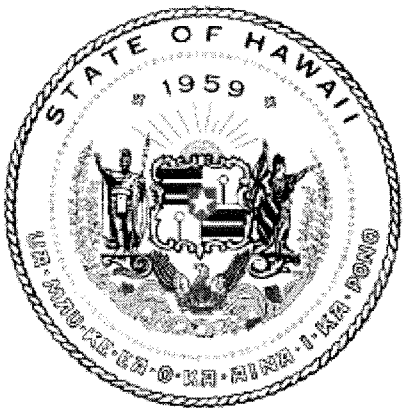

Report of the Hawai'i Health Care Task Force

to the

Hawai'i State Legislature Regular Session of 2006

In Accordance with
Act 223, Session Laws of Hawaii 2005

Prepared by
The Hawai'i Uninsured Project
for the
Insurance Division
Department of Commerce and Consumer Affairs
State of Hawaii

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Approved by TF 12/13/05

Membership The Task Force comprises thirteen members appointed by the Governor from recommendations submitted by the Senate President, Speaker of the House, and Insurance Commissioner pursuant to Act 223, Session Laws of Hawai'i 2005.

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Part I

Background Act 223, Session Laws of Hawai'i 2005, established a temporary health care task force (Task Force) within the Insurance Division of the Department of Commerce and Consumer Affairs to develop a plan to implement health care for all Hawaii residents and report its findings and recommendations, including recommended legislation and a cost analysis and detailed rationale for implementation, to the 2006 Legislature. Act 223 also required the Task Force to contract with the Hawai'i Uninsured Project[1] to: (1) facilitate Task Force meetings; (2) provide meeting minutes and other staff support; and (3) facilitate contracting for expert testimony or studies, including a cost analysis comparing the costs of the status quo with various coverage options including a single-payer system and recommendations of the Hawai'i Uninsured Project to decrease the uninsured population. The Task Force will cease to operate on June 30, 2006.

Website In an effort to provide timely information about Task Force activities and enhance public participation, a Hawai'i Health Care Task Force website was created in September 2005. Meeting information and materials, research, public testimony, and other information is available online at:

www.healthcoveragehawaii.org/taskforce/

Snapshot of the Uninsured in Hawai'i

In the 1980's, Hawaii's uninsured population was estimated at five percent – one of the lowest uninsured rates in the U.S at that time. As of calendar year 2004, the rate of uninsured has increased from its historic low to **9.6 percent – approximately 120,000 people**, according to data analyzed by the University of Hawaii Social Science Research Institute from the U.S. Census Bureau's Current Population Survey (CPS), Annual Social and Economic (ASEC) Supplement, March 2005. Among the 50 states and the District of Columbia, Hawaii has one of the highest proportions of the population covered by health insurance, a statistic attributed in large part to the State's unique Prepaid Health Care Act, Chapter 393, Hawaii Revised Statutes.

Community hospitals and health clinics as well as private hospitals all shoulder the burden of providing care for the uninsured with little or no reimbursement, resulting in revenue shortfalls that continue to grow. Specifically in Hawaii, the Compacts of Free

[1] The Hawai'i Uninsured Project (HUP) is an initiative of the Hawai'i Institute for Public Affairs (HIPA), a nonprofit research and educational organization. The HUP is a collaboration between HIPA, the Hawai'i State Department of Health, University of Hawai'i Social Science Research Institute, and the Hawai'i Health Information Corporation and is led by a diverse group of community stakeholders. The Project is funded by grants to the Department of Health from the U.S. Department of Health and Human Services, Health Resource and Services Administration and the Robert Wood Johnson Foundation.

Association allow migrants from Pacific island compact nations to access Hawaii's health care system without having either public or private insurance coverage. Hawaii's public insurance program for low income adults, QUEST, has been forced to impose a cap on enrollment of adults due to budget constraints on the program. Finally, while the Prepaid Health Care Act (PHCA) requires employer-sponsored insurance for the majority of workers, those who are exempt from the PHCA – part-time public and private sector employees and sole proprietors – struggle to find affordable coverage options.

Characteristics of the Uninsured

Age distribution. Of the approximately 120,000 Hawaii residents who are uninsured, an estimated 99,000 are adults aged 19 to 64 years, and an estimated 2,000 are individuals aged 65 years or older. Many of the aged are immigrants who do not qualify for government insurance under Medicaid and Medicare.[2] (CPS 2003-2005)

According to 2005 CPS survey data, an estimated 16,500 children aged 0 to 18 years are uninsured, of which 50% are qualified but not enrolled in government insurance programs. [3](CPS 2005) However, this figure represents a decrease in uninsured children from 25 percent of the uninsured population in 2003 to only 13 percent in 2005. This decrease is primarily attributable to administrative reforms and increased outreach efforts implemented by the Department of Human Services, resulting in an additional enrollment of 16,885 children as of September 2005 in the State Medicaid and State Children's Health Insurance Program (SCHIP).

Income. More than half of uninsured adults aged 19-64 are below 200 percent of the Federal poverty level (FPL) as defined by the Hawaii-specific Health & Human Services, Federal Poverty Guidelines. Approximately 27,000 are less than 100% of the FPL, 23,000 are between 101-200%, 18,000 between 201-300%, and almost 24,000 are above 300% (CPS 2000-2003).

Gender. In Hawaii, males are more likely to be uninsured than females. Eleven percent of the male population in the state is uninsured compared to 8 percent of females (CPS 1994-2004 11-year average).

Family composition. Approximately 36,000 uninsured adults aged 19-64 (about 40%) have children, and about 50,000 are without children (CPS 1994-2004 11-year average).

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[2] Analysis of the Current Population Survey (CPS), Annual Social and Economic Supplement, 2003-2005 Social Science Research Institute, University of Hawaii, October 2005. These statistics reflect three year averages taken from annual CPS surveys.

[3]Analysis of the Current Population Survey (CPS), Annual Social and Economic Supplement, March 2005, Social Science Research Institute, University of Hawaii, October 2005.

Race & Ethnicity. Based on racial and ethnic breakdowns from the Hawaii Health Survey (HHS) and the Behavioral Risk Factor Surveillance System (BRFSS), Hawaii residents of Japanese and Chinese ethnicity tend to have high coverage rates, while Native Hawaiians and Caucasians are more likely to be uninsured. There is some preliminary evidence that this is due to differences in unemployment rates, as employment and coverage are highly correlated. Uninsured self-identified Hawaiians & Pacific Islanders residing in the State totaled approximately 15,000 persons (CPS 2003-2004 2-year average). However, if all the mixed-race responses with part Hawaiian are included the number of uninsured self-identified Hawaiians and Pacific Islanders residing in the State is approximately 32,000 (CPS 2003-2004 2-year average).

Geographic location. The uninsured rate for the counties of Hawaii, Kauai, and Maui combined is 11.4 percent, higher than the uninsured rate for the City and County of Honolulu at 9.0 percent. Nearly 30 percent of the total uninsured population reside in the counties of Hawaii, Kauai, and Maui (CPS 1994-2004 average). Multi-year estimates produced with the HHS (1997-2002 average) and BRFSS (1994-2002 average) indicate that the percentage of the total uninsured population residing in the neighbor island counties is higher than that estimated with the CPS, at 40 and 36 percent, respectively. It should be noted that these island counties represent approximately 28 percent of the state's total resident population (U.S. Census Bureau) and, therefore, have a disproportionate share of the uninsured.

Profile of the Working Uninsured. Eighty percent of Hawaii's uninsured population are adults between the ages of 19 and 64 (CPS 2003-2005 3-year average).

- 12,000 are self-employed (14 percent),
- 5,000 work part-time (1-19 hours per week) (6 percent),
- 50,000, work full-time (20+ hours) (52 percent)
- The remaining 24,000 are students or individuals who are not working (28 percent).

Interestingly, although the PHCA requires employers to provide health care coverage to employees working 20+ hours per week, the CPS data indicates that a significant number of working uninsured are working full-time and should be covered. In response to this information, the Hawaii State Department of Labor and Industrial Relations (DLIR) conducted random audits of a small number of employers and discovered a 2% non-compliance rate. Thus, there is continuing debate concerning the scope of non-compliance within the Hawaii labor market.

Percentage of Part-Time Workers. Research by the University of Hawaii also indicates that the PHCA has shifted the distribution of employees by hours worked. Hawaii has a significantly higher percent distribution of employees working less than 20 hours a week. However, the PHCA mandate has increased the employer-provided coverage for those working 20 hours or more per week in comparison to the US and selected states.

Employer Size. In 2002, 100 percent of private employers in Hawaii with 100 or more employees offered health insurance to their employees. This compares to 95 percent of employers in the U.S. overall with 100-999 employees and almost 99 percent of employers with 1000+ employees. However, for small employers with less than 10 employees, 83 percent of Hawaii employers offered health insurance compared to 37 percent of U.S. employers.

Hawaii's Health Care Coverage Landscape

Hawaii is the only state in the nation with a law mandating that employers provide health care coverage for their employees. Under the Prepaid Health Care Act of 1974 (PHCA), employers must provide coverage for any employee who works 20 hours a week or more, and they must cover a portion of the employee's individual premium so that the employee's share is no more than 1.5 percent of their annual wage. Excluded from provisions of the Act are state and federal government employees, seasonal workers, sole proprietors, employees of family businesses, unpaid volunteers, public sector (i.e., federal, state, and county) employees, individuals working on commission and recipients of government assistance. Employers may offer coverage for spouses and dependents, but are not required to pay most of the premium as they do if they are only covering the employee.

In 1977, Standard Oil Company of California filed suit against the State of Hawaii claiming that the federal Employee Retirement Income Security Act of 1974 (ERISA) prohibited state regulation of self-insured employers. Hawaii lost the case in 1977, lost again on appeal in 1980 and failed to get the U.S. Supreme Court to hear the case in 1981. With the PHCA deemed unlawful by the courts, Hawaii's congressional delegation successfully sought an exemption from ERISA for the PHCA. This exemption took effect in 1983. However, the exemption included language that prohibits any substantive changes to the PHCA. In effect, the law is frozen in its 1974 form.

Thus, the PHCA remains the cornerstone of health coverage in Hawaii, providing unparalleled health benefit equity with minimal costs for government oversight. More than 90 percent of Hawaii's insured receive health care coverage from two principal sources – the Hawaii Medical Service Association (HMSA) Blue Cross/Blue Shield of Hawaii, a mutual benefit society, and Kaiser Permanente, a health maintenance organization (HMO). Further, another effect of the PHCA is that premium rates are generally lower than the average U.S. rate, while Hawaii benefit packages are generally more comprehensive. This higher coverage rate is reflected in a healthier workforce and longer life expectancy for Hawaii's residents.

However, Hawaii's economy has evolved significantly over the past 30 years, from one controlled by a small number of large agribusiness corporations to a service-based economy comprising 95 percent small businesses. The rising cost of health

insurance premiums makes it increasingly difficult for small employers to meet the original intent of the Prepaid Health Care Act, which balanced wages with health care coverage.

Government-sponsored programs such as Medicaid, Medicare, and TRICARE are available to certain populations. Medicaid Fee for Service is a state/federal program that covers services for those aged 65 and older, and those certified as blind or disabled. Available to eligible low-income individuals and families, Medicaid's QUEST program offers coverage through managed-care similar to private insurance. Medicare, for people 65 years of age and older and certain younger disabled individuals, and TRICARE, which serves active duty personnel, their families, and retirees, operate as national health insurance programs throughout the U.S.

Immigrants. Compared to most other states, Hawaii has a large per capita immigrant population. The 1996 federal Personal Responsibility and Work Opportunity Reconciliation Act eliminated immigrant eligibility for government-sponsored programs for five years. Since that time, Hawaii has restored Medicaid eligibility to pregnant immigrant women and children. In addition, the Hawaii Immigrant Health Initiative, a state-funded program developed in response to the federal welfare reform law, targets the many uninsured immigrants who meet income and asset criteria for Medicaid but remaining ineligible for coverage. Services include primary medical care and other outpatient services that would be covered by Medicaid. There is a cap imposed on reimbursements for specialty and other referral services because of the limited funding available, and currently, the appropriation for the initiative does not cover the costs of primary care. In 2004-2005, 1,501 individuals were served, of which 62% were women, 73% were Filipino, 30% were 18 years of age or younger, 28% were 45-64, and 21% were 65 and older. More than $100,000 in uncompensated care was provided and will undoubtedly rise if outreach efforts are increased.

Compacts of Free Association. Another major challenge is coverage for migrants from the countries with Compacts of Free Association (CFAs) with the U.S. government. CFAs are international agreements between the U.S. and certain Pacific Island nations including the Republic of the Marshall Islands, Federated States of Micronesia, and the Republic of Palau. In exchange for strategic defense interests and privileges, the CFAs confer certain rights and privileges to these migrants, including the right to reside and work in the U.S., and access to health care and public education. An estimated 6,000 to 8,000 CFA migrants are currently in Hawaii. Most CFA migrants are below the federal poverty level. In 2002, the State of Hawaii spent more than $32 million in assistance to CFA migrants, for which the federal government does not fully reimburse the State.

Hawaii's Low Unemployment Rate. Hawaii's strong economy has currently rendered the lowest unemployment rate in the nation, which may be affecting the pattern on employment-based coverage. However, it is also a well-known fact among local economists that Hawaii has a higher rate of under-employment, with many

individuals working multiple jobs in order to accommodate the higher cost of living reflected by above average housing and transportation costs. Since Hawaii's health insurance coverage is largely employer-based, statistics might reflect a slight decrease in the uninsured rate due to higher levels of employment.

On-Call & Trauma Care Crisis. Hospitals across the State are facing increasing challenges in providing emergency services at their facilities. With Queen's Medical Center on O`ahu operating the only Level II trauma center in the State, there is a crisis surrounding the availability of on-call physicians to provide emergency medical services. Several factors have had a negative impact on the availability of physicians to be on-call for emergency services and trauma care, including the adverse effect on a physician's private practice and personal quality of life, uncompensated care, low reimbursement rates, and liability and medical malpractice concerns. This has led to an alarming reduction of physician specialists available to be on-call, creating a crisis for emergency departments throughout the State.

Medical Malpractice Insurance Costs & Tort Reform. Over the past several years, increases in medical malpractice insurance premium rates have raised concerns amongst physicians that they will no longer be able to afford malpractice insurance and will be forced to curtail or discontinue providing certain services. Additionally, some insurers have stopped selling medical malpractice insurance due to a lack of profitability, fueling concerns that physicians will not be able to obtain coverage. In some parts of Hawaii, hospitals are facing a critical shortage of emergency room orthopedic surgeons who handle trauma cases, and the number of obstetricians dropped by 9 percent between 2003 and 2005. No physicians are willing to deliver babies on Molokai; midwives are doing the job, and the State pays for their malpractice insurance.

Changes in Medicare Part D. The Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA) added prescription drug coverage under Medicare beginning January 1, 2006, and is probably the most significant change to Medicare in forty years. Medicare's elderly and disabled beneficiaries can enroll in private plans that contract with Medicare to provide the drug benefit. Beneficiaries can join a prescription drug plan for drug coverage only, or join a Medicare Advantage plan that covers drugs and all other Medicare benefits. In addition, the MMA makes a fundamental change in federal policy affecting seniors and individuals with disabilities who are enrolled in both Medicare and Medicaid, the "dual eligibles." On January 1, 2006, these dual eligibles, like other Medicare beneficiaries, will become entitled to receive coverage for outpatient prescription drugs by enrolling in a Medicare Part D plan. At the same time, these individuals will lose their Medicaid prescription drug coverage. States will no longer be able to receive federal Medicaid matching funds to provide any drugs that could be covered by a Medicare Part D plan to dual eligibles with Medicaid benefits. In Hawaii, there are approximately 26,000 dual eligibles who will be affected by the new law.

Other Issues & Trends. Other issues and trends impacting health care coverage in Hawaii include:

- The rising cost of retiree health care coverage and the growing trend for employers to reduce and/or drop retiree health benefits;
- The growing number of early retirees (ages 50-64) who are having a difficult time finding affordable health care coverage; and
- The aging of Hawaii's health care facilities infrastructure with inadequate funding to update and improve while the population continues to increase and age.
- The impact of possible federal budget cuts on government insurance programs.

Part II

Task Force Activities The Task Force held eight meetings between August 24 and December 13, 2005. Due to the magnitude of the responsibilities assigned to the Task Force, they agreed to focus first on identifying issues contributing to and affecting the uninsured in Hawaii. Second, they agreed to undertake a selection process for a consultant to perform the cost analysis for a single payer system, as required under Act 223. Pending the results of the costs analysis, the task force agreed to continue to meet to discuss proposals from members and the public related to the uninsured.

The agendas, including public testimony and meeting minutes can be found on the task force website at:

www.healthcoveragehawaii.org/taskforce/

To facilitate the work of the Task Force, the following four focus areas were created, and a detailed description of findings and recommendations in each of the focus areas follows.

- **Delivery of Health Care.** Analysis of existing data on the availability of physician and non-physician providers by specialty; identification of barriers to recruiting and retaining health care professionals.

- **Health Insurance Coverage.** Identification of problems and barriers in the current system; development of a menu of potential solutions and options to provide health care coverage to the uninsured; exploration of the viability of a basic health care plan and consumer-driven health care models, i.e., health savings accounts.

- **Efficiency & Effectiveness of Health Care Delivery System.** Review of various health care delivery system models with a focus on improving efficiency and effectiveness through adoption of business models and including prevention as part of treatment; development of a list of barriers and inefficiencies in the current system; review of administrative costs in the current health care delivery system.

- **Single-Payer System.** Review and comparison of single payer models, including systems in other countries and proposals in other states.

Delivery of Health Care

This area focuses on issues related to the health care workforce – identifying and analyzing the current availability of health care providers, barriers to recruiting and retaining health care professionals, and meeting our future health care needs.

Currently, there is a growing shortage of health care professionals in Hawai`i, especially on the neighbor islands and in rural areas. Thus, even if people have health insurance, they are often unable to access appropriate care. The state's growing aging population will increase demand for health care services and long-term care. As the general population ages, so does the health care workforce, exacerbating the growing shortage of health care providers. In addition, low reimbursement rates for providers, issues related to living and working in remote communities, challenging working conditions, and the cost of medical malpractice insurance continue to create barriers to recruitment and retention. Finally, Hawaii's health care facilities infrastructure is aging, and there is inadequate funding to make necessary capital improvement to accommodate our increasing aging population.

The Task Force also plans to solicit input from major providers, including the Hawaii Health Systems Corporation, Kaiser Permanente, community health centers, the Department of Health, and the State Health Planning & Development Agency (SHPDA), to identify provider and workforce issues and develop possible solutions.

In addition, several health agencies and organizations in the State have created the Hawai`i Health Workforce Collaborative to address these issues. The Collaborative is working on a comprehensive plan to improve access to and quality of health care by creating a database to map the health workforce infrastructure statewide and make projections for future needs. (Attachment 1). The Task Force will monitor and support the efforts of the Collaborative.

Health Care Workforce Development

The Task Force is considering the feasibility of gathering information to assist in workforce planning through a questionnaire to be included in the license renewal applications for health care professionals. Modeled after questionnaires in other states such as Vermont (Attachment 2), licensees would be asked questions related to age, type and location of their practice, whether they are practicing part-time or full-time, and their intention to return or to leave Hawaii within five years. For physicians, questions about whether or not they currently accept new Medicare or Medicaid patients, and an estimate of what percent of their practice includes these patients might be included. The data collected would give the State a continuously updated source of information about the health care workforce, and would also assist in projecting future workforce needs. However, the additional administrative burden to distribute the questionnaires, collect and analyze the data, as well as issues regarding privacy, access, and use of the data, must be considered and explored.

Health Insurance Coverage

This area focuses on identifying Hawaii's uninsured population, issues that prevent or restrict coverage, and coverage options for the uninsured.

Hawai`i has one of the lowest rates of uninsured in the country and a substantially higher percentage of employers offering health insurance because of the Prepaid Health Care Act (PHCA) of 1974. However, national and state data about the uninsured analyzed by the University of Hawai`i Social Science Research Institute (SSRI) indicates that:

- Hawaii's proportion of part-time workers is greater than the national rate;
- Gaps in coverage exist for the self-employed, part-time workers, and certain government employees;
- Hawai`i has below average rates of coverage of adults through public insurance programs, i.e., QUEST[4]; and
- A number of the uninsured report on federal surveys that they are working full-time and therefore should be receiving coverage under the PHCA.[5]

The Task Force is reviewing the issues related to the uninsured and will continue to explore options to provide coverage for and access to health care including:

- The viability of a basic health care plan that provides a minimum amount of coverage for the uninsured. Basic health care plans, or "bare bones" plans, reduce premiums by decreasing the number of covered services or by raising deductibles and other consumer costs for covered services.

- Consumer-driven health care models such as health savings accounts.

- Policy changes such as removing the QUEST enrollment cap to cover uninsured adults who fall into one of the gap groups.

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[4] The Department of Human Services, in partnership with Hawai'i Covering Kids, developed a simplified application, a passive renewal process, and conducted extensive outreach to enroll 16,885 additional children as of September 2005, significantly reducing the number of uninsured children. The U.S. Current Population Survey's latest estimates confirm a decrease in uninsured children between 2001 and 2004.

[5] The Department of Labor and Industrial Relations initiated a Compliance Assistance program in March 2005, which involved site visits of randomly selected employers throughout the state to determine whether eligible employees were denied health insurance coverage and to educate employers about their responsibilities under the law. As of September 2005, 160 employers with a total of 1,950 employees were visited. 14 employers were found to have employees who should have been provided with health insurance coverage, and a total of 39 eligible employees were not covered.

Community Health Centers & Other Safety-Net Providers

Hawaii's safety net providers include the 13 federally qualified community health centers, the 12 hospitals managed by the Hawai`i Health Systems Corporation (HHSC), and several critical access private health care facilities.

The Hawai`i Essential Insurance plan (Attachment 3) would allow the uninsured to access these safety net providers and cover any Hawai`i resident who is not currently enrolled in a health insurance plan offered by an employer or not eligible for government insurance. It is estimated that half of the enrollees in the Hawai`i Essential Insurance plan will include individuals who purchase their own coverage, and half will be part-time workers whose employer will pay for their coverage.

In order to support expansion of coverage of the uninsured through Hawaii's safety net, several additional proposals are being considered.

- Acquisition of health information technology systems at community health centers that can capture and share standardized data across centers to assist in treatment of patients with chronic conditions, provide documentation of treatment outcomes; and sharing patient authorization among providers to improve care from primary to specialty to inpatient care.

- Expansion of primary care services at community health centers to reach the broader community without health insurance. Dental and behavioral needs must also be addressed.

- Expansion of services at community health centers oriented to prevention of certain pervasive problems: crystal methamphetamine problem, obesity, chronic conditions, smoking. Services to include outreach, case management, individual and group counseling, and exercise in addition to clinical care.

- Expansion of telehealth capabilities at community health centers and partnerships with private providers and HHSC to provide access to specialty care.

- Support for multiple options for expanding community health center facilities to match expanded role. Options include but are not limited to access to public and private funding, making public land available for building, and sharing public facilities (schools, hospitals, administrative buildings, public health clinics) for clinical and administrative functions.

- Cost/benefit analysis of dollars spent on community health centers.

- Feasibility of establishing a health care referral system to provide health care to the uninsured similar to Project Access, an Asheville North Carolina community-based program (Attachment 4).

Improving Efficiency and Effectiveness of Health Care Delivery System

This area focuses on identifying alternatives for improving efficiency and cost-effectiveness in health care delivery. Improving the efficiency in health care delivery could result in lower costs and thereby generate revenue to finance care for those who are uninsured on underinsured.

Experts have analyzed our health care delivery system in three major areas – cost, access, and quality. A 2002 study by the National Center for Health Care Statistics, the World Health Organization, and the Rand Corporation determined that the U.S. has the highest cost per capita among the G-7[6] yet the U.S. ranks last in the health status of its citizens and the efficiency of our health care system. According to a study produced in 2000 by the Department of Health and Human Services (DHHS), Hawaii's health care industry ranks as low as 48th in the US in computer systems expenditures. The DHHS estimates that as much as $81 billion dollars in current administrative costs could be reduced if the U.S. implemented new IT systems. Implementing new information technology (IT) infrastructure will improve efficiency, reduce costs, and improve quality of care. Administrative savings could then be re-directed to provide health care coverage to the currently underinsured and uninsured population.

Developing electronic information systems will allow the health care delivery system to provide and share information in a timely manner, identify duplicate services ordered and services not medically necessary or needed, measure outcomes, and reduce costs.

The Task Force will continue to look at models to improve efficiency and cost-effectiveness including:

- Computerized electronic infrastructure to connect all health care providers, health plans, employers, and patients.
- Proposals to shift the focus of the current health care model to include prevention and improving health status in patient treatment.
- Administrative costs incurred by health care providers in complying with various financial and legal requirements.

[6] A group of seven heads of state from major industrialized democracies, consisting of the United States, France, Germany, Italy, Japan, the United Kingdom, and Canada.

Single-Payer System

Act 223, SLH 2005, charged the task force with investigating a single-payer health insurance system as one option to address Hawaii's uninsured.

While there are many variations of a single-payer health care system, the most common definition of single-payer health insurance is the financing of health care expenditures for a nation's entire population through a single source, presumably the government, with funds collected through progressive taxation of citizens and businesses.[7] Unlike 'socialized medicine,'[8] in a single-payer health insurance system, the government collects and distributes money for health care but interferes minimally with the actual practice of medicine. A single-payer system is just one model towards universal health coverage. Another model would be to extend and improve Medicare, proposed by Rep. Dennis Kucinich and Rep. John Conyers.[9]

On an individual state level, no state has succeeded in passing legislation to implement a single-payer health system. However, states such as California, Massachusetts, Wisconsin, Maine, Rhode Island, and Missouri have either introduced legislation, or have commissioned studies on the viability of a statewide single-payer health system. Studies have found that a single-payer system would reduce health care spending while providing coverage and protecting the doctor-patient relationship.[10]

Internationally, in Western industrialized nations, single-payer systems exist in Australia, Canada, Finland, New Zealand, Sweden, and the United Kingdom. See comparison of single-payer health systems in Canada, England, and Taiwan done by HUP (Attachment 5). Generally, funds for health services are primarily raised through taxes and premiums, and paid from a single source for hospital services.

The Task Force spent significant time developing a Request for Proposals (RFP) to hire a consultant to conduct a cost analysis of a single payer system in Hawai`i. An RFP was issued on November 2, 2005 and three proposals were received. On November 16, 2005, the Task Force selected The Lewin Group to conduct the analysis to be completed in March 2006. (See proposal at Attachment 6).

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[7] Hackney, David, and Rogan, Debra, *A Single Payer Health Care System for the U.S.,* American Medical Student Association, November 2005

[8] Refers to the direct government ownership of hospitals and clinics and control over the daily operation of the health care industry.

[9] In 2003, Rep Conyers introduced HR 676, The United States National Health Insurance Act, co-sponsored by Dennis Kucinich, (D- OH), Jim McDermott, (D-WA, and Donna Christensen (D-VI). Under HR 676, Medicare is extended and improved so that all individuals residing in the United States would receive high quality and affordable health care services.

[10] The Lewin Group, *Cost and Coverage Analysis of Nine Proposals to Expand Health Insurance Coverage in California,* Prepared for the California Health and Human Services (CHHS) Agency, April 2002.

Other Issues to be Explored

The Task Force is reviewing a number of issues and potential options to provide health care for all Hawaii residents and will make recommendations in its final report.

1. Funding strategies to pay for any proposed coverage options.

2. Free health screenings and immunizations for every child in Hawai'i.

3. Health care models that encourage consumers to participate and be responsible for their own health care, including, but not limited to:
   a. A preventive medicine model where the uninsured are covered based on their ability to meet defined health milestones. The greater the ability to meet the milestones, the better the coverage.
   b. Consumer-directed health care models such as Health Savings Accounts (HSAs), tax-free accounts that can be set up by individuals or employers which can be drawn upon to help pay for qualified medical expenses. HSAs allow individuals to own and control their health care spending and save for their future health care costs, and together with high deductible health coverage, help people finance their medical expenses.
   c. Worksite wellness models to encourage and reward healthy behavior, preventive care, and proactive management of health conditions.

4. Strategy to provide care for the chronically ill – those who may not qualify for a traditional health plan.

5. Strategy to pay for specialty and inpatient care for the uninsured.

6. Review of the rising cost of medical malpractice insurance and its impact on the provider network and health care costs.

7. Review and modification of the Certificate of Need (CON) law enacted in 1975, which requires health care providers to obtain permission from the State prior to committing substantial resources to expand facilities or purchase equipment. However, critics of the law argue that it stifles competition in the marketplace and gives unfair economic advantage to established facilities.

8. Given Hawaii's unique geography as an island state, telehealth and telemedicine should be expanded to support provision of services to individuals in underserved areas. Telehealth and telemedicine use of electronic information and telecommunications technologies to support long-distance clinical health care, patient and professional health-related education, public health, and health administration.

Interim Recommendations In addition to the areas identified for investigation by the Task Force, we respectfully make the following interim recommendations for consideration by the Legislature:

The Legislature is encouraged to provide financial support for the development of a comprehensive health care provider map to include an analysis of existing data on the availability of physician and non-physician providers by specialty, including all doctors, specialists, nurses, dentists, mental and behavioral health providers, nutritionists, educators, and other health care professionals; and focus on workforce needs.

The Task Force is especially concerned with fragile populations, in particular uninsured children. While the Task Force will provide additional recommendations in its final report, we urge the Legislature to seriously consider legislation during the 2006 Legislature Session to increase access to health care and coverage for all children in Hawaii.

Next Steps The Task Force will continue to meet through June 30, 2006, at which time they will submit a final report with findings and recommendations that will form a plan for providing health care for all of Hawaii's residents.

Attachment 1

Mapping the Health Workforce Needs of Hawaii

Severe health disparities exist in rural and Native Hawaiian populations that must be addressed if Hawaii is to truly be the 'Health State'. Our rural counties have more poverty, unemployment, and obesity than the state average. They also have higher rates of diseases, such as, diabetes, hypertension, coronary artery disease, chronic obstructive pulmonary disease, pneumonia, and kidney failure that requires chronic dialysis.

Native Hawaiians have a life expectancy almost five years less than the state average; their rates of breast, cervical, colon and lung cancer are higher than any other ethnic group in the State, and their mortality rates from malignant cancers and strokes are more than three times that of Non-Hawaiians.

In order to improve these health disparities, we must have fully staffed healthcare facilities with culturally competent, well-trained staff accessible to all of our residents. However, there are recognized shortages of many types of health professionals in Hawaii, and no system in place to directly assess our staffing needs or by extension, to meet our projected workforce demand. Current surveys are incomplete, but give a picture of the needs.

Solution:

Last spring these organizations created the Hawaii Health Workforce Collaborative:

1. Hawaii Area Health Education Center
2. John A. Burns School of Medicine
3. Hawaii Primary Care Association
4. Native Hawaiian Health Scholarship Program/Papa Ola Lokahi
5. Center for Nursing
6. Office of Rural Health
7. State Department of Health
8. Hawaii Healthcare Information Corporation
9. Hawaii Health Systems Corporation
10. Family Medicine Residency Program, JABSOM
11. State Health Planning and Development Agency

The following is the plan to address our healthcare workforce needs.

Vision: We envision a healthcare system in Hawaii with a full complement of health care workers distributed to meet the health needs of the entire state.

Mission statement: Improve access to and quality of healthcare in Hawaii by identifying unmet health workforce needs and developing solutions.

Goals and Activities:

1. To perform an ongoing, coordinated, comprehensive assessment of the health workforce needs throughout Hawaii.
   a. Compile and analyze existing health workforce data
   b. Survey all healthcare facilities for existing service gaps
   c. Identify recruitment barriers

2. Facilitate healthcare worker recruitment and placement
   a. Identify alternative means of filling positions (NP/PA/J1, telemedicine)
   b. Research successful recruitment models (national and international)
   c. Develop an integrated health communications and marketing plan
      - Advertising/publications
      - Facilitate communication and networking between healthcare facilities/agencies
      - Encourage provider incentives
      - Specific promotional activities/recruitment efforts
      - Facilitate communication and networking between workforce collaborative and educational systems.
      - Alert health facilities to resources

3. Develop an effective pipeline for local students to pursue health science careers
   a. Identify barriers to entry into training programs
   b. Support and expand successful recruitment programs
   c. Work to expand local training in health careers
   d. Work to increase federal funding for local healthcare worker training (GME, etc.)

4. Expand retention efforts across Hawaii
   a. Research existing barriers to retention in Hawaii
   b. Explore possible incentives and other retention methods

5. Project future health workforce needs and develop a plan for meeting those needs.
   a. Develop a baseline workforce assessment
   b. Project workforce demand based on population growth and other factors that influence need
   c. Facilitate communication and networking between workforce collaborative and educational systems.

The following expands section 5:

In order to facilitate recruitment and retention of healthcare workers, the Hawaii Health Workforce Collaborative will develop a comprehensive database that can utilize existing data to map the health workforce infrastructure statewide and make projections for future needs. We will create a secure SQL database with

fields for demographic and educational information on licensed providers and selected non-licensed staff, such as information technology employees.

All available datasets on locations of providers in Hawaii will be collected. These will include DCCA data, professional association data, national provider databases, large health group employment data and all other data as appropriate.

A standard form will be developed to include in all Hawaii State licensing applications for regular updating of the database of supply data. This will include practice locations, specialty, hours spent in locations, and case mix.

GIS mapping software will be applied to the data collected to determine the distribution of our healthcare workforce.

Demand models will be utilized to project future health workforce needs.

Provide a regularly updated repository of information on all vacant positions and post advertisements for positions on the Internet.

References

http://www.state.hi.us/health/statistics/hhs/index.html/hhs_04/index.html, accessed 11/13/05.

http://www.ahrq.gov/data/hcup/factbk5/factbk5a.htm, accessed 11/13/05.

NIH Publication 96-4104.Hawaii, Cancer, Facts and Figures 2003-2004. Hawaii Department of Health/Cancer Research Center of Hawaii/American Cancer Society, 2004.

Office of Hawaiian Affairs Webpage, www.OHA.org, accessed 3/2/2002.

Miller BA, Kolonel LN, Berstein L, Young JL Jr., Swanson GM, West D, et al (eds.). Racial/ethnic patterns of cancer in the Unites States 1988-1992. Bethesda, MD: National Cancer Institute, 1996.

Attachment 2

When is license # — will it be on every pay?

??

License # must be pre-printed

VERMONT DEPARTMENT OF HEALTH
BOARD OF MEDICAL PRACTICE
108 Cherry Street, PO Box 70
Burlington VT 05402-0070
802 657-4220 or 800-745-7371

2004 PHYSICIAN'S LICENSE RENEWAL APPLICATION

PART I

1. **Your legal name:**

Last Name First Name Middle Name: Suffix

a. Have you ever legally changed your name? ___Yes ___ No

If yes, enter your former name and any other name(s) under which you were licensed in Vermont or elsewhere in the past two years;

Last Name First Name Middle Name: Suffix

b. Indicate your name, as it should appear on your license:

Last Name First Name Middle Name: Suffix

2. **Your Date of Birth:**_____/_____/_____
Month / Day /Year

3. **Home Address:**

(Street)

(City) (State) (Zip)

4. **Work Address:**

(Street)

(City) (State) (Zip)

5. **Please check your preferred mailing address:** ____ **Home** ____ **Work**
NOTE: ***The mailing address will be publicly listed on the Board's web site.***

→ Common license for separates — so as mailing address public access Access

6. **Home Telephone Number with Area Code:** (_____)_____

7. **Work Telephone Number with Area Code:** (_____)_____

Please check which address you prefer listed on the Board's web site — Home — Work

8. E-mail address:

_____

Please check here if the Department of Health may use this e-mail address to send you public health information.
□ yes □ no

PART II

9. Were you in active practice in Vermont in the past 12 Months? □ yes □ no

10. Do you hold, or have you ever held, a medical license in any other state? □ yes □ no
If yes, complete the section below and attach additional pages if necessary.

State	License Number	Type of License	Date Issued	Status (Active or Inactive)

ANY "YES" RESPONSE TO THE QUESTIONS BELOW MUST BE FULLY EXPLAINED ON THE ENCLOSED FORM A.

11. Have you ever applied for and been denied a license to practice medicine or any other healing art?
□ yes □ no

12. Have you ever withdrawn an application for a license to practice medicine or any other healing art?
□ yes □ no

13. Have you ever voluntarily suspended, surrendered or resigned a license to practice medicine or any other healing art in lieu of disciplinary action?
□ yes □ no

14. Are any formal disciplinary charges pending or has any disciplinary action ever been taken against you by any governmental authority, by any hospital or health care facility, or by any professional medical association (international, national, state or local)?
□ yes □ no

15. Have you ever been denied the privilege of taking an examination before any state medical examining board?
□ yes □ no

16. Have you ever discontinued your education, training, or practice for a period of more than three months for reasons other than a family need?
□ yes □ no

17. Have you ever been dismissed or suspended from, or asked to leave a residency training program before completion?
□ yes □ no

18. Have you ever had staff privileges, employment or appointment in a hospital or other health care institution denied, reduced, suspended or revoked, or resigned from a medical staff after a complaint or peer review action was initiated against you?
□ yes □ no

19. Has your privilege to possess, dispense or prescribe controlled substances ever been suspended, revoked, denied, or restricted by, or surrendered to any jurisdiction or federal agency at any time?
□ yes □ no

20. Are you presently or have you ever been a defendant in a criminal proceeding?

□ yes □ no

PART III

(Unless otherwise ordered by a court, your responses to the questions in Part III are considered exempt from public disclosure.)

Any "yes" response to the questions below must be fully explained on the enclosed Form A.

21. To your knowledge, are you the subject of an investigation by any other licensing board as of the date of this application? □ yes □ no

22. To your knowledge, are you presently the subject of a criminal investigation? □ yes □ no

The following definitions are provided to assist you in answering questions 23 through 25.

"Ability to practice medicine" - This term includes:

1. The cognitive capacity to make appropriate clinical diagnoses and exercise reasoned medical judgments, and to learn and keep abreast of medical developments; and
2. The ability to communicate those judgments and medical information to patients and other health care providers, with or without the use of aids or devices, such as voice amplifiers; and
3. The physical capability to perform medical tasks such as physical examination and surgical procedures, with or without the use of aids or devices, such as corrective lenses or hearing aids.

"Medical condition" - Includes physiological, mental or psychological conditions or disorders, such as, but not limited to, orthopedic, visual, speech, and hearing impairments, cerebral palsy, epilepsy, muscular dystrophy, multiple sclerosis, cancer, heart disease, diabetes, mental retardation, emotional or mental illness, specific learning disabilities, hepatitis, HIV disease, tuberculosis, drug addiction, and alcoholism.

"Currently" - This term means recently enough to have a real or perceived impact on one's functioning as a licensee.

"Chemical substances" - This term is to be construed to include alcohol, drugs, or medications, including those taken pursuant to a valid prescription for legitimate medical purposes and in accordance with the prescriber's direction, as well as those used illegally.

"Controlled substances" - This term means those drugs listed on Schedules I through V of Section 202 of the Controlled Substances Act (21 USC § 812).

"Illegal use of controlled substances" - This term means the use of drugs, the possession or distribution of which is unlawful under the Controlled Substances Act, as periodically updated by the Food and Drug Administration. This term does not include the use of a drug taken under the supervision of a licensed health care professional or other uses authorized by the Controlled Substances Act or other provisions of federal law.

23. Do you have a medical condition that in any way impairs or limits your ability to practice medicine in your field of practice with reasonable skill and safety?

□ yes □ no

In explaining a "Yes" answer on Form A, please provide reasonable assurances that your medical condition is reduced or ameliorated because, for example, you have received or do receive ongoing treatment (with or without medication) or have participated or do participate in a monitoring program.

24. Are you currently engaged in the use of alcohol or other chemical substances that in any way impairs your ability to practice medicine in your field of practice with reasonable skill and safety?

□ yes □ no

In explaining a "Yes" answer on Form A, please provide reasonable assurances that your use is reduced or ameliorated because, for example, you have received or do receive ongoing treatment (with or without medication) or have participated or do participate in a monitoring program.

25. Are you currently engaged in the illegal use of controlled substances?

□ yes □ no

In explaining a "Yes" answer on Form A, please provide reasonable assurances that such use is not a real and ongoing problem in your practice of medicine.

CONFIDENTIAL ASSISTANCE IS AVAILABLE

Since 1999, part of each license fee has been used to create and maintain the **Vermont Practitioners Health Program**, a service of the Vermont Medical Society. This is a **confidential** program for the identification, treatment and rehabilitation of physicians affected by the disease of substance abuse. For further information about this program, call 802-223-0400 (a confidential line).

PART IV

The following questions are required by Vermont law, 26 VSA § 1368, to update and maintain a data repository within the Department of Health and to make individual profiles on all health care professionals licensed, certified, or registered by the Department available to the public. Your physician profile is located at the following website http://healthyvermonters.com/bmp/mbsearchform.shtml.

Please include photocopies of court papers, licensing authority decisions, and any other relevant documents if your answers to questions 26 through 31 have changed since your last application. We cannot process your application without them.

26. **Criminal Convictions** [26 VSA § 1368(a)(1)] □ Check here if none

Please provide a description of all crimes (felonies and misdemeanors; this includes DUI but not speeding or parking tickets) of which you have been convicted within the past ten years not listed below. **Please provide complete copies of documentation for each matter.**

(Conviction Date) (Court) (City/State) (Crime

27. **Nolo Contendere/Matters Continued** [26 VSA § 1368(a)(2)] □ Check here if none

Please provide a description of all charges to which you pleaded "nolo contendere" ("I will not contest it") or where sufficient facts of guilt were found and the matter was continued without a finding by a court of competent jurisdiction not listed below. **Please provide complete copies of documentation for each matter.**

(Conviction Date) (Court) (City/State) (Charge)

28. **Vermont Board of Medical Practice Matters** [26 VSA § 1368(a)(3)] □ Check here if none

Please provide a description of all formal charges served, findings, conclusions, and orders of the Board of Medical Practice (including stipulations), and final disposition of such matters by the courts, if appealed.

(Date) (Final Disposition - Summary)

29. Licensing or Certification Authority Matters in Other States [26 VSA § 1368(a)(4)]
□ Check here if none

Please provide a description of all formal charges served by licensing or certification authorities of other states, the findings, conclusions, and orders of such authorities, and final disposition of such matters by the courts, if appealed, in those states, if not listed below. **Please provide complete copies of documentation for each matter.**

(Date of Final Disposition) (Licensing or Certification Authority) (Court) (City/State) (Nature of Charge)

30. Restriction of Hospital Privileges [26 VSA § 1368(a)(5)]

A. Revocation/Involuntary Restrictions □ Check here if none

Please provide a description of any revocation or involuntary restriction of your hospital privileges that were related to competence or character and were issued by the hospital's governing body or any other official of the hospital after procedural due process (opportunity for hearing) was afforded to you if not listed below. **Please provide complete copies of documentation for each matter.**

(Date) (Hospital) (State) (Nature of Restriction) (Reason for Restriction)

B. Other Restrictions □ Check here if none

Please provide a description of all resignations from, or non-renewal of, medical staff membership or the restriction of privileges at a hospital taken in lieu of, or in settlement of, a pending disciplinary case related to competence or character in that hospital if not listed below. **Please provide complete copies of documentation for each matter.**

(Date) (Hospital) (State)

(Nature of Action) (Action)
In lieu In settlement

(Reason for Action)

31. Medical Malpractice Court Judgments/Settlements [26 VSA § 1368(a)(6A)]

A. Judgments □ Check here if none

Please complete the attached Form A and provide a description of all medical malpractice court judgments against you and all medical malpractice arbitration awards against you within the past 10 years (10 years from payment date) in which a payment was awarded to a complaining party if not listed below. **Please provide complete copies of documentation, to include final disposition and, if possible, a copy of the complaint for each matter.**

Judgement Arbitration

(Date) (Court) (State) (Nature of Case) (Amount Assessed Against You)

B. **Settlements** ☐ Check here if none

Please provide a description of all settlements of medical malpractice claims against you within the past 10 years (10 years from payment date) in which a payment was awarded to a complaining party if not listed below. **Please provide complete copies of documentation, to include final disposition and, if possible, a copy of the complaint for each matter.**

(Date) (Court) (State) (Amount of Settlement Against You)

32. **Medical Professional Schools** [26 VSA § 1368(a)(7)]

Please provide the names of medical professional schools you attended and the dates of graduation it not listed below.

(School/Institution) (City) (State) (Year of Graduation)

If necessary, please use an additional sheet and check this box: .....☐

33. **Graduate Medical Education/Residency** [26 VSA § 1368(a)(8)]

Please provide information about any graduate medical education/residency attended or completed that is not listed below.

(School/Institution) (Specialty) (City) (State) (Year of Graduation)

If necessary, please use an additional sheet and check this box .....☐

34. **Specialty Board Certification** [26 VSA § 1368(a)(9)]

Please verify the following information regarding your specialty board certification and update as necessary using the attached Specialty Codes List.

Specialty Code	Specialty Name (if code unknown)	Board Certified	Name of Board	Year Certified	Year Recertified
		☐ yes ☐ no			
		☐ yes ☐ no			

35. **Years of Practice** [26 VSA § 1368(a)(10)]

Month and year you started practicing as a physician?

36. **Hospital Privileges** [26 VSA § 1368(a)(11)] ☐ Check here if none

List all information for all hospitals where you currently have hospital staff privileges if not listed below:

(Name) (City) (State) (Year Started)

37. **Appointments/Teaching** [26 VSA § 1368(a)(12)]

Note: Answering #37 is optional. By answering, you are granting permission to have this information posted on the web.

A. Appointments ☐ Check here if none

Please provide information about your appointments to medical school or professional school faculties if not listed.

(School) (City) (State) (Nature of Appointment) From (year) To (year)

B. Teaching ☐ Check here if none

Please provide information regarding your responsibility for teaching graduate medical education within the past 10 years if not listed.

(School/Institution) (City) (State) (Nature of Teaching) From (year) To (year)

38. **Publications:** [26 VSA § 1368(a)(13)] ☐ Check here if none

Note: Answering #36 is optional. By answering, you are granting permission to have this information posted on the web.

Please provide information regarding your publications in peer-reviewed medical literature within the past 10 years if not lsited.

(Title) (Publication) (Year)

39. **Activities** [26 VSA § 1368(a)(14)] ☐ Check here if none

Note: Answering #39 is optional. By answering, you are granting permission to have this information posted on the web.

Please provide information regarding your professional or community service activities and awards if not listed.

(Activities or Awards)

40. **Practice Setting** [26 VSA § 1368(a)(15)] ☐ Check here if none

What is the location of your primary practice setting?

Town or City State

41. **Translating Services** [26 VSA § 1368(a)(16)] ☐ Check here if none

Please identify any translating services available at your primary practice location.
Are any translating services available at your primary practice location? ☐ Not applicable

If yes, please describe here the translating services available:

If necessary, please use an additional sheet and check this box: .....☐

42. **Medicaid/New Patients** [26 VSA § 1368(a)(17)]

A. **Medicaid participation**
Do you participate in the Medicaid program? ☐ yes ☐ no ☐ not applicable

B. **New Medicaid Patients**
Are you currently accepting new Medicaid patients? ☐ yes ☐ no ☐ not applicable

Part V

I hereby affirm that the information provided above is true and accurate, and that I have answered the questions to the best of my knowledge and ability.

Date:_____ _____
Applicant's Signature

Reminder - You must also complete the enclosed Applicant's Statement Regarding Child Support, Taxes, Unemployment Compensation Contributions regardless of whether or not you have children

Attachment 3

Hawaii Essential Insurance

A plan to end the problem of the uninsured in Hawaii

Overview : An inexpensive, preventive healthcare insurance option for the 112k Hawaii residents who remain uninsured in our current system.

The Plan:
Available to anyone who is a Hawaii resident and at any given time is not covered by an employer under the Prepaid Health Act, private insurance or a Medicaid plan. Primarily targeted to the uninsured working poor and uninsured children.

Hawaii Essential enrollees will receive their care at any of the state's 13 federally qualified community health centers and at any of the state's 12 HHSC run hospitals. Other providers may choose to be participants with the plan. Specialty providers in Hawaii (many of whom already do participate with the Quest plans) will be encouraged to participate.

The plan will be put out to bid with the understanding that cost containment will be achieved by contracting with Hawaii's CHCs and Community hospitals. It is conceivable the state would prefer to run Hawaii Essential as the state already has a quasi-parent relationship with the CHCs and the HHSC facilities.

Prevailing Plan mandates are met because the CHCs and Community Hospitals offer all necessary services.

Hawaii Essential will be able to contract in advance for bulk tests, labs, and meds for the population who is covered by the plan, thus controlling costs.

Hawaii Essential will be legislatively mandated to increase it's cost to consumers at no more than 2% each year.

The Hawaii Essential plan will be monitored by a newly formed Hawaii Healthcare Authority (a possible recommendation of the Hawaii Healthcare Taskforce) which is tasked to offer annual updates to the legislature and Governor on its progress of covering the uninsured, containing healthcare costs in the state and the potential need to overhaul the system with a different solution if Hawaii Essential fails to solve the problem of the uninsured.

Who benefits

1. the uninsured in Hawaii, no fear of bankruptcy or morbidity due to no insurance coverage
2. the state of Hawaii no longer absorbs 'charity care costs', estimated at 525mil over 5 years
3. the CHCs already bear the burden of the uninsured, now they will be paid for their work and can staff based on more reasonable expectations
4. the HHSC hospitals decrease their % of charity care and their need to go to the legislature annually for money in excess of 40mil/year
5. small businesses have a way to insure part time employees

Total expected Hawaii Residents who will qualify, 50-100k

Cost of Plan $80/month, i.e. 1k/year

Who pays for the plan?

> Currently the entire population, businesses and unions absorb the cost of the uninsured.
>
> Under Hawaii Essential approximately 50% of the enrollees will pay for their own plans and 50% will receive it as part-time workers from their employers.

How can we afford Hawaii Essential?

Proper use of services must be mandated for its consumers. People need to be seen at primary care facilities instead of emergency rooms for their primary care. I estimate that the insured and uninsured annually spend between 200 million and 300 million dollars of resources in the Emergency room that could have been spent in healthcare dollars at CHCs and private offices. This is based on my experience as a primary care physician in a CHC for 3-plus years in rural Hawaii and as an Emergency Room doctor for 4 years in Hawaii. This data needs to be confirmed by our state's hospitals and state insurers, but I am confident that there are large savings to be realized here (and preventive care in general) that could alone pay for the Hawaii Essential Program if necessary.

An improved healthcare business model which includes a universal medical records plan for Hawaii is being pursued by the Hawaii Healthcare Taskforce. Implementation of these ideas is estimated to reduce cost by up to 23%, this based on several national studies.

Up-front costs:
Some modest injection of state funds into our 13 Community Health Centers and Community Hospitals will be necessary to ensure that they have enough staff to accommodate the newly qualified clientele

Estimated 10 million dollars each, in fiscal years 2006, 2007 and 2008. These funds will help the facilities build out more rooms, hire more providers and expand some services such as on-site dental, primary mental healthcare and low-cost pharmacy services.

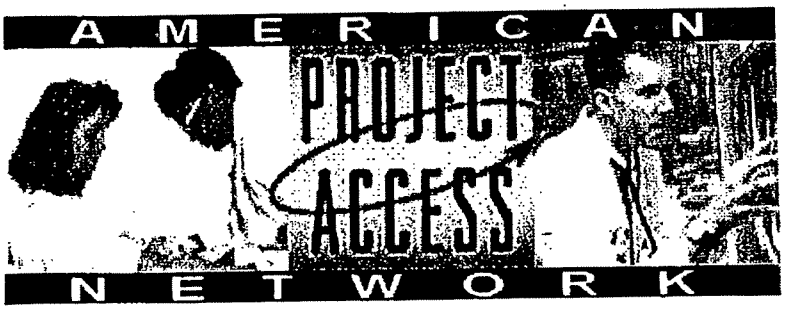
Initial estimates by my team suggest that the state of Hawaii can realize savings in excess of 1 billion dollars by 2015 by covering its uninsured and limiting waste in the form of uncontrolled chronic disease, misuse of ER facilities, duplicative tests and unnecessary non-reimbursed hospitalizations. This figure does not include increased workplace productivity and avoidance of personal bankruptcy. These are very significant additional benefits with enormous positive economic impacts for Hawaii.

Finally, it is good public policy to care for people who otherwise will face crises in their lives. If implemented, Hawaii Essential will prevent thousands of such crises each year in Hawaii.

It is always less expensive in human and economic terms to prevent a crisis rather then to react to one.

Submitted by Josh Green M.D., State Representative
Vice-chair Health Committee
Family Physician/Emergency Room Physician
Chairperson, Hawaii Healthcare Taskforce
October 12th, 2005

Attachment T



"Celebrating the Compassion of Caregivers"

APAN Home Page
About APAN
Community Consultation
APAN Staff
Physician Champions
What People Are Saying
Connections Newsletter
Special Events
APAN FAQs
The Project Access Model
What Is Project Access
Why Physicians Champion a Project Access System
Project Access Communities
Project Access FAQs
Recent News
Free Newsletter Subscription

304 Summit Street,
Asheville, NC 28803
828-274-9957
Contact Us

Frequently Asked Questions About Project Access

What is Project Access?

Project Access is a system that provides healthcare to low-income individuals who do not have insurance, nor do they qualify for public assistance. Project Access patients see physicians for free (both primary care doctors and specialists) and get all other healthcare services they need at no cost (hospital inpatient and outpatient services, lab work, x-rays, rehabilitation, medications, etc.).

How does Project Access work?

Simply put, Project Access is based on physicians volunteering their time to see patients for free, and other community partners, such as hospitals, donating the other medical services the patients need.

Do doctors already sometimes provide free care?

Most all physicians have treated patients who were not able to pay, either in their offices, in community clinics or in the emergency room. Hospitals also provide charity care. This care is often fragmented and the patients served usually lack full access to medications, diagnostic services and physician specialists.

In a Project Access system, this already existing (but fragmented) charity healthcare is organized into an equitable, cost-effective system. By donating care as part of an organized, integrated system, the care physicians and hospitals give in a Project Access system results in better health outcomes for patients and lower overall, long-term costs to the providers and the community.

Who is eligible for Project Access?

Typically, those who are eligible are age 18 to 64, have no medical insurance of any type, do not qualify for Medicaid or Medicare, and have gross household income of less than 150% of the federal poverty level (income criteria varies across communities). If a patient is eligible for Medicaid or Medicare he/she is required to accept it.

How does Project Access differ from Medicaid or Medicare?

Medicaid and Medicare are federally funded programs. Medicare is for people 65 or older. Part A provides free inpatient hospitalization, skilled nursing care, and hospice care. Part B of Medicare is optional and helps cover physicians' services and outpatient hospital care. It costs about $60 per month.

Medicaid is a program that covers low-income pregnant women, infants and the disabled. Sixty percent of the money is federally funded; 35% comes from the state and 5% is county-funded. The financial eligibility is 185% of federal poverty level for pregnant women and infants under 1 year of age. Contrary to popular belief, the majority of low-income individuals are not eligible for Medicaid.

Project Access is a community-based healthcare system that is financed and supported locally through the donated care of local providers.

Who qualifies for Project Access?

Each Project Access community may have different standards for accepting Project Access patients. In Buncombe County (Asheville, NC), where the system originated, the criteria are as follows:

- Patient must live in Buncombe County
- Patient cannot have any type of health insurance
- Patient must have household gross income of 200% or less of the federal poverty level

How do patients become enrolled in Project Access?

Patient must be referred to Buncombe County Medical Society Project Access by the health department, one of our community clinics, or private physicians.

Is there a limit as to how long a patient can be enrolled in Project Access?

No. The average enrollment in BCMS Project Access is approximately 6 months. Patients are rescreened for eligibility on a 3 or 6 month basis. More than 50% of patients become insured after 12 months.

Is there a limit to the number and kind of services a patient can receive through Project Access?

Typically, physician and hospital services are not limited. There is a list of medications (a formulary) that the patients have access to using their Rx card and there may be an annual cap on medication expenses per patient. Only healthcare services and medications received in the patient's own Project Access community are covered.

How was Project Access developed?

The Project Access system was developed in 1995 by physicians in the Buncombe County Medical Society in Asheville, NC. It has since won numerous awards and recognition, including an Innovations in American Government award. Communities all across the country are now replicating this model of care.

How do I know if Project Access can work in my community?

To find out how whether Project Access can work in your community, or to learn how to get such a system started, contact American Project Access Network:

304 Summit St.
Asheville, NC 28803
828-274-9957

George F. Bond

Health Director
Buncombe County
Asheville
North Carolina
September 9, 2005

Project Access – Expanding Care at the Local Level

Bringing Greetings from Asheville North Carolina

- Our County Commissioners
- Our Medical Society
- Our Tertiary Care Hospital
- Our Pharmacists
- Our Safety Net Providers

I've Been Here Before – Hillbilly in Paradise

- Hawaii Was Still a Territory
- At age 10 I met my dad here!
- Was I born without a father?
- Am I some kind of illegitimate child?
- Almost!

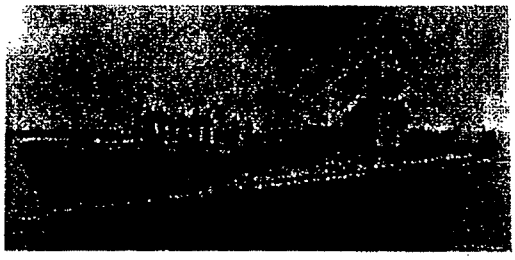
Standard of Medical Care in Bat Cave

North Carolina 1950's

- Solo Practice
- 24/7
- General Practitioner
- Surgeon
- Orthopedist
- Obstetrics
- Never home
- Great doctor
- Absentee father!

Probably explains why I'm not a doctor!

1954 - Lt. George Bond, MC,
Drafted at the end of the Korean War



Submarine Squadron Medical Officer

Let's set the medical stage
Asheville 1995

- County of 225,000 Residents
- 700 Physicians
- 803 bed tertiary care Regional Hospital
- 3 Safety Net clinics
- Home of the Biltmore Estate Vanderbilts
- Home of NASCAR
- Mountains of Western North Carolina

History - Asheville 1995
Community Health Assessment

- 1000 Households Surveyed
- 78% had source of medical care
- 22% did not
- Hospital Emergency Room indigent costs going up
- Hospital in-patient indigent write off's up

History - Asheville 1995
The Safety Net

- Ridgelawn Clinic (FQHC look alike) - 1000 pts
- ABCCM – 500 pts
- Buncombe County Health Center – 9000 pts
- Safety Net providers all under-performing
- Trying to be all things to all people

History - Asheville 1995

The Safety Net

- My Department had 5 RNS "begging" for specialty referrals every day
- We're good at primary care
- Not competent but stuck with cardiology, orthopedics, dermatology, endocrinology
- Revolving door of unresolved specialty care needs
- Excessive rate of visits/year/patient
- Frustrated staff

History - Asheville 1995

The Primary Care Docs

- Waiting for a Federal or State solution
- 2 AM calls from ER for undesignated patients
- Deeply concerned with plight of underserved
- Afraid to take the first indigent referral – fear of being "buried" with no pay patients

History - Asheville 1995
The Specialists

- Don't want to take indigent consultation
- Afraid it won't be a true "consult"
- Nowhere to send patient back
- I'm stuck with both specialty and primary care for that patient forever!

History - Asheville 1995
The Medical Situation

- Safety Net providers trying to be specialists
- Hospital buried with avoidable admissions
- Doctors "hunkered down" for self protection
- Medical Gridlock – All dug in for survival
- 22% of residents have no care
- We're ready for a new approach

Our Doctors Take Charge
The Medical Society

- We've had enough!!!
- People need appropriate care
- It's our calling
- We're seeing them anyway on undesignated call
- We'll all be retired before a national solution comes!
- Do It Yourself healthcare reform!

Our Doctors Take Charge
The Medical Society

- Project Access is born!
- Spread the load and nobody gets buried
- 2000 patient practice – can you take 10 indigent?
- A way to give back to the community without being overwhelmed
- Robert Wood Johnson "Reach Out" grant

Our Doctors Take Charge
The Medical Society

- Physician Champions emerged – Dr. Landis, Powell, Davis
- Recruitment in men's room
- Momentum builds
- 40% of our docs sign on in first year
- Hospital joins in - full array of services
- A huge boost

Our Doctors Take Charge
The Medical Society

- Hired consultant to build management/referral software
- Doctors complaining about lack of pharmaceuticals
- Patient can get a $500 cardiology workup – can't get $10/month medication!
- County commissioners give $350,000 support
- Pharmacists join program
- Limited formulary developed as guideline

Our Doctors Take Charge
The Medical Society

- Project Access really takes off!
- Rest of Asheville's Doctors join in – over 600
- Primary care pledge – 10 patients / year
- Specialty care pledge – 20 referrals / year
- Computer software completed – pledges, visits
- Evaluation system designed/operating
- HCFA 1500's to local PPO for tracking
- The perfect HMO – nobody gets paid!

Our Doctors Take Charge
The Medical Society

- The doctors run the program
- Hires case manager – eligibility, appointments, reminders, transportation
- Patients get actual "card" to present when seen through Project Access
- Safety Net clinics are main referral source
- County Commissioners take pride – The "Good Health Commissioners"

History

We reengineer the Safety Net

- My department, a Public Health Department is 90% of the local Safety Net
- I was brand new on the job coming back from 8 years in free enterprise and for profit Health Care Management
- Called clinicians together
- Production stinks
- Costs are exorbitant

History

We reengineer the Safety Net

- Quality controls non-existent
- 3 month wait for appointments
- Unboarded staff or practicing outside specialty
- Patient satisfaction low
- A mountain of lost records
- "Silo" clinics
- Set goal – double production / same staff!

History

We reengineer the Safety Net

- CQI team appointed
- 30 days to report
- Reengineered our clinic
- Physically consolidated – silos gone
- Hired practice manager
- On-site eligibility for Medicaid and Project Access

We Reengineer the Safety Net

- A sleeping giant begins to awake
- Production grows by over 70%
- All staff appropriately credentialed
- Pharmacy filling up to 1000 prescriptions/day
- 66% of drugs free from Patient in Need programs

We Reengineer the Safety Net

- One person makes Project Access referrals instead of 5 nurses "begging"
- Converting to electronic medical records in September – expect 30% more efficiency
- Joint domain with our hospital
- Many couldn't see the new vision
- 70% of staff turned over

We Reengineer the Safety Net

- Now Health Care home for 18,000 underserved
- Integrating Behavioral Health into Primary Care
- Open Access Scheduling
- 1/3rd of staff bilingual
- Staff turnover back down to 15%

We Reengineer the Safety Net

Keys to our success

- Get out of specialty care business
- Stop revolving door of unresolved medical issues
- Clinic efficiencies through job reengineering, outsourcing, automation
- PROJECT ACCESS!!
- Enabled us to do what we do best - Primary Care

The Results

Community Health Assessment 2000

- 93% of residents have source of regular care
- Up from 78% just 5 years earlier
- Last year over $8,000,000 in documented free care split between hospitals and MD's
- 16 to 1 return on investment
- 70% of Project Access referrals from Safety Net

From Buncombe County

The Results

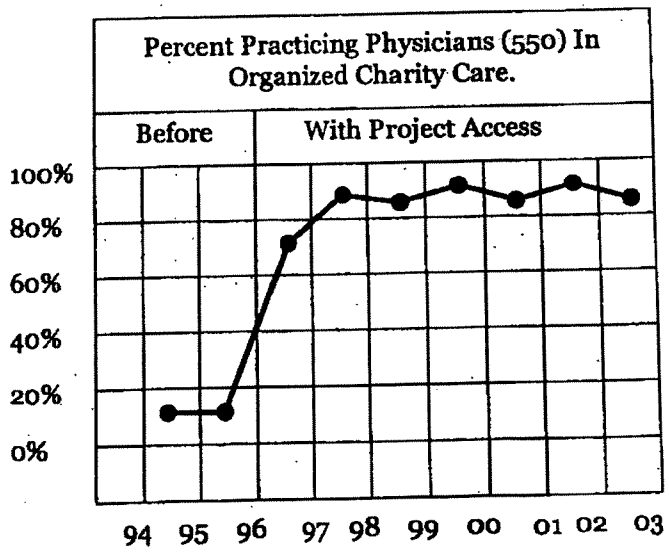
Community intent: "do the right thing"

Organizing program creates mutual accountability

Integrated Safety Net SYSTEM

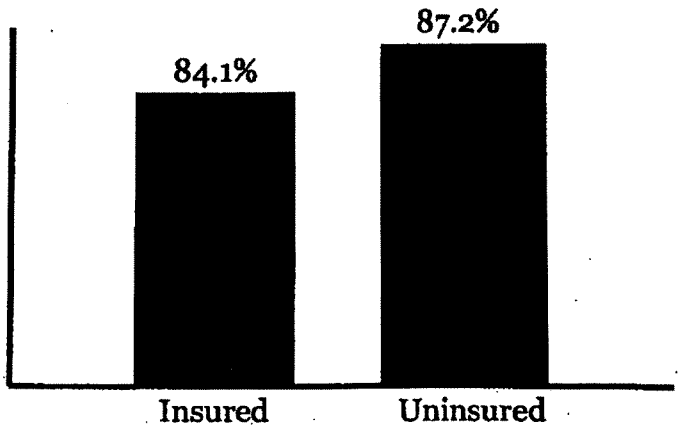
"We saw good things happen"

The Results



The Results

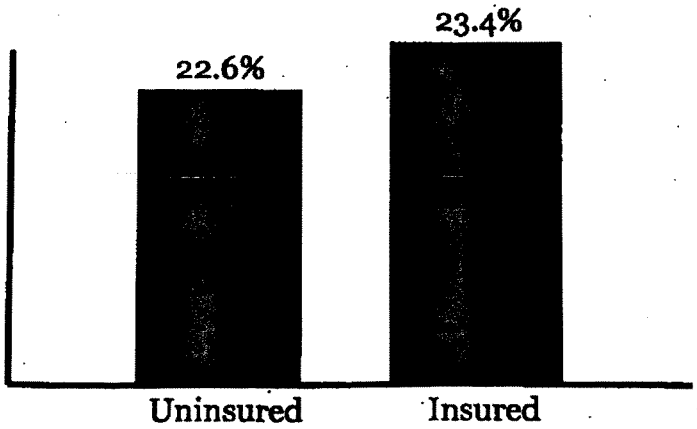
Experience "Good" or "Excellent" Physical Health



Source: 2000 PRC Community Health Survey, Professional Research Consultants

The Results

Utilization of ER in the Past Year



Source: 1. 2000 PRC Community Health Survey, Professional Research Consultants
2. 2000 Buncombe County Latino Health Survey

The Results

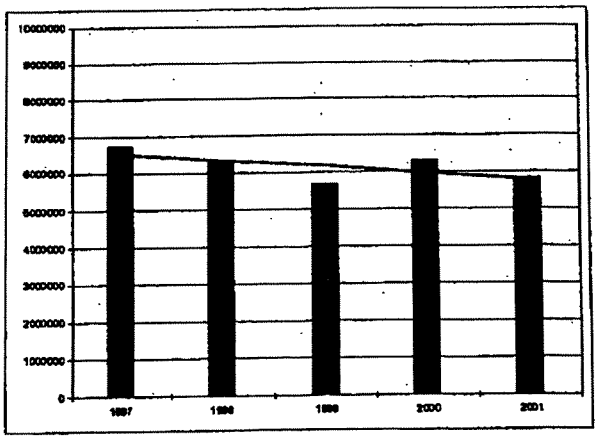
Employment Study Of Project Access Patients.

	% Surveyed
Gain in employment since enrolling	14%
Services helped return to work or do better job	25%
Since leaving have job with health insurance	46%
Routine check up within last two years	98%
Health is better or much better	80%

MAHEC October, 1998. Sample: 276 Project Access patients (51% no longer enrolled.)

The Results

Hospital Charity Cost Decreases Over Life of BCMS Project Access



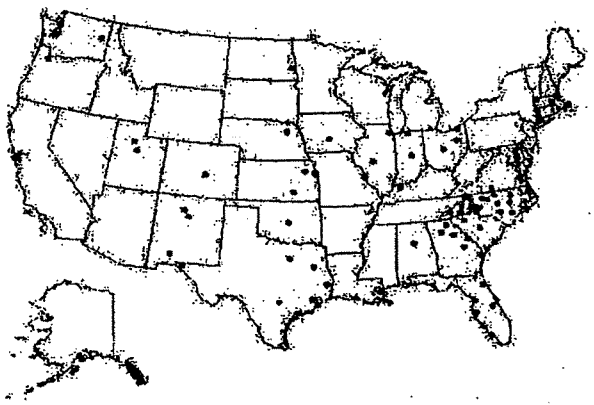
The Results

It is working in many communities

Wichita, Kansas	450,000
Dallas, Texas	2.1 million
Swainsboro, Georgia	25,000
Raleigh, North Carolina	750,000
Danville, Virginia	150,000
Boone, North Carolina	75,000
Greenville, South Carolina	300,000

Plus over thirty others!

Project Access Across the Nation



Medical Care in Asheville, NC

- We're proud of our model – 93% access
- Being replicated all over Country
- Innovations in American Government award
- Growing pains – Eligibility levels, interpreters, illegal aliens
- Hospital indigent care costs down
- Safety Net much stronger due to Project Access
- Buncombe County very close to universal access to full continuum of health care

Could it Work for Hawaii?

Absolutely!

- We increased access from 78% to 93% in 5 years
- Hawaii already at 90% insured
- 95%/96% is essentially full coverage – people in transition and wealthy self insured
- Your goal is only 5% increase in access – That's 60,000 for Hawaii

Could it Work for Hawaii?

Remember

- Project Access was a driver of system change
- Doctors ran the show
- Safety Net clinics had to be optimized
- Hospital had to join in
- Local government provided funds for drugs and administration

Could it Work for Hawaii?

Remember

- You are a already national leader
- 1974 Prepaid Health Care Act
- Only State law of it's kind in the USA
- Only Minnesota, Rhode Island, Iowa, and Massachusetts have fewer uninsured
- You have the capacity to achieve universal health care

Thank you for listening to our story!

QUESTIONS?

George.bond@buncombecounty.org

828-250-5214

Attachment 5

3-Country Side-by-Side of Single-Payer Health Care Systems

	Canada	Taiwan	England
Enabling Legislation	Canada Health Act: puts in place conditions by which individual provinces and territories in Canada may receive funding for health care services. Enacted in 1984.	National Health Insurance (NHI) Act was passed by the Legislative Yuan on July 19, 1994, and implemented in 1995; expanded job-related health insurance to univerally covered insurance program, which includes family members.	The National Health Service (NHS) was established in 1948 to provide healthcare for all citizens, based on need, not ability to pay. The Department of Health funds, directs, and supports the NHS; Primary Care Trusts assesses local needs and commissions care; and Strategic Health Authorities manages, monitors, and improves local services.
Coverage	Covers basic services such as primary care physicians and access to hospitals, as well as dental surgery and additional medical services.	NHI offers comprehensive benefits package: ambulatory care, hospitaliation, ancillary services, dental care, home health care, px drugs, traditional Chinese medicine, and some preventative heatlh services.	The NHS will provide access to a comprehensive range of services throughout primary and community healthcare, intermediate care and hospital-based care. The NHS will also provide information services and support to individuals in relation to health promotion, disease prevention, self-care, rehabilitation and after care.
Supplemental coverage	Private health insurance plans, primarily through employers, cover dental and vision care, and prescription medications. Private insurance also allows access to private clinics for specialized services, and covers 80% of costs.		
Insurance structure	Handled by individual provinces and territories. Health card allows coverage in that particular province or territory. Certain provinces require health care premiums, but cannot deny health services due to financial inability. Provinces can provide additional services, but are not obligated to.	Insurance premiums are shared by individuals, employers, and the government. Medical expenses are paid by a single-payer (BNHI).	

Accessing Care	Requires obtaining a provincial health card. A waiting period not to exceed three months for new immigrants. Health card contains an ID number, which is used to access a person's medical information. There are typically no forms to fill out or individual service fees. Availability of doctors depends on demand, and there are 1 primary care doctor for every 1000 Canadians.	All citizens are obligated by law to join the NHI program. Insurance vouchers, medical and special, are used in the NHI plan. It is a paper card, used to record six doctor visits, then traded in for a new one.	Regarding waiting times, at the moment, most patients are referred to a hospital and consultant chosen by their GP (local Doctor surgery). As part of the Patient Choice programme, by summer 2004 all patients waiting over 6 months for surgery will be offered a choice of moving to another hospital or provider for their treatment. From December 2005 all patients who need planned surgery will be offered a choice of 4 or 5 hospitals or providers when they are referred by their GP.
Providers	Primary care doctors, specialists, hospitals and dental surgery are all covered by provincial insurance policies. There are about 30,000 primary care doctors and 28,000 specialists. Ambulatory services are provided for those unable to transport themselves in an emergency.	15,872 medical institutions have been contracted by NHI, of these, 3.32% are public and 96.68% are private.	
Financing	Funded at both provincial and federal levels via taxation both from personal and corporation income taxes. At federal level, funds are allocated to provinces and territories via the Canadian Health and Social Transfer. Funding to provinces and territories topped $35 billion in 2002-2003. Publicly financed, but privately run.	Financed by payroll-related premium contributed by the employer (33%), the employee (40%), and the government (27%). Administered by government, single-payer, and compulsory. There is also a copayment system. Remainder paid by insurance.	Financing is by taxpayers.
Total Insured	95% to 98% are insured. In addition to taxes, two provinces charge residents a premium to help fund their health plans. Those who do not pay the premium are uninsured.	99% as of July 2005.	

Attachment 6

The Lewin Group
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Falls Church, VA 22042
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www.lewin.com

November 9, 2005

Ms. Laurel Johnston
Executive Director
The Hawai`i Uninsured Project
Hawaii Institute for Public Affairs
American Savings Bank Tower, Suite 1132
Honolulu, HI 96813

Re: Proposal Submitted in Response to RFP for Consulting Services to the Hawai`i Uninsured Project

Dear Ms. Johnston:

The Lewin Group is pleased to submit the enclosed proposal in response to the Hawaii Institute of Public Affairs (HIPA), through the Hawai`i Uninsured Project (HUP)'s request for proposal to analyze the costs and benefits of establishing a single payer system in Hawaii.

The Lewin Group has nearly 20 years of experience in providing objective, non-partisan analyses of health reform initiatives at both the state and federal levels. We have modeled the impact of single payer reform proposals in California, Georgia, Vermont, Massachusetts, Maryland and nationally. We look forward to the opportunity to support HIPA/HUP in this important initiative.

Please call me at 703-269-5610 or email me at john.sheils@lewin.com if you have any questions or need additional information.

Sincerely,

John Sheils
Vice President

Enclosures

The LEWIN GROUP

Proposal for Consulting Services for Hawai'i Uninsured Project

prepared for:
Hawaii Institute for Public Affairs

November 9, 2005

Table of Contents

I. EXECUTIVE SUMMARY

The Hawaii Institute of Public Affairs (HIPA), through Hawaii Uninsured Project seeks a comprehensive evaluation of the costs and benefits of a single payer system as outlined in HB 1617, to assist the Health Care Task Force in developing a comprehensive health care coverage plan for the citizens of Hawaii. Once again, Hawaii can play a leadership role in shaping the future of health care reform for the nation. The Lewin Group's team of experienced professionals, committed to providing excellent, unbiased, and in-depth quantitative and qualitative analysis of health care reform, is eager to assist HIPA in its effort to change the face of health care and to effect affordable, quality health care coverage to the citizens of Hawaii.

Hawaii's Prepaid Health Care Act (PHCA), in effect since 1974, requires most employers to provide health insurance for their employees at minimal cost to the workers. However, employees that work less than 20 hours per week do not receive coverage leaving many Hawaiians employed but uninsured, and creating a perverse incentive for employers to rely heavily on part-time workers to avoid the increasing costs of insuring workers. Thus, this law has not completely shielded Hawaii from the high cost of health care, the rise in insurance premiums, and the increasing numbers of people without health insurance. Like many states, Hawaii has responded to this crisis through a patchwork of employer-sponsored coverage, anchored by the PHCA, and government-supported health care coverage. Still, many individuals are not able to access these benefits because their income or resources exceed the programs' maximum levels.

The increasing health care costs, insurance premiums, employer costs, prescription drug costs, long-term care costs, as well as the growing number of uninsured individuals has propelled the Hawaii legislature to enact House Bill 1617, calling for the development of a plan to overhaul the hybrid-system of health care and to provide health care coverage to all of Hawaii's citizens under a single payer plan. The RFP is the result of this legislation, to provide a comprehensive analysis of the impact of a single payer plan on Hawaii's health care system.

A. Qualifications and experience

The Lewin Group has nearly 20 years of experience in analyzing health systems reform initiatives, including single payer models, requested in the RFP. The Lewin Group has developed analyses of several single-payer proposals at both the state and national levels. This has included estimates of cost impacts for major stakeholder groups and the impact on health spending. All of these projects included analyses of various funding mechanisms.

In these projects, we worked with our clients to refine the specification of these proposals to a point where their effects could be measured. We then estimated the impact of these proposals on system-wide health spending including the effects of covering all citizens with a comprehensive health benefits package on health services utilization and costs, and changes in administrative costs, including the effect on insurer and provider administration. We also showed the cost impact on major stakeholder groups including governments (state, federal and local), employers, providers and households.

We developed these analyses using the Lewin Group Health Benefits Simulation Model (HBSM). HBSM is a micro-simulation model of the United States' health care system developed by The Lewin Group that provides state-level analyses of how changes in the health care financing system affect the sources and uses of funds for various public and private payers. HBSM provides a framework for analyzing the impact of these reforms on the number of people with insurance coverage and provides comprehensive analyses of health system reform on: provider revenues; employer costs by firm size, industry and other employer characteristics; state and federal governments; and consumers, by age, income and other demographic characteristics. The model is also designed to simulate the impact of various types of funding mechanisms for coverage expansions including income taxes, payroll taxes and consumption taxes (i.e., sales taxes).

B. Proposed fees (hourly per staff type; maximum annual; and maximum for the total contract)

We propose Mr. John Sheils, Vice President, as Project Director. Mr. Sheils, who has been with the Lewin Group for 25 years, is a nationally recognized authority on health system reform who is known for his in-depth understanding of the complexities of health system incentives and the professional integrity of his analyses. He is the architect of The Lewin Group Health Benefits Simulation Model, which has been used to estimate the cost of expanding coverage at the state and national levels. He directed the Lewin Group analyses of single-payer plans in several states including California, Vermont, Georgia, Massachusetts and Maryland. He has also provided analyses of alternative single-payer proposals nationally for the Robert Wood Johnson Foundation (RWJF). Mr. Sheils directed several Lewin projects on approaches for expanding coverage under State Planning Grant (SPG) projects funded by HRSA.

We propose Ms. Evelyn Murphy, Senior Manager at Lewin in the firm's Health Care Management practice, as Project Manager. Ms. Murphy has more than 10 years combined state experience in Medicaid program development, management and oversight. Prior to joining Lewin, Ms. Murphy worked as an independent consultant on evaluations under Indiana's State Planning Grant, including evaluating the adequacy of access to safety net providers by insured and underinsured Indiana residents. We also include Mr. Randall Haught, a Senior Scientist, who has been responsible for the development and use of state-level health benefits models, including estimates of the impact of single payer models, at The Lewin Group for more than 15 years.

Other Lewin personnel (primarily research analysts) will be involved in the project as needed and will account for no more than 24 percent of total project hours. Total costs for labor is $81,460. We will invoice HIPA monthly for services performed. The following table provides the breakdown by staff level.

Table 1
Budget Hours and Budget by Staff Level

Staff	Hourly Rate	Total Contract
Vice President	$325	$14,950
Senior Manager	$205	$28,290
Senior Scientist	$260	$29,640
Research Analyst	$90	$8,280
Administrative Assistant	$75	$300
Total labor		**$81,460**

C. Costs and expenses

We estimate an additional $500 in direct costs including, long-distance phone charges, printing and postage. Travel costs are excluded however, we are available to present our findings at a time and location of your preference. Should travel be required, they will be charged at cost. The total budget to complete the assigned tasks including the estimated direct charges will be $81,960.

Table 2
Total Project Budget

Total labor	**$81,460**
Direct Costs	$500
Grand Total	**$81,960**

D. Why The Lewin Group should be selected

Lewin is perfectly qualified to provide the services requested in the RFP. Lewin's leadership is drawn from the highest ranks of government, academia, and industry. Lewin's consultants possess diverse and complementary background in multiple disciplines. Our multi-talented staff possesses a powerful combination of health care industry-specific knowledge, cutting-edge analytic capabilities, and demonstrated success in the development of health care initiatives at the local, state and federal level. We also bring what we believe to be a unique level of commitment and enthusiasm for our work in this area, as we believe state-level initiatives truly reform health care.

We have developed economic models to estimate the impact of numerous reform proposals on major stakeholders throughout the health care system, including governments, employers, consumers, and providers. This includes providing comprehensive analyses of single payer models in California, Georgia, Vermont, Massachusetts, Maryland and nationally, using our HBSM tool.

The Lewin Group is the best possible candidate for this project given our objectivity, integrity, analytical superiority and dedication to delivering the best possible advice and products to our clients.

II. TECHNICAL APPROACH

We propose to analyze the impact of the single payer system in Hawaii using models and data specifically designed to estimate the impact of the House Bill 1617 reform on Hawaii's health care system. HBSM is a model of the United States' health care system developed by The Lewin Group that shows the sources and uses of funds for various public and private payers. It is designed to simulate the cost and coverage impacts of health reform options ranging from narrowly defined Medicaid expansions to large-scale reforms such as single-payer and employer coverage mandates at the state and national levels.

HBSM provides a framework for analyzing the impact of these reforms on the number of people with insurance coverage and system-wide health spending. It also provides comprehensive analyses of health system reform on: provider revenues; employer costs by firm size, industry and other employer characteristics; state and federal governments; and consumers, by age, income and other demographic characteristics. The model is designed to simulate the impact of various types of funding mechanisms for coverage expansions including income taxes, payroll taxes and consumption taxes (i.e., sales taxes). In addition, the model simulates policies for re-capturing uncompensated care savings to fund coverage expansions.

The model can be customized for use in individual states, such as Hawaii, based upon available and credible state and private data including recent surveys of sources of health insurance in the state, health spending under public programs, spending for safety-net providers and uncompensated care, and data on employer health spending in the state. The resulting model is capable of estimating a full range of impacts under proposals designed to expand health insurance coverage including:

- The effect of universal coverage on health services utilization by provider type.
- Changes in state-wide health spending.
- Impacts on state and federal government program spending, including safety-net providers.
- Employer impacts by firm, industry and current insuring status.
- Pooled purchasing systems and the effects of adverse selection.
- Changes in health spending for families by age, income and other characteristics.

An illustration of HBSM is provided in **Appendix A**. The following sections describe our approach to each of the tasks specified in the RFP. As requested in the RFP, we have repeated the task to facilitate review of our proposal.

A. Analyze Costs/Benefit of the Single Payer System for Hawaii

The RFP calls for the following specific tasks:

> *Analyze the costs and benefits of a single payer system for Hawaii as outlined in H.B. 1617. The cost analysis shall estimate the total cost for a single payer system, to include the*

amount of state funds required. The cost analysis shall evaluate the financial impact, including:

a. *the extent to which mandating coverage will increase or decrease the cost of the service;*

b. *the extent to which mandating coverage will increase use of the service and attendant costs;*

c. *the extent to which the mandated service will be used as a substitute for a more expensive service and result in cost savings;*

d. *the extent to which mandating coverage will increase or decrease the administrative expense of carriers, and the premiums and administrative expenses of policyholders, members of mutual benefit societies, and subscribers of health maintenance organizations;*

e. *the effect of mandating coverage on the total cost of health care; and*

f. *the effect of mandating coverage on consumer access to health insurance, and on employers' ability to purchase health benefits policies to meet employees' needs.*

1. Our understanding of the unique system in Hawaii

With the Prepaid Health Care Act (PHCA), an employer mandate implemented in 1974 and employer subsidies, Hawaii is the first state to effect a strategy towards universal coverage. In fact, Hawaii received a waiver from the federal government when the Employee Retirement Income Security Act of 1974 (ERISA)—the federal law that sets minimum standards for most voluntarily established pension and health plans in private industry to provide protection for individuals in these plans, was passed into law.

Hawaii's PHCA requires most employers to provide health insurance for their employees at minimal cost to the workers. Employers must cover a significant portion of the employee's individual premium. However, employees that work less than 20 hours per week do not receive coverage leaving many Hawaiians employed but uninsured, and creating a perverse incentive for employers to rely heavily on part-time workers to avoid the increasing costs of insuring workers.[1] Thus, this law has not completely shielded Hawaii from the high cost of health care, the rise in insurance premiums, and the increasing numbers of people without health insurance.

Hawaii's inflation rate for medical care has risen sharply just in the last decade from the low 1.1 percent in the late 1990's to more than eight percent in early 2000's. During the same period, the retail costs for prescription drugs grew by more than twelve percent. The health care market place in Hawaii also continues to change in an attempt to control costs. By the early 2000's most Hawaii residents were covered in some form of managed care, an increase of 31 percent from the

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[1] Lipson, Debra, Keeping the Promise? Achieving Universal Health Coverage in Six States, Kaiser, Summer 1994

early 1990's.[2] In addition, the uninsured rate in Hawaii has doubled in the last ten years from less than five percent in 1994 to ten percent in 2005.[3]

Like many states, Hawaii has responded to this crisis through a patchwork of employer-sponsored coverage, anchored by the PHCA, and government-supported health care coverage. The QUEST program provides health coverage through Medicaid managed care for eligible, low income pregnant women and children in Hawaii. The program provides a standard benefits package with emphasis on preventive care for adults and children. Through its Medicaid-integrated SCHIP program, Hawaii was also able to cover more children. MED-Quest, the Medicaid fee-for-service program, covers the aged, blind and disabled population. QUEST-Net provides limited benefit transition for persons who fall off the Medicaid rolls due to increasing income and assets. Still, many individuals are not able to access these benefits because their income or resources exceed the programs' maximum levels.

In 2000, the Hawaii Uninsured Project (HUP) was created by a group of local health care leaders in response to the rising number of uninsured, and was first sponsored by the Robert Wood Johnson Foundation. The vision of HUP was for Hawaii, once again, to lead the nation by having a cost-effective system of quality health care for all its citizens. Specifically, HUP sought to bolster employer-based insurance through the PHCA to make insurance available to most working people and their dependents; for unemployed, and part-time workers and their dependents to access coverage through government-sponsored programs that take maximum advantage of federal funds; and to strengthen the health care safety net to provide quality services.[4]

Despite its solid legislative history and hybrid-system to ensure coverage for all, Hawaii, like many states, continues to be plagued with increasing health care costs, insurance premiums, employer costs, prescription drug costs, long-term care costs, as well as a growing number of uninsured individuals. This propelled the Hawaii legislature to enact House Bill 1617, calling for the development of a plan to overhaul the hybrid-system of health care and to provide health care coverage to all of Hawaii's citizens under a single payer plan.

The Hawaii Institute of Public Affairs (HIPA), through HUP seeks a comprehensive evaluation of the costs and benefits of a single payer system as outlined in HB 1617, to assist the Health Care Task Force in developing a comprehensive health care coverage plan for the citizens of Hawaii. Once again, Hawaii can play a leadership role in shaping the future of health care reform for the nation. The Lewin Group's team of experienced professionals, committed to providing excellent, unbiased, and in-depth quantitative and qualitative analysis of health care reform, is eager to assist HIPA in its effort to change the face of health care and to effect affordable, quality health care coverage to the citizens of Hawaii.

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2 Health Trends in Hawaii, www.healthtrends.org.

3 HB 1617, estimate provided by the Healthcare Association of Hawaii.

4 Hawai'I Uninsured Project, A Plan for Action, 2001

2. *Specifications of Hawaii's Single Payer Model*

Our first priority for this task will be to refine the specifications of the single payer model. Our analysis will be based on the assumptions outlined in the RFP (further described below). In addition, we would work with you and your associates to refine key specification of the single-payer program that would be implemented under HB1617, needed to conduct the analysis. We would offer guidance in developing specifications that best meet your objectives. The result of this process would be a set of program specifications sufficient to estimate the impact of such a program on consumers and various stakeholder groups in Hawaii.

As required in the RFP we will utilize the following assumptions:

- Covered services: we would assume that the benefits package to be offered by the single payer system will be the same as the benefits package offered by the Hawaii Employer Union Health Benefits Trust Fund and shall include medical, dental, vision and drug coverage;
- Covered population: we would assume that all persons in Hawaii who wish to be part of the program will be covered, except those covered through the Federal Employee Health Benefit Plan, Medicare, and TRICARE;
- Provider payment levels: we would assume three levels of reimbursement for analysis (1) the current Medicare reimbursement rates, (2) current rates plus five percent, and (3) current rates plus ten percent.

Additional specifications or further clarification of the HB1617 provisions will be needed for the following:

- Patient co-payments (if any);
- Key administrative features including budgeting process, hospital budgeting, etc.;
- Financing method as specified by HB 1617, including: individual and employer contributions, Federal Medicaid matching funds, state general fund appropriations, individual monthly dues, and the medical payment portions of auto insurance, public liability insurance and homeowner's insurance policy premiums; and
- Managed care: the RFP requires an assumption of a moderate level of managed care. We will work with you and your associates to refine this criteria.

3. *Data and Methods*

The HBSM would be used to input the available data on health coverage and expenditures for Hawaii. These data sources include:

- Bureau of the Census Decennial Census data on Hawaii residents by income and demographic group;

- Health insurance coverage data for the Hawaii sub-sample of the March Current Population Survey (CPS) data (data for most recent four years are pooled to obtain sufficient sample size);
- Other Hawaii specific population survey data;
- Hawaii Medicaid and SCHIP enrollment and expenditures data;
- Medicare enrollment and spending data for Hawaii residents;
- Total health expenditures estimates for Hawaii by type of service and source of Payment supplied by the Centers for Medicare and Medicaid Services (CMS);
- Direct services expenditures under state and local government programs;
- Hospital revenue and expenditures data for the state from published data provided; and
- Other data developed by or for the state of Hawaii.

This study would include a detailed analysis of insurer and provider administrative costs. The analysis would also be based upon published data on administrative costs for insurers, hospitals and physicians.

4. Analysis and Evaluation

We will evaluate the impact of mandating coverage on utilization and costs. Our analysis will show the overall impact on service utilization and associated costs of the change in utilization. This would include increased utilization among newly insured Hawaii citizens, and additional utilization by currently "under-insured" Hawaii citizens as they become covered under a more comprehensive benefits package. The level of utilization would also be influenced by the level of managed care required under the single payer system. Traditionally, managed care involves risk-bearing on the part of the managed care organization to drive more appropriate utilization towards less expensive forms of care, for some benefit. As such, risk-based models have been used to save costs overall. Other care management models exist such as disease management and primary care case management models. The level of management in the single payer model will impact utilization and overall costs of care. This analysis would reflect the savings associated with the specifications with respect to managed care, and also the savings resulting from expanded use of primary and preventive care model, which would substitute more expensive services.

Our study would include a detailed analysis of the impact of the program on administrative costs in the system, including policyholders, members of mutual benefit societies and subscribers of health maintenance organizations, such as claims processing, marketing, enrollment and profit/risk.

We would evaluate the effect of mandating coverage on employers by estimating the following:

- Change in total health spending for private employers;
- Changes in employer spending for currently insuring and non-insuring employers;
- Impact of key provisions on retiree health spending;

- Changes in spending due to financing provisions of the plan;
- Net change in spending by firm size; and
- Net change in spending by industry.

These estimates will inform HIPA of the financial impact that the single payer system will have on employers' ability to purchase health benefits to cover employees. We will evaluate how these employer costs as well as other aspects of the single payer system (such as cost-sharing) affect employee's access to insurance benefits. Even if employers provide benefits, there is no guarantee that employees will avail themselves of such benefits for a variety of reasons, including cost-sharing requirements. Finally, Lewin's analysis would show the impact of the program on state-wide health spending, assuming it is fully implemented in 2006.

5. Final Report

These analyses would be provided in a series of memoranda showing the effect of adopting each of these alternative approaches. The analyses would result in a final narrative report describing the single-payer model that we analyzed. It would also include a narrative discussion of our estimates of the impact of the program on total health spending in the state and the impact on major stakeholder groups. We would provide projections of expenditures in future years reflecting the health expenditure budgeting system included in the single-payer model. In addition, we would provide a detailed technical appendix describing the data and methods used in the analysis. We will work with you in developing the final report.

B. Analyze the cost and benefit differential between the single payer system and the system currently in place in Hawaii, including any administrative cost savings.

In this analysis, Lewin would quantify the difference in costs and savings under the single payer system and under the current health system in Hawaii. The current system would be the "base case" data, which served as our reference point for the simulations of alternative single payer system models.

Our study would include a detailed analysis of the impact of the program on administrative costs in the system. The cost of administration includes the insurer's cost of providing benefits including claims processing, marketing, enrollment and profit/risk. Administrative costs also include the provider's cost of filing claims, adjudicating claims and negotiating payment levels with carriers. A single-payer program would reduce these administrative costs by:

- Eliminating insurer functions such as marketing, network formation and profit; and
- Simplifying the provider payment process through a single provider payment schedule with standardized rules that reduce claims adjudication activities.

C. Evaluate whether the existing Hawaii healthcare delivery system can support a single payer system.

Under this task, Lewin would estimate the increase in the demand for health professionals for newly covered people. This would include an estimate of the net increase in services resulting from the proposal and the number of doctors and nurses required to provide health services. The analysis would reflect the fact that administrative simplification would free-up time among current health professionals to provide much of the increase in services demanded (currently, about 11 percent of hours worked by physician is devoted to administration).

This analysis would also include the likely impact of the program on employment, especially in the health care sector, to evaluate whether the health care system can support the single payer system. This would include an analysis of job loss for people employed in administration of insurance and other effected employment. We would also estimate job loss separately for administrative personnel with medical training (i.e., nurses and doctors) from those who do not have medical training. This is because medically trained personnel are potentially re-employable in providing direct patient care to the uninsured people who would become covered as a result of the program.

D. Evaluate the effects that a single payer system will have on healthcare providers, including their ability and willingness to remain in Hawaii.

To inform our evaluation, we propose to undertake limited secondary research of literature from national sources on the expected effects of single payer systems on provider behavior.

The effect of a single payer system on in- and out-migration of healthcare workers will depend on multiple factors, such as the payment levels that the single payer system offers and reduced administrative burdens on direct care workers. It would also depend on the characteristics of the healthcare providers. Reduced risk from a single payer model may be more attractive to certain non-for-profit, mission-driven providers; however, the reduced competitive environment may create an open door for any provider regardless of their characteristics. Since a single payer model presumably allows participation by all licensed providers, it may adversely impact safety-net providers who would be on a level-playing field with traditional providers in competing for funding and resources.

E. Evaluate the costs associated with non-Hawaii residents coming to Hawaii to take advantage of the single payer system.

We would estimate the impact of the program on households, including the following:

- Changes in consumer out-of-pocket expenditures for healthcare;
- Reduction in family premium payments;
- Increase in consumer tax payments to fund the program;
- Changes in wages resulting from changes in employer costs (i.e., changes in employer health spending are generally thought to be passed-on to workers in the form of wage changes over time); and

- Changes in average health spending by income, age, insured status, under current law, and other socio-economic groups.

This would inform our evaluation on how "attractive" non-Hawaii residents might perceive the state based on its insurance program in comparison to other states.

We would also consider migration changes in Hawaii. Between 2000 and 2020, net in-migration to Hawaii is estimated to average 6,400 annually.[5] The population forecasts performed by the Hawaii Department of Business, Economic Development and Tourism (DBEDT) ties overall net in-migration to stronger economic growth and increase in jobs. Historically, Hawaii has seen greater numbers of in-migration during the economic booms of the 1960s and 1980s. Thus, the extent to which the single payer plan attracts employers to Hawaii will influence migration of people into Hawaii—i.e., the more affordable health insurance purchasing is for employers, the more likely they are to locate in Hawaii, and consequently attract new residents to the state. The converse is also true. Decline in jobs (regardless of the reasons, including high costs of providing insurance benefits by employers) would reduce migration into the state. According to the DBEDT, Hawaii has experienced population out-migration in only five of the last 35 years. Furthermore, overall in-migration is expected to slow down in the future (as compared to the last 35 years) because of slower projected economic growth.

While we cannot directly tie the single-payer program to in-migration of non-residents, we will work with the HIPA to identify sources of data, such as the DBEDT, to factor in the increased costs to the healthcare system associated with such increase in population. We propose to conduct limited literature research on the impact on health insurance on population change to inform our analysis on this task.

[5] Hawaii Department of Business, Economic Development and Tourism (DBET), 2020 Series Projections.

III. STATEMENT OF QUALIFICATIONS AND EXPERIENCE

The Lewin Group has nearly 20 years of experience in analyzing health systems reform initiatives, including single payer models, requested in the RFP. We present our qualifications and professional staff in the following sections:

- Company description
- Corporate experience
- Professional staff

In accordance with Section VI of the RFP, the following describes The Lewin Group's qualifications, experience and professional staff assigned to this project.

A. Company Description

The Lewin Group is a management consulting firm that specializes in health policy and research. The company, formed in 1970, includes about 110 consulting staff and has about $29 million in annual revenues.

1. State the name, address, telephone, e-mail and Internet addresses and fax number(s) of your corporate offices and the principal contact for this RFP.

The Lewin Group
3130 Fairview Park Drive, Suite 800
Falls Church, VA 22042
Phone: (703) 269-5500
Fax: (703) 269-5501
www.lewin.com

Principal Contact for this RFP:

John Sheils, Vice President
Phone: (703) 269-5610
Email: john.shiels@lewin.com

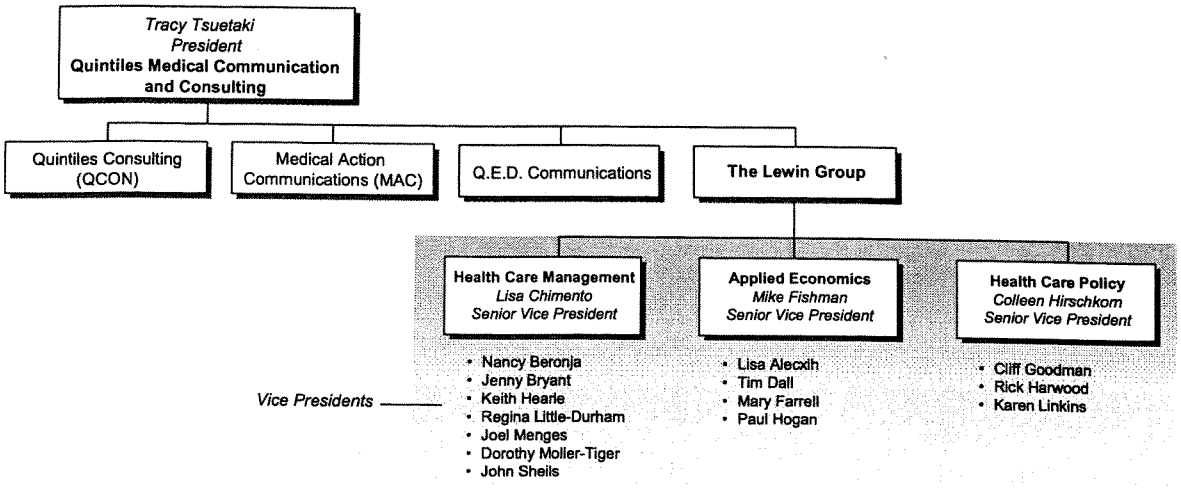
2. Describe fully your company's corporate or other business entity structure, including the state of incorporation or formation and list any controlling stockholders, general partners, principals, etc.

The Lewin Group, incorporated in North Carolina, is a wholly owned subsidiary of Quintiles Transnational Corporation, a private company whose mission is to advance health care through research and information-based technology. The Lewin Group, Inc. is an internationally recognized policy research organization and management consulting firm specializing in health care and related human services issues.

The Lewin Group is organized into practice groups, each of which focuses upon a health industry segment or a discipline, or in some cases both. The leaders of the practice groups comprise the

firm's Executive Committee. Notwithstanding the divisional boundaries that appear on the organization chart, The Lewin Group operates as a close-knit group of professionals. Lewin consultants team up both within and across practice groups to deliver the best expertise and the highest possible level of service to each client. ***Exhibit 1*** illustrates the firm's organization. John Sheils, Vice President in the Health Care Management Group, will serve as the anchor point for this Project.

Exhibit 1: Present Organization
Lines of Responsibility



The firm specializes in helping public and private sector clients develop proactive and timely solutions to the challenges of today's dynamic health care, insurance and economic markets. Lewin leadership is drawn from the highest ranks of government, academia and industry. Members possess diverse and complementary backgrounds in multiple disciplines and state-of-the-art capabilities. The Lewin Group combines real world experience with a broad, national perspective on public policy to address our clients' needs in areas including:

- policy and regulatory development and analysis;
- micro-simulation modeling and data analysis;
- technical assistance for program design and implementation;
- qualitative and quantitative analysis;
- strategic planning and management;
- grassroots stakeholder facilitation, education and training;
- financial and cost-effectiveness evaluation;
- program evaluation, planning and design; and
- public health and disease management.

The Lewin Group is comprised of about 110 professionals who work in cross practice project teams to combine complementary expertise and skill so as to meet the needs of individual clients. These dedicated project teams can always call upon the significant resources of the entire Lewin organization to find specialized expertise for addressing particular issues. Our work extends well beyond the normal boundaries of health care to interrelated human services and linked systems (e.g., labor economics, social security, education, welfare and economic development). Lewin consulting clients include organizations in both the private and public sectors.

The Lewin Group has a premier national reputation for conducting microsimulation modeling that enables the national and state governments and stakeholders to understand how many people could be newly covered by various policy alternatives, the cost of different policy options, and how the cost would be distributed among federal, state, and local governments and between the public and private sectors. The Lewin Group is committed to objectivity, integrity, and analytical superiority. It enjoys a reputation as a results-oriented consulting firm producing significant value to its clients, based on excellence and rigor in work products, a professional and experienced staff and, most importantly, a commitment to independence.

3. *State that the Offeror is in good standing and qualified to do business in the State of Hawaii.*

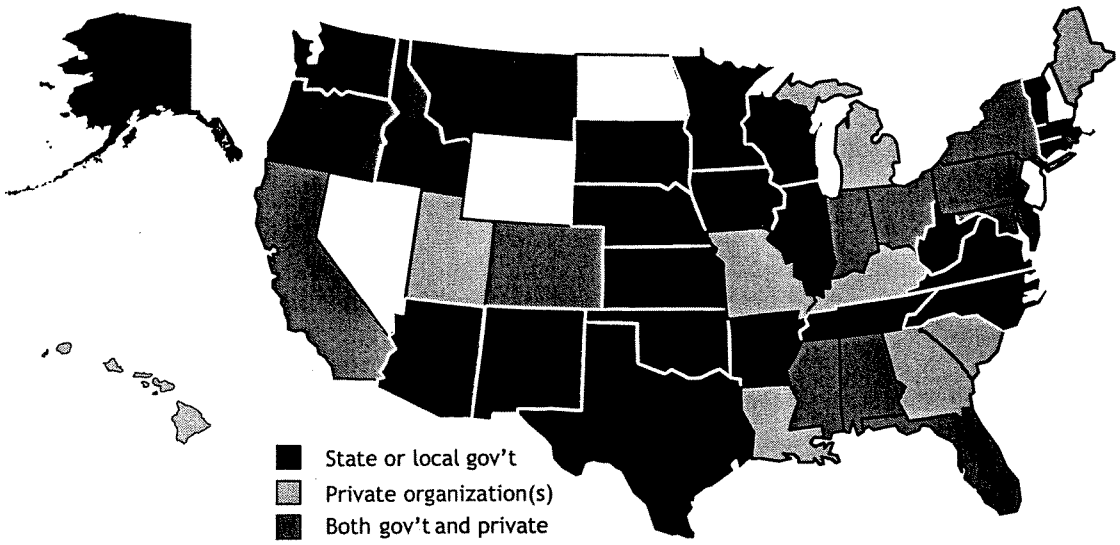
The Lewin Group is in good standing and qualified to do business in the State of Hawaii. As illustrated in ***Exhibit 2*** below, Lewin provides continuous, extensive support to federal, state and local agencies—helping design, implement, evaluate, and improve health coverage programs. During the past ten years Lewin has worked with state agencies in over half the nation's states on projects that either involve health insurance coverage expansions for uninsured persons or that seek to strengthen the state's Medicaid program in some fashion. Many of our state clients have used Lewin's services for multiple projects across a multi-year period.

During the past ten years Lewin has worked with state agencies in over half the nation's states on projects that involve health insurance coverage expansions for uninsured persons or that seek to strengthen the state's Medicaid program.

We also bring what we believe to be a unique level of commitment and enthusiasm to our work in this area. State-level initiatives truly reform health care – fundamentally changing the way care is accessed, delivered and paid for. Through our experience in working directly with states, counties, and localities, we understand the integral relationships that exist between the different levels of government.

Thus, our career focus in this area is by no means accidental. We find these projects to be extremely important and challenging – many project team staff have joined Lewin for the express purpose of being able to work on these types of assignments.

Exhibit 2:
The Lewin Group's Nationwide Medicaid Experience



4. Given your current contractual obligations, will your company have any problem providing the services required under this RFP?

The Lewin Group successfully executes project management aspects involving multiple large-scale projects. We have the capabilities, talents, staffing and the experience to deliver the services required under this RFP through a well-coordinated approach to the scope of work, and the effective and efficient use of staff time and contract dollars. While dedicated project teams are available to meet the specific needs of each client, the vast resources of the entire organization are available to provide specialized expertise as needed. We are ready and able to put our talents and energies to work in support of the state of Hawaii.

5. Has any contract of your company ever been terminated for cause? If so, when, by whom and under what circumstances?

The Lewin Group combines real world experience with a broad, national perspective to address our clients' needs in areas including: quantitative and qualitative analysis; strategic planning and management; grassroots stakeholder facilitation, program evaluation, planning and design; technical assistance for program implementation and monitoring; policy and regulatory development and analysis; and financial and cost-effectiveness evaluation. The firm's hallmarks are objectivity, integrity, analytical superiority, and a dedication to delivering the best possible advice and products to our clients. To the best of our knowledge, The Lewin Group has not been terminated on a contract for nonperformance of services.

The Lewin Group's hallmarks are objectivity, integrity, analytical superiority, and a dedication to delivering the best possible advice and products to our clients.

6. *Corporate Experience*

Our experience in performing analyses of major health reform initiatives is presented in the following sections:

- Analysis of single payer proposals;
- Analysis of other health reform proposals;
- Experience with the Medicaid program;
- Analyses of options and technical assistance in other states;
- Benefits design; and
- Hawaii experience.

a. Analysis of Single Payer Proposals

The Lewin Group has developed analyses of several single-payer proposals at both the state and national levels. This has included estimates of cost impacts for major stakeholder groups and the impact on health spending. All of these projects included analyses of various funding mechanism. We developed these analyses using the Lewin Group Health Benefits Simulation Model (HBSM). The study performed for Vermont is attached in **Appendix B**. Some of our single-payer analyses include:

- Maryland – Health Care For All Foundation;
- Vermont – Vermont state planning grant;
- Georgia - Georgians for A Common Sense Health Plan;
- California – Senator Sheila Kuehl;
- Massachusetts - the Massachusetts Medicaid Society; and
- Nationally - the Robert Wood Johnson Foundation.

In these projects, we worked with our clients to refine the specification of these proposals to a point where their effects could be measured. We then estimated the impact of these proposals on system-wide health spending including the effects of covering all citizens with a comprehensive health benefits package, and changes in administrative costs, including the effect on insurer and provider administration. We also showed the impact on major stakeholder groups including governments (state, federal and local), employers, providers and households.

These analyses showed the impact of the program on state-wide health spending. This included the increase in utilization of health services among newly insured people, and additional utilization by currently "under-insured" people as they become covered under a more comprehensive benefits package. We also estimated the impact of expanded use of primary and preventive care on health costs.

In addition, we estimated the program's impact on administrative costs in the system. The cost of administration includes the insurer's cost of providing benefits including claims processing, marketing, enrollment and profit/risk. Administrative costs also include the provider's cost of filing claims, adjudicating claims and negotiating payment levels with carriers.

b. Analysis of Other Health Reform Proposals

For more than two decades, Lewin has assisted in the development of policy proposals and legislation at the state and federal levels to accomplish health reform. During this time, Lewin staff built and continually improved upon the firm's Health Benefits Simulation Model (HBSM). A summary of the various types of reform initiatives that have been modeled appears in ***Exhibit 3.***

Comparison of the Presidential Candidates' Health Care Proposals

The Lewin Group developed a non-partisan comparison of the cost and coverage impacts of the various health proposals introduced by President George W. Bush and Senator John Kerry. To assure the non-partisan nature of the analysis, the Lewin Group financed the full cost of the study and did not accept funding from any other source. A crucial element of this study was the use of a uniform simulation methodology to simulate the impact of different policy alternatives designed to expand coverage. The uniform methodologies used in HBSM were essential to assuring the comparability of our results. The result of the project was a report describing the proposals and their impact on coverage for children and adults, federal and state government costs, and family health spending, which was accompanied by technical appendices describing key assumptions. The study was released in a Lewin sponsored press conference three weeks prior to the election. Our approach with the media was carefully designed to preserve the non-partisan nature of the work.

Commonwealth Fund - 2020 Vision
The Commonwealth Fund

The Lewin Group developed an analysis of the cost and coverage impacts of a proposal to expand insurance coverage developed by the Commonwealth Fund during 2001-2002. Results from the analysis were featured in an article in Health Affairs by Karen Davis and Cathy Schoen of the Commonwealth Fund. The proposal included an expansion of employer sponsored coverage through a "pay-or-play" mechanism; expands upon existing Medicaid/SCHIP programs; provides premium subsidies to middle-income individuals to purchase insurance; creates a Medicare buy-in for the near elderly and accelerates Medicare coverage for the disabled; refundable tax credits for small employers and individuals; and permits the purchase of coverage from health plans offered through the Federal Employees Health Benefits Programs (FEHBP). Lewin subsequently developed state-level estimates for the same reforms proposed through a contract with Columbia University.

Comparative Analyses of Alternative Health Reform Proposals in California
California Health and Human Services (CHHS)

Lewin provided an independent assessment of the impact of proposals to expand coverage in 2001. We developed estimates of the impact of nine widely divergent proposals, including a single-payer health program, a pay-or-play model, and incremental expansions in coverage under the Medi-Cal and Healthy Families programs. The analysis showed cost and coverage impacts on households, employers, providers and governments. In addition, we provided detailed analyses of out-of-pocket spending, premiums and changes in wages resulting from changes in healthcare costs for employers. Throughout the project, we worked with sponsors of each of the proposals

to ensure we understood the intent of each proposal and to assist them in designing program parameters that achieve their objectives. The project culminated in a series of conferences throughout the state sponsored by CHHS, where we presented the results of the analysis. Following that project, we assisted the California Legislature in designing S.B. 2, which was based on one of the proposals analyzed in the study. Lewin's reputation for objective non-partisan analyses was essential to our having the credibility to perform this role.

Covering America: Cost and Coverage Analysis of Ten Proposals to Expand Health Insurance Coverage
Robert Wood Johnson Foundation (RWJF)

Two years ago, Lewin performed a detailed analysis of ten national proposals to expand insurance coverage through various types of public and private policy options under RWJF's "Covering America" initiative. The options included programs designed to expand insurance coverage by reducing the cost of insurance through tax credits to employers and individuals, as well as expanding in coverage under the Medicaid program. The analysis resulted in a comparative description of the key provisions of these proposals and estimates of the impacts on employers, families, governments and providers.

Analysis of Health Reform Proposals for Stakeholder Groups
Robert Wood Johnson Foundation (RWJF)

Lewin developed estimates of the cost and coverage impacts of tax reform proposals introduced by eight major stakeholder groups participating in RWJF's "Health Coverage 2000" initiative in January 2000. These include proposals developed by the American Medical Association (AMA), the American Hospital Association (AHA), the American Nurses Association (ANA), the Catholic Health Association (CHA), Families USA, The Health Insurance Association of America (HIAA), the Service Employees International (SEIU), and the U.S. Chamber of Commerce. Proposals range from Medicaid expansions to universal coverage proposals. Lewin's reputation for objective analyses was instrumental to our effectiveness in completing this task.

Modeling Medical Savings Accounts (MSAs)
National Committee to Preserve Social Security and Medicare

Nearly a decade ago, The Lewin Group analyzed the enrollment effects and net change in Medicare program costs that would occur under implementation of an MSA option within Medicare. We estimated the impact of varying MSA program design elements, including: permitting tax deductions for additional beneficiary contributions to MSAs; varying catastrophic plan deductibles; and permitting MSA disbursements for non-medical uses. We provided estimates of 1) selection effects (cost to Medicare of healthier people opting for MSA), 2) tax effects (cost of allowing tax-deductible contributions to MSA, corresponding enrollment and Medicare program costs, all of above broken down by income), 3) effects of variation in catastrophic plan deductible ($3,000, $5,000, and $10,000 deductibles), 4) effects of variation of MSA withdrawal policy (allowing beneficiaries to make withdrawals only for medical expenses and allowing withdrawals of year-end balances in excess of 60 percent of the catastrophic plan deductible), and 5) impact of a revenue-neutral policy for Medicare.

Exhibit 3
Health Reform Initiatives and Key Analytic Issues Simulated with the Health Benefits Simulation Model (HBSM)

Health Reform Model	Key Analytic Issues Simulated	Analytic Methods Used
Tax Credit/Vouchers for Non-group Coverage (low income)	• Increase in the number of people with coverage • Employer decision to discontinue employer coverage	• Multivariate price response model • Firms assumed to maximize net benefit to worker
Targeted Tax Credits (i.e., workers, low-income, etc.)	• Increase in number covered	• Multivariate price response model
Replace Health Benefits Exemptions With Tax Credits (e.g., AMA, Heritage Foundation)	• Increase in coverage for those with net increase in subsidy • Decrease in coverage for those with net loss of subsidy • Discontinuation of health plans by employers	• Multivariate price response model • Multivariate price response model • Firms assumed to maximize net benefit to worker
Small Employer Tax Credit	• Increase in firms offering coverage • Increase in workers and dependents with coverage	• Modeled as a direct subsidy to workers in affected firms
Medicaid/SCHIP Expansions	• State response to eligibility expansion options • Number of eligible people who enroll • Substitution of public for private coverage ("crowd out")	• Decision rules based on federal match rate • Multivariate model of enrollment behavior • Analysis of crowd out under prior expansions
Single Payer	• Utilization increase for newly insured • Impact of cost sharing on utilization • Administrative savings (provider and insurer)	• Simulate impact of coverage on utilization • Published studies on the impact of cost sharing • Lewin Group study of administrative costs
Employer Mandate	• Worker wage effects	• Costs passed on to workers as lower wages
Employer "Pay or Play"	• Employer decision to provide coverage or pay tax • Costs in public plan	• Employers assumed to do whichever minimizes costs • Health spending of people enrolled in public plan by employers
Individual Mandate	• Change in employers offering coverage • Enrollment in current employer plans	• Employers maximize efficiency of employee compensation package • People who currently decline employer offer will take coverage
Managed Competition	• Impact on enrollment in managed care plan • Savings resulting from managed care	• Studies of enrollment behavior in firms offering lower cost options • Studies of savings in managed care plans • Studies of long-term savings from competition
The President Clinton's Health Reform Proposal	• Risk composition of insurance pool • Effectiveness of cost controls	• Utilization profiles of people assigned to pool • Sensitivity analysis

7. *Medicaid Experience*

A Candidate's Proposal to Expand Medicaid
Dean for America

The Lewin Group was engaged by the "Dean for America" campaign to develop the details of a proposal for expanding insurance coverage that was consistent with the candidate's principles for reform. The proposal included expanding dependent coverage to age 25 under private insurance, a community rated small employer insurance pool, mandatory Medicaid expansion to cover parents and non-custodial adults, expanded Medicaid and SCHIP coverage of children to age 25, and capped family health spending to 7.5 percent of family income.

Medicaid Managed Care Expansion
Texas Health and Human Services Commission

In a two-phased project, The Lewin Group developed a comprehensive set of cost estimates for potential expansion of Texas' Medicaid managed care programs. The study included a projection of potential savings as a result of implementing various managed care expansion options (such as capitation and exclusive provider arrangements), as well as a geographic analysis of potential expansion regions and population subgroups (such as TANF, disabled, etc.). The study also took into account the potential effects managed care expansion would have on other programs and benefits, such as pharmacy. The Lewin Group then assisted the Texas Health and Human Services Commission staff with an assessment of technical issues involved in designing an expanded Medicaid managed care program. As part of this work, we modeled expected costs and savings of various options the commission was considering, including benefit package service options, expanding eligibility and effects of cost sharing. Technical options for inclusion of long-term care and mental health services were presented as well as research on other eligibility innovative program designs in these areas. The technical assistance aided the Commission staff in preparing a briefing for the Texas Legislature. Lewin staff also provided testimony at a special joint meeting of relevant legislative committees.

Medicaid Expansion and Managed Care
Oregon Health Plan

The Lewin Group provided planning services to Oregon's Medicaid agency to broaden the use of managed care in conjunction with the State's effort to expand Medicaid coverage. This work entailed modifying the current HMO and partial capitation Physician Care Organizations program to attract a broader array of providers. The Lewin Group designed new risk-sharing mechanisms, revised standards of participation for contractors, created new financial viability standards for contractors, and set forth specifications for a fee-for-service primary care case management program to be implemented in rural areas. The Lewin Group prepared a waiver application for the State's proposed demonstration program, assembling a projection methodology for estimating the cost of serving uninsured persons newly eligible for coverage under the demonstration; estimating the impact of an employer health insurance mandate on Medicaid program enrollment and costs; and integrating the impact of prioritized health services on the cost of the demonstration.

Medicaid Modernization
Florida Statutory Teaching Hospital Council

Lewin assisted the Council in evaluating the potential impact of implementing the Governor's "Medicaid Modernization" proposal in 2005. The purpose of the analysis was to provide an understanding of the research and experience with similar approaches to program design, review any experiences to date of other state Medicaid programs, identify potential issues for the Medicaid population with using this consumer-directed model, and assess the program's potential impact on teaching hospitals as well as other provider and stakeholder groups in the state.

Medicaid Expansion and Employment
Assistant Secretary for Planning and Evaluation
Department of Health and Human Services (DHHS)

This study reviewed available information on how access to health insurance affects the employment patterns of persons with significant disabilities. The project entailed: (1) a review of literature on the relationship between health care coverage and labor force participation; (2) analysis of employment patterns of persons with disabilities using data from two national surveys; and (3) analysis of Medicaid expansion on employment and program participation of persons with disabilities.

Medicaid Expansion Waiver for HIV
DC Medical Assistance Agency (MAA)

The Lewin Group worked extensively with the DC Medical Assistance Administration to identify budget-neutral mechanisms to extend Medicaid coverage to uninsured persons infected with HIV. This effort included numerous meetings with agency and stakeholder staff. The Lewin Group assisted with the collection of epidemiologic and utilization data and conducted an extensive claims analysis of HIV-infected Medicaid beneficiaries. Lewin helped to draft the concept paper and subsequent 1115 waiver application to CMS based on these findings. The Lewin Group assisted MAA in discussions with CMS, OMB and other federal agencies regarding the approval and implementation of the initiative.

Medicaid Eligibility Options
Ohio Department of Social Services

The Lewin Group assisted Ohio in reengineering its Medical Assistance program. The central tasks included: conducting a current inventory and analysis; analyzing innovative approaches including the present and emerging state of the art regarding Medicaid benefits including Medicaid managed care and the integration of acute and long term care services; identifying potential models for enrolling dually eligible persons; conducting a pricing feasibility study to determine the scope of alternative pricing methodologies that could be employed for different population and service groups, including the aged, blind and disabled population; producing cost estimates of policy alternatives based on changes in eligibility categories, covered benefits, and service use/cost patterns; supporting the State in its strategy development process to determine specific budgetary, legislative and regulatory initiatives for implementation of the overall reform strategy.

Extending Medicaid to Targeted Groups
Kaiser Family Foundation

The Lewin Group assisted the Foundation in organizing and implementing a demonstration project in six states to extend Medicaid eligibility to uninsured/under-insured persons infected with HIV. The Lewin Group used a cost projection model to estimate the financial impact of the proposed HIV initiative on state and federal budgets, and provided overall program design support in Colorado, Florida, Massachusetts, and North Carolina, and secondarily, to the states of Washington and California. Because a key component of the state-tailored cost estimates involved identifying Medicaid's per capita costs by disease stage and medical service category and trending these costs forward, many of the techniques used in actuarial rate-setting for Medicaid managed care programs have proven useful in our other Medicaid work in states.

8. Analysis of Options and Technical Assistance in Other States

The Lewin Group has assisted many states in performing analyses of their own health care financing system for close to 20 years, including analyses of trends in health coverage through employers, government programs, and other sources. We have analyzed health care costs by state for all types of health services including hospital care, physician services, prescription drugs, long-term care and behavioral health services, to various public and private payers in the state, including the cost burdens of uncompensated care and the distribution of these service costs.

Some of the most extensive analyses of proposals to expand insurance coverage were conducted for State Planning Grant (SPG) projects funded by the Health Resources and Services Administration (HRSA). The Lewin Group has assisted seven states in designing policies to increase insurance coverage, including Alabama, California, Indiana, Iowa, South Dakota, Vermont, and West Virginia. For these states, we provided a wide range of services that are summarized in ***Exhibit 4***. In all cases, projects were completed within the time frames specified by state clients.

Exhibit 4
Tasks Performed by The Lewin Group under SPG Projects.

	Alabama	California	Indiana	Iowa	South Dakota	Vermont	West Virginia
Research & Technical Assistance	√	√	√	√	√	√	√
Focus Groups of Individuals				√	√	√	√
Focus Groups of Employers				√	√	√	√
Options Design	√	√	√	√	√	√	√
Economic and Actuarial Analysis of Options	√	√	√	√	√	√	√
Briefing Stakeholders	√	√	√	√	√	√	√
Draft Plan for DHHS				√	√	√	√

Expanding Insurance Coverage in Alabama
Alabama Department of Health

The Lewin Group assisted the state of Alabama in identifying options to expand health insurance coverage including both public and private health insurance coverage in 2004-2005. The report included development of estimates and a narrative report on the cost impacts of these options.

California Department of Health Services, Comparative Analysis of Alternative Health Reform Proposals in California
California Department of Health Services

Lewin developed detailed estimates of the impact of nine proposals, including a single-payer health program and a pay or play model to expand coverage, in California in 2001, as described in preceding sections. The analysis included estimates of increases in utilization for previously uninsured persons; changes in utilization due to the elimination of beneficiary co-payments; savings in administrative costs for insurers, hospitals and physicians; payroll tax rates changes to fully fund the program; and net change in employer spending for health care (by industry and firm size).

Proposals to Expand Insurance Coverage in Indiana
Indiana Family and Social Services Administration

The Lewin Group estimated the cost of expanding Medicaid eligibility under a wide range of design alternatives including: alternative income eligibility levels; use of a health insurance purchasing program (HIPP) for low-income workers with access to employer coverage; coverage for parents, children, and childless adults; and the use of waiting periods to deter people from discontinuing private coverage to enroll in the state program (e.g., "crowd-out"). We also evaluated a wide range of benefits packages, including variations on patient cost-sharing (e.g., deductibles and co-payments).

Iowa State Planning Grant
Iowa Department of Public Health

The Lewin Group assisted Iowa develop and analyze policy options that would help uninsured residents obtain health coverage between 2002 and 2004. For each option, Lewin estimated the number of persons who would become insured, the cost of adopting each option, and the distribution of spending that would result. Lewin also provided a range of technical assistance services; designed and carried out telephone surveys of uninsured individuals and private employers; and arranged for and lead 15 focus group discussions with uninsured individuals and private employers (both who do and do not offer health insurance). Lewin conducted a "Phase II" study focused on analyzing long-term uninsured Iowans, and researched a concept of "health security trust," that was proposed by state officials.

South Dakota State Planning Grant Program: Identifying South Dakota's Uninsured and Designing Options for Health Coverage
South Dakota Department of Health

In 2001-2002, The Lewin Group assisted South Dakota in developing policies that would help uninsured residents obtain health insurance. Surveys and focus groups of the uninsured and small employers were designed and implemented. Once survey and focus group data were analyzed

and interpreted, the development of coverage options uniquely suited to South Dakota was initiated. Preliminary policy options to increase affordable health insurance coverage were developed by The Lewin Group, then discussed and evaluated by state staff and interagency work groups. Based on the state's assessment of several issues, including the feasibility of proposed approaches, policy options were refined and revised. For each option, Lewin estimated the number of persons who would become insured and the cost of adopting each option, and the distribution of public/private and state/federal spending that would result. Lewin drafted the state's final report to HRSA.

Health Insurance Coverage Expansions in Vermont
Vermont Agency of Human Services

The Lewin Group assisted the state of Vermont with its SPG project between 2000 and 2002, the purpose of which was to identify policies which would help cover Vermont residents who do not have health insurance. A key step in this process was conducting research that helped the state better understand why some individuals go without coverage and to identify ways of bringing down any barriers to coverage that exist in the state. This formed the basis for designing strategies to expand insurance coverage in Vermont. The project included a survey of Vermont residents designed to identify the characteristics of the uninsured and the reasons why they do not have coverage and a series of focus group and workgroup sessions with employers, insurers and providers. These sessions were designed to identify ways of providing lower cost insurance that are marketable to employers, while still providing adequate coverage to beneficiaries. The result of this research was joined with Lewin's actuarial analyses of alternative benefits and program designs to develop recommendations on how to expand coverage in Vermont.

West Virginia State Planning Grant Health Insurance
West Virginia Health Care Authority

In 2002-2004, The Lewin Group helped the state develop proposals to assist uninsured West Virginians obtain health insurance. First, we designed and carried out an employer survey and numerous focus groups to evaluate the viability of options to expand insurance coverage through employers. Lewin developed a series of policy options for expanding coverage, some of which were variations related to a Medicaid HIFA waiver design, and examined reconfiguring the Medicaid and SCHIP eligibility levels in a way that would permit an expansion in eligibility without an increase in state expenditures. Lewin developed a benefits package with an actuarial analysis of costs for a proposed program to provide health insurance coverage to low-income residents in West Virginia. We adjusted the results to reflect potential anti-selection and expected future cost trends. Lewin developed analyses of the cost of establishing a high-risk pool in the state using the grant monies made available under the Trade Adjustment Assistance Reform Act. In addition, we estimated the impact of several other types of public and private models for expanding insurance coverage. Finally, we developed step-by-step presentations and executive briefings to assist state officials and stakeholders explain these analyses.

9. Benefits Design

The Lewin Group has extensive experience in designing benefits packages for low- and middle-income populations. These projects typically involve balancing the health care needs of eligible persons against the need to hold down costs in various programs. We have assisted states in

designing benefits packages for populations with special needs under various waiver models, have designed private insurance benefits packages in West Virginia and Kentucky. Our experience in these areas includes:

Benefits Design for the New Mexico Medicaid HIFA Waiver

The Lewin Group developed a benefits package and addressed actuarial and data-related issues that arose during the rate-setting process. Lewin calculated the program's historical utilization trends, and developed projected utilization trends for the program, after researching historical and projected utilization trends for Medicaid programs nationwide based on data provided by the Centers for Medicare and Medicaid Services. The Lewin Group developed projected unit cost trends after conferring with the primary consultants and state Medicaid officials, and developed a methodology for identifying and redistributing outlier claims and for smoothing rate changes across various age/sex cohorts. Lewin drafted a Statement of Actuarial Opinion to conform to the Medicare managed care regulations published in June 2002 (effective August 2003).

Benefits Design for the West Virginia Public Employees (PEIA) Managed Care Plan

The Lewin Group assisted the insurer of one out of every eight residents of West Virginia in establishing a managed care program for its beneficiaries. Lewin consultants met with all major PEIA stakeholders to devise a process for designing and implementing the program. Lewin designed the benefit package, specified the plan qualifications, developed an incentive arrangement for non-capitated plans, drafted the Request for Proposals, evaluated the 11 offerors' written materials, performed site visits, evaluated each plan's provider network and service area, and made recommendations for plan selection. In the program's first year of operation, PEIA was able to contract with five managed care organizations offering eight plans, and to offer a choice of managed care options to its enrollees in all fifty-five counties of the state.

Benefits Design for Proposed Medicaid Expansion in West Virginia

Lewin developed a benefits package and actuarial analysis for a proposed program to provide health insurance coverage to low-income residents in West Virginia. Based analysis on then current and historical Medicaid costs for selected eligibility categories, along with quoted premiums for low-cost commercial plans offered in the state. Analyzed the cost impact of benefit and population differences between the Medicaid program, the commercial plans, and the proposed program for low-income residents. Adjusted results to reflect potential anti-selection and expected future cost trends. Developed step-by-step presentation to explain the process to state officials and HMO representatives.

West Virginia Medicaid Managed Care Program Development and Support.

The Lewin Group assisted the WV Bureau for Medical Services (BMS) in designing its Medicaid managed care program, including populations, benefits, and geographic areas to be included, types of risk arrangements, delivery system and administrative requirements, outreach and enrollment plans, and quality assurance approach. The Lewin Group developed the capitation rate-setting methodology, extracted and analyzed claims and eligibility data, and calculated managed care rates for participating plans for the initial program year as well as three subsequent rate periods. Lewin also developed a system of incentive payments for contracts

with state-designated publicly supported providers to encourage the parties to develop working relationships.

Development of Standard Benefit Packages under Kentucky Health Insurance Reform.

The Lewin Group assisted the Kentucky Health Board in the comprehensive redesign of its health insurance market. The project was comprised of three tasks. Task 1 required consulting support in determining appropriate benefits options. Task 2 involved determining the scope and character of permissible community rating methodologies, and establishing uniform rating areas. Task 3 involved consulting with the Board on their mandated implementation of a risk adjustment system. All phases of this process required extensive group process facilitation and analytic support of the decision-making process.

Coverage and Eligibility Analyses for the California Medi-Cal Program

The Lewin Group assisted the State of California/Medi-Cal Policy Institute in preparing cost projections for various coverage expansions and eligibility simplification options for Medi-Cal (California's Medicaid program). Options modeled include continuous eligibility for children, guaranteed eligibility for managed care enrollees, removal or simplification of the assets test, move from a gross to net income standard, and elimination of certain documentation for applicants. Lewin also conducted a business case analysis of Health-e-App, an internet-based enrollment application for California's Medicaid and SCHIP programs.

10. Hawaii Experience

Medicare Product Assessment
AlohaCare

The Lewin Group assisted AlohaCare with Medicare Advantage program capabilities assessment, implementation planning and CMS site visit preparation. As a Medicaid only health plan, AlohaCare asked Lewin to conduct an initial feasibility study on whether the plan should enter the Medicare market and obtain CMS approval as a Medicare Advantage and Special Needs Plan. Following the feasibility study, Lewin prepared and submitted a Medicare Advantage Coordinated Care Plan application to CMS on behalf of AlohaCare and conducted an extensive three-day on-site review, building on the feasibility study findings and using a detailed diagnostic assessment tool based on CMS requirements. The Lewin Group presented operational components required for both Medicare Advantage and Special Needs Plan programs, operational gap analysis based on existing organizational capacity, and consideration of functions to be outsourced, as appropriate. The final implementation plan was designed around the following key considerations: (1) key CMS dates; (2) critical path items for systems implementation; (3) minimizing organization out-of-pocket expenditures prior to program "go-live" and realization of new program revenues; (4) ensuring adequate time for recruitment and hiring of new staff; and (5) ensuring adequate time for staff training in new function and operational requirements, new systems and new program elements prior to enrollment and delivery of services to new members.

B. Professional Staff

Our Project Director for this project will be John Sheils, Vice President, who has directed all health reform analyses performed by Lewin. Evelyn Murphy, Senior Manager will oversee the day to day execution of tasks. Prior to joining Lewin, Ms. Murphy worked as an independent consultant on a number of research and evaluation project under Indiana's State Planning Grant to expand health care to the uninsured and underinsured. Modeling will be performed by Mr. Randall Haught, a Senior Scientist at Lewin. Mr. Haught has developed all health system reform models at Lewin and provided estimates of single payer proposals. Other Lewin consultants will be utilized as needed on this project. The following sections provide detailed responses to the RFP Professional Staff requirements.

1. *Offeror must have at least five (5) years experience (within the preceding five (5) years of the award of the Contract) in providing relevant consulting services.*

The Lewin Group has nearly 20 years of experience in providing objective, non-partisan analyses of health care reform initiatives at both the state and federal levels. We have developed economic models to estimate the impact of numerous reform proposals on major stakeholders throughout the health care system, including governments, employers, consumers, and providers. The Lewin Group has a health benefits actuary on staff who is experienced in performing complex benefits design analyses to help states develop benefits packages that balance competing objectives of comprehensive coverage and containing costs.

Lewin staff also have a "first hand" understanding of the empirical analyses and modeling, as we have organized and led scores of focus groups of uninsured, under-insured, and low-income persons and conducted surveys of employers and individuals that were designed to help assess the likely effects of alternative reform proposals. The Lewin Group is not proposing to subcontract any part of the required tasks under this RFP. The Lewin Group is capable of performing all of the services required under this RFP and assumes full accountability and responsibility for all tasks.

2. *Overview of project staff and responsibilities*

Identify the individuals who would be responsible for the specific tasks required by this RFP, and provide background and experience information on each individual as they relate to the specific tasks, emphasizing their specific experience with providing health policy consulting and the relative contribution each is expected to make. Please provide resumes of these individuals with your proposal.

We recognize that the modeling efforts required for this project would entail meeting an ambitious (and possibly changing) timetable. It will be essential that The Lewin Group commit sufficient staff and resources to assure that the micro-simulation modeling is completed and associated technical assistance is available within time frames required. The following provides a narrative description of project staff qualifications and responsibilities. A summary of key staff, their role on this project, along with the percent time that each would commit to this project, is listed in ***Exhibit 5***. Resumes for all key staff are provided in **Appendix C**.

Additional Lewin junior staff will be assigned to the project to assist senior team members, as needed, and resumes for these additional staff are not included. We estimate the junior staff (primarily research analysts) time commitment during the project period to be more than 24% FTE.

Mr. John Sheils, Vice President is Lewin's proposed **Project Director** Mr. Sheils is a nationally recognized authority on health system reform, for his in-depth understanding of the complexities of health system incentives, and for the professional integrity of his analyses. He is the architect of The Lewin Group Health Benefits Simulation Model, which has been used to estimate the cost of expanding coverage at the state and national levels. In 2004, Mr. Sheils completed a comparative analysis of the Presidential candidates' proposals to expand insurance coverage, which was widely reported in the press. Mr. Sheils directed several Lewin projects on approaches for expanding coverage under State Planning Grant (SPG) projects funded by HRSA. Of particular significance is California where he provided an independent assessment of the impact of nine different proposals. For the Commonwealth Fund, Mr. Sheils estimated the cost and coverage impacts of its 2020 Vision project. He has testified before Congress and various state legislative committees on numerous occasions. Mr. Sheils has an MS in Public Policy from Carnegie-Mellon University and a BS in Political Science from the State University of New York.

Ms. Evelyn Murphy, Senior Manager at Lewin in the firm's Health Care Management practice, will serve as **Project Manager**. Ms. Murphy has more than 10 years combined State experience in Medicaid program development, management and oversight. She currently provides consultation to states on Medicaid managed care programs, including member satisfaction surveys, development of federal waivers and amendments, and development of requests for proposals related to managed care programs. Prior to joining Lewin, Ms. Murphy worked as an independent consultant on a number of Medicaid leveraging programs and project evaluations under Indiana's State Planning Grant, including evaluating the adequacy of access to safety net providers by insured and underinsured Indiana residents, reviewing funding for such providers and proposing options for leveraging state dollars. Ms. Murphy would assume day-to-day responsibilities for assuring project task completion, coordinating completion and review of project research and deliverables, and assuring timeliness of products and adherence to project budget. Ms. Murphy earned her Juris Doctorate from Indiana University School of Law and her Master's in Planning from the Indiana University School of Public and Environmental Affairs.

Mr. Randall Haught, a Senior Scientist, has been responsible for the development and use of state-level health benefits models, including estimates of the impact of single payer models, at The Lewin Group for more than 15 years. Working closely with Mr. Sheils, Mr. Haught developed Medicaid and other reform proposal cost projection models in numerous states, and has developed long-term projections of health spending in the U.S. and for individual states. He developed estimates of the cost of health care reform proposals and the distributional impacts of these initiatives on health spending for households, employers, and state/federal governments for countless Lewin engagements, including states involved in the HRSA State Planning Grant program. With Mr. Sheils, Mr. Haught would modify Lewin's HBSM to accommodate Hawaii's new proposed policy options, input data updates from numerous sources, and program output.

Exhibit 5
Key Project Staff

Lewin Name	Title	Role on Hawaii Project	Percent Time (FTE)
John Sheils	Vice President	**Project Director**	**12**
Evelyn Murphy	Senior Manager	**Project Manager**	**35**
Randall Haught	Senior Scientist	**Modeling**	**29**

C. References

Each Offeror shall provide the names, addresses, contact persons, and telephone numbers of at least three (3) clients who can be contacted for reference purposes.

By providing the information under this section, the Offeror consents to HIPA contacting any of the Offeror's private sector and governmental clients for reference purposes.

We encourage HIPA to contact our references. These include:

Ms. Sally K. Richardson
Executive Director
Center for Healthcare Policy and Research
3110 MacCorkle Avenue, SE
Charleston, WV 25304-1299
Phone: (304) 347-1246
Fax: (304) 347-1236

Cathy Schoen Ph.D.
Program Director
Commonwealth Fund Health Care Reform Program
One East 75th Street
New York, NY 10021
Phone: (212) 606-3838
Fax: (212) 606-3508

Mr. Gary Claxton
Vice President and Director,
Changing Health Care Marketplace Project
The Kaiser Family Foundation
1330 G Street NW 20005
Phone: (202) 347-5270

IV. MANAGEMENT PLAN

Our proposed Project Director will be responsible for overall direction of the project. The Project Manager will oversee day-to-day task completion and manage overall completion of the project within the agreed-upon timelines and budget.

It is our understanding from HB 1304 (the companion bill to HB 1617) which establishes the Task Force, that a report on findings and recommendations for development of the single payer plan is due to the legislature no later than twenty days prior to the regular session.[6] Thus we propose a aggressive seven weeks timeline to complete the project an present a final report to HIPA.

The Lewin Group has significant experience managing and executing microsimulation models and preparing analytic reports to inform decision making for numerous clients from a broad range of perspectives. We have developed and continue to utilize a wide variety of project management techniques to ensure our projects meet or exceed our clients' expectations in terms of quality, time, scope and budget. Lewin's management plan, described below, includes:

- Communication
- Project management tools; and
- Work product review

A. Communication

Solid project management is imperative for the delivery of a high-quality work product, especially under aggressive timelines. Lewin feels that the key to successful project management is consistent and frequent communication among project team members, both from the State and Lewin. We will encourage Lewin's Project Director or Project Manager and HIPA's Project Manager to be involved on all calls, to the extent possible, so that the key persons at each organization have ongoing access to all of the relevant information. This is critical given the HIPA-Task Force level of collaboration in developing the Single Payer Plan outlined in HB 1617. We welcome and encourage as "hands-on" a role as the HIPA Project Manager's competing responsibilities permit.

In addition to ensuring that the HIPA Project Manager is constantly aware of the status of our work and any issues that may arise, John Sheils, Lewin's Project Director, and Evelyn Murphy, Lewin's Project Manager, will ensure that members of the Lewin internal team are kept apprised of all relevant issues related to this project. The team will maintain regular communication throughout this project.

B. Project Management Tools

Our proposed workplan is provided in **Exhibit 6** below. We would revise the workplan according to input from the state to best meet the needs of HIPA. The work plan will serve as an

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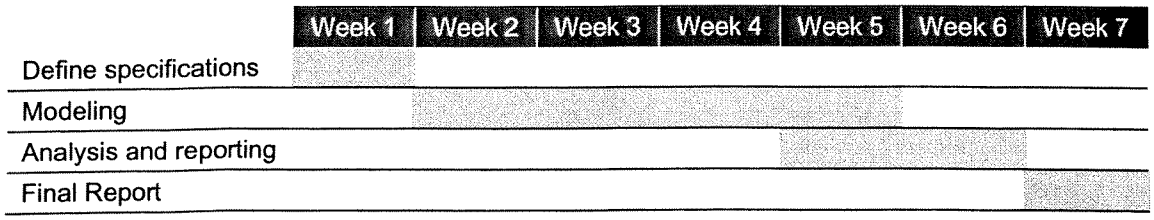
[6] HB1304, Section (c)(3).

ongoing project management tool, as the status of tasks and anticipated deadlines will be tracked. The Project Manager will be charged with tracking and monitoring progress against the workplan and updating it regularly and will communicate on an ongoing basis with the project's Principal Investigator. We anticipate completion of the project and delivery of final report within seven weeks of a fully executed contract.

Exhibit 6
Project Timeline



C. Work Product Review

Each work product will be subject to internal review prior to submission to HIPA. That review will be conducted on several levels, including a review of the methodology and approach, actual analysis, and the conclusions drawn from the analysis. Lewin's expert team members will provide this review on various levels, which will contribute to the overall analytical strength of the project.

In addition to internal review, Lewin appreciates the feedback that HIPA will provide on each of our draft products. In addition to comments and questions regarding these drafts, we will engage HIPA staff in frequent discussions to ensure the most appropriate understanding of the specifications of the Single Payer Plan. These discussions will provide us with valuable insight along the way to ensure the most appropriate interpretations of our findings are expressed in the draft and final deliverables.

V. FACILITIES RESOURCES

The Lewin Group's offices feature comprehensive facilities that enable thorough and efficient project support. The Lewin Group offices, in Falls Church, Virginia, equipped with computers, FAX machines, printers and copiers. The Lewin Group maintains a sophisticated Local Area Network (LAN) that connects over 150 IBM Pentium III and IV personal computers, 50 percent of which are laptops, via 100 megabit connections. Each computer operates using a Microsoft Windows 2000 Professional operating system and is equipped with Microsoft Office XP Professional. The firm operates a fully functional library staffed by one full-time librarian and one part-time librarian.

VI. COMPENSATION

The following table ***Exhibit 7*** provides a summary of total hours and dollars for each of the tasks (A through E) specified in the RFP and preparation of a final report. ***Exhibit 8*** provides detail costs and hours by staff for each key staff as well as other Lewin personnel. We anticipate 24 percent of labor hours for other personnel (primarily research analysts).

We estimate a total of $500 dollars for direct costs, which includes printing, long-distance phone charges and postage and will be billed monthly at actual cost. Our budget assumes no travel expenses; however, we are available to present our work in person at a time and place of your preference. Should travel be requested, travel will be charged at actual cost.

We propose to complete all modeling and to submit a draft report to you within six (6) weeks of a fully executed contract. In addition we estimate an additional one week to finalize the report from the date we receive your feedback on the draft report, for a total of seven (7) weeks to complete this project.

Our total project costs are $81,460 for professional fees and $500 for direct expenses, for a total amount not to exceed $81,960. All costs (labor and other direct costs) will be invoiced monthly for services rendered under a contract with HIPA.

Exhibit 7
Project Hours and Budget Summary

Tasks	Total Hours	Total Cost
A. Analyze cost-benefit of SP system	96	$ 20,120
B. Analyze cost benefit differential between SPand current system, including admin costs	86	$ 18,180
C. Evaluate whether existing Hawaii healthcare system can support SP system	66	$ 13,290
D. Evaluate the effects that an SP system will have on hearlth care providers and their willingness to remain in HI	47	$9,910
E. Evaluate costs associated with non-Hawaii residents coming to Hawaii to take advantage of SP system	55	$ 11,680
Final Report	44	$ 8,280
Total Labor	**394**	**$ 81,460**

Exhibit 8
Project Hours & Budget

Tasks	John Sheils V.P.	Evelyn Murphy Sr. Mgr	Randy Haught Sr Scientist	Research Analyst	Admin. Assistant	Total Hours	Total Dollars
A. Analyse cost-benefit of SP system							
Define specifications	2	2	2	4		10	$ 1,940
Modeling	4		24	8		36	$ 8,260
Client calls	2	2	2			6	$ 1,580
Analysis and reporting	4	24	4	12		44	$ 8,340
B. Analyze cost benefit differential between SP and current system, including admin costs							
Modeling	4		24	8		36	$ 8,260
Client calls	2	2	2			6	$ 1,580
Analysis and reporting	4	24	4	12		44	$ 8,340
C. Evaluate whether existing Hawaii healthcare system can support SP system							
Research		8		4		12	$ 2,000
Modeling	4		20	8		32	$ 7,220
Client calls	2	2	2			6	$ 1,580
Analysis and reporting	4	24	4	12		44	$ 8,340
D. Evaluate the effects that a SP system will have on health care providers and their willingness to remain in HI							
Research		4		2		6	$ 1,000
Modeling	2		12	4		18	$ 4,130
Client calls	1	1	1			3	$ 790
Analysis and reporting	2	12	2	4		20	$ 3,990
E. Evaluate costs associated with non-Hawaii residents coming to Hawaii to take advantage of SP system							
Research		8		2		10	$ 1,820
Modeling	2		8	4		14	$ 3,090
Client calls	1	1	1			3	$ 790
Analysis and reporting	4	16	4	4		28	$ 5,980
Final Report	4	24	4	8	4	44	$ 8,280
Total labor	46	138	114	92	4	394	$ 81,460
Percent of total project hours	12%	35%	29%	23%	1%		
Hourly Rate	$325	$205	$260	$90	$75		
Total Budget	$14,950	$28,290	$29,640	$8,280	$300		**$ 81,460**
Misc costs							$500
Grand Total							**$81,960**

VII. DISCLOSURE OF CONFLICTS OF INTEREST

We know of no potential conflict of interest in the performance of this study. Equally important, the firm's hallmarks are analytical expertise and objectivity – dozens of consulting engagements are awarded to our firm each year due to the stellar reputation and track record in providing an objective and accurate assessment of the policy options confronting our client.