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Goal
To develop and propose viable health coverage solutions for Hawai`i's growing number of uninsured.

Team Overview: Key Players
Hawai`i State Department of Health** has designated two research partners. The **University of Hawai`i's Social Science Research Institute (SSRI) directs quantitative and qualitative research activities. The **Hawai`i Health Information Corporation** (HHIC) is responsible for data collection and storage. **The Hawai'i Uninsured Project** (HUP) spearheads development of stakeholder policy teams, facilitates policy options development, oversees market research activities such as focus groups and surveys, as well as directs communications and reporting. HUP is a project of the Hawai'i Institute for Public Affairs.

General Objectives

- Develop a comprehensive understanding of Hawai`i's uninsured (including demographic, social, ethnic, cultural, economic, health status characteristics and reasons for not having health coverage) through research.
- Secure key informant support by identifying and addressing their concerns, information needs, and model potential outcomes to assess public and private policy changes. This includes gathering their responses to various policy scenarios.
- Identify and develop viable coverage options through research of the uninsured, care and plan providers, policymakers, and the general public, as well as economic modeling of policy options.
- Develop an action plan through a cumulative and collaborative effort of stakeholders and researchers to expand health care access within a fixed period for Hawai`i residents.
- Report, communicate and educate Hawai`i's policy-making leadership and the general public of the issues, the research, potential solutions and the final proposal of solutions.

Executive Summary

Backdrop. In the 1980s, Hawai`i's uninsured population was estimated at 5 percent – one of the lowest uninsured rates in the U.S. By 2001, the rate had increased to nearly 10 percent - about 120,000 people, according to the U.S. Census Bureau's Current Population Survey.

The problem is larger than the 120,000 who are directly affected. It reaches out to all areas of society. Hospitals and community clinics shoulder the burden of providing care with little or no reimbursement, while businesses and individuals are affected with higher insurance premiums.

**Coverage for All in Hawai`i - Planning Grant.** Coverage for All in Hawai`i is a statewide planning effort to develop and propose viable health care coverage solutions for Hawai`i's growing number of uninsured.

To support the development of possible solutions for expanding coverage, research is underway. With some survey analysis completed, a quantitative and qualitative profile of the uninsured is emerging.

Quantitative research shows that 12% of the uninsured in Hawai`i are children (birth – 18 yrs of age), residing in households with incomes at or below 200% of the federal poverty level. Between 5 to 10% of the total population is uninsured, with men more likely to be uninsured than women. Young adults, ages 18-29, are also more likely to be uninsured, and an estimated 60% of the uninsured are working in one or more part-time jobs or are self-employed. A disproportionate number of uninsured reside on the islands of Hawai`i, Kauai and Maui, rather than on O`ahu, where the majority of the state's population lives. With regard to ethnicity, Japanese and Chinese tend to have the highest coverage rates, while Hawaiians and Caucasians have the lowest.

Over 230 semi-structured field interviews have been conducted with a sample of individuals who are uninsured, care providers, and health care leaders. Based on interviews with the uninsured, coverage means confidence to send children on field trips, to walk into a hospital or clinic with dignity, to know society will repay contributions when help is needed, to know homes, cars or savings won't be lost when disaster strikes, and to know everyone will receive equal care regardless of economic status.

Other important findings include:

- Hawai`i's uninsured want coverage that is affordable, accessible, equitable, flexible, easy to understand, uninterrupted, and worthwhile. Having health care coverage provides a sense of security, equity, and confidence to have an active life.
- Low QUEST (Medicaid managed care) reimbursements rates are seen as a barrier to provider participation. Some providers believe that QUEST intake process is a coverage barrier and also contributes to a low self-image for the uninsured.
- Working families, part-time workers and the self-employed usually cannot afford the cost of premiums or care for chronic conditions.
- Continuity of care is an issue for individuals who go in and out of eligibility for publicly funded coverage, use interim and/or emergency services, or change providers frequently.

- Safety net providers are in the position of providers of last resort. It is not likely that they will be able to continue to cover the cost of uncompensated care.

For nearly three years, prior to the onset of this grant, intensive analysis was carried out that led to the identification of five areas for coverage expansion. With support from the HRSA State Planning Grant, work groups, made up of a broad spectrum of interests, have been convened to develop solutions in these five areas:

- the employed but uninsured
- eligible adults not enrolled in government- sponsored programs
- expanding coverage for children
- those relying on our community health centers as their safety net
- uninsured Pacific Islanders from compact of freely associated states

Hawai`i's Prepaid Health Care Act of 1974 (PHCA) is also being studied.

In each case, the work groups are considering a breadth of coverage options and identifying scenarios from which economic modeling is then conducted. An iterative process of policy option development, economic modeling and policy option refinement will continue until solutions can be identified which will have the most potential for success.

Next Steps. In addition to continuing options development and modeling, another activity under this planning grant is in-depth market research. The general public's opinions and behaviors on health care policies in Hawai`i and health insurance coverage will be examined. Employers, the self-employed, and others not covered by PHCA will be surveyed. Hawai`i State Legislators will be polled to assess their receptivity to and acceptance of proposed policy scenarios and recommendations.

In October 2003, a conference will be held that will share the results of the research on the uninsured to date, educate stakeholders on the magnitude of the problem and variety of issues, present potential policy options, gather feedback in order to further refine options and to address stakeholder concerns and secure statewide media coverage on the research and policy issues.

Over the next year, we will continue analysis of an expanded sample of personal interview data, and further analyze utilization and expenditure data from community health centers, hospitals and emergency rooms. The research findings will be shared in technical workshops for critical review and shared with the work groups and policy makers to further refine viable strategies.

Section 1
HAWAI`I'S MARKETPLACE
Factors Influencing Health Care Coverage

Hawai`i's Health Care Marketplace: Leadership & Policy Makers
Two principal health insurers – the Hawai`i Medical Service Association (HMSA (Blue Cross/Blue Shield of Hawai`i; a mutual benefit society) and Kaiser Permanente – provide more than 90% of Hawai`i's health insurance coverage. In 2003, both have proposed double-digit premium increases. Although generally lower than on the U.S. mainland, Hawai'i premiums continue to escalate due to rising costs of care and higher utilization.

In the 1980s, Hawai`i's low (five percent) uninsured population was credited in no small part to the state's Prepaid Health Care Act (PHCA). The law requires the following from employers: to provide health insurance to employees who work 20 hours a week or more; to pay for most of the premium cost; and to provide a package with a certain benefits level. The "prevailing plan" rule is cited as an issue for some employers who cannot afford to purchase this plan – one that has grown rich in benefits.

Hawai`i's marketplace has changed dramatically from an economy controlled by a small number of big corporations to a service economy where 95% of businesses are small businesses. Today's cost of health insurance premiums may work against the intent and mission of the Prepaid Health Care Act, which is to increase health coverage. According to employer focus groups conducted in July 2003, small to large human resource decision-makers expressed that many Hawai`i employers hire more part-time workers than full-time workers or outsource services specifically to avoid the mandate. Some focus group participants admitted to this practice as a means to control business costs. This observation has also been collaborated by the results of econometric analysis and experiments.

Health coverage continues to be an important issue of the Hawai`i Legislature. In the 2003 session, numerous measures were introduced on health insurance and care access; four concurrent resolutions were adopted that are tied to the *Coverage For All* mission and focus on the study, discussion, and development of affordable and accessible care.

Hawai`i's first Republican governor in 40 years took office in 2003. At this time, the new administration's view on strategies to expand access to health coverage is not clear. However, one of the Governor's major election platforms was the advancement of coverage. The project team has met with the Governor's Senior Policy Advisor who is supportive of the project's intent and has subsequently requested updates and information. The team has also been working with the Governor's cabinet members, particularly the Director of Health and the Director of Human Services, whose influence and support are critical. The Department of Health also plays a significant role in the project's work as Principle Investigator. In April 2003, the Director of Human Services joined The Leadership Group, which serves as the project's steering committee. In addition, several state departments are represented in the work groups (policy teams): Labor and Industrial Relations; Commerce and Consumer Affairs; Business, Economic Development and Tourism; and the Attorney General's Office.

Employer-based & Government-sponsored Options

As in other states, health care coverage in Hawai`i is mostly a mix of employer and government programs. Since state law mandates employer-based health insurance, most of Hawai`i's working citizens are covered under an employer group plan. However, there are employed individuals who are exempt from coverage: part-time workers; sole proprietors; individual contractors; certain classes of government workers; and family members of these groups.

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 age 65 and older, and those certified as blind or disabled. Available to eligible low-income individuals and families, Medicaid's QUEST offers coverage through a managed-care program that operates similarly to private insurance. Two national health insurance programs include: Medicare, for people 65 years of age and older, certain younger disabled people, and those with kidney failure; and TRICARE, which serves active duty personnel, their families and retirees.

Compared to most other states, Hawai`i has a large per capita immigrant population. The Personal Responsibility and Work Opportunity Reconciliation Act eliminated immigrant eligibility for government-sponsored programs for five years and is a coverage barrier. Another major challenge is coverage for migrants of the Compact of Free Association (CFA), which allows citizens of Micronesia, the Marshall Islands, and Palau to "freely" enter the U.S. where they can access services (primarily health and education). These migrants frequently have difficulty paying for health care and often their claims go unpaid. Hawai`i has not received any substantial federal compensation or reimbursement for services provided to CFA migrants. This has placed a tremendous strain on Hawai`i's healthcare system, and government programs such as Medicaid.

Key Stakeholder Perspectives: Employer & Government

In discussing key stakeholders' perspectives, many facets must be explored. For the sake of brevity and for report purposes, some relatively "safe" assumptions and generalizations are made with the caveat that there are always exceptions.

In the 1970s, the Prepaid Health Care Act firmly established the employers' role in caring for its employees. This philosophy can be traced to the paternalistic plantation days and rise of organized labor in the late 1950s and early 1960s. Hawai`i has long-been considered a pro-labor state and even today, health care benefits are a powerful bargaining tool for employers and unions.

As expressed in recent employer focus groups, workers have grown accustomed to rich health care benefits at a relatively low employee contribution rate, and Hawai`i employers are the primary bearers of the insurance costs. Mandates such as the PHCA drive up business expenses. For employers wanting to offer health insurance to all employees, coverage costs are often considered high and prohibitive. More employer mandates probably would be looked upon unfavorably. This sentiment was strongly affirmed in employer focus groups, particularly in discussions with small businesses.

Both employers and employees make compelling arguments on health coverage provisions, fairness issues on benefits and the premium cost share. Scheduled for summer 2003, the project's survey work aims to address how much each side is willing to compromise. Creative and resourceful approaches to expanding coverage will be required. Economic modeling activities enable a close examination of marketplace response to changes in both government-sponsored and private insurance sectors. Take-up rates, crowd-out effects and costs of various proposals are of particular interest.

Many believe it is government's role to provide for the general public's well being, but there is also a strong case for individual responsibility. Hawai`i is faced with increasing Medicaid expenses, rising health care costs, a struggling economy, and state budget shortfalls. Policymakers and state officials may want to provide coverage for more people, but are limited to what the budget will bear. While government supports health care coverage with laws, taxes, incentives, program development and administration, more mandates and increased taxes may not be attractive options. Without raising taxes, the state has little room to maintain – let alone expand – coverage for the uninsured.

Section 2
Research on Hawai`i's Uninsured
Understanding the Uninsured & Community Impact

Characterizing the Uninsured

Through the initial quantitative research, a picture of Hawaii's uninsured is developing. The number and characteristics of the uninsured are drawn from three sources, which are designed to support state-level estimates: the Current Population Survey (CPS) March Demographic Supplement 1996-2002, the Hawaii Health Survey (HHS) 2000, 2001 and the Behavioral Risk Factor Surveillance System (BRFSS) survey 2000, 2001. Point estimates and standard errors are computed throughout with consideration for the respective survey designs. The HHS is also designed for limited county-level estimates. Since the BRFSS only surveys adults, the overall population and children are derived from the HHS and CPS.

Based on the analysis of these sources, 5% to 10% of Hawaii's population lacks health insurance coverage. Estimates based on the CPS March 2002 Supplement and the traditional CPS definition, indicate that 117,000 persons, representing 9.6% of Hawaii's population, were uninsured in 2001. A 7-year average of the CPS renders an uninsured rate of 9.4% implying an average annual number of 112,000 persons. By contrast, the CPS rate for the U.S. over the same 7-year period is 15.4%. As of March 2002, the CPS Demographic Supplement featured a new question to confirm insurance status. This has resulted in lower state estimates of the uninsured of which Hawaii is not an exception. Based on the CPS March 2002, the direct estimate of uninsured in Hawaii is 8.4%, or 102,000 persons with no coverage for all of 2001. Nationwide, state surveys generally render lower estimates of the number uninsured than the CPS. Re-weighting for missing observations and updating to the 2001 Census projections, we compute a point-in-time estimate based on the HHS 2001 of 5.6% uninsured implying 68,000 persons. The BRFSS point-in-time estimate for 2001 indicates 7.3% of adults are considered uninsured under the Centers for Disease Control & Prevention (CDC) definition.

Many of Hawaii's uninsured are gainfully employed. The 2002 CPS indicates that 52.5% of all uninsured persons are older teens, age 16 and older, and adults who work at least part-time. The comparable figure from a 7-year average of the CPS 1996-2002 is 56.2%. Estimates of working adults and older teens from the HHS and BRFSS show that approximately 60% of uninsured adults are working. Many of those work part-time (less than 20 hours per week) or are self-employed — both groups are excluded from mandatory health coverage provision of the Prepaid Health Care Act.

In Hawaii, males are more likely to be uninsured than females. Males represent approximately 60% of uninsured adults (BRFSS 2000, 2001) and more than 55% of all uninsured persons (HHS 2000, 2001, CPS 1996-2002).

Young adults, ages 18-29 years, are disproportionately represented among the uninsured with rates that are roughly double than that of the general population (i.e., 10-20% uninsurance rate).

Children (1-18 years of age) in households with family income below 200% of Hawai`i's federal poverty level make up 12% of Hawaii's uninsured. This is true, despite the fact that Hawai`i's publicly funded programs (Medicaid, QUEST and S-CHIP) have offered free medical assistance to these children since July 1, 2000. This represents a significant portion of those who are eligible, but are not enrolled in public insurance programs, and an important target for increasing coverage.

According to the Hawaii Health Survey (2000, 2001), 40% of the uninsured reside in the counties of Hawai`i, Kauai and Maui. These island counties represent only 28% of the state's total resident population (U.S. Census Bureau). This has important implications for the delivery system and health care financing as policy makers debate the relative merits of expanding the safety net and formal insurance.

Hawai`i residents of Japanese and Chinese ethnicity tend to have high coverage rates, while Native Hawaiians and Caucasians are more likely to be uninsured, 7.6% and 7.1%, respectively, in 2001, according to the Hawai`i Health Survey. There is some evidence that this is due to differences in unemployment rates, as employment and coverage are highly correlated. Native Hawaiians comprise approximately 30% of the uninsured population (Hawai`i Health Survey 2001).

Voices of the Uninsured

An understanding of the uninsured is being developed through qualitative research – why they are uninsured, how they obtain and pay for care, what barriers they face, and how being uninsured impacts them and their families, the health care system, and the state. The intended purpose is to provide the research gathered on the uninsured and their providers, including their stories, their issues and their needs to the work groups to inform the policy development process.

As of July 2003, we have completed 180 interviews (about 1 hour in length each) of uninsured individuals on Oahu, Maui, Hawai`i, Molokai, and Kauai (see attached map). Although analysis of interviews is incomplete, the following themes have emerged:

Delaying Health Care

"Why haven't you gone back to see the doctor?"
"Because I don't have insurance now.
I can't afford to pay him. (If you feel sick?) Just suffer."

Often seeking care and waiting for their next medical crisis, it is not unusual for uninsured persons in Hawai`i to have major medical debt.

Health Coverage – Complex and Costly

"Have you looked at what those companies charge? –
I can't pay that and keep my business going! ....
Why pay for insurance when I need to pay for things for my family?"

Those below or near the federal poverty level cannot afford coverage as offered by commercial carriers. Their decisions about being insured are usually rational and include such factors as current health status, competing expenses, and a belief that their financial situation will improve. Health insurance is almost always perceived as a "mystery" in terms of what is and is not covered. COBRA and other transitional programs are not well understood and are seen as too costly.

Complicated and Inconsistent
QUEST (Medicaid managed care) Application Process

"I didn't do it, all that paperwork was too much..."

The QUEST application process is very demanding and often beyond the ability of the applicants. Usually, care providers help to obtain QUEST coverage; still, the effort to maintain or recover coverage once lost is often as difficult as the initial application. An interruption of coverage often contributes to health problems, especially for those with chronic diseases.

Unequal Treatment of the Uninsured

"They were so mean when I needed help..."

Although care providers are not usually seen as discriminating, their clerical staff often appears to treat uninsured persons differently. Patients often feel embarrassed and unwelcome because of their lack of insurance. Consequently, they perceive that a different care standard applies to them, and feel that there is no one they can talk to.

Substance Abuse Complicates Access

"I'm on Methadone right now. I was using heroin for a while. Because of [the suicide] I started using heroin again."

Although not a consequence of being uninsured, substance abuse seriously affects the ability to access treatment – for example, QUEST applicants cannot divulge assets and other funds. The result is a different risk profile in terms of opportunistic infections and compromised immune systems. Addiction may be used as a reason for not seeking work and for unemployment. It may also be seen as a problem to be hidden from QUEST workers.

Additional Challenges: Problems Never Come Alone

"My denture broke and it's all-misaligned because I tried to put it back together with Crazy Glue"

Oral health is almost universally defined as a problem.

Other problems include:

- Transportation to jobs and clinics.
- Paying for expensive medications for chronic diseases.
- Keeping track of renewal issues, bill payments, getting a job, raising a family, and in general, surviving.
- Always having to "tell your story" is embarrassing and depressing.

Optimism or Despair

"If I made only $800, I'd get free medical coverage? (Yes) How to survive? How to keep my leg?"

Being uninsured is usually not a choice but a consequence of employment status. Some of the uninsured are healthy and have good coping skills and support networks, while others have complex social and health issues with limited options. Responses from the more vulnerable population describe it as unrealistic to expect that the future will get better. Few social and health services offer support and assistance directly to them.

The Bottom Line: Coverage is Confidence

Hawai`i's uninsured want coverage that is affordable, accessible, equitable, flexible, easy to understand, uninterrupted, and worthwhile. Some of the recurring themes expressed:

- Premiums that are geared to income and family size, medical debt amnesty and/or debt restructuring assistance.
- A user-sensitive system, knowledge about options, multilingual services, accessible services, mental health and addiction counseling in rural areas.
- To be treated with respect and equal care regardless of the amount of premiums paid.
- Flexible payment options and care services.
- A system that is easier to understand than the current patchwork of plans, providers, gap-programs, intra-state rules and forms - including proactive information dissemination and a health coverage ombudsman.
- Proactive options to ensure continuity.
- Acceptance that cradle-to-grave coverage is a long-term societal benefit and responsibility.

Coverage means confidence to send children on field trips, to walk into a hospital or clinic with dignity, to know society will repay their contributions when help is needed, to know homes, cars or savings won't be lost when disaster strikes, and to know everyone will receive equal care regardless of economic status.

Stretching the Safety Net: Providers to the Uninsured

Interviews with providers were undertaken to include their voices and recommendations in the policy-making process. In particular, we sought to determine:

- Impact on individuals, families, safety net facilities and providers.
- Costs and who pays the price.

Impact on Safety Net Facilities: Data collection and analysis is in progress. Preliminary results indicate that the safety net facilities are losing money caring for uninsured patients who cannot qualify for Medicaid and cannot pay themselves. Medicaid and Medicare reimbursements are seen as too low to cover costs. Safety net facilities cannot turn away uninsured patients and must raise funds from other sources, including state and federal governments. Additionally, they must often provide services, which are not being provided elsewhere, such as homeless shelters or substance abuse treatment.

Impact on Providers. Many outreach workers are frustrated, using terms such as "angry," "crying," and "losing sleep" over issues related to working with the uninsured. Physicians note that their diagnostic ability is limited as it is difficult to find specialists, lab and x-ray facilities to treat the uninsured. Much time is spent obtaining free drug samples for patients and seeking alternative, affordable treatment. Most providers provide pro bono care, and one physician uses her personal credit card for prescription drugs for patients. One social worker described her job as a "calling."

Impact on Patients. Providers said their uninsured patients become depressed, frustrated and angry at the difficulties of becoming enrolled in government-sponsored coverage or trying to pay for services. Providers said that they often cannot afford drugs, were harassed for payment of large debts, had few choices of care, and experienced poor health outcomes – especially those with chronic health conditions.

Safety Net Policies. Safety net providers have mission statements, agreements with the federal government and internal policies that guarantee health care. Many have sliding-fee plans for those who can afford to pay something, while others provide free care and drugs. Some are able to use rural health grant funds to provide limited care to the uninsured. Hawai`i's quasi-private Hawai`i Health System Corporation hospitals have a system of "charity care," for which indigent clients can apply.

What Providers Need from the System. Providers say that they need affordable coverage that covers drugs, diagnostic laboratory tests, x-rays, and basic treatments. In addition, they need some coverage for pre-existing conditions. They need an easing of QUEST's eligibility criteria and administrative rules. They need more community health centers and free clinics. They need health promotion and disease prevention services to prevent avoidable health problems.

Native Hawaiians. Providers, some of whom are native Hawaiian, describe loss of cultural identity such as access to land and water as being additional health risk factors for native Hawaiians. They point out that poor health indicators speak for the inadequacy of culturally appropriate services. They note the importance of the Native Hawaiian Health System of care and the inclusion of spirituality as integral parts of indigenous healing.

Caring for Uninsured Diabetics. Providers point out that diabetic patients often avoid health care facilities because of debt. They don't take needed drugs, because they can't afford them. They often experience avoidable complications – such as amputation – that lead to more expensive care over time.

Uninsured and Disabled. Both providers and clients describe the acute problems of patients transitioning between QUEST and Social Security Disability Insurance (SSDI). They call the system "abysmal" and say that even they can't understand its "spend-down" requirements. One physician advises his patients not to apply for SSDI unless they have no other choice.

Creative Solutions to the Dilemma of Who Pays. Safety net providers usually are successful in helping patients enroll in QUEST. Hospitals give assistance prior to hospitalization to help patients plan on how they will make payments. They have also implemented aggressive collection procedures to get their bills paid. Providers have suggested considering reverse mortgages, and other avenue to become proactive about guardianship and advance directives.

Health Leaders' Perspectives on Factors Influencing Coverage

As part of our research, health leaders on each island were consulted for their input concerning the issues of the uninsured on their respective islands and to identify sources of information and contacts for recruiting uninsured persons and provider interviewees. The factors that were identified that were consistently cited by health care leaders on all islands include:

- Low QUEST (Medicaid managed care) reimbursements rates are seen as a barrier to provider participation.
- Some providers see the QUEST intake process as a barrier to coverage and contributing to low self-image for the uninsured.
- Working families usually cannot afford the cost of family coverage.
- Part-time workers and self-employed persons usually can't afford to pay the costs of premiums or care for chronic conditions.
- Continuity of care is an issue for many clients who may go in and out of eligibility for publicly funded coverage, use interim and/or emergency services, and change providers frequently.
- Safety net providers are in the position of providers of last resort. It is not likely that they will be able to continue to cover the cost of uncompensated care.

Section 3
Option Design & Economic Modeling:
POLICY MAKING PROGRESS IN TARGET AREAS FOR EXPANSION

In 2002, HRSA funding was secured to pursue the following strategies outlined in this section. Prior to the onset of work under this grant, nearly three years of intensive analysis led to the identification and refinement of areas in which we should pursue expansion. These insights were recorded and presented to a cross-section of experts in a Coverage for All Design Forum on May 30, 2002. This group collectively generated what are considered Hawai`i's best set of target areas for expansion**.**

The HRSA funding has enabled the creation of two major leadership entities:

- The Leadership Group (overall community steering committee) This group preceded the HRSA grant by some time and was set up during the 1st RWJ grant period.
- Work Groups (policy teams focused on each target area for expansion)

The work groups are made up of a broad spectrum of interests, including labor, government agencies, small and large businesses, health care experts, provider associations, advocacy organizations and academia. More than 60 organizations are involved in these teams, which are developing targeted and incremental solutions in these five areas:

- on the job but uninsured
- expanding enrollment of eligible adults in government-sponsored programs
- expanding children's coverage
- expansion and enhancement of the safety net
- uninsured Compact Citizens who use Hawai`i's Health Care Services

Hawai`i's **Prepaid Health Care Act** of 1974 is also being studied.

Two principles governed the work group design:

- Full and open stakeholder discussions will facilitate early "buy-in" among key informants and will increase the project's chances of success. To this end, considerable time and effort was invested to ensure the involvement of critical stakeholders in the work groups.

- Sound data and research should inform and support the policy option development process.

All work groups are considering a breadth of coverage options through:

- legislation (statute and administrative rule development and changes)
- private market development
- accessing special federal programs and monies
- government program expansion
- tax credits and other solutions

While the project's mission and intent have gained support, the challenge is to develop solutions that will be universally endorsed, equitable, affordable, and appropriate.

Status of Policy Recommendations & Economic Modeling

Nearly 35 work group meetings have been held to date. And all work groups continue to meet — discussing and developing potential solutions. At the May 28, 2003 Work Group Planning Session, the first iteration of economic modeling results were presented. A series of refinements will be needed.

It is too early in the policy development process to offer sound recommendations. However, the modeling schemes reflect the work groups' general direction and interest. Policy recommendations will be contingent upon the final modeling results.

The data sources used for modeling include but are not limited to: household and individual survey data, health plan data, emergency room and hospital inpatient discharge records, administrative records, and laboratory-generated experimental data. The main simulation techniques rely on econometric or theoretical models with associated experimental designs. Modeling results outlined in this report are not policy recommendations rather these outcomes represent points of departure for both policy modeling and discussions.

Uncovered Worker: On the Job but Uninsured in Hawai`i

Issue Identification. People who are employed but who don't qualify for employer-based or government-sponsored health insurance make up the largest percentage (estimated at 60%) of Hawai`i's uninsured. The vast majority are employed part-time – some with two or more jobs. Others work full time as sole proprietors, independent contractors, or for government (classified as temporary or casual hires). These categories of workers are exempt from coverage under Hawai`i's Prepaid Health Care Act.

Work Group Focus. The project has assembled a work group to develop affordable options that best serve the uninsured, employers and government. Insurance alternatives and solutions through a private or quasi-government initiative are being explored. If such plans are proposed, other potential beneficiaries could include individuals who may have some financial resources to pay for "affordable" health insurance such as students (i.e. non-traditional and graduate) and early retirees ineligible for Medicare.

Challenges

- To develop enabling legislation that will not compromise the ERISA waiver (if needed).
- To develop an equitable financing system that is supported by Hawai`i's small businesses, service industries, labor, private health plans and government.
- To develop a position on benefit structuring and cost sharing – whether offering reduced coverage to more people is preferable to providing extensive coverage to a smaller group and understanding the affects of utilization?

Economic Modeling. This work group has presented the research team with the following scenarios for first-iteration modeling:

"Design and implement a health insurance scheme to cover self-employed persons, sole proprietors, and part time workers." (two types of plans - one "rich" in benefits and one with "minimal" benefits)

"What would be the impact of mandating insurance plans to provide coverage to family members up to age 30?"

How would these affect part-time workers?

Hawai'i has about 17,200 uninsured self-employed persons, age 19 to 64, according to the Behavioral Risk Factors Surveillance System (BRFSS). Assuming a monthly individual premium of $283 and 100% compliance among the mandated self-employed, implies an annual direct cost of nearly $58 million to insure this population of 17,200 persons. It is intended that this amount will be financed through private premiums which will in-turn be partially financed through the existing federal self-employed health insurance deduction. If 20% of the self-employed avail themselves of this deduction, $3.3 million of the above premium cost will be financed through reduced federal tax liability. Our estimate of the medical resources used by uninsured self-employed adults is a little more than $6.9 million per year based on 2001 estimates of hospital emergency room and inpatient expenses alone. Netting out these amounts, implies about $47.9 million in new costs to be borne by Hawai`i.

Market Research. In order to best understand the issues, concerns and viewpoints of the working but uninsured, a market research firm was secured in May 2003. Comprehensive statewide surveys (July through September 2003) of small to large employers, sole proprietors, the self-employed and part-time workers are underway.

COMPLETE ENROLLMENT OF ADULTS: Expanding Enrollment in Government Programs

Issue Identification. An estimated 20% of Hawai`i's uninsured (about 25,000 adults) are eligible for government-sponsored coverage, but are not enrolled. Obstacles are varied: limitations on the number of enrollees accepted into a program; a lack of knowledge about available programs; language or cultural barriers; and system barriers that make enrollment difficult.

Work Group Focus. A work group is exploring solutions for increasing enrollment that may include creative outreach, as well as a simplified application form and easier enrollment process.

Challenges

- As with other states, Medicaid funding is a critical issue.

- Benefit structuring is a major issue. The work group must wrestle with the question of whether or not it is better to cover more people with fewer benefits, and then to define "fewer."

- To develop solutions within the parameters of existing programs and explore creative approaches to funding sources such as waivers and SCHIP expansion.

Economic Modeling. First iteration modeling scenarios are:

"What is the impact of extending the SCHIP to parents who would not be eligible for employer-based coverage? What would be the impact if SCHIP was extended to parents at the 200% FPL and 300% FPL?"

"What would be the effect if the QUEST caps were removed? What are the various effects?"

"What would be the impact if applicants self-declared their income and assets at enrollment?"

Our initial estimates are that 127,349 adults age 19-64 would potentially be eligible for Medicaid/QUEST if the family-income upper limit increased to 200% of the federal poverty level (FPL). Our model-based estimates indicate that of the newly eligible adults, about 38,200 would be expected to enroll, of whom 34,300 adults are expected to have switched from private to public insurance (crowd-out) and only 3,500 adults become newly insured. Assuming a capitation rate of $3,000 per adult and the current Federal Medical Assistance Percentage (FMAP) for Hawai`i, federal taxpayers would bear about $67.3 million while state taxpayers' direct burden would be more than $47.2 million. The net cost to society would be less than $10.3 million, based on expenses incurred by uninsured adults.

Another proposal under consideration would extend free medical assistance to the parents of currently eligible SCHIP children residing in households with family income up to 200% FPL. Preliminary predictions are that about 7,800 adults would become enrolled at an annual direct cost of about $24.5 million with federal taxpayers bearing $16.7 million (71.14%) of the cost and state taxpayers bearing a little less than $6.8 million (28.86%) of the cost. About 3,600 persons would become newly insured, due to a sizable crowd-out. Netting out emergency room and hospital inpatient expenses and recognizing crowd-out as refinancing, renders a net cost to society of about $9.3 million to cover nearly 3,600 newly insured SCHIP adults.

COMPLETE ENROLLMENT OF CHILDREN: Expansion of Children's Coverage

Issue Identification. There are 22,000 children without health coverage, according to research conducted by Hawai'i Covering Kids. Of these, it is estimated that more than 14,000 are eligible but not enrolled in QUEST or Medicaid programs.

Work Group Focus. A committee of advocates, state agencies as well as health care and health coverage experts is analyzing enrollment barriers and looking at solutions to open eligibility to children in families with incomes from 200% to 300% of the federal poverty level (estimated at 8,000 children).

This policy team is closely linked to the Complete Enrollment of Adults work group with overlapping initiatives and discussion topics.

Challenge

- The major challenge is how to fund the expansion with federal and state funds.

Economic Modeling. This Work Group has presented the research team with the following scenarios for first-iteration modeling:

"Expand the eligibility requirement for the State Children's Health Insurance Program for children and youth, ages 0 – 18 years, from 200% to 300% of the federal poverty level."

The first iteration of this modeling scenario generated unstable results. In order to address this, the researchers are developing a difference-in-difference approach. This method utilizes information on other states and the near low-income in Hawai`i to estimate the counterfactual in order to lessen the potential bias in the previous method. This method will be implemented in a retrospective analysis to compute take-up and crowd-out rates of previous SCHIP expansions in Hawai`i. These previous expansions represent a natural experiment to investigate take-up and crowd-out rates in Hawai`i because we can measure what actually happened.

SAFETY NET:
Expansion & Enhancement of the Safety Net

Issue Identification. Without universal health coverage, a tightly woven and strong safety net will always be needed. It serves as a necessary provider to those who are difficult to insure such as the homeless and immigrants.

Work Group Focus. Community representatives are developing and analyzing potential solutions for expanding safety net services. General public education on the safety net's community value with a data-supported position statement may help these provider centers to increase funding of services and the number of centers. Interest has also been expressed in doing a cost-benefit analysis that would "prove" the safety net's value.

Challenge

- A major concern is regular and consistent funding – particularly the state's contribution – which is often in jeopardy. The Legislature has often made efforts to cut funds to safety net providers.

Economic Modeling. This work group has presented the research team with the following scenarios for first-iteration modeling:

"What is the cost of providing insurance for those who are uninsured versus the cost for providing services by way of health centers and hospitals?"

"What would it cost if we didn't have a safety net?"

**"What if the SCHIP weren't in the QUEST cap?
What would the impact be to the state?"**

Initial Results. Data use agreements have been submitted to the U.S. Department of Health and Human Services for the request and use of information on Federally Qualified Community Health Centers and Medicaid enrollment information specific to Hawai`i. Modeling is pending the approval and the receipt of the data.

COMPACT OF FREE ASSOCIATION:
Uninsured Compact Citizens Who Use Hawai`i's Health Care Services

Issue Identification. Hawai`i is unique with respect to the number of migrants from the Compacts of Free Association States (CFA)— Federated States of Micronesia, the Republic of the Marshall Islands and the Republic of Palau. An estimated 6,000 to 8,000 CFA migrants are in Hawai`i. In all likelihood, this is an undercount. Most CFA migrants are below the federal poverty level.

Unintended effects of the compacts are that the states are left to subsidize the costs of care for CFA migrants – a large financial burden on Hawai`i's health care, social services and education systems.

Work Group Focus. Health care providers, health coverage experts and representatives of Hawai`i's congressional delegation and the federal government – are exploring this issue. Solutions may include obtaining federal reimbursement of these state-funded health services and eligibility reinstatement for CFA migrants for government-sponsored programs. Action is timely because portions of the compacts (specifically the ones between the Federated States of Micronesia and the Republic of the Marshall Islands) are being re-negotiated in 2003.

Economic Modeling. Economic modeling is not required for this work group. Solutions are being explored that include federal reimbursement of state-funded health services and eligibility reinstatement in government-sponsored programs for CFA migrants.

Prepaid Health Care Act: Understanding Its Impact on Hawai`i

Issue Identification. Hawai`i's Prepaid Health Care Act (PHCA) is the only mandate in the nation that requires employers to provide their (20 hrs/week or more) employees with health insurance, pay a large percentage of the premium, and offer a package that meets a certain benefits standard. An Employee Retirement Income Security Act (ERISA) waiver allows Hawai`i to have such a law with a stipulation that no substantive changes can ever be made to the PHCA without jeopardizing the waiver.

Many areas of contention among labor, employers, and government regarding this mandate exist, such as equity and cost sharing of health insurance premiums. Private sector employers are typically contributing 90% toward single coverage and 70% toward family plan premiums. The "prevailing plan" rule is often cited as an issue for some employers who cannot afford to purchase this plan type – one that has grown rich in benefits.

Work Group Focus. A committee of community leaders is assessing the impact of the Prepaid Health Care Act on Hawai`i's consumers, providers, insurers and businesses.

Challenges

- Although the PHCA is about 30 years old, it often serves as a controversial issue among employer groups, labor, health plan providers, and government.

- There is much misunderstanding about the PHCA's employer requirements. Given the contentious nature and special ERISA waiver, understanding PHCA's important and basic impacts must precede any recommendations to change it.

- There is no recent, comprehensive PHCA study on state and stakeholder impact.

Economic Modeling. This Work Group has presented the research team with the following scenarios for first-iteration modeling:

"What would happen if we repealed the Prepaid Health Care Act?"

Recent double-digit premium increases have generated renewed interest in examining the PHCA. Our analysis seeks to bring fact and reason to the discussion.

Applying standard econometric methods to examine the impact of the PHCA on hours worked and insurance coverage, we find that Hawai`i has significantly more employees working part-time (i.e., 0-19 hours) than the U.S. as whole – in other words, higher than the national average. While the percent insured among full-time workers in Hawai`i is significantly greater than the U.S. as a whole, no such difference is found for part-time workers. Based on these results, we conclude that PHCA has increased coverage but has also induced labor market sorting, as some employers and employees seek to avoid the mandate. In other words, employers who do not want to provide mandated coverage would hire part-time workers at less than 20 hours. Employees who want coverage would seek employment at greater than 20 hours. Those who preferred higher salaries might seek employment at less than 20 hours.

With human subjects, we simulated labor market interactions with mandated benefits for full-time workers only as a baseline corresponding to Hawai`i's status quo under the Prepaid Health Care Act. We then simulated three possible reform scenarios: 1) complete removal of the mandate; 2) imposition of the mandate for all workers; and 3) having employers contribute in proportion to hours worked. With regard to economic efficiency, having no mandate and the 20-hour rule are equally efficient and significantly exceed that of a full mandate or sliding scale. Hawai`i's current mandate results in a significantly larger proportion of part-time workers than the other scenarios and increases the number of workers insured over the no mandate rule.

Section 4
NEXT STEPS: Moving the Project Forward

The table below outlines the work to be accomplished over the next 12 months.

2003 (3rd & 4th Quarter)	**2004**
Research • Qualitative interview data collection and analysis with focus on uncovered sole proprietors, self-employed, part-time workers, and underinsured, as well as uptake issues following special post-9/11 coverage. • Hospital and ER expenditure & utilization data extended analysis. • Community Health Care Center data analysis. • Experimental economics research design. • Updated and extended econometric analysis of survey data. • Economic modeling refined. • Education and updating policy-makers. • Technical workshop for researchers, policy-makers and work-group leaders. **Market Research** For detailed information on research scope, visit "The Hawai`i Uninsured Project" at www.HipaOnline.com. (Click on "Work Group Log In." Passcode is "Coverage for All.") Activities will include: • Employer Focus Groups • Employee Telephone Survey • Public Opinion Survey • Neighbor Island Community Input Meetings • Policy Maker Survey **Coverage for All Conference (October 29)** The first major community presentation to communicate the results of our research on the uninsured to date, educate stakeholders on the magnitude of the problem and variety of issues, present potential policy options, gather feedback in order to further refine options and to address stakeholder concerns and secure statewide media coverage on the research and policy issues. **Policy Options Development** Ongoing work group meetings to refine policy scenarios.	**Policy Options Development** Ongoing work group meetings to refine policy scenarios. **Policy Options Proposal to the State of Hawai`i** Research issues of Uninsurance. Target Areas for Expansion. Policy Options. Community Response to Options. This breadth of information will be compiled and communicated in a comprehensive recap of our work under the HRSA grant. **Research** • Analyses and reports on 1) interview data; 2) hospital and ER utilization data; 3) quantitative survey data; 4) experimental economics and economic modeling • Quarterly technical workshops • Refinement of policy options through presentation of research results at work group meetings, to policy-makers. Preparation of peer-reviewed publications • Final Technical Reports • Final report to DHHS Secretary.

Appendix 1
METHODOLODY: Qualitative Methods

Qualitative Research:
Statewide Interviews with Providers & The Uninsured

The qualitative researchers for the "Coverage for All" are a multidisciplinary (Anthropology, Sociology, and Public Health) team of faculty from the University of Hawai'i at Manoa, working collaboratively with numerous community partners, including the Hawai`i Health Information Corporation, which manages the data. The project requires a multi-faceted approach, since the outcome is a plan to cover the uninsured and the research results are intended to inform policy-makers and stakeholders as they make decisions on how to address Hawai`i's uninsured. The qualitative research faculty team is assisted by a team of research assistants (RAs), who are graduate students in the College of Social Sciences.

The qualitative research methodology for this study involves one-on-one semi-structured field interviews and future imaging with uninsured people and care providers to uninsured persons. Interviews range in length from 1/2 to over 1 hour. Twenty-dollar gift certificates to a local pharmacy are provided to uninsured interviewees as a way of thanking the people who have shared their time and personal experience of not having health coverage in Hawai'i.

The RAs received two weeks training on issues of not having health coverage in Hawai'i, operation of equipment, personal safety, confidentiality, interview techniques, the interview prompts and domains for investigation, field notes recording, post interview précis and data management. The RAs and faculty record, digitize, and summarize all collected interviews. A professional transcriber is transcribing selected interviews verbatim.

The University of Hawai`i's Committee on Human Subjects granted an exemption for the study, allowing us to move quickly into field interviews. An approved consent form is utilized for all interviews. Confidentiality is maintained throughout the study. Self-selected pseudonyms are used to identify interviewees. Actual names of the interviewees are not retained.

Domains for Uninsured Data Collection

Questions for clients:

After the introductions and some talk story about the interviewer and the project, the focus should move to:

- **Background information**

  Name to be used? Age? Gender? Ethnicity? Education (how far)? What High School? Post-secondary? Employment status and history? Source of income? How regular is your income? Recent changes in income source, type? Housing arrangement? How long have you been in this arrangement? Transportation arrangements – how do you get around? Family Size? Relationships – Ohana? – Hanai? – etc. Where Born? How long in Hawaii? Where have you lived most of your life?

- **Personal Health and Health of Family Members**

"How is your health? Do you consider yourself to be healthy? What health problems do you currently have? Are these of short or long duration (ie < or > than 10 days? What are you doing about it (them)? Do they limit you in terms of mobility, work opportunity, etc.? Who do you go to?

What about your family (children, partner? parents, siblings?) Are they doing ok? Are they healthy? Do they have any major health problems? How do they get care?

- **Regular Source of Care**

Do you have someone that you usually go to for health care? Have you always had someone like that? Where are they? How often do you go? When do you go for care/ how do you decide you should go? How do you pay for that care? Has the care been good? Regular? How far away is that provider of care? How do you get there?

- **Satisfaction with Health Services / Insurance**

What are some of the problems in using your current care giver? Tell me about a time when you had a problem with your health (while living in Hawai'i). How did you deal with it (see a doctor? Alternative?). How did that work for you? Were you satisfied with this treatment? Was your satisfaction affected by the type of coverage available? What type of treatment would you have preferred?

- **Customizing Health Insurance**

What do you want from a health insurance system? What kind of coverage would work best for you? In your opinion, what kind of coverage should Hawaii have? Why would that work better than what we have now?

DOMAINS FOR UNINSURED DATA COLLECTION
Questions for Providers / Care Professionals / System employees

We are interested in getting people who work in the health care system and have had experiences with the uninsured to talk about how lack of coverage impinges on their work. These stories are confidential, and we do not want to identify the speakers, nor the people they are describing. But we want a general description, enough to get a sense of how lack of insurance affects health care professionals and adjunct staff. Ask them to give a code name for themselves.

- **Remembering the uninsured**

Could you tell me about a case when someone you wanted to give treatment to did not have insurance? What did you do? How did you help that person? Does this place (clinic, hospital) have a formal policy for dealing with the uninsured? Do you know what it is? Do you think it works from a health care perspective?

- **Personal Capital**

Have you ever worked pro bono (free) in order to give someone treatment that they could not pay for? Give some examples? How do you account for this (financially)? How often does this happen? Have you ever asked a colleague to provide free service for an uninsured person? How often have you done this? When was the last time – can you

describe the situation?

- **Professional Discourse**
  Is the problem of lack of coverage something you discuss with colleagues? Often? Regularly? Do you think it affects the way in which you provide health care services? Do you think lack of health insurance has an effect on treatment decisions that you make/accept?

- **Future Imaging**
  As a health care professional (health system worker), what do you need from a health insurance system? What flaws can you identify, and how would you suggest improving the insurance system

For each island, health professions leaders, including District Health Officers and Public Health Nursing of the Department of Health, were first consulted for their input concerning the issues of the uninsured on their respective islands. They were also asked to identify other important sources of information and contacts. Those contacts and others known to the researchers were then consulted for their input to the process, additional contacts, and to determine if their clients would be appropriate participants. The providers were given a packet of information on the project, including the proposal abstract, the consent form, Committee on Human Subjects exemption information, the domain prompts, and a sample flyer to inform clients of the research activity. The provider then recruited the interviewees and we set an interview schedule.

As of June 30, 2003, we will have interviewed 180 uninsured persons and 50 providers on Oahu, Kauai, Molokai, Maui and Hawai'i. We have not interviewed uninsured persons on the island of Lanai due to the small numbers of uninsured persons reported by health leaders, but we have consulted providers by telephone.

Data analysis is conducted using a qualitative software program (ATLAS.ti) to manage the large and growing data set. The analysis, based in grounded theory, seeks to allow the voices of the interviewees to command the data and determine new domains for further theorizing. Thus, the initial categories (domains) reflected in the interview prompts are reassigned by the interviewees themselves, allowing the issues that are the most compelling to emerge, rather than constrain the interviewees' concerns into pre-existing (and potentially biased) constructs.

Appendix II
Market Research

Objective. Focus Groups & Surveys of Employers
To examine the opinions and behaviors of employers, self-employed persons, part-time employees and those not covered by the Prepaid Health Care Act and the general public.

Specifically, the research will seek to answer these questions:

- *How do people feel about Hawai`i's current health care policies in Hawai`i?*
- *What are the choices that part-time employees or self-employed persons feel they have in health insurance coverage? How do they make these choices?*
- *Does health insurance coverage have an effect on employer behaviors, such as the number of employees, hours worked, etc.?*
- *What do employed people do about health care if they do not have health insurance?*
- *Who should be responsible for providing health insurance to those who are not covered under the current policy?*

Focus Groups & Surveys of Employers

EMPLOYERS

In order to obtain the most complete information from employers (those who provide health insurance), focus groups and a telephone survey will be conducted among human resource decision-makers of small, medium and large businesses.

Focus Groups: Focus groups among human resource (HR) decision-makers will helps to gain an in-depth understanding of attitudes on the issues of the uninsured and employed persons of Hawai`i. Focus groups will allow us to probe the concerns, thoughts, and attitudes of HR decision-makers on this subject. Key learning from these focus groups will be used to develop the telephone survey among employers.

Focus groups will be conducted, composed of approximately 6-8 HR decision-makers: Two among small businesses (1-19 employees). One group among medium and large businesses (20+ employees).

Participants will be recruited from lists maintained by Ward Research, a Hawai`i Market Research firm, and will receive $100 cash in appreciation. Ward Research will send out introductory letters to HR decision-makers prior to contact to alert them of the study, as well as introduce the organization. The research will be kept confidential.

All groups will be moderated by Rebecca Ward of Ward Research and held in Ward's focus group facility. This facility features a conference room, sound system, one-way mirror and viewing room. All groups will last one and one-half hours and will be audio- and videotaped.

Prior to the focus groups, a discussion outline will be submitted to the Coverage for all project team for review. This outline is a guideline only, allowing the moderator to pursue unanticipated areas of discussion. This will be limited to the following.

General purpose is to learn more about employer attitudes about benefits offered to employees

What's going on in the world of benefits? What are the trends that you see?

Questions on benefits offered

- What types of benefits do you offer to your employees?
- How do you decide what benefits to offer to your employees?
- Do you offer all of your employees the same benefits (full-time vs. part-time)? If not, how do you decide who gets what?
- What is the role of benefits in your staffing decisions? To what extent is benefits a consideration?
- Are there any benefits that you would like to offer to employees but do not? Why is that?
- How, if at all, do you control benefit costs to the company?

Health insurance discussion

- Tell me about the health insurance that you offer to your employees.
- What level(s) of coverage do you offer? Who do you offer health insurance to?
- Do you share the costs with the employee? If so, how did you determine the proportion you share?
- What factors go into deciding what features are included in coverage?
- Are you familiar with the Prepaid Health Care Act? How do you feel about the Prepaid Healthcare Act?
- Does the Act impact your handling of benefits and/or human resource issues? How?
- Do you feel there should be any changes made to the Prepaid Health Care Act? What should they be?
- What is your opinion about the uninsured people of Hawai`i? Do you think there is a cause for concern?
- How many people do you believe are without health insurance in Hawai`i? (If estimates are off, tell them that about 120,000 people are uninsured) Does this change any of your opinions?
- Is this an issue of concern to you? What about as a member of the community? What are the impacts of the uninsured group on the community?
- What kinds of people do you believe are uninsured in Hawai`i? What would you say if I told you that over half of the uninsured are gainfully employed?
- Any ideas of what should be done for the uninsured people in Hawai`i?
- What is your opinion about part-time employees (< 20 hours/week) and their health insurance options?
- Are your part-time employees who work less than 20 hours/week covered? If yes, how?
- Has your organization considered offering health insurance to your part-time employees?
- What barriers currently exist, relative to covering part-time employees?

Discussion of options that could allow more working people to obtain health insurance

- Is there anything that you have heard from other organizations or thought about in terms of offering health insurance to employees who aren't covered by the Prepaid Healthcare Act? What do you think about them?
- What, if anything, would your company be willing to do to insure those who aren't covered by the Prepaid Healthcare Act?
- Who do you feel should contribute to the costs of providing insurance to part-time employees? How much should be contributed by each party?
- Based upon what you are currently paying in premiums for your employees, what would you be willing to pay for your part-time employees? The same amount? 50% of the costs? 25% of the costs? Nothing?
- What about in dollars – what would you be willing to pay for each part-time employee?
- How much do you think your part-time employees would be able or willing to pay per month for health insurance?
- What types of benefits would you feel are necessary to include in a plan to be offered to part-time employees not covered by the Prepaid Healthcare Act? (Prescription, Dental, Preventative, etc.)
- Let's say that there was a plan available that would allow you to offer health insurance to your part-time employees at a cost that you believe is reasonable. How would you handle the administrative task of offering this benefit?
- If a plan was developed and funded by another party that would make health insurance available to employees not covered by the Prepaid Healthcare Act, would you be willing to assist your employees in obtaining this insurance in terms of education, paperwork, eligibility requirements, etc.?
- What about a program where the employer would withhold a portion of the employee's payroll to submit to a type of insurance pool – would this be something you may be willing to do?
- What do employers need to know about this issue?
- Who will you want to hear from on the issue and possible solutions?
- What kinds of information would you like to have about possible solutions for the uninsured employees?
- Is there anything else you'd like to say about this issue?

Telephone Survey among Employers, Self-Employed Persons, and the Public:

(A) EMPLOYERS

Once we gain an in-depth understanding of the decision-makers' attitudes and concerns about Hawai`i's uninsured telephone survey will be conducted among HR decision-makers. The sample of employers will consist of small (1-19 employees), medium (20-99 employees), and large (100+ employees) businesses, which will be weighted based upon their proportion of the Hawai`i market. According to the 1999 Statistics of U.S. Businesses (U.S. Census Bureau), 75%

of the businesses had 1-19 employees, 9% 20-99 employees and 5% had 100+ employees. Following is a table detailing the sample that will be collected.

	Total Sample	Sample Error	Oahu	N.I.
Total Employers	**450**	**+/-4.6%**	**320**	**130**
Small (1-19 emp)	300	5.6%	210	90
Medium (20-99 emp)	100	9.6%	75	25
Large (100 + emp)	50	13.3%	35	15

Sample

Employer sample will be purchased from the Hawai`i Business Directory, which lists over 45,000 Hawai`i businesses and includes information such as offices, number of employees and sales volume. A letter will be sent to the person who makes health insurance decisions at each business. This letter will introduce them to Ward Research and alert them of a future contact for possible participation in the study approximately 2-3 days prior to interviewing. Ward Research has found that this significantly increases response rates and participation in studies among business decision-makers. This letter will also be sent on Ward Research letterhead to keep the research sponsor confidential – encouraging honest participation from employers.

A 10-minute questionnaire will be designed and submitted for review and approval. A total of 2 open-ended questions will be included. Prior to the survey, the questionnaires will be pre-tested for length and to ensure that the language flows smoothly and is easily understood.

All interviewing will be conducted from the Ward Research Calling Center which allows for the 100% monitoring through observational and electronic means. The Center is equipped with a 12-station CATI system (Computer Aided Telephone Interviewing).

Upon interview completion, data processing will be accomplished using SPSS v11.5 for Windows, an in-house statistical software package. This software allows for data examination by key variables. For cross-tabulation purposes, these variables might include: revenue, number of employees and industry.

(B) SELF-EMPLOYED AND PUBLIC

In order to learn more about those affected by health insurance policies, a telephone survey among the public will be conducted. This population segment will include:

- Self-Employed Workers
- Part-time Employees (less than 19.5 hours per week)
- Others not covered by the Prepaid Health Care Act (the "Act")
- General Public

Sample
The public sample will be derived from a database file containing all published home telephone numbers in Hawai`i and by using the RDD method. Self-employed persons will be found using both of the business sample and the above-mentioned sample.

The sample will be weighted to reflect total populations. Following is a table of projected sample sizes that we will attempt to obtain, given the hours budgeted.

	Total Sample	Sample Error	Oahu	N.I.
Public				
Self-Employed	300	+/-5.6%	210	90
Part-Time Employees	200	6.9%	140	60
Others not covered	≥50	TBD	TBD	TBD
General Public	600	4.0%	300	300

Respondents will be directed toward unique questioning for their segment according to their responses to several screening questions. The self-employed sample will consist of business owners who are not incorporated (i.e. sole proprietors) and do not have other full-time work. According to the Census 2000 (U.S. Bureau of the Census), there were 41,109 self-employed workers in Hawai`i.

The remaining sample of part-time employees, others not covered by the Act, and other public constituents will consist of those age 18 – 64 years old. During the screening process, those who work less than 19.5 hours in any one occupation, and do not receive health insurance from their employer will be categorized as a part-time employee. Those who are neither part-time nor self-employed but are otherwise not covered under the Act, will be categorized separately. All others will be considered part of the "general public".

One questionnaire will be designed for each of the four public population segments and swill consist of structured and (2) open-ended questions based on an average length of 15-minutes. Prior to the survey, the questionnaire will be pre-tested for length and language.

Data processing will be accomplished using SPSS v11.5 for Windows, an in-house statistical software package. This software allows for date examination by key variables. For cross-tabulation purposes, these variables might include: age, gender, profession and income.

Appendix III
Health Insurance Policies and Recommendations

POLICY MAKERS

Objectives. To assess the receptivity and acceptance of proposed policy options and recommendations that may remedy the problem of the employed but uninsured. Specifically, the research will seek to answer these questions:

- *Do policy-makers feel there is a problem with the uninsured in Hawai`i?*
- *How do policy--makers feel about the proposed changes and recommendations to existing policies on health insurance coverage?*

Methodology. To best answer these questions, we will fax/phone poll the Hawai`i State Legislators.

Sample.

In order to achieve a minimum sampling error, a census of the above population will be attempted.

A two-page survey will be developed. The State Legislators will be sent a letter introducing Ward Research and alerting them of the fax survey approximately 2-3 days prior to faxing the survey. After approximately one week, any persons who have not yet responded to the fax survey will be contacted via telephone and will be given the option to complete the survey via telephone or fax.

Appendix IV
Modeling Policy Options

Policy options to cover Hawai's uninsured can be grouped into four broad categories — policies directed at the State administered public insurance system (i.e., Medicaid/QUEST/SCHIP), private, employment-based coverage, private non-group coverage, and direct delivery of services. The first three involve formal insurance and third-party financing while the fourth involves direct financing of the safety net and other providers. Our economic modeling efforts focus on the first three, insurance-based solutions.

Five working policy scenarios have been developed that directly lend themselves to economic modeling. These are not policy recommendations around which a community consensus has coalesced, but rather represent points of departure for both policy modeling and ongoing discussions.

- Expansion of the States Children's Health Insurance Program (SCHIP) family-income eligibility criterion for children aged 0-18 years from an upper limit of 200% to an upper limit of 300% of the Hawai`i specific Federal Poverty Level (FPL);
- Expansion of SCHIP coverage to adult parents aged 19-64 years of children aged 0-18 years residing in households with incomes 100-200% of the Hawai`i specific FPL who are not otherwise eligible for employment-based coverage or Medicaid/QUEST;
- Expansion of Medicaid/QUEST eligibility for free medical assistance to include all adults aged 19-64 years up to 200% or 300% of the Hawai`i specific FPL (with possible premium cost-sharing for the higher income);
- Imposition of an individual mandate for the self-employed, sole proprietors and part-time workers (with possible mandatory inclusion of their dependents) under a publicly-sponsored, privately-financed, privately-underwritten insurance pool; and
- Reform of Hawai`i's private-sector employer mandate under the Prepaid Health Care Act of 1974 (PHCA). Our data, methods and assumptions for modeling these scenarios are discussed below.

In general, modeling efforts attempt to answer the following types of questions. How many persons will become enrolled in the program or health plan under the new policy regime (i.e., take-up)? Of the newly enrolled persons, how many will have switched from existing coverage to the new expansion or plan (i.e., crowd-out)? How many persons will become newly insured? What is the direct cost of the new expansion or program? How much of this cost is borne by federal taxpayers, state taxpayers and other parties, respectively? What is the cost per newly insured person? With regard to those newly insured, what was their cost of care while uninsured? What is the net social cost of the program or policy? What is the net cost to the Hawai`i state economy and Hawai`i health system?

Additional questions are relevant to employment-based (employer sponsored) insurance. For example, what is the impact of the employer mandate on employment and productivity? How does the PHCA affect hours worked and the mix of part-time and full-time workers? What is the effect of PHCA on coverage rates of workers and their dependents? How does the PHCA affect economic efficiency? Will an individual mandate induce the self-employed to seek regular

employment? These and other questions are directly relevant to the policy discussions, which surround proposals to insure the uninsured.

A variety of data sources are employed in answering these questions, including but not limited to, household and individual survey data, health plan data, emergency room and hospital inpatient discharge records, administrative records, and laboratory generated experimental data. The main simulation techniques rely on econometric models or theoretical models with associated experimental designs.

SCHIP Expansion: Children

In the case of the SCHIP expansion for children we follow a multi-step procedure to generate enrollment figures. First, we fit econometric models over a sub-set of eligible children to predict the probability of enrollment in public insurance, enrollment in private insurance or being uninsured. Surveys employed for this purpose include the Current Population Survey March Demographic Supplements (public use versions), 1996-2002, and the Hawai`i Health Survey (confidential versions) 2000, 2001. Because sample sizes are small, we pool multiple years of these respective surveys in attempt to generate reliable estimates. Second, a similar model is estimated over a subset of ineligible children within the same survey samples. Third, we predict enrollment rates using the characteristics of the target population (i.e., children age 0-18 residing in households with incomes between 200% and 300% of the Hawai`i specific FPL) for both models. The difference in predicted values renders estimates, albeit potentially biased, of the take-up rate, crowd-out rate and percent newly insured. Finally, combining these estimates, with the weighted population figures from these same survey data, generates estimated head counts for new enrollees in SCHIP (take-up), children dropping private coverage (crowd-out) and children newly insured. Analysis is incomplete.

Because SCHIP in Hawai`i is administered as a Medicaid expansion, Medicaid capitation rates represent a good first approximation of the expected expenditures for those newly covered. (Medicaid in turn is administered as a managed care/managed competition scheme, under the acronym QUEST, with risk-adjusted capitation payments from the State of Hawai`i to three private non-profit insurers, HMSA, Kaiser and Aloha Care, which directly provide or further sub-contract care for able-bodied beneficiaries. Elderly, blind and disabled beneficiaries continue to be covered under the traditional Medicaid fee-for-service payment system.) One alternative method for estimating the direct cost of coverage involves the analysis of Medicaid encounter data that contains the universe of claims and utilization for extant beneficiaries. This information will be used to impute expenses for the target population based on the age-sex profile of this group. To the extent possible health status will also be used to predict costs for new beneficiaries. Similar methods will be applied to private health plan data for comparative purposes. Per capita expenditure estimates combined with the federal medical assistance percentage (FMAP) renders the respective contributions of federal and state taxpayers. The Hawai`i SCHIP FMAP for federal fiscal year 2003 is 71.14%, which represents a significant allure for Hawai`i policymakers seeking to expand coverage.

Uninsured children as a whole certainly receive some care and incur expenses in Hawai`i's health system. Therefore, the medical costs of the uninsured children need to be estimated and netted out from the total direct costs of expansion in order to produce an estimate of new resources necessary to cover uninsured children. For this purpose we utilize proprietary information in the form of emergency room and inpatient discharge, claims and payment data

from the vast majority of Hawai`i's hospitals. By matching the age-sex distribution of discharges of the uninsured with population-based estimates of the age-sex distribution of the uninsured, we compute synthetic utilization rates for our target population by age and sex. Applying these estimated utilization rates to the age-sex specific emergency room and inpatient charges incurred by the uninsured who seek care renders an estimate of the expected expenses incurred by a typical uninsured child in our target group (i.e., age 0-18, 200-300% FPL). Preliminary estimates render an amount of $188 per uninsured child in calendar year 2001. This figure, however, is an underestimate in that it is based on hospital charges only. Data acquisition from other providers, including primary care facilities is in progress. Similar methods will be applied to these data, which will help complete the estimates of medical resource use, by the uninsured.

SCHIP Adult Demonstration

One proposal under consideration in Hawai`i is an SCHIP adult demonstration. The proposal would extend free medical assistance to the parents of currently eligible SCHIP children. The target population is parents with SCHIP eligible children residing in households with family income between 100% and 200% of the Hawai`i specific FPL. Since adults aged 19-64 years residing in households with family income 0-100% FPL are typically eligible for Medicaid/QUEST subject to assets test, this demonstration represents an expansion for adult parents in households with incomes 100-200% FPL. Pregnant women with SCHIP eligible children, however, would only gain coverage if their family income was between 185-200% FPL, since current Medicaid eligibility rules cover such persons up to 185% FPL.

Here we begin with the SCHIP eligible children sub-set from survey samples, Current Population Survey (CPS) 1996-2002 and the Hawai`i Health Survey, 2000, 2001. We identify the households in which these children reside and the adults in these households. Approximately 80% of these adults are parents of the SCHIP children. We split the sample between eligible adults (FPL 0-100%) and ineligible adults (FPL 100-200%) and estimate models as described above. We then predict insurance coverage for the target population (i.e., SCHIP parents 100-200% FPL) using both models. The difference in predictions renders an estimate of the take-up rate, crowd-out rate and percent newly insured. Applying these rates to the survey-based estimates of the number of persons in the target population, renders the desired adult head counts.

Using this method, preliminary results based on the CPS are as follows. We estimate the number of SCHIP adults residing in households with family incomes between 100-200% FPL to be 35,756 based on a 7-year average. Before the proposed expansion our model-based estimates indicate 14.0% are uninsured, 80.2% have private, Medicare or military coverage and 5.8% are currently covered by State administered insurance through spend-down provisions, pregnancy, QUEST-net or other qualifications (although these are not identified). Our prediction of the impact of adult expansion is a 10 percentage point drop in the number of uninsured to 4.0%, 11.9 percentage point drop (crowd-out) in the number privately insured to 68.3% and an 21.9 percentage point increase (take-up) in public insurance to 27.7%. This implies 7,831 adults will become enrolled under an SCHIP demonstration. However, only 3576 persons will become newly insured, because 4,255 will have switch from their private coverage to free public coverage, representing a sizable crowd-out.

Assuming a direct cost to SCHIP of $3000 per adult per year and 7831 new enrollees implies an annual direct cost of $24,493,000 with $16,711,354 (71.14%) borne by federal taxpayers and $6,781,846 (28.86%) borne by state taxpayers. (These amounts should be adjusted downward for the indirect tax expenditure (tax subsidy) afforded employment-based insurance, which will be partially reduced due to crowd-out.) However, because of the substantial crowd-out, the public burden is estimated to be $6849 per newly insured adult per year with a federal burden and state burden of $4873 and $1976, respectively. These are the relevant figures for state and federal budgetary purposes. It should be noted that the net cost to society is considerably less, because the public sector burden in large part represents a reallocation of financing rather than an allocation of new resources. Our demographically based imputations render an expense of $388 per uninsured SCHIP adult per year in 2001 for ER and hospital inpatient services. Netting out these already incurred expenses and recognizing crowd-out as refinancing renders a net societal cost of $9,340,522 per year to cover 3576 newly insured SCHIP adults. Furthermore, because the Hawai`i SCHIP FMAP of 71.14% is considerable more generous than the federal tax break afforded private insurance, the net burden on the Hawai`i economy is likely to be negative. (This assumes, of course, no additional waste in health services due to the policy change.) This is the case precisely because crowd-out shifts a substantial portion of the burden of health insurance financing from Hawai`i households and private businesses to federal taxpayers. Policies that limit crowd-out will dampen this effect.

Medicaid/QUEST Expansion for Adults

Another proposal under consideration would increase the Medicaid/QUEST family-income upper limit eligibility criterion for adults aged 19-64 years from 100% FPL to 200% FPL (or 300% FPL with possible premium cost-sharing). We have produced preliminary estimates for the case where free medical assistance would be made available to all adults aged 19-64 with family income up to 200% FPL. Our initial estimates are based on 7 years of the Current Population Survey March Demographic Supplement 1996-2002. Based on these data we estimate that 127,349 additional adults age 19-64 are potentially eligible for free medical assistance under the Medicaid/QUEST expansion from 100% to 200% FPL. Our model-based estimates indicate that of the newly eligible adults, 38,205 are expected to be enrolled in Medicaid/QUEST. Of the newly enrolled Medicaid/QUEST beneficiaries, 34,297 adults are expected to have switched from private to public insurance (crowd-out) and only 3498 adults will become newly insured. Preliminary enrollment and crowd-out predictions are overestimates in that we are not able to properly apply the asset criterion in simulating eligibility. Nonetheless, our crowd-out estimate is remarkably large even at half the amount reported. We are in the process of validating this estimate with adult samples from the Hawai`i Health Survey 2000, 2001 and the Behavioral Risk Factor Surveillance System survey 2000, 2001. We are also revising our method to account for dual eligibility. The cost of expansion based on CPS estimates is reported below.

Assuming a capitation rate of $3000 per adult, a Medicaid/QUEST expansion from 100% to 200% FPL will generate direct cost per year equal to $114,615,000. Based on the federal fiscal year 2003 FMAP for Hawai`i of 58.77%, federal taxpayers will bear $67,355,415 while state taxpayers' direct burden is $47,259,585. The net societal cost is less than one-tenth this amount, $10,264,800. The net cost to society is based on expenses incurred by uninsured adults of approximately $400 per year and assuming the movement from private to public insurance is dollar for dollar with no loss in efficiency. As is the case in the SCHIP adult demonstration, Hawai`i households and private businesses will gain at the expense of federal and state taxpayers

as a shift from private to public financing occurs. The net cost to Hawai`i is likely to be negative as long as no substantial increase in waste occurs.

Uninsured Worker Pool

The initial proposal involves the imposition of an individual (household) mandate for the self-employed, sole proprietors and part-time workers (with possible mandatory inclusion of their dependents) under a publicly sponsored, privately-financed, privately-underwritten insurance pool. Although the operational details have yet to be formulated, the salient features of this plan are that participation is mandatory and financing is largely private.

Our initial analysis focuses on individual coverage for uninsured self-employed adults aged 19-64 years. We estimate the number of persons in our target population using two surveys, a 7-year average from the CPS 1996-2002 and the most recent year of the BRFSS which is 2001. These are the most appropriate surveys for this analysis. The CPS is a labor force survey and therefore is well designed to identify persons by type of employment. The BRFSS is a survey of adult individuals and therefore the respondent in each case is the adult in question. Our estimates of the number of uninsured self-employed persons aged 19-64 years are 17,175 based on the BRFSS 2001 and 11,838 based on the CPS 1996-2002. Our preliminary results are based on the BRFSS 2001 estimate, 17,175 adults aged 19-64.

Assuming a monthly individual premium of $283 and 100% compliance among the mandated self-employed implies an annual direct cost of $57,933,875 to insure 17,175 persons. It is intended that this amount will be financed through private premiums which will in-turn will be partially financed through the existing federal self-employed health insurance deduction. The federal health insurance deduction is scheduled to rise to 100% for tax year 2002. Self-employed persons can avoid significant federal taxes by utilizing the health insurance deduction. These include the Medicare Hospital Insurance (HI) federal payroll tax (2.9%), the Social Security Old Age Security and Disability Insurance (OASDI) federal payroll tax (12.4%) and the federal income tax (typically 15%). To receive this tax subsidy, which combined could easily be 30.3%, the self-employed must have taxable income and claim the deduction. If 20% of the self-employed are able to avail themselves of this deduction, $3,338,050 of the above premium cost will be financed through reduced federal tax liability. Our estimate of the medical resources used by uninsured self-employed adults $403 per person per year based on hospital ER and inpatient expenses alone. For 17,175 persons, this totals to $6,921,525 per year base on 2001 estimates. Netting out these amounts, implies $47,866,725 of new costs to be borne by Hawai`i.

Reform of the PHCA 1974

The Pre-Paid Health Care Act 1974 mandates (with some exceptions) employer-sponsored insurance for private sector employees engaged 20 hours or more per week by their employer. The Act also specifies that the employee's contribution cannot exceed 1.5% of cash wages. Private sector employers are typically contributing 90% toward single coverage and 70% toward family plan premiums (MEPS-IC 1999). Recent double-digit premium increases have generated renewed interest in examining the PHCA. Our analysis seeks to bring fact and reason to the discussion.

Our analysis is based on two separate, yet complementary, methodologies. First, we apply standard econometric methods to the Current Population Survey March Demographic Supplement 1996-2002 to examine the impact of the PHCA on hours-worked and insurance coverage. Controlling for industrial structure, we find that Hawai`i has significantly more employees working part-time (i.e., 0-19 hours) than the U.S. as whole. While the percent insured among full-time workers (i.e., 20 hours or more) in Hawai`i is significantly greater than the U.S. as a whole, no such difference is found for part-time workers. Based on these preliminary results, we conclude that PHCA has increased coverage but has also induced labor market sorting as some employers and employees seek to avoid the mandate.

Our second method is based on theoretical models and associated experimental market simulation conducted in an economics laboratory with human participants. Here we simulate labor market interactions with mandated benefits for full-time workers and no mandate for part-time workers as the baseline case corresponding to the status quo in Hawai`i. We then apply three additional treatments corresponding to possible reform scenarios: complete removal of the mandate; imposition of the mandate for all workers, part-time and full-time; and a sliding scale where employers are required to contribute to insurance in proportion to the hours worked. We compare these scenarios using three criteria: labor market efficiency, proportion of part-time workers employed, and insurance coverage rates among the employed. With regard to economic efficiency, having no mandate and the current 20-hour rule are equally efficient and significantly exceed the efficiency of a full mandate or sliding scale. This is because the 20-hour rule allows employers and employees to opt out by going part-time. Not surprisingly the partial mandate of Hawai`i's current 20-hour rule results in significantly larger proportion of part-time workers than the other three treatments. This is a result, which is consistent with our econometric analysis of survey data. The current 20-hour rule also increases the number of workers insured over the no mandate rule. It should be noted that all these results are based on competitive wage determination. Extended analysis will be undertaken to include non-competitive wage determination (e.g., minimum wage law) and interactions with premium cost-sharing rules. Further, more original software will be developed to simulate market outcomes.