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UpDate

I. STATE REPORT

Hawaii's Health QUEST

by Annette Gardner and Deane Neubauer

Hawaii's Health QUEST was initiated 1 August 1994 to control rapidly escalating Medicaid costs, extend managed care to all public beneficiaries, and eliminate shifting of clients and costs.[1] Between 1989 and 1993 state Medicaid costs increased 80.1 percent, but the population served increased 36.1 percent.[2] The State Health Insurance Program (SHIP) was initiated in 1991 to provide transitional coverage for gap groups.[3] The combined financial burden of these programs produced a crisis in state funding, aggravated by a downturn in the state's economy triggered by the 1991 Gulf War.

While little agreement exists about why Medicaid costs have risen drastically, reformers note that in 1993 the average Medicaid client cost the state nearly $2,300 a year; comparable private-sector coverage cost $1,400 a year.[4] QUEST seeks these savings, estimated at $435 million over six years in the 1993 waiver application, assuming they can be obtained through a shift from public-sector reimbursement to private-sector administration. QUEST reduces use of services primarily by controlling hospital emergency room use by the uninsured. Improving access to medical services for Medicaid recipients also is sought, particularly outside Oahu, where some physicians have refused to accept Medicaid patients.

Development and implementation of QUEST have been controversial. Proponents see the program as a vehicle for greater efficiency and cost savings and as consistent with the prevailing mood to resolve health coverage issues with private-sector solutions. Opponents charge that estimates of savings to be gained are inflated and often disguise the full cost of such programs, such as the Behavioral Health Plan, for which enrollment may be six times higher than estimated. Further, it is claimed that proponents underestimate real health care costs in Hawaii and fail to see the factors really driving those costs, such as the relatively low availability of nursing home beds in Hawaii.

Program description. **QUEST** is **a** top-down program set in motion by former Governor John Waihee to be a capstone to his second and last term in office. External consultants worked with the Department of Human Services (DHS) to design the program, with modest input from the community, the legislature, or the Department of Health. QUEST's provisions represent, however, the public commitment of Waihee and his long-term health director, John Lewin, to demonstrate the efficacy of health reform situated firmly in the private sector and embracing the basic elements of managed competition and care.

Preserving the image of "Hawaii, the Health State" was an important political priority of the Waihee administration, one that was ultimately sold to a somewhat reluctant legislature that had virtually no role in creating QUEST. Later, in the spring 1994 session, the legislature was faced with the hollow choice of going along with the program's essential features or playing spoiler without good cause.

QUEST folds Medicaid and SHIP together into a large purchasing pool, fostering

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competition among private health plans to provide a common benefit package at a capitated rate. The largest proportion of QUEST coverage for beneficiaries (General Assistance [GA], Aid to Families with Dependent Children [AFDC], and SHIP) is delivered through five managed care health plans that were awarded contracts by the DHS 1 April 1994. March 1995 tentative enrollment data showed that 80,000 persons were enrolled in the HMSA plan; 27,000 in the Queens plan; 18,000 in AlohaCare; 7,600 in Kaiser; and 2,700 in the Straub plan. All five plans are available on Oahu; other islands can choose from at least two plans. Two dental plans have been awarded contracts (DentaCare and HMSA). A contract for the Behavioral Health Plan was implemented 1 November 1994 by HMSA-Biodyne.

QUEST continues the Hawaii tradition of providing a "rich" benefit package to Medicaid recipients. Former SHIP enrollees receive increased benefits, especially for physician visits and hospital stays. QUEST shifts the basis of health care coverage for this population from a health entitlement program to an insurance enrollment program. Presumptive eligibility with no "assets test" facilitates program enrollment.

Hawaii gained $647 million in new federal funding over five years to support service delivery, as well as 90 percent of the cost for the new Managed Care Information System (MCIS), based on a federal match of 54 percent for program costs. The state prefers matching funds to state-funded SHIP and GA coverage.[5]

QUEST is meant to not incur costs in excess of those projected for the fee-for-service Medicaid program, which it subsumes.

QUEST plans were marketed as other private plans are. Enrollees could choose a health plan, a primary care doctor, and a dentist. Enrollees not selecting a plan are assigned to the least expensive plan in their residential area. QUEST is free to enrollees at income levels up to 133 percent of the federal poverty level. Above this level, up to a limit of 300 percent of the federal poverty level ($26,000 a year for a single person and $45,000 for a family of four), premiums are determined by a sliding scale. Enrollees do not lose benefits as incomes increase.

One goal of the program is to find a balance between consumer choice and disciplining the medical marketplace to reduce client shifting. It accomplishes this by providing open entry periods for plan selection, permitting a change of physicians within plans, and requiring plans to accept all enrollees up to the contracted limit.

Managed care mechanisms provide each enrollee with a case manager. Also, the income base of 300 percent of the federal poverty level permits Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) services to be offered to more children.

In addition to medical and dental care packages, QUEST has developed two important carve-outs. Mental health problems are treated by enrolling all prospective clients in QUEST, then directing them to two distinct beneficiary groups. Adults (380 enrollees) with severe mental illness are transferred to HMSA, and children (120 enrollees) with severe emotional disturbances receive care from the state Child and Adolescent Mental Health Division. A catastrophic care carve-out was initiated in November 1994. Cost implications of these carve-outs are unclear, but critics point out that the behavioral package in particular appears difficult to accomplish within the limits initially proposed.[6]

The aged, blind, and disabled categories of Medicaid are not covered by QUEST and will continue to receive services under the current system from the DHS. Discussions are under way to integrate this category into Phase II of QUEST in 1997.

Program observations. QUEST was designed to reduce annual cost increases from 15.6 percent to 9.9 percent, primarily from a reduced capitated rate and a significantly lower projected inflation rate for QUEST than for Medicaid.[7] Initial medical plan rates of $156-$172 per month per beneficiary on Oahu, and $140-$170 on other islands, are higher than the originally projected $107 per beneficiary. Yet they remain considerably below those of the previous programs, except those of SHIP.[8]

Overall program cost savings are threatened by higher-than-expected enrollment,

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initially targeted at 90,000 SHIP and Medicaid enrollees. The current enrollment of 130,000 is accounted for in part by university students and the self-employed. Increased enrollment may diminish cost savings, but program supporters insist that private plan capitation is inherently less expensive than direct reimbursement. The 1995 budget of $230 million represents no savings and no cost overruns. The legislature will be asked for $5 million in additional safety net funding for 1996-1997. Mechanisms for reducing enrollment, such as reinstatement of an assets test or payment of higher program costs by beneficiaries, are being discussed.

Extending private insurance was intended to overcome the lack of access to primary and preventive care. But access issues persisted during the early implementation period. Some beneficiaries were confused about the plan to which they were assigned, often one distant from their residence. Nearly 34,000 people were assigned to plans they did not choose. However, proponents cite a very high mail response rate-66 percent-and enrollees were allowed to change plans up until 9 September 1994. Because beneficiaries are locked into a given plan for one year, resolving these transitional access issues has proved something of a bureaucratic muddle. Other bureaucratic access complaints include difficulties in establishing relationships with new providers, errors in providing membership cards, and lack of communication between beneficiaries and the QUEST program.[9] The QUEST hotline fielded 2,000 calls a day during the first two months of operation. Supporters discount the importance of these complaints as inevitable transitional difficulties; opponents charge that these represent the characteristic inability of private-sector programs to meet the needs of a population that does not respond readily to middle-class norms of administrative compliance.

Despite increased access to coverage, care for these two residual groups remains problematic: those who have too much income to qualify for QUEST but cannot afford private care and are not covered under the Hawaiian Prepaid Health Care Act of 1974 (Prepaid); and those who are already eligible for Medicaid/ SHIP but do not apply, such as recent immigrants, the recently unemployed, and part-time workers in low-paying jobs.[10] Disenrollment from QUEST because of an income increase above 300 percent ofpoverty also may contribute to the number of persons without coverage. Family coverage is voluntary under SHIP and Prepaid, requiring premium payment only for dependent members. It is unclear whether non-AFDC recipients who are dependents, especially children, will go uncovered even though they are eligible for QUEST.

Hawaii's diverse ethnicity requires culturally appropriate delivery mechanisms for public programs to succeed. While language translation, case management, medical social work, outreach, and health education are required services under QUEST, some fear that these efforts may be underplayed or be early victims of cost cutting if administrative economies must be sought.

A major issue is the impact of QUEST on community health centers. Critics contend that QUEST shifts from a health care entitlement model that works well with lower-income and immigrant users to a capitated managed care insurance model that is relatively untested with this population. Denied their customary supply of patients and income, community health centers may be economically harmed and cut back on services-a net loss in community health terms and an outcome contrary to QUEST's stated goals. Seven such centers project a total $2.2 million shortfall during a twelve-month period ending July 1995 as a result of the elimination of cost-based reimbursement.[11]

A long-term goal of health care reformers in Hawaii has been a "seamless" system, providing all public clients with access to services within one administrative program. QUEST consolidates many administrative services to these target populations within the DHS. Shifting most administrative services to the plans is meant to reduce bureaucracy. Plans deal directly with patients, phy sicians, and hospitals who are reimbursed directly by the plans. Form simplification and cost savings are major goals. But the Department of Health continues to provide some services, especially in mental health.

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Critics contend that when the dust has settled, QUEST will require more public bureaucratic effort, not less, for activities such as the new information system, program compliance, and so forth. The logic of a seamless system is often belied by the piecemeal way it is constructed and implemented.

Lessons learned. Several lessons seem to be unfolding as the state begins its experiment with QUEST. First, timing is critical and serendipity welcome. Like Prepaid, QUEST was a way to preempt the local effects of national health care reform. Now the concern is prospects for reductions in federal Medicaid support or program caps. Ironically, any cost overruns may benefit the state under the Medicaid cap scenario by creating a high baseline year against which future federal funding will be determined.

Second, QUEST demonstrates in part the limits to piecemeal health care reform. Its focus on health insurance diverts attention away from those forces in the social, economic, and medical environment that contributed to the dramatic and constant increase in health care costs over the past two decades. The essential question suggested by the QUEST process is: Do these efforts decisively affect those forces that continue to drive health care costs upward?

Even within accepted categories of public health care assistance, QUEST does not address the impact of the behavioral intervention and services to the aged, blind, and disabled, which many hold are major drivers of health care costs. However, supporters of the program argue that managed care needs to be implemented in stages, starting with healthier populations.

Third, universal coverage and cost containment may be mutually exclusive. The values driving QUEST are to serve a limited population at less cost-a welfare control goal. Universal coverage-a health care goal-will, it is argued, require more effort rather than less.

Fourth, community support and participation should not be discounted. Many complained about the rapid development of QUEST and the resulting lack of community participation. Effective consulting of provider and client groups could have improved implementation, and the enrollment period could have been extended. Both the plans and the DHS had difficulty processing applications and coordinating services and practitioners.

Further remarks. Until full information is available for 1995 program costs and service utilization, we must reserve judgment on the program's success. Even with a rocky start, this experiment in state health care reform could meet some or all of its intended goals. If national health care reform does not materialize in the near future, states will have an added incentive to learn from each other as they deal with increasing Medicaid costs and possible spending caps. Unique in many ways, Hawaii continues to serve as a laboratory to the nation on choices to be made and obstacles to be avoided.

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NOTES

1. The acronym reflects the program's goals of providing Quality of care; ensuring Universal access; and encouraging Efficient utilization, Stable costs, and Transformation of the way in which health care is provided to public citizens.
2. Summay of the State of Hawaii's Medicaid Program Operations during the period July 2 ,1992 through June 30, 1993 (Honolulu: HMSA, 1993), 3.
3. For a description of SHIP, see D. Neubauer, "Hawaii: A Pioneer in Health System Reform," *Health Affairs* (Summer 1993): 32.
4. John Lewin, former director of the Hawaii State Department of Public Health, presentation 29 November 1994.
5. Hawaii Department of Human Services, "In Pursuit of Keeping Hawaii Healthv: Hawaii's Health QUEST" (Honolulu: DHS, 19 April 1993).
6. "Hawaii Moves to Implement Health QUEST MH 'Carve Out'," State ADM Report (October 1994): 2.
7. DHS, "In Pursuit of Keeping Hawaii Healthy."
8. B. Creamer, "Pain. Anger over New Health Plan," *The Honolulu Advertiser*, 25 September 1994, A6.
9. Ibid.
10. B. Grossman, "Gap Group Policy Response Still Needed with Health QUEST," *Ke Ola Kino* (Hawaii Public Health Association Newsletter, Spring 1994): 4.
11. Bob Grossman, former executive director of the Hawaii State Primary Care Association, personal communication, 7 December 1994.

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