhaps, but certainly do not in themselves explain Hawaii's excellent health mortality outcomes and lower costs.

While Hawaii's warm climate reduces health care expenses due to cold weather (eg, pneumonia, falls from slipping on ice), the state experiences more drowning, bodysurfing and ocean injuries, and skin cancers. Because Hawaii is a gateway for immigration from the Asia/Pacific region, it has the second highest rate of tuberculosis in the nation, and ranks among the top 10 states in per capita incidence of human immunodeficiency virus contraction.[18] It also has been calculated by the Hawaii State Department of Health to have the highest rate of hepatitis B in the nation and a high rate of Hansen's disease.

Access to basic health care appears to have been a key factor in improving the health status of Hawaii's people through the reduction of unnecessary inpatient and emergency department care. However, this analysis needs further documentation and investigation.

PUBLIC PERCEPTION OF EFFECTS

Public support for Hawaii's system is strong in the state. A recent poll conducted by Louis Harris and Associates, New York, NY, and sponsored by the Kaiser Family Foundation and the Queen Emma Foundation shows this.[19] The study was designed to be comparable to a national study conducted by the Kaiser Family Foundation and the Commonwealth Fund in late 1991. The Harris poll provides a good comparative base for the perceptions of Hawaii respondents with those of the rest of the nation. In that survey, 76% of the respondents felt that Hawaii's system "works as well as can be expected" or "fairly well, but minor changes are needed," with 55% of Hawaii respondents indicating similar confidence in the nation's system. Nationally, only 40% of the respondents had a similar opinion. On the other hand, 18% of Hawaii's respondents felt the system worked badly and needed major changes or an entirely new system, as opposed to 57% of the national sample (Table 9).

Table 9.—Comparison of Satisfaction With Health Care System in Hawaii and the Rest of the United States*

Base	Hawaii		
	Hawaii's System, % (n=1000)	Nation's System, % (n=1000)	Total US, % (n=2000)
"It works as well as can be expected" or "It works fairly well, but minor changes are needed."	76	55	40
"It works badly and major changes are needed" or "It works so badly that an entirely different system is needed."	18	39	57
Not sure/refused.	6	7	3

*Data derived from the *Hawaii Health Care Survey*.[19]

Citizen confidence in Hawaii's state-based system is also evident when the respondents are asked about their choices of who should lead the health care reform effort. While 62% of the national sample looked to the federal government to lead health reform, only 48% of the people polled in Hawaii picked the federal government to lead. In Hawaii's case, 43% chose the state to lead, compared with only 30% of the national sample.[19] Thus, while Hawaii recognizes the need for a 50-state system for true health care reform, the response of its citizens implies confidence in the directions and responsibility taken locally.

LESSONS FROM HAWAII'S EXPERIENCE

Hawaii's experience with an employer mandate injects several lessons into the national debate. As the only state with an employer mandate, Hawaii runs the risk of being termed "an outlier" or an anomaly owing to factors as diverse as its geographic location or the ethnic makeup of its people. While unique in many ways, Hawaii's overall health care system, hospital costs, provider salaries, and standards of care are not atypical among states. However, the state's commitment to universal access, community insurance rating, and primary and preventive care have paid unexpected cost-containment dividends in addition to the expected social rewards. This experience does deserve consideration by national and state policymakers.

Hawaii's experience suggests much from which the nation can benefit:

1. An employer mandate can be a pow-

erfully effective means of increasing access, without a devastating impact on business. Several hypothetical studies based on projections and a limited number of variables have predicted that an employer mandate would result in a loss of jobs or a business slowdown.[20,21] Hawaii's actual experience suggests the opposite: Insurance rates are lower, there's a sizable reduction in uncompensated care, insurance practices are more equitable, and all employers are included. We do not believe an overall negative effect on either business or employment has occurred in Hawaii owing to the employer mandate.

2. Fair insurance practices are essential for and are supported by an employer mandate. By providing a base for community rating, Hawaii's employer mandate provided a base for the generally fair system of insurance coverage in the state. Because all employers are in the risk pool, community rates are affordable, and insurance is transportable. This provides the strong argument from Hawaii's perspective for a simple and clear, "everybody plays" mandate.

3. A broad standard benefits package, emphasizing primary, outpatient, and community care, but including a comprehensive spread of benefits extending from preventive services to inpatient and catastrophic care, is necessary to contain overall costs. Hawaii's experience supports inclusion of benefits and services that are demonstrated to be clinically and financially effective and appropriate and that collectively reduce unnecessary emergency department, inpatient, and high-technology care by design. We believe that some mental health, substance abuse, dental, and pharmaceutical drug coverage must be included in a cost-effective, minimum-benefits package to promote cost containment through more successful primary and noninstitutional care.

4. Universal access is in itself a cost-containment strategy. Because virtually all of Hawaii's people have access to primary care coverage through the employer mandate and the state programs it has made possible, utilization of high-cost services in Hawaii is well below the rest of the nation. This leads to the lower health care costs, comparatively low small-business insurance rates, and a lower portion of gross domestic product spent on health care when the state is compared with the nation.[2] By allowing free access to primary care, a national or state health policy could decrease the use of expensive modes of care and thus decrease health costs. Universal access, then, has been our best cost-cutting tool.

5. States can be successful in health care reform. Even though a "small business" state, Hawaii has demonstrated that states can implement comprehensive health reforms when given flexibility by the federal government to design and implement these reforms. Hawaii's ERISA exemption was crucial in this reform process. Recent federal court decisions are citing ERISA to limit an ever-increasing number of incremental state-mediated reforms. For example, in New Jersey, the decision in *United Wire, Metal, and Machine Health and Welfare Fund v Morristown Memorial Hospital* overturned that state's long operating uncompensated care fund. It would seem prudent public policy to allow for careful and deliberate state experimentation through ERISA exemptions or waivers in the event the needed national reform does not happen right away.

CONCLUSION

While health care reform has increased significantly in importance to the American public in recent years, no specific health reform strategy has yet found general support by a majority of American people.[19] Hawaii offers positive and nonhypothetical experience with the nation's only employer mandate, coupled with the advantages of community insurance rating and an emphasis on primary and preventive care. Our state demonstrates and validates that this approach is a viable one for serious consideration in health care reform not only by other states, but by the nation itself as the Clinton administration and the Congress proceed to grapple with the issues involved.

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THE WHITE HOUSE

Office of the Press Secretary
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REMARKS BY THE FIRST LADY
AT HEALTH CARE ROUNDTABLE

Ala Moana Hotel
Honolulu, Hawaii

9:00 A.M. AHT

GOVERNOR WAIHEE: Good morning and aloha. It's a pleasure to be able to welcome all of you to this health care forum. We had a very exciting and interesting morning. Russell Watanabe from Watanabe Florists was kind enough to invite the First Lady and myself to his business so she can get a chance to see what 97 percent of Hawaii's businesses look like. We wanted an opportunity before coming to this forum to talk to some small business employers about what it's like to be under the Hawaii prepaid health care plan. And they were very informative. And we want to thank them for their participation.

We are very fortunate, obviously, to have our nation's dynamic First Lady, Hillary Rodham Clinton, with us. As you know, Mrs. Clinton has been at the forefront of the President's initiative to look into health care reform so that affordable quality health care services can be made available to all citizens of this nation. As the President mentioned in his comments on Sunday at the Great Aloha Celebration on the beach of Waikiki, spiraling health care costs is the number one drain on our nation's economy. Providing universal coverage and containing health care costs are among the top priorities for his administration.

In Hawaii, we found a way to offer more people greater access to primary care than any other state. And we've done it by building partnerships between the state, insurance companies, doctors and hospitals -- all who share in the costs -- and by pioneering innovative concepts like short hospital stays, out-patient surgery and preventive health programs.

But we haven't done it overnight. The most significant factor in Hawaii's success story is experience. We've been working to be the health state for 20 years, and this forum allows us to share our experience with the rest of America. The keystone of Hawaii's system is its employer mandate which

requires employers to provide health care coverage for most workers. And while controversial nationally, we have found this program to be a success, ensuring a high level of coverage for Hawaii's people and strengthening our ability to control costs.

And, frankly, after nearly 20 years, as indicated this morning, employers in Hawaii recognize that providing health care is good business. And so, for this morning's forum, we have also provided more of Hawaii's business owners to discuss this issue with us, as well as experts on health care.

A significant cost control resulting from universal access to coverage has been the ability of people in Hawaii to make use of preventive and primary care, and thus, reduce Hawaii's need for expensive emergency room and hospital care. Universal access, then, has been Hawaii's most effective cost control mechanism. And while Hawaii's successes in solving access and cost containment have been notable, they are not complete. Costs continue to surge both in Hawaii and throughout the nation.

That is why a strong partnership with our federal government is just as crucial as the local partnerships -- we are forged with the private sector here in Hawaii. And that is why I and my fellow governors were so pleased to hear the President on the eve of his inauguration promise to look to the states as laboratories for innovation and creativity in resolving the nation's current health care crisis.

In his initial months as President, President Clinton has been true to his word. Through the First Lady's work on the Health Care Task Force, his administration has sought the input and suggestions from a broad range of citizens and professionals. And that is why she is here today -- to learn more about Hawaii's health care system.

And so, on behalf of all of the participants, we want to, first of all, thank Mrs. Clinton for joining us here, taking time out from her busy schedule, what should, in fact, be a vacation, to be with us here today. And the second thing I want to do is ask all of you to join me in welcoming Hillary Rodham Clinton to our health care forum this morning. Thank you. (Applause.)

MRS. CLINTON: Thank you very much. Well, I am delighted to be here. And I appreciated the invitation from the Governor to have some time to learn more about how the Hawaiian health care system works, to learn what could be done to improve it, and to provide a forum for those of you who are financing it and delivering care in it and receiving care from it, to share your experiences with the rest of the country.

Because, oftentimes, as I have traveled around the country talking about health care, people have asked me about

what is going on in Hawaii. And I have tried to educate myself so that I could give answers that were at least close to the mark. But I think there is no substitute for going to the people as we did this morning at Mr. Watanabe's Florist shop, for which I am very grateful to him and his family, and then coming here this morning to hear from a broad cross-section of Hawaiians who are on the front lines.

I really believe that the rest of the country has a lot to learn from what you have done over the last 20 years. And I am looking forward to having that chance this morning. So I am here to listen and ask questions and not only enhance my own awareness, but to take back with me to Washington specific suggestions from you as to how the national system should be implemented and what you would expect it to be able to do based on your experience.

GOVERNOR WAIHEE: Thank you, Hillary.

I thought at this time it might be beneficial if we have Dr. Jack Lewin, who is our Director of the Department of Health here in Hawaii, give us a brief walk-through on what the Hawaii health care system is all about, how it functions, some of our strong points, some of our weaknesses, and maybe some of the areas we may want your help.

So, Jack, why don't you say a few words.

DR. LEWIN: Thank you, Governor. Welcome, Mrs. Clinton. And good morning, everybody.

It really is a privilege once again to have a chance to talk a little bit about the successes that we have enjoyed here in Hawaii and how those successes may be relevant to the rest of the country in terms of health care reform and the challenge that our First Lady has taken on behalf of the President.

I've often been accused, Governor, of being a salesman for Hawaii's health care system --

GOVERNOR WAIHEE: Make it salesman, Jack, period. (Laughter.)

DR. LEWIN: But I want to say that our health care system sells itself if you take a look at the facts and you really give it a chance.

Until recently, Hawaii really has been a very well-kept secret in terms of health care innovations. We don't claim to be perfect. We are experiencing cost increases here. Our small businesses will be able to share that with us. Maybe less than the mainland, but nevertheless, we experience it. We need more investment in mental health and substance abuse, like the

nation does. We have cultural groups -- our native Hawaiians who need special access considerations taken into account. We need primary care providers in some of our rural areas where they're hard to acquire. We need to deal with long-term care, the cost of long-term care, and address that issue squarely. And we certainly can accomplish even more in Hawaii with prevention and with wellness and with approaches toward public health intervention. So there's a lot more still to be done.

But 98 percent of Hawaii's public currently has access to high-quality, excellent, high-tech medical care. And that includes a full array of services. The outcomes in Hawaii for the public are very, very good. We have the greatest longevity in the nation; some would say that's just so we can live long enough to pay off our mortgages. (Laughter.) But, frankly, we have great longevity. We have the lowest morbidity and mortality rates for cardiovascular disease, for cancer, for emphysema. We are tied with one or two states with the lowest infant mortality rates in the nation, and we have excellent outcomes for our people. And that's with a population that starts out with many of the same adversities and health problems that exist in the other states of the nation.

We have a Harris Poll and a Kaiser Family Foundation Survey that did consumer satisfaction recently, and it showed that Hawaii had the highest amount of consumer satisfaction of any of the states, and even more than Canada. So, while we have some problems, we have a tremendous amount of support for what has happened here from our people.

And the big issue is this: that the costs in Hawaii are 35 to 40 percent lower than the rest of the country. While the nation is at 14 percent of gross national product for health care costs, Hawaii is between 8 and 9 percent of our gross state product. And that is, in fact, very, very remarkable when you consider the good outcomes.

Now, our doubters around the country are going to say, that's fine, that's dandy, that's Hawaii, but how does that relate to all of us on the mainland of the United States? And there are a lot of myths that I'm sure the First Lady has heard, that it's the great weather, that it's superior genetics, the lifestyles here are so much better, that there's a mysterious island factor that somehow doesn't work for the islands in the Caribbean and so forth but it does here. And we need to debunk those myths because we've gathered data using Center for Disease Control to look at lifestyles and genetics and so forth. And those do not explain 40 percent lower costs. We simply can't explain those costs on the basis of those myths and we have to look further, and that's what this meeting is about.

Part of debunking the mystery about Hawaii is to understand our employer mandate, the Prepaid Health Care Act. And I think if we look over here at some of these banners that

are out here, you can see that we have a number of factors going into play. But, first of all, without the Prepaid Health Care Act, we would not have been able to do the SHIP* program, to move ahead and provide insurance for the people in the gap. We would not have been able, Mrs. Clinton, to go ahead with prevention programs in AIDS, in early intervention, in child abuse prevention, and emergency medical services, in training primary care and some of the other things that our state is doing.

None of that could happen if we didn't have the efficiencies of our system. The Prepaid Health Care Act reaches 84 percent of Hawaii's population. That's all the work force and that's the dependents of the work force. It's been here for 20 years. It does not have a large government involvement. It is not a bureaucracy, it is not -- come under the guise of socialism. Instead, it is a partnership of business, of government and of health care providers together, working in a marketplace with a lot of consumer-driven choice that makes the system work. So, in a way, Hawaii is closer to managed competition than, frankly, anyplace in the nation can purport to be.

People have said on the mainland that we're forcing people into HMOs and into managed care. Now, we have some of best HMOs and managed care the nation can offer. And we're very proud of them. But on the other hand, two-thirds of the people in Hawaii still seek fee-for-service medicine in the very typical freedom of choice approach that is so prevalent and popular elsewhere in the country as well as HMOs.

How does it work? Well, it's administratively simple. Employers and employees split costs and pay their fair share, although, as you'll hear today, when the law was passed it said that 1.5 percent of employees' wages was the maximum the employee could pay. Wages have increased more slowly than health care costs. And today that would need to be somewhere between three and six percent of wages if we were really going to be equitable with the goal we had back then of a 50-50 cost split. So businesses would like to see some modification in that area.

But for 20 years, today even, the cost split is probably 75 percent cost share for the employer and 25 percent for the employee across the board. For example, for state government workers, the government pays 60 percent and the employees pay 40 percent of cost.

The benefit package in this law is very critical to its success. It is very broad. It's prevention to catastrophic care. It includes 120 days in the hospital and major medical, lab, X ray, out patient, emphasis on primary care and out-patient surgery. The law didn't include pharmaceutical drug coverage. It didn't include dental coverage. And it didn't include mental health and substance abuse.

Now, we have kind of gotten mental health and substance abuse in through the back door, and now more than 95 percent of our people do have mental health and substance abuse in limited benefits.

Dental and drug has been handled differently. A supplemental package has been offered to all workers and their families. And, in fact, that supplemental has been taken up by more than 80 percent of the people. So we actually have achieved that kind of coverage for the most part by consumer choice.

The dependent coverage is not mandated in the law, but it, de facto, is universal. And there are several features of our law that you need to understand when we think of a national employer mandate that we would recommend. Our law doesn't absolutely require community rating by insurance companies. But that has resulted because the law says that all workers and their families must be accepted without regard to a preexisting medical disease.

Because of that, our insurance companies have learned how to manage medical care rather than reject and eject people from care. And that puts us in a very different game plan.

So insurance reform, dependent coverage, mandatory participation, with a standard benefit package that cannot be undercut, these are the critical factors of success in this law. And the results of it are quite simply these: that we have more primary care and prevention because of these things; and instead of genetics, instead of lifestyle, instead of weather, here is where we achieve our success very clearly -- we reduce emergency room use and high-tech use by 35 percent compared to our mainland counterparts. And we reduce per capita use of hospital beds by 35 to 40 percent in this state. And its because we provide better up-front and primary care without copayment and deduction barriers and with a real emphasis on that care.

There's where Hawaii's success comes. And that's why our system really works. I think that's important for people to understand and to debunk the myths, because there's the success.

The other real important success that is critical to you and the President is that when Hawaii's law was passed, 17 percent of our employees, mostly small business people, were uninsured. The law took that gap group down to three to five percent. And that would happen in any mainland state because, as you well know, that two-thirds to three-fourths of our uninsured people in America are, frankly, people who are working or are the dependents of workers.

In Hawaii that is not a problem. If you're working or you're the dependent of a worker, you're covered. It doesn't

matter if you have cancer, if you have heart disease -- you come in and you pay the same rate as anybody else. And those are incredible results that we need to share with the nation.

In terms of business, we do have some effects that we need to go into in the discussion and there are people here that will really entertain that. But in essence, our program is not a bureaucracy, it was implemented quickly. We can show you that in terms of new business creation, since '74 to now, we do better than the national average. In terms of business failures and bankruptcies, we have fewer than the national average.

Some can say, but what about this year and last year? And, yes, on Kauai, we lost a lot of businesses this year. But, frankly, Mr. Clinton, they will be back next year as the hotels open. And Hawaii has been a very healthy environment for small business, even though small businesses are always going to say that they don't appreciate worker's compensation, disability insurance, family leave mandates, health insurance mandates. It's worked, and we've had 20 years of great success with it.

So I think the one key factor that the Governor and I like to emphasize is that satisfaction of people on the job, satisfaction of employees and their families knowing they have coverage -- satisfaction is really an important factor which is very much underrated in our society.

I think that we can wrap this up in this discussion by making a very important point to you: Yes, Hawaii has a terrific system going here, but we need what you're doing. We need national health care reform very, very much. A lot of the cost increases to small businesses in this state have come from Medicare and Medicaid increasing costs, which shift back to business and insurance rates. A lot of the cost increases come from drug cost increases and medical supply increases. We need a national program to get those kind of things under control. We need a national program for tort reform and malpractice, for a common data system for emphasis on training and primary care. Those are things you have been talking about and we're very grateful for that.

We also need a national system to get worker's compensation, disability insurance, auto insurance, and those things contracted and compacted down for businesses back into a health package that is more efficient. And I think these are all great areas that give us a challenge to go ahead with national reform.

We want to say Hawaii's not perfect. We're not a blueprint. But we have powerful lessons for the future. We're not theoretical. We're real; we've been up and running for 20 years with an employer mandate. And we know that a well-designed employer mandate with insurance reform, with irreducible benefits that are broad and generous, and with mandatory participation

happened was that he amputated his leg. I was thinking about that because I thought if this was now the preventive measures that could have been taken would have definitely changed the quality of his life as he got older. Then I thought of myself because I didn't know that if you had a pre-existing condition in the mainland, you could be turned down for health insurance.

When I came to Zippy's, I had a chronic condition that if this was somewhere else I could have been turned down for insurance and then it would have been a burden on me because my medication costs and my ongoing costs, you know, would have been really hard for me.

This coming together with everybody else has really helped me appreciate what we have here in Hawaii. I also still strongly believe, though, that as a consumer we have a lot of responsibility in prevention. You know, prevention of getting sick, prevention of the kind to help keep the cost down, you know. And I think that's what we need to do as employees.

MRS. CLINTON: May, I'm really glad you mentioned the pre-existing condition because I've lost track of how many states I've visited and how many people I've talked with, but that is the single complaint I hear everywhere. It doesn't matter what attitude people have or who they are, the fact that, in the mainland, as you point out, there are many people in your condition who either are uninsurable or whose insurance is so costly they might as well be uninsurable.

And it is a particularly difficult situation for people who want to change jobs on the mainland but can't because if they have insurance they would have to give it up in order to go to a better job opportunity to maybe make more money, but it would be a net loss for them. So, this whole issue of pre-existing conditions, which I don't hear about in Hawaii because you have taken care of that, is a major problem in the rest of the country.

Q Steve Love: I think that, well, as May and I were discussing this, I recalled that in Missouri in the Midwest when I was growing up, we didn't really -- we didn't go to the doctor very often; we only went when we had to go. And I recall an experience where I had injured my finger and I was up all night in excruciating pain. So, when the same thing happened to my son, Matthew, I didn't think twice about it. It wasn't even -- I mean, within a few minutes we were already on our way to the doctor and we had it taken care of.

And, again, my son, John, when he came down with pneumonia we caught that very early so it was an inconvenience rather than a major problem for my family. So, I think that we take the system for granted and I think that's an important part because of the cooperation that you mentioned, Governor. We don't have to be concerned about the paperwork or who's going to

pay. We don't get embroiled in all of that. The system works for us and we really love it. And, now that I'm involved with this I hope I can go back tomorrow and again take it for granted. (Laughter.)

MRS. CLINTON: One of the points we were talking about earlier at the florist was that in Hawaii, I been told -- and Jack you probably know this statistic -- but actually people in Hawaii may even see a doctor or go to a clinic more frequently than people in the mainland and therefore get problems taken care of sooner at less cost. Because what May was talking about with her father and diabetes is still all too common in places where people either can't afford to, or don't think they can, or they can't keep up with the medication, or they don't have the kind of access to the system. And it's always struck me that it's a very backwards way to go about providing health care, to wait until people get really sick which then costs us more in human costs and in dollar costs. So your example about the difference between you and -- your experience and your son's is just right on target.

GOVERNOR WAIHEE: Why don't we deviate a little bit again. We'll go to Russell. We've been talking about this morning so much, Russell, I thought you ought to tell us a little bit about it.

Q Russell Watanabe: We're a family-owned business -- small business, and I think as most small businesses are organized, workers who are not members of the immediate family are almost an extension of the family in a small business. And so it's a great concern of ours to provide quality health benefits to our employees.

I think one of the strengths of the Hawaii health plan that has made it affordable for Hawaiian employees is that there's a reasonable amount of competition by the health care providers. And the last thing I would like to see, in all due respect, Governor, is to have the state government totally take over that and run the program. I think having a good input from the private sector is very important in keeping costs down and quality service up.

GOVERNOR WAIHEE: Okay, I thought that was very well spoken. Now we will go to Richard, a man with the bank.

Q Richard Dahl, Vice-President, Bank of Hawaii: I'd like to talk a little about the employer mandate and how the employers views that and certainly I come from a perspective of a large employer with about 4,000 employees in the State of Hawaii, but I also get to deal from the standpoint of a small employer in that I've got about 800 employees in 17 different countries and two different states. And I can tell you from a small employer standpoint which you've heard from before, but on the U.S. mainland it's terrible to try to get health insurance in New York

City. It's costly, it costs about three times as much as it costs here if you can get a carrier who wants to do it. In Arizona it's a little better, it costs about twice as much and there are plenty of people who will do it. And certainly the people who do it in some of these places have had fair amount of financial problems themselves, so it's always a little scary whether you're promising the employee you're going to give them some and it doesn't come true.

So I guess I come at it from a couple of different handles. Also in the countries that we do business in, many of them provide health care services free to everybody. But I tell you in about, let's see, 12 of those countries we buy a supplemental policy for them so they can come to Hawaii to get health care coverage. And it's the biggest thing on their agenda to have, much more than an increase in pay.

The Prepaid Health Care Act, when it came in, I think from our standpoint as a local large employer, probably didn't have a significant impact because we were probably all ready -- we were already covering employees. I think the significance came in for us later -- past '74, probably into the early '80s when the economy was suffering very high inflation rates, 21, 22 percent as well as health care in excess of that. And we saw many employers and certainly considered ourselves what we could do to reduce those costs or leave that benefit behind. Certainly with the Prepaid Health Care Act that really was not an option for us. We had to stay; we had to figure how we could manage those costs and still provide that benefit. And yes, we took some options of allocating some to the employees who had really not incurred much of that expense themselves. And to our delight, most of the employees I think really understood why we had to do it, and I think became much more educated as to what health care costs them.

And presently our employees carry about 25 percent of the premium costs for health care. Any suggestions for something on the mainland, I think it would be advantageous to have the kind of programs that we have here for the U.S. mainland. I would encourage you to have the kind of flexibility that's built into these programs. Our employees do have choices of HMOs or fee-for-service. We are fortunate in this state in that we are large enough so that we can effectively self-insure and the Prepaid Health Care Act allows that to be done. And we tell our employees that that's what we're doing. And when we have good success, when they have low claims, when they think about their health care services, that reduces our costs. And we've had two holidays now, both of them two months apiece, where the employee and the employer have had to pay no health care costs or no premium for those months. If they keep it up, we're probably going to have another one in 1994.

So I think flexibility is a big key in any program. It shouldn't be so rigid that there isn't a way --

MRS. CLINTON: Is there a particular plan or provider that they have to belong to, or how much choice can you give them as a self-employed company?

Q We give them free choice between HMO programs or fee-for-service. We can really only self-insure the fee-for-service. They make their choice. If they like going to their own physician, fine. And they can participate in the self-insured pool and participate in any premium holidays that may come about. If that pool gets too small, obviously, then we would have to stop self-insurance. But that would be the choice that the employees are making. We do not try and influence them one way or the other.

We certainly advertise, and the carriers we have actively solicit the employee group as to programs and what advantages they've got and so on. But we let that take it's course.

MRS. CLINTON: What do you think has been the biggest reason for your success in reducing costs?

Q The attention -- as a large employer, we've got the luxury of having people that can devote attention to how you reduce costs. And we've also had the luxury of being able to create wellness programs, smoking programs, alcoholism programs, drug-free programs. And so we've usually taken those savings and plowed them back into what we felt would be ways of reducing it. But also, the employee has a good understanding of where we're incurring our costs.

And so if too many people are going to the emergency centers, we don't go out and, say, too many people are going to the emergency centers. We're saying: do you know what it costs to go to an emergency center? Do you know that you could go to someplace else? Have you considered something else? They all understand how much an AIDS patient costs. They all understand how much cancer patients costs. All that may influence healthier lifestyles. That's an intangible -- I mean, I can't quantify it. But we do definitely feel as though it's come back to us as a positive.

GOVERNOR WAIHEE: In addition to being a banker, Richard was also the chair of the Governor's Blue Ribbon Panel on the Future of Health Care in Hawaii. And as we discussed this morning, Hillary, one of the problems -- one of the problems with the Hawaii Prepaid Health Care Act is that it is frozen in the 1974 mode. Our act exists because we are the only state in the nation that was allowed a congressional exemption to the ERISA legislation. And one of the conditions of that was that we would not change our plan from the original proposal in 1974.

Now, obviously, since that time we have gained a lot of experience and have discovered things that we might want to improve. So I thought I'd ask Richard as the chair of the Governor's Blue Ribbon Panel if he had some thoughts about how we could improve the Hawaii health care plan if we had the ability to reform our legislation.

That's sort of known as a curve and a slider. (Laughter.)

Q Well, I did bring the Blue Ribbon Panel's report.

GOVERNOR WAIHEE: It just so happens -- (laughter).

Q Just so happen to have that. But I think it would be nice -- and one of our recommendations was to be able to reopen the Prepaid Health Care Act. I think that it's something that is 20 years old. Nothing can just stay cast in concrete forever. And we need to reopen it, take a look and see what a basic package is again. There have been some additions to the basic package, which, quite candidly are very good, and, quite candidly, benefit relative few.

And I think that there has to be some mechanism where we can constantly go back and review what that basic package is -- with a goal, really, of holding the cost side down because everybody's concern will always be what it costs to provide this benefit. And I think we have to stay there and think what truly is a basic package in 1993 is not necessarily what it was back in 1994.

That process will certainly help us prioritize what the basic package is. It will also allow us to focus on if there are additional things that people desire, how do you allow those outside of a basic package. If they want to pay for them, fine, allow them to pay for them. And then through the collective bargaining process or through the employer process or whatever, they decide that it's picked up as an employer or a union issue, fine, let that take its course, but not damage the basic package which could ultimately damage our good access program.

I think we all agree -- and the Blue Ribbon Panel was very adamant about it -- access is the most important thing that we've got in this state. The Prepaid Health Care Act has influenced it and driven it for 20 years, but its cost could dismantle it if we aren't diligent in doing that.

MRS. CLINTON: I wanted to ask something, and maybe Jack could answer as well, because when you were talking, Jack, you said that you have tried to provide access without copay and deductible barriers. What is the role, if you could clarify for me, of copayments and deductibles within the average policy in Hawaii?

Q Okay, well, we have -- our rates of copayment, we have calculated some comparison with other states. And we do have a lower out-of-pocket and copay than our neighbor states anywhere on the West Coast -- in fact, much greater -- a difference increase in the East Coast when you look at copays and out of pocket.

But what's real significant about Hawaii that we take for granted is that our policies to our employees and employers don't come with a $200, $300, or $500 deductible up front that says you pay this much first and then we start covering you.

That up-front kind of major deductible, which is very commonplace -- in fact, the normal on the mainland -- is what discourages women from going for prenatal care and for immunizing their kids and for going in to treat that hypertension that will reduce the risk of stroke, et cetera.

Hawaii has made it the norm to give first dollar coverage and let people, as soon as they're covered, they can immediately go get care. If they choose the traditional fee-for-service plan, they will pay a 20 percent copayment for each visit with a certain cap on those costs.

MRS. CLINTON: Do you know what the average cap is?

Q Marvin Hall can probably give us a better --

Q Marvin Hall, President, Hawaii Medical Service Association: Twenty percent, it says right there.

Q -- average --

MRS. CLINTON: Annually?

Q -- annually per person.

Q About $1,000 annually.

MRS. CLINTON: So the additional out-of-pocket costs added onto whatever the employee contribution is about $1,000 on average?

Q Hall: No, not average, but that would be the maximum that somebody would pay on the average. So for most people they have little that would not be covered. These might be --

MRS. CLINTON: This is a really important point. It may sound kind of obscure to some people, but this is a significant issue because, in making cost projections about what a national health care plan would cost the country, there is a

real split of opinion among those who cost out health care as to whether you have to have deductibles in order to save money and discourage unnecessary utilization, because in the absence of deductibles, the theory is you will drive up costs, because you will increase utilization for the very reason that Jack was talking about how people will actually go to the doctor to get their care. It's very important that we know as much as we can about the experience in Hawaii because, if your experience has been that with first dollar coverage so that you have no front end deductible that serves as a barrier to access, you've not had that kind of increased cost, that increase utilization but it sort of plays itself out in the whole system as being able to prevent greater cost.

Q Lewin: I think, Mrs. Clinton, we would say that in the design of -- you know, in recommending the future, that we would certainly take all barriers off clinical preventive services. We'd put no barriers or cost barriers on those services at all because those are things we want people -- we want to bring them in. We almost need to put incentives to get them in there somehow. And then we probably need to look at a certain number of outpatient visits, a few at least, that would give people the chance to go to their physician or provider and make sure that they're well each year before we start throwing copayments in the way. Because, frankly, we want people to get care at the doctor's office, not in the emergency room and not in the hospital. So we've got to open the door for that. There may be some place where we have to bring into play for people that choose more expensive programs, copays.

Q Hall: Well, I think it's been stated by Jack, a really basic foundation of the health care, both coverage and system in Hawaii is to cover first dollar coverage and without -- with no coinsurance, even on many of the preventive services. So I think as some of the previous speakers have commented, people seek out care early on, which we would consider to be part of preventive. It's not just immunizations and that type of thing, it also goes to seeking care early in illness.

We have not found that coverage of these things has overwhelmed the cost or visits; physician visits in Hawaii is something near the national average. So we're certainly not trading off one kind of cost for another.

So certainly it has built a system of people seeking care, low-cost. There are essentially no deductible programs in Hawaii in the insurance market. Only a very limited number of people have any kind of a deductible program.

MRS. CLINTON: Could I just be sure I understand, because I have read that there was a higher than the national average physician visit per patient in Hawaii. But your information is that's not accurate?

Q No, I don't know where anyone else gets the numbers, but we're aware of the physician visits throughout the United States. And Hawaii numbers for both fee-for-service programs and for HMO programs are similar to anyplace in the United States.

Q That's interesting.

MRS. CLINTON: Yes.

Q What we do see, though, is the proportion of outpatient care, the dollars going to outpatient and nonhospital care is greater in Hawaii. And so the total proportion of care ends up greater in the outpatient side.

Q Chaffin , Kaiser Permamente Medical Care Program: Yes, I think Jack has articulated the issue very well. I tend to agree that the less of a barrier we have for seeking medical care, the better off we are. I know that many of the businesses are interesting in increased clinic visit fees as a matter of utilization control. I personally worry the most about the folks who would have the most difficult time paying those fees. They would also be the ones that would be the most likely to get into trouble for untreated or inadequately treated illness until they waited to a point at which they were forced to seek medical care.

Our experience in Kaiser is, having just looked at the statistics recently -- in fact, in Hawaii -- and why this is different for Kaiser in Hawaii, our outpatient visits are the highest of any Kaiser in the country per year. I tend to like Jack's explanation that it's because we do more as outpatients; although, across the country, Kaiser is a very effective outpatient utilization program.

But I share Jack's concern that significant copays up front, significant barriers to care, really are going to hurt the people that can afford it the least and need the care the most.

Q Susan McWilliams, (Small Businesswoman): I would like to mention, I was born and raised here. And I also went to school in Albuquerque, New Mexico. And when I was living here, I kind of took for granted our health insurance. And when I went away to school, my husband got a health plan right away, and I noticed the expense (unmatched)
my husband got a health plan right away and I noticed, you know, the expense of it.

But what I really noticed is we had to file all our insurance forms -- that wasn't the big issue -- the big issue was that we had to pay our provider first and then the insurance company would pay us in return. So, we would have to file our insurance and pay the provider and then also meet a high

deductible. This was real taxing on our family income and when he came home, I immediately thought, well, we'll have health insurance and I was real pleased. But it's just a way of life in Hawaii that we take for granted so often.

Another experience I would like to share with you is I have a small son who broke his arm about six weeks ago. And, my husband has very good health coverage and I took him to the doctor -- excuse me, I took him to the hospital because it was a compound fracture -- I didn't hesitate. I just took him in right away and said, well, we'll be covered. I did know that the plan did cover accidents within 24 hours. So, I took him in right away and the accident was paid for, the services were paid for at 100 percent.

Now, if we didn't have that type of coverage, if we had the coverage on the mainland, we would probably be paying for that today. It was something that I too often take for granted.

So, I think it's a very good system. I would like to see it happen throughout the United States. Thank you.

Q Dr. Chang, President, Hawaii Medical Association: Thank you, Governor and Mrs. Clinton. I'm thrilled, elated to have you here this morning to follow our -- to take a look at our health care system. I think we have a wonderful system. I hate to brag about it, but I have to put a plug in for the physicians of Hawaii. I think we practice excellent medicine here. And not only do we practice excellent medicine but our cost containment and everything like this is really in place.

We have the lowest insurance premiums here and we have the best coverage I think. -- the rest of the nation could follow our example very easily. And I think, however, their doctors have to give a little because our doctors don't really get paid what we really feel we deserve. We get 80 percent of our eligible charges, whatever they want to set for us, then the patient pays the 20 percent. So, we take a beating. I'd be lying if I said we get paid what we think we deserve. We don't.

But then you have to give up something to get something better. It still beats the single-payer system. We get freedom of choice of physicians, freedom of choice of insurance plans that you want. If you want a deluxe plan, you pay a little bit more for it. If you want a bare-bones, you pay a lot less. So, you really get what you want, and I think that that's America. Freedom of choice, and I hope that you will look into all these parts.

I'm a pediatrician and I feel preventive medicine is tremendously important. For every dollar that you spend on preventive medicine, you're saving $10 in the future, because healthy children become healthy adults someday. So, if we take

care of them young, you don't have all the hypertension and all the terminal illnesses, that's where the big money comes in.

The last two weeks of life is probably -- that's where you spend most of your money -- not in prevention. So, I hope we'll continue to have the wonderful programs that you have given to children -- EPSDT, the healthy start. And you're really very wise for spending money there because you're going to save a lot of money in the future.

As a pediatrician I feel I would like more time to practice medicine like the good old days before all this government regulations come in. I want to get rid of some of this paperwork. We have tons of paperwork that I would rather spend time practicing medicine than filling out forms that are so aggravating. You sit there, and not only is it expensive in my time, but it costs a lot of money for these forms that patients really glance at, says, they read it, they sign their informed consent and throw it away.

And I just had to get a whole batch because I've been using some of the state health department forms, and they're running out so we have to order our own. I saw this little, tiny little phone number at the bottom of the print that says you can have these printed for a price. Saw what the price -- 1,000 forms cost me $400 for paper that the patient's going to throw away. And they don't even look at it.

So, she said well if you buy 10,000 it will be much cheaper. I don't have 10,000 patients. (Laughter.) I said all I want is 2,000 of them -- $800. This is a fact. And I said, well, let me think about it. For something people are going to discard, I think this is a waste of money. So, I want you to look into that. I want a single claim for all insurance and not 10,000 forms that we have to look at -- am I filling out the right form. This is nonsense. I want electronic billing where everybody gets, you know, we save a lot of money. That's where you're going to have cost containment not in the nitty-gritty.

Doctors aren't profiteering doctors and they do not make that much money. If I wanted to make money, I'd go into business like own Zippy's or whatever. (Laughter.) I'm sorry, but this is where you get the big bucks, not in medicine. We go into medicine because we love to help people to get well and it's not a money-making thing, believe me. I'd be much richer if I went into business.

So, I think that these are the points I want you to think about. There are a couple of other things I would like for you to really look into -- liability reform. Doctors are spending a lot of money ordering MRIs and ultrasound and a lot of things to really defend -- you get on that stand someday and did you do an MRI on that patient; no, because I didn't suspect a

brain tumor or whatever. But you know we do it -- a lot of money spent there that's unnecessary.

So, I think if we have liability reform I think we will rest a lot easier, practice medicine, use our clinical judgment a lot more. Many times I'm taking X-rays not because I feel it's necessary, but because mothers say, "Aren't you going to take an X-ray?" I say, "Well, I really don't think it's necessary because the child's fall was not that bad. I can't find anything. Why don't we sit and watch?" If they're really your patients, they will say, "Okay, Doc, I'll do whatever you say." But lots of times you don't know this patient and, so, you take it not because I'm going to find something. It's to really save your neck someday.

So, I think these are things I would like you to look at. And also I would like you to look at antitrusts. Doctors are so afraid of talking to each other anymore because you're going to get sued someday. And I think to practice in this kind of a climate is really nonsense. I want more time to practice medicine and do it the good old way where you have the good rapport, a doctor-patient relation. You trust each other. You don't have to worry about lawsuits. But now you get sued for everything.

So, I think that these are the points I'd like to make.

MRS. CLINTON: Well, Doctor, you are very eloquent in making those points. And they are ones that I have heard from doctors all over the country. And particularly from pediatricians and family practice doctors and internists, others who are on the kind of clinical frontlines of primary and preventive health care who feel that they do not have the time to deal with their patients in the kind of way that they think is optimal for the patients because of the paperwork and the bureaucracy and the interference. And also because they are not usually reimbursed for sitting down and talking to somebody; they're reimbursed for ordering that test. And that is one of the real problems is, we have sort of perverted the incentives in the medical field by not rewarding clinical judgments and time with people in the same way that we do reward the test-taking.

So your points are very well taken and we're going to be trying to do what we can to answer those.

Q Thank you very much. And we want to be of help to you. Any time you need us we're here.

MRS. CLINTON: Thank you very much.

Q Since Dr. Chang was so eloquent in her discussion of what physicians need and want to serve, I thought we ought to give Linda a chance to say a little bit about nurses

in Hawaii. Linda Beechinor, who is the president of the Hawaiian Nurses Association, and she happens to be sitting right up there. So why don't you -- do you want to make a few comments about what nursing -- nurses can contribute to the dynamic or anything else you want to say?

What's interesting about Linda is that she actually spent a lot of time in Canada, so she has some sense of the Canadian system as well.

Do you want to join in, Linda?

Q Thank you, Governor. I'd certainly like to. I've been a registered nurse for 20 years and I was brought up in Canada and educated there. I've taught in the nursing education system in Canada. And in the past nine years I've been a practicing nurse and nurse educator in Hawaii.

For the past six years, I've had a very successful business providing staff nurses from other countries, particularly Canada, for hospitals in Hawaii during the critical nursing shortage that we've had here. But I have a very strong feeling about where health care is going in this country, and my contribution is going in a particular direction in that I have now gone back to the University of Hawaii and I'm working on my nurse practitioner master's degree program to practice in primary care in family practice.

Nurses in this country are educated and under utilized in the present system. There are two million nurses in this country, and we can provide much of the teaching and much of the primary care that is needed by the people of our country.

I remember in Canada in 1971 there was a report from the federal government that targeted preventive health care as the way to control costs and the way to provide health care to the people of Canada. That was in 1971. And that report gathered dust, I guess, because it was never implemented in Canada. And Canada is in the same situation as we are now in the United States where we have spiraling health care costs.

Nurses see our role in this system as providing support in the system, support for the people of this country to maintain their health. We can teach and educate, we can provide the kind of care that families need in order to stay healthy. Nurses are not interested in treating disease; we are interested in helping people to stay well.

I'm looking forward to being a primary care health provider as an advanced practice nurse and to assisting people in the state of Hawaii to maintain our healthy lifestyle.

MRS. CLINTON: Linda, could I ask you if you have any comments about comparisons between the Canadian system and what you have found here in Hawaii?

Q The Canadian system is a single-payer system, of course, whereas there's more choice of the kinds of coverage that you can ask for in Hawaii. I see nurses as under utilized in their system as they are here. I don't think that either country is any further ahead in that regard, although I do see the federal system here in public health and in Veterans' Administration utilizing advanced practice nurses much better than the private sector does. And I certainly see that as a cost-effective measure and we're looking to the Clinton administration to lead us into better utilization of other practitioners to keep our costs down and provide that quality care throughout the country.

MRS. CLINTON: It's interesting you had mentioned the VA, because it is the case that in both the VA and in the Department of Defense medical programs, nurses have a much broader scope of practice than they do in the private sector.

Q Since we are sort of floating to that side of the room, I see Rich Miers sitting there. And we've heard from the physicians, we've heard from the nurses. We ought to hear from the medical business -- the hospitals.

Q Rich Miers, President, Health Care Association of Hawaii: Thank you very much, Governor. Mrs. Clinton, probably one of the big advantages that the hospitals here have enjoyed as a result of the Prepaid Health Care Act compared to other hospitals on the mainland, we really have minimized our uncompensated care. And if you talk to the folks on the mainland -- when I talk to other health care hospital administrators on the mainland, that is a very, very big issue. There is still some uncompensated care; I don't want to mislead you. But the Prepaid Health Care Act has really minimized that.

I, too, am sort of a small business. I have nine employees and I participate in this program. And, personally, I feel good in knowing that my employees, if their families get sick, that they are going to get the health care, that I'm not going to worry about other spinoffs from the families that -- you know, they would be worried whether their families are going to get health care, et cetera.

As far as other issues, we, of course, are looking for some tort reform, as -- talked about earlier. And certainly the antitrust is extremely important to us, because we, as hospitals, need to talk to each other. We need to form these networks. And, you know, we have to be very, very careful if we sit down and try to do that in today's environment, because we may find ourselves in court. So it is extremely important to us that we, of course, do have some kind of antitrust legislation.

And universal access -- I just came from a meeting yesterday in Seattle -- I got back late last evening -- where all the Western states gathered to talk about this whole plan. And the one issue that was voted as the most important issue by the providers from Colorado west to Hawaii was the universal access to coverage. And that is, quite frankly, an issue that we felt that has to stay in the program. That's just one of the key elements that we as an industry, so to speak, feel has to stay in the program.

MRS. CLINTON: Richard, could I ask you -- when you say you do have some uncompensated care still, can you describe in general who makes up that population that is uncompensated?

Q Yes, the uncompensated care that we would have would perhaps come from the SHIP program, for example, which, you know, is basically an outpatient program with limited services. But sometimes those patients will come into the hospital and stay beyond what is normally reimbursed.

But, again, here in Hawaii that's something that providers have just made up their mind that they will accept, and that will be their contribution towards providing health care -- good health care to our citizens. But that would be an example. Of course, with the Hawaii QUEST program, which is now --

Q I wondered when you were going to get to that. Put a plug in there for the waiver.

Q Yes.

Q Go ahead.

Q Well, anyway, the Hawaii Quest program, which the Governor brought to Washington a month or so ago, will combine all of these programs. And I don't want to go into a long explanation of what the program is. But should combine all of these programs into one program and, hopefully, should eliminate even those areas of uncompensated care. And perhaps Jack might want to say a little bit more --

Q Rich, why don't you -- could you comment a little bit about the uncompensated care major areas in terms of Medicare as well and Medicaid, too, in terms -- because I think that you've talked about that before.

Q Yes. This past year -- in just the past year alone -- our hospitals and long-term care facilities lost $38.8 million, even with our own plan here. And that was the difference between the cost of providing care -- not charges -- the cost of providing care, and the amount of reimbursement.

Now, again, hopefully if this program comes out as we think it will, we shouldn't have those kinds of problems in the future.

And what did that cause? That caused us to have to cost shift, because there's no way you can stay in business if you're losing $38.8 million to $40 million a year. You have to take that shortfall, if you will, and cost shift to -- to something else. So that's why we're hoping that you all in Washington will take a close look at that program.

Also, long-term care is of extreme importance to us. We have a shortage of long-term care beds here in Hawaii, and there are efforts, of course, to build additional beds. We actually have acute care beds being blocked right now, because we have no place to put long-term care patients that are in acute care beds. So I know long-term care is a very expensive to put long-term care patients that are in acute care beds. So I know long-term care is a very expensive program. I know it's also going to be down the road a little bit. But we cannot forget about long-term care. Home care -- very, very important.

Q Thank you, Rich.

We have with us this morning also Dr. Julia Frohlich, who is not only the Director of the Blood Bank, but the chairperson-elect for the Hawaii Chamber of Commerce. And so she sort of, again, is a blending of the medical profession and the sense of business. So, Julie, would you like to share some thoughts with us this morning?

Q Yes, thank you. Perhaps I could just provide some additional information to take back -- and some of it in the area of cost. You mentioned earlier reexamining or opening up the 1974 prepaid health plan might provide some opportunity to reexamine in 1993 terms what does the basic package contain.

Another thing that it might also provide, which Jack alluded to earlier, is who shares the cost of the premium which is paid for the insurance, which we all support what it does for our community. And when the health plan -- 1974 plan was put in, it was meant to be roughly a 50-50 cost-sharing.

Well, a recent survey done by our Hawaiian Employers Council of about 250 companies representing all sizes -- 50 percent of them had under 100 employees -- showed that in actual fact, 100 percent of the employee cost is paid by about 80 percent of the companies that were surveyed. So I think when we talk about joint sharing of the premiums, that is another way of having the person who benefits -- all of us workers -- take responsibility for our role in using health care services if we are also contributing to paying for it in that way -- not so much as we talked about earlier as high deductibles, but actually taking part of the natural premium to a larger degree than it is

right now in the States. So there may be benefits in looking back at the plan beyond looking at a basic package in terms of 1993, but also a way that both the employer and employee once again, contribute and understand they each have a role in responsible health care.

MRS. CLINTON: One thing I want to be sure that I understand clearly is that although dependent coverage is not required under the act, there is a trend toward employers contributing -- now, do they contribute in the same ratio as they do for the employee coverage, or is a different ratio? And what do we do with children who fall between the cracks or who are in families of divorce, or, you know, some of the practical applications of not mandating dependent coverage in terms of making sure all children are covered? I really need to understand how that works.

Q Lewin: As was stated by Dr. Frohlich, probably 75 percent of employers pay 100 percent of the employee costs. On the dependents from our best studies is that two-thirds of employers pay for part of the cost of dependents -- spouses, children -- and that contribution is all the way from some nominal sum up to 100 percent. Probably half of employers pay 100 percent of all the costs of coverage for employees and dependents.

Typically, divorces, children, putting the responsibility to one of the spouses, that sort of thing, are provided for and are covered based upon whatever the arrangement that family has. So I think we feel that there is coverage, it is provided for all of these kinds of situations.

MRS. CLINTON: That is one of the areas, though, that I think there may well be some differences we have to be aware of because the sort of Hawaiian tradition, which several of you have alluded to of covering employees, even before it was required, of having family businesses kind of growing up with the state's economy; perhaps a different set of attitudes might be in place here that you wouldn't find elsewhere.

And one of the issues that we have to be especially concerned about from the national level is, given mobility and given the needs of children, how to make sure that every child needs are met, no matter who that child's parents is or where that child is employed. So I would appreciate, maybe not now, but any advice that you would have based on your experience, because I don't -- I don't know that we can count on the same level of voluntary support for dependent coverage in the rest of the country that seems to have developed here in Hawaii.

Q I wanted, maybe just to add to that, when we started the SHIP program, Mrs. Clinton, we had the situation in which any dependents that weren't covered by the -- because if the employee so chooses, the dependents would have to be covered

and added into the care pool and in the community rating pool. They cannot be rejected, they cannot be risk adjusted and so forth.

But we weren't certain how many of those people might be out there. And we were heartened to learn that frankly our dependent coverage has turned out to be, de facto, almost universal. And that is part of the generosity that's built into the plan and it's become an expectation for employers to have to deal with that.

We would recommend heartily that dependent coverage be part -- a mandated, integral part of any employer mandate, that we not approach it on the national level, we need to just put the children, put the dependent spouses in if they're not covered and have it be a fair cost split with the employer and the employee. Because we can't afford to have those people we left out.

We've been very fortunate in Hawaii.

GOVERNOR WAIHEE: Okay, one thing, when we talked about uncompensated care earlier, which -- I didn't hear any mention about the fact that some of our -- a portion of our uncompensated care came from tourists and the Pacific islanders and aliens and -- do you have any statistics on that?

Q I don't, Governor, I don't have any statistics on those issues that you mentioned or those types of patients that you mentioned. But, yes, that is true -- whether they're visitors, whether they're homeless, whatever. They all do fit into that compensated care.

But having said all that again, our problems as a result of the Prepaid Health Care Act are nowhere near as great as they are on the mainland.

MRS. CLINTON: You mean, the total for Hawaii of uncompensated care in the hospitals is only $38 million? Is that what I understood you to say last year?

Q This past year, we had a shortage in just the Medicare and Medicaid what I understood you to say last year.

Q Meiers: This past year we had a shortage in just the Medicare and Medicaid funding -- of approximately $38.8, $38.9 million.

GOVERNOR WAIHEE: Under compensated care would be a better way of saying it. (Laughter.) It's not really uncompensated care.

MRS. CLINTON: That is pretty remarkable, though, because, you know, I've been in lots of hospitals on the mainland

that have, you know, a third of that in one hospital because of under compensated care.

Q -- a $3 billion system that's not very good.

Q Bettye Jo Harris, Chair, State of Hawaii Board of Health: Thank you. In terms of the Board of Health, it's an advisory committee appointed by the Governor, and we have representation from all the Islands to be an advisory to the Director of Health.

And some of our issues -- we have been working together now about two years, some of us three years. And, I, personally, have been reappointed for another term. And some of our challenges have been to understand our role. And I think with the Health Director, his staff, we are beginning to find our niche and how we can best advise, quality advising, I would say.

One of the issues we took up was Hawaiian health, health for Hawaii people, native Hawaiians. And we were able to bring that to the forefront. We've had a minor setback, but I believe that working with our state legislature that those physicians that are needed in order to move that program forward will be carried out within the year. We're excited about that.

We went to Kauai about three weeks ago to hear some of the problems that even we were not aware of that are still going on and to see how well the health staff and other community workers have been working so hard, even with their own personal loss they have been able to carry on while the hospitals there -- they saved every patient with windows flying out, walls caving in without losing a single person. And I personally touched by that woman who was able to direct that kind of movement with the storm happening.

So, we are here to able to bring departments together so that we're working together interdependently with issues, with Health and Human Services -- State Health Department Planning Agency and some of the other departments that will be working on some of the same issues.

In terms of the grassroots, I'm involved in substance abuse -- agency that is building a residential facility for our people here that don't have adequate funds to get treatment. And the problem is a challenging one, but we feel that this community has responded through its legislature in order that those services are available to people that need them without regard to ability to pay.

Q Dr. Lonnie Bristow, Chair, Board of Trustees, American Medical Association: I would share with you that I am your next-door neighbor because I live in California.

I've long been impressed with what you've been able to accomplish here and have felt for many years that there are important lessons that the rest of the country could benefit from. I want to compliment the administration on its action today. This is the highest level of any administration that I know of that has expressed the kind of interest that you've expressed in what is going on here.

We believe that the ability to use the private sector to let market forces generate what should occur to provide high quality care at a reasonable cost for the entire population is exemplified by what you see here. We think the certain principles that I'm certain you will carry away with you -- those of having a standard benefit package is exemplified by what you see here.

We think the certain principles that I'm certain you will carry away with you, those of having a standard benefit package, those of having community rating, and those of having an employer mandate are three of the essentials. There are some other things that can be done to enhance it, but we greatly admire what had occurred here, and as I'm sure you're aware the American Medical Association's own proposal, Health Access America, which was developed in 1990 was largely based on what we saw in this community. And we think that there are many valuable lessons that we are quite certain you will take away and we applaud you for coming.

MRS. CLINTON: Thank you very much.

GOVERNOR WAIHEE: Thank you. I think we're just about to the end of our forum this morning. I want to thank all of you for participating, but before I do that and end the forum, I would like to invite Mrs. Clinton to ask any last questions she may have of any one here this morning or to make any statement that she may want to make at this time.

MRS. CLINTON: Well Governor, as you know, you and Dr. Lewin and other members of your administration have been involved in our efforts in Washington from the very first day. And we are very grateful for that kind of support and good advice. But I have often found that there is no substitute for actually listening to and being with people who are delivering what I read about in reports or what I hear about from visitors from Hawaii to Washington. And that's the way I feel this morning. I've taken a whole page of notes, I have some follow-up questions that we will be coming back to you with.

It is very exciting for me, personally, to be in a group of people who have worked together to help solve a problem that is a national one, but for which you didn't wait like every other state has to try to see what would happen coming out of Washington. But, instead, really took you own destiny in hand 20

years ago. And have built on that in a way that does deserve a lot of close attention from the rest of the country.

So we are grateful for what you've done and as several of you, including the Governor, have referred to earlier, at this moment in Washington the Department of Health and Human Services, at the direction of the President is reviewing your latest proposal in order to continue the kind of improvements that Hawaii is known for in providing health care.

So we're very excited by what you've done, what you're doing, and what you will be doing. And I'm so pleased that you're such a full partner in what we're trying to do for the whole country.

GOVERNOR WAIHEE: Well thank you very much. (Applause.)

Once again, on behalf of all the people here, we want to thank our dynamic First Lady for taking time out to be with us this morning. I also want to thank all of you for being present and for participating in this forum. Thank you very much. (Applause.)

END 10:34 A.M. (AHT)