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Goal

- To develop and propose viable health care coverage solutions for Hawaii's growing number of uninsured.

General Objectives

- Develop a comprehensive understanding of Hawaii'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 Hawaii residents.
- Report, communicate, and educate Hawaii's policy-making leadership and the general public of the issues, the research, potential solutions and the final proposal of solutions.

Team Overview: Key Players

The **Hawaii State Department of Health** has designated two research partners:

  - The **University of Hawaii's Social Science Research Institute** (SSRI) directs quantitative and qualitative research activities.
  - The **Hawaii Health Information Corporation** (HHIC) is responsible for data collection and storage.

The Hawaii 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 Hawaii Institute for Public Affairs.

Executive Summary

Background. In the 1980s, Hawaii's uninsured population was estimated at 5 percent – one of the lowest uninsured rates in the U.S. By 2004, the rate has increased to nearly 10 percent – approximately 112,000 people, according to data analyzed from the U.S. Census Bureau's Current Population Survey. However, the problem is larger than those who are directly affected. 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. Specifically in Hawaii, the Compact of Free Association allows migrants from compact nations to access Hawaii's health care system without having either public or private insurance coverage. Finally, while Hawaii's unique Prepaid Health Care Act (PHCA) requires employer-sponsored insurance for the majority of workers, those who are exempt from the PHCA – part-time public and private sector employees and sole proprietors – struggle to find affordable coverage options.

Coverage for All in Hawaii. Coverage for All in Hawaii is a statewide effort to develop and propose viable health care coverage solutions for Hawaii's growing number of uninsured. Quantitative research indicates that the uninsured are composed of: 26,000 children (birth – 18 yrs of age); 84,000 adults (age 19-64); and 2,500 adults (age 65 and above). A disproportionate number of uninsured reside on the islands of Hawaii, Kauai, and Maui, rather than on Oahu, 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 this past year, with support from the HRSA State Planning Grant, work groups comprising a broad spectrum of interests, were convened to develop policy options 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 the Compact of Freely Associated States

In each case, the work groups considered the data offered in several iterations and economic modeling conducted in consideration of various options.

The employed but uninsured work group surveyed various policy options and programs either being considered or implemented in other states, particularly those targeted for gap groups and small businesses. Because of the PHCA, the work group was constrained to develop something that would complement, rather than replace this cornerstone of health coverage. The work group, based upon the quantitative data produced for those not covered by the PHCA, deliberated over the development of a private insurance product, with various financing and administrative mechanisms proposed. However, data analysis that has yet to be fully explored indicates that the majority of the working uninsured in Hawaii should be enrolled in employer-sponsored coverage through the PHCA. This work group will continue to deliberate and explore additional options and data prior to offering a comprehensive policy solution.

Based upon the data provided with regards to those eligible for government insurance, the working group focused on expanding coverage for eligible adults and children have been combined, as the primary issue of additional state funding for both these programs needs to be considered in totality and as it affects both populations. During the 2004 legislative session, additional funds were requested and appropriated for SCHIP expansion. Modeling related to crowd-out and take-up indicates that if all children currently eligible for SCHIP were enrolled, the additional federal match would go a long way towards maximizing state funds. Further, administrative improvements through form simplification and passive enrollment have resulted in an additional enrollment of approximately 800 children per month in SCHIP. Thus, the additional funds will be tapped if this trend continues. Finally, as the state's Medicaid 1115 waiver is currently up for renewal, the Director of Human Services will be considering expansion options and has been provided data from the project to assist in their planning process.

The co-chairs of the safety net work group were successful in articulating its critical importance in the Coverage for All project. During this past legislative session, additional funds were requested and appropriated for the community health centers and to offer state-funded coverage to pregnant immigrant women. While there is no federal match for pregnant immigrants, data and research provided by the Department of Health clearly substantiates the role of insurance coverage in participation in prenatal care. Therefore, investment of state funds in this area will go a long way toward healthier pregnancies and birth outcomes.

The compact of free association work group was successful in communicating the need for additional federal funds through compact impact aid to assist with the unfunded health care services provided to compact migrants who are not required to have government nor private health insurance coverage. The work group, in consultation with representatives of Hawaii's congressional delegation and appropriate federal agencies, will be working with health care facilities and providers to develop a more effective method of data collection to more accurately reflect the amount and total costs of these uncompensated services. A policy brief was developed by the group and will be distributed to appropriate key influencers and stakeholders.

Finally, a work group representing a broad spectrum of business and community organizations convened to identify the most pressing challenges of the administration of Hawaii's Prepaid Health Care Act of 1974 (PHCA). Due to the diversity of opinions within the work group, the role of the group was limited to identifying the parts of the PHCA which present the greatest challenge within today's health care environment, given that the PHCA may not be amended by the state legislature, but would require Congressional approval. The group concluded its deliberations in late May 2004, from which a historical brief and a policy research brief have been developed. The historical brief is attached and the policy research brief has been recently completed and is awaiting comment from group members prior to final distribution.

Next Steps. In addition to continuing to analyze relevant data and modeling for policy options, further analysis of data regarding uninsured workers and community education and engagement on this issue is critical to achieving success.

In October 2004, several national consultants will be working with the HUP leadership group to further evaluate and develop private and public insurance options for gap group workers not

covered by the PHCA. Also, these national experts will present their latest research and critical analysis of Hawaii's PHCA to a gathering of business and community leaders, health care industry representatives, and key stakeholder groups. A diverse representation of members of the leadership group and the work groups will comprise a panel of local experts who will engage with the national experts in a public dialogue about the PHCA, sharing their concerns and their reasons for supporting it.

As we head into 2005, we will connect with key business and community groups through speaking engagements, to raise awareness about the Coverage for All project and the various policy options. We will also participate in educational briefings with executive administration and legislative leaders to emphasize the need for government support of the safety net and government insurance, as well as employer-sponsored and individual private insurance options.

Section 1
UNINSURED INDIVIDUALS AND FAMILIES

QUANTITATIVE RESEARCH

The University of Hawaii Social Science Research Institute (UH SSRI) produces survey-based estimates of the number and characteristics of the uninsured population in Hawaii drawn from three sources:

- the U.S. Census Bureau, Bureau of Labor Statistics, Current Population Survey (CPS) Annual Social and Economic Supplement (ASES) 1994-2003 and 2004 March estimates,
- the Hawaii Health Survey (HHS) 1997-2002, and
- the Behavioral Risk Factor Surveillance System (BRFSS) survey 1994-2002.

All three are designed to support state-level estimates. The HHS is also designed for limited county-level estimates. Because the BRFSS only surveys adults, overall population estimates and estimates of children are derived from the HHS and CPS. Throughout, point estimates and standard errors are computed with due consideration for the respective survey designs.

It is well known nationally that different survey instruments render considerably different estimates of the uninsured at the State level. Hawaii is no exception in this regard. For calendar year 2002, the CPS, Behavioral Risk Factor Surveillance System (BRFSS) Survey (which only surveys adults) and Hawaii Health Survey (HHS), render estimates of 10.0%, 8.6%, and 4.8%, respectively. This variation in uninsured rates across survey instruments is quite common and comparable to results seen in other states.

Because the U.S. Congress relies on estimates produced by the U.S. Census Bureau and because it is uniformly implemented throughout the 50 states, the CPS data provides the most recognized, frequently quoted and easily comparable estimates for national and state policy makers. Furthermore, there is no data source available in Hawaii which combines information on insurance coverage, family income and labor market activity as comprehensively as the CPS.

Overall Level of Uninsurance

The most recent estimate of the percent of the population without health insurance comes from the CPS ASES March 2004 estimates released August 2004. These estimates indicate that approximately 127,000 persons, representing 10% of Hawaii's population, were uninsured in 2003.

The Hawaii sample of the CPS typically does not exceed 3,000 persons, so the estimates are produced with a fair amount of sampling error. The estimated head count of the uninsured is produced with a standard error of 9,000 persons and the estimate of the percent uninsured is

produced with a standard error of 0.7 percentage points. Therefore, there has been no detectable change in the rate of coverage for the past several years.

Characteristics of the Uninsured

The UH SSRI also produces multi-year estimates based on CPS micro-data public use files released by the U.S. Census Bureau, the Hawaii Health Survey (HHS) 1997-2002, and the Behavioral Risk Supplement 1996-2002. Highlights of the findings are outlined below. Detailed estimates are included in: "*Uninsured Population: Hawaii*" by Gerard Russo, Ph.D., et al., September 17, 2004 (Appendix A) and *"Uncovered Workers in Hawaii – Part-Time, Full-time and Self-Employed: Estimates from the Current Population Survey (CPS) 1994-2003"* by Sang-Hyop Lee, Ph.D., et al., September 17, 2004 (Appendix B).

Age distribution. A ten-year average based on the 1994-2003 CPS renders an uninsured rate of 9.5% or 113,000. Of these uninsured, approximately 26,000 are children aged 0 to 18 years, 84,000 are adults aged 19 to 64 years, and less than 3,000 are individuals aged 65 years or more.

Income. More than half of uninsured adults aged 19-64 are below 200 percent of the Federal poverty level (FPL). Approximately 24,000 are between 1-100% of the FPL, 23,000 are between 101-200%, 14,000 between 201-300%, and almost 23,000 are above 300% (CPS 1994-2003 average).

Gender. In Hawaii, males are more likely to be uninsured than females. An analysis of the CPS reveals that approximately 11 percent of the male population in the state is uninsured compared to 8 percent female (CPS 1994-2003 average).

Family composition. Approximately 35,000 uninsured adults aged 19-64, (about 40%) have children, and about 49,000 are without children (CPS 1994-2003 average).

Employment status. Analysis of the CPS data also reveals that a significant percentage of full-time workers are uninsured. Of the 84,000 uninsured adults aged 19-64, 44,000 were employed full-time (working 20 hours or more per week). Approximately 12,000 were self-employed, 5,000 worked part-time, and the employment status of the remaining 23,000 is unknown.

Race/Ethnicity. Hawaii residents of Japanese and Chinese ethnicity tend to have high coverage rates, while Native Hawaiians and Caucasians are more likely to be uninsured. There is some evidence that this is due to differences in unemployment rates, as employment and coverage are highly correlated. Native Hawaiians comprise approximately 30 percent of the uninsured population in Hawaii (HHS 2001).

Geographic location. The uninsured rate for the counties of Hawaii, Kauai, and Maui is 11.4 percent, higher than the uninsured rate for the City and County of Honolulu, at 8.9 percent. Nearly 30 percent of the total uninsured reside in the counties of Hawaii, Kauai, and Maui (CPS 1994-2003 average). Multi-year estimates produced by the HHS (1997-2002 average) and BRFSS (1994-2002 average) indicate that the percentage of the total uninsured residing in these counties is much higher, at 40 and 36 percent, respectively. It should be noted that these island

counties represent approximately 28 percent of the state's total resident population (U.S. Census Bureau).

Target populations. Although Hawaii's Prepaid Health Care Act (PHCA) mandates that employers provide health insurance coverage for their employees working 20 hours or more per week, a significant number of full-time workers remain uninsured and the number appears to be rising. In addition, those working part-time (less than 20 hours per week) and the self-employed, groups excluded from the mandatory coverage provisions of the PHCA, make up a large proportion of the uninsured population. Together, these groups comprise over 50 percent of the total number of uninsured in Hawaii, and significant effort was made to analyze the barriers to coverage for these groups and to develop workable solutions and options.

QUALITATIVE RESEARCH

In 2003, the UH SSRI conducted interviews of 188 uninsured persons and 21 providers on the islands of Oahu, Maui, Kauai, Molokai, and Hawaii to understand the reasons they are uninsured, the means by which they obtain and pay for health care, the barriers they face, and how uninsurance impacts families, the health care system, and the state. Analysis has been completed and the full report, "*Final Report, Qualitative Research Findings*" by the UH SSRI, dated June 1, 2004, is attached as Appendix C. The following themes have emerged:

Participation in Public Programs. The QUEST application process is very demanding and often beyond the applicants' ability, and the effort to maintain coverage is often as difficult as the initial application. A discontinuation of coverage often causes health problems due to interrupted treatment.

Barriers to Purchasing Insurance. Those near or below the federal poverty level cannot afford commercial coverage. 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 (including COBRA and transitional programs) is almost always seen as a "mystery" in terms of what is and is not covered.

Obtaining Health Care. Uninsured persons in Hawaii often delay care and wait for the next medical crisis before seeking care. Most have medical bills as a major debt and many feel that they are not treated equally be medical staff. Patients often feel embarrassed and unwelcome because of their lack of coverage, perceive a different care standard, and feel there is no one they can talk to.

Additional Challenges. There is a continuing and serious need for dental services within this group. Other problems include transportation, paying for expensive medications, keeping track of renewal issues, bill paying, and in general, surviving. Few social and health services offer support and assistance directly to the uninsured.

Coverage is Confidence. To the uninsured, coverage means confidence to send children on field trips, to walk into a clinic of hospital with dignity, to be assured of equal treatment, and to know that the remaining assets they own will not be taken from them.

Hawaii'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.

Impact of the Uninsured on Providers. Interviews with providers highlight the impact on the individuals, families, the safety net, the costs and who pays. Data collection and analysis is complete and results indicate the following:

- Safety net facilities are losing money caring for uninsured patients and consider Medicaid and Medicare reimbursements too low to cover costs.
- Many providers express frustration over working with the uninsured. They say their diagnostic ability is limited and uninsured patients often experience poor outcomes.
- Many providers have sliding fee scale plans, provide free care and drugs, and may utilize rural health funds to provide limited care. Hospitals provide 'charity care."
- Providers want affordable comprehensive coverage for patients, solve QUEST problems, more community health centers, payment plans for patients, health promotion and disease prevention to prevent avoidable health problems.
- Loss of cultural identity and access to land and water are seen as health risk factors for native Hawaiians with inadequate services contributing to poor health indicators.
- Diabetic patients experience avoidable complications because they can't afford care.
- Patients transitioning between QUEST and Social Security Disability Insurance (SSDI) often experience problems. Physicians often advise patients not to apply for SSDI.
- Safety net providers are creative in helping patients enroll in QUEST
- Providers clearly describe the suffering of those they treat. More than one physician believes their patient died as a result of being uninsured.

In August and September 2003, Ward Research, Inc., a market research firm based in Honolulu, Hawaii, conducted statewide telephone surveys and focus groups of:

- employers,
- the self-employed, part-time workers and other employees not covered by the PHCA, and

- the general public

to examine their opinions and behaviors related to health insurance coverage. Complete results are available in: "*Uninsured Workers in Hawaii,"* Ward Research, Inc., October 2003 (Appendix D).

For the Work Force Survey, 300 self-employed persons, 203 part-time employees, and 93 other employees not covered by the PHCA between the ages of 18-64 years old were interviewed. The following are highlights of the results:

Health Insurance Preferences of the Uninsured

- **Cost of insurance:** Both insured and uninsured workers prefer high deductible plans and are willing to pay more up front for services and have a lower overall cost. When asked how likely they would be to pay $195 per month for a health insurance plan that covered doctor visits, hospital costs, drugs, dental, and vision, approximately half of the self-employed and part-time uninsured surveyed that are currently not eligible for coverage under the PHCA stated that they "definitely" or "probably" would.

- **Prioritizing additional coverage:** In terms of prioritizing additional benefits outside of medical coverage, 50 percent of uninsured workers believe that dental insurance is the most important, with 37% opting for drug coverage.

- **Obtaining medical coverage:** More than half of the self-employed and part-time persons stated that they do not have a regular place to go for medical care. If they did seek care, self-employed persons were likely to go to a doctor's office rather than a community clinic. Part-time workers were more likely to access care from a public health or community clinic and would pay with cash, check, or credit card.

- **Tax incentives**: Approximately 60 percent of the uninsured self-employed persons surveyed indicated that they were "extremely" or "somewhat" interested in a government program that would allow them to receive partial payment for insurance costs up front.

- **Tax increase:** Over half of the self-employed, part-time workers, and others not covered by the PHCA reportedly would accept a tax increase to expand coverage, with part-time workers offering the most support. All respondent categories offered even more support for a tax increase to expand children's coverage.

Ward Research's General Public Survey included interviews with 602 Hawaii residents between the ages of 18-64 who are working 20 or more hours per week, the unemployed and those not working, retirees, full-time students, and unpaid workers for a family business. The following are the highlights of the responses from this group.

- **Cost of insurance:** The uninsured general public would be willing to pay an average monthly premium of $48 that covered doctor visits and hospital costs, and $71 per month

for insurance that included drugs, vision, and dental insurance. They would also be willing to pay $15 for each doctor visit. Compared to the more than 50 percent of the working uninsured who are willing to pay $195 per month for insurance that covered doctor visits, hospital costs, drugs, dental, and vision, only 30% of the uninsured general public respondents said they would "definitely" or "probably" pay $195 per month for insurance. Regardless of insurance status, the majority in this group would prefer a higher deductible and lower overall premium.

- **Prioritizing additional coverage**: Dental and drug coverage are valued equally, with 40 percent choosing dental insurance as the most important and 40 percent choosing prescription drug coverage as the most important.

- **Obtaining medical care:** The most common location for medical care for the uninsured general public was a doctor's office (47 percent) with almost half that many (24 percent) seeking care in community clinics.

- **Tax increase**: Both the insured and uninsured General Public agreed when asked about accepting a tax increase to insure more children, and they similarly agreed that all children should have health insurance (86 and 80 percent completely agree, respectively).

Section 2
EMPLOYER-BASED COVERAGE

Hawaii is the only state in the nation with a law mandating that employers provide coverage for their employees. Under the Prepaid Health Care Act of 1974 (PHCA), employers must provide coverage for any employee who works 20 hours a week or more, and they must cover a portion of the employee's individual premium so that the employee's share is no more than 1.5% of her/his annual wages. Excluded from provisions of the Act are state and federal government employees, seasonal agricultural workers, sole proprietors, individuals working on commission and recipients of government assistance. Employers are free to provide more than the law requires. For example, employers often make coverage available for spouses and dependents.

In 1977, Standard Oil Company of California filed suit against the State of Hawaii claiming that the federal Employee Retirement Income Security Act of 1974 (ERISA) prohibited state regulation of self-insured employers. Hawaii lost the case in 1977, lost again on appeal in 1980 and failed to get the U.S. Supreme Court to hear the case in 1981. With the PHCA deemed unlawful by the courts, the only hope for its survival was in the hands of Hawaii's congressional delegation. After tremendous effort on their part, an exemption to ERISA was granted to Hawaii in 1983. This reaffirmed the PHCA as the law of Hawaii. However, the exemption included language that would prevent any substantive changes to the PHCA. In effect, the law is frozen in its 1974 form.

Thus, the PHCA has been the cornerstone of health coverage in Hawaii, providing for unparalleled health benefit equity in a process with minimal costs for government oversight.

QUANTITATIVE RESEARCH

The UH SSRI data also analyzed the CPS data regarding the number of uninsured workers in Hawaii. As stated previously, approximately 84,000 individuals, representing 75 percent of Hawaii's uninsured population, are adults between the ages of 19 and 64.

- 12,000 are self-employed (14 percent),
- 5,000 work part-time (1-19 hours per week) (0.5 percent),
- 44,000, or work full-time (20+ hours) (52 percent)
- The remaining 23,000 are students or individuals who are not working (27 percent).

Interestingly, although the PHCA requires employers to provide health care coverage to employees working 20+ hours per week, the data indicates that a significant number of working uninsured are working full-time and should be covered.

Industry. Analysis of the CPS data (1994-2003 average) reveals that 70 percent of the working uninsured in Hawaii are employed in the wholesale & retail trade and service industries.

Percentage of Part-Time Workers. Researchers also reviewed the effect of the PHCA on the percent uninsured relative to the U.S. and several individual states (Nevada, Michigan,

California, Florida). Using the CPS data (1994-2003 average), we have concluded that the PHCA has shifted the distribution of employees by hours worked. Hawaii has a significantly higher percent distribution of employees working less than 20 hours a week, suggesting that there may be substantial eligibility avoidance by the employer. However, the PHCA mandate has increased the employer-provided coverage for those working 20 hours or more per week in comparison to the US and selected states. See *"The Effect of Mandatory Employer-Sponsored Insurance (ESI) on Health Insurance Coverage and Employment in Hawaii: Evidence from the Current Population Survey (CPS) 1994-2003"* by Sang-Hyop Lee, Ph.D., et al., September 17, 2004 (Appendix E).

Employer Size. In 2002, 100 percent of private employers in Hawaii with 100 or more employees offered health insurance to their employees. This compares to 95 percent of employers in the U.S. overall with 100-999 employees and almost 99 percent of employers with 1000+ employees. However, for small employers with less than 10 employees, 83 percent of Hawaii employers offered health insurance compared to 37 percent of U.S. employers. More details are available in *"Hawaii Employer Sponsored Health Insurance: MEPS-IC 2002"*, Gerard Russo, Ph.D., September 17, 2004 (Appendix F).

QUALITATIVE RESEARCH

The Ward Research Employer Survey results provided information about employer attitudes and behaviors about health insurance for their employees. 451 employers were surveyed, including interviews with 278 small business employers (1-19 employees), 108 medium businesses (20-99 employees), and 65 large businesses (100+ employees).

Decision to Offer Coverage. The top five reasons employers offer health insurance to the employees:

- Required by law (70 percent)
- Employee needs it (36 percent)
- Retain employees (9 percent)
- Company responsibility (8 percent)
- Reduce absenteeism (6 percent)

Coverage Features. If the PHCA did not mandate employers to provide health care coverage, 62 percent of Hawaii employers claimed that they would continue to offer their employees the same benefits. However, if given the freedom to create their own policies, almost 23 percent would make employees pay a larger share of premium costs. Another 13 percent would discontinue health insurance benefits entirely, and 12 percent would prefer to compensate employees in other ways (e.g., pay directly for medical costs). Other changes include designing a less expensive plan (11 percent) and reducing coverage (10 percent).

Insuring Part-Time Employees.

Although the law does not require them to do so, 13 percent of employers surveyed indicated that they provide health insurance to their employees working less than 20 hours per week. Of the employers who do not offer insurance to their part-time employees, 44 percent stated that they do not offer insurance because of cost. 27 percent stated that their employees access health

coverage elsewhere and 24 percent stated that the law does not require it of them. 12 percent felt that the cost to insure part-time workers outweighed the benefits, stating that there is little value to insuring them, the employees are not working or contributing enough to justify the costs, or high employee turnover.

Section 3
HAWAII'S HEALTH CARE MARKETPLACE

Hawaii's Health Care Marketplace. More than 90 percent of Hawaii's insured receive health care coverage from two principal sources – the Hawaii Medical Service Association (HMSA) Blue Cross/Blue Shield of Hawaii, a mutual benefit society, and Kaiser Permanente, an HMO. In 2003, both have proposed double-digit premium increases. Although generally lower than on the U.S. mainland, Hawaii premiums continue to escalate due to rising costs of care and higher utilization.

Hawaii'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 Hawaii 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 corroborated by the results of econometric analysis and experiments.

Employer-Based & Government-Sponsored Options. As in other states, health care coverage in Hawaii is a mix of employer and government programs. Since state law mandates employer-based health insurance, most of Hawaii'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 aged 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, Hawaii 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. Hawaii has not received any substantial federal compensation or reimbursement for services provided to CFA migrants. This

has placed a tremendous strain on Hawaii's healthcare system, and government programs such as Medicaid.

Key Stakeholder Perspectives: Employer & Government. In the 1970s, the PHCA 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. Hawaii 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 Hawaii 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.

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. Hawaii 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 by 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 may have little room to maintain – much less expand – coverage for the uninsured.

Section 4
OPTIONS AND PROGRESS IN EXPANDING COVERAGE

Uncovered Workers: On the Job but Uninsured in Hawaii

Target Group. People who are employed make up the largest percentage of Hawaii's uninsured population. According to the estimates based on the CPS 1994-2003 multi-year average, 15 percent of the total number of uninsured are working part-time (less than 20 hours per week) or 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 Hawaii's Prepaid Health Care Act. Interestingly, however, CPS data also reflects that 39 percent of the uninsured are full-time employees who should be covered under the requirements of the PHCA.

Policy Options. The work group surveyed various policy options and programs either being considered or implemented in other states, particularly those targeted for gap groups and small businesses. Because of the PHCA, the work group was constrained to develop something that would complement, rather than replace this cornerstone of health coverage. A number of alternatives have been discussed, ranging from coverage for all employees on a sliding scale based upon hours worked, a full mandate that would require everyone to have coverage, health savings accounts and medical savings accounts, to a state-sponsored sliding scale program in which government pays for certain populations and those with higher incomes can fully buy in.

However, data analysis that has yet to be fully explored indicates that the majority of the working uninsured in Hawaii should be enrolled in employer-sponsored coverage through the PHCA. This work group, therefore, will continue to deliberate and explore additional options and data and discuss this issue with several national experts in October 2004, prior to offering a comprehensive policy recommendation.

Expanding Enrollment in Government-Sponsored Programs

Target Group. An estimated 20 percent of Hawaii's uninsured (about 26,000 adults) are eligible for government-sponsored coverage, but are not enrolled. Recent estimates suggest that more than 14,000 children in Hawaii are eligible but not enrolled in QUEST or Medicaid programs.

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.

Policy Options. Based upon the data provided with regards to those eligible for government insurance, the working groups focused on expanding coverage for eligible adults and children

have been combined, as the primary issue of additional state funding for both these programs needs to be considered in totality and as it affects both populations.

Potential coverage expansion continues to be explored, but as with other states, funding remains a critical factor in the feasibility of this option. In comparison to funding cuts experienced in other states and despite fiscal challenges, additional funds were provided by the 2004 Hawaii Legislature to increase enrollment in SCHIP. Modeling related to crowd-out and take-up indicates that if all children currently eligible for SCHIP were enrolled, the additional federal match would go a long way toward maximizing state funds. Thus, the additional funds will be tapped if this trend continues.

Further, administrative improvements have resulted in an additional enrollment of approximately 800 children per month in SCHIP. Through the efforts of the Hawaii Department of Human Services and the Hawaii Covering Kids initiative, a simplified Med-QUEST application form for children and pregnant women has been created. The form, available in January 2004:

- Eliminates the requirement to provide information on absent parents
- Eliminates questions that do not pertain to children and pregnant women
- Includes a request for bilingual and sign interpreter services in fifteen languages
- Provides information on Early and Periodic Screening, Diagnosis, and Treatment (DPSDT) services
- Provides helpful question and answer handout with list of resources.

In addition, as of September 2003, women can self-declare their pregnancy status – proof of pregnancy is not required. Beginning June 2004, a passive renewal process has been put into place to help retain eligible children and youth in Medicaid and QUEST programs.

Finally, as the state's Medicaid 1115 waiver is currently up for renewal, the Director of Human Services will be considering expansion options and has been provided data from the project to assist in their planning process.

Expansion & Enhancement of the Safety Net

Target Group. 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.

Policy Options. The co-chairs of the safety net work group were successful in articulating its critical importance in the Coverage for All project. During this past legislative session, additional funds were requested and appropriated for the community health centers and to offer state-funded coverage to pregnant immigrant women. While there is no federal match for pregnant immigrants, data and research provided by the Department of Health clearly substantiates the role of insurance coverage in participation in prenatal care. Therefore, investment of state funds in this area will go a long way toward healthier pregnancies and birth outcomes.

Community representatives are continuing to develop solutions for expanding and strengthening safety net services. General public education on the safety net's community value with a data-supported position statement may help these providers to obtain increased funding support. Interest has also been expressed in doing a cost-benefit analysis that would "prove" the safety net's value. Finally, targeted education of policymakers about the need for a stable source of continued funding was successful in obtaining increased funding during the last legislative session.

Uninsured Compact Citizens Who Use Hawaii's Health Care Services

Target Group. Hawaii is unique with respect to the number of migrants from the Compacts of Free Association (CFA) states. The CFA is an international agreement between the U.S. government and certain Pacific Island nations including the Republic of the Marshall Islands, Federated States of Micronesia, and the Republic of Palau. In exchange for certain strategic and defense interests and privileges, the CFA provides certain rights and privileges to these citizens, including the right to reside and work in the U.S., and access to services such as health care and public education.

An estimated 6,000 to 8,000 CFA migrants are currently in Hawaii. Most CFA migrants are below the federal poverty level. In 2002, the State of Hawaii spent more than $32 million in migrant assistance.

Policy Options. During this time, the Compact has been renegotiated, and in December 2003, federal legislation to provide Compact Impact Aid was authorized, and Hawaii will be receiving additional funds in 2004, of which a substantial portion will be allocated to health care services for this population. The work group, in consultation with representatives of Hawaii's congressional delegation and appropriate federal agencies, will be working with health care facilities and providers to develop a more effective method of data collection to more accurately reflect the amount and total costs of these uncompensated services. A policy brief describing this issue, "*Impacts of the Compact of Free Association on Hawaii's Health Care System"* is attached as Appendix G.

Prepaid Health Care Act: Understanding Its Impact on Hawaii

Issue Identification. Hawaii's Prepaid Health Care Act (PHCA) is the only mandate in the nation that requires employers to provide their employees who work 20 hours per week or more 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 Hawaii 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.

Under the PHCA, the employer must provide for a share of the premium such that the employee's contribution is not more than 1.5% of the employee's wage. Since 1974, health plan costs have escalated 1150% while the minimum wage has increased only 260%; as a result, employers have had to shoulder a larger portion of health care costs or change labor hours to avoid the requirements of the PHCA. This has brought about calls for change from all sides, but the risk of the loss of Hawaii's ERISA waiver brings us here today—Hawaii realizes that it must come together on this issue, using data and community collaboration and avoiding haphazard, politically motivated approaches.

Policy Options. While the PHCA remains controversial, UH SSRI analysis validates the following assumptions:

- In the absence of the PHCA, Hawaii's uninsured rate would be substantially higher.
- The PHCA appears to create an abundance of part-time jobs for which employer-sponsored health insurance is not required.

The PHCA work group represents a broad spectrum of business and community. Due to the diversity of opinions within the work group, the role of the group was limited to identifying the parts of the PHCA which present the greatest challenge within today's health care environment, given that the PHCA may not be amended by the state legislature, but requires congressional approval. The group concluded its deliberations in late May 2004, from which a historical brief and a policy research brief have been developed. The historical brief, *"A Historical Overview of Hawaii's Prepaid Health Care Act"* is attached as Appendix H, and the policy research brief has been recently completed and is awaiting comment from group members prior to final distribution.

To date, the HUP Leadership Group has not reached consensus as to what changes, if any, need to be made to the PHCA. The project has tabled discussion on specific amendments, repeal, or other changes to the Act. The project will continue to seek a greater understanding of the law – how it is implemented, labor market effects, and interaction with new ideas for improving access.

SECTION 5.
CONSENSUS BUILDING STRATEGY

Governance Structure. *Coverage for All* is Hawaii's statewide planning effort to develop and propose viable health care coverage solutions through a dynamic and interactive engagement of research and community leadership.

- **Project team**. The project team includes:
  - State of Hawaii - Department of Health;
  - University of Hawaii - Social Science Research Institute (UH SSRI);
  - Hawaii Health Information Corporation (HHIC); and
  - The Hawaii Uninsured Project, Hawaii Institute of Public Affairs (HIPA).

Ms. Loretta Fuddy, Chief of Family Health Services Division, Department of Health, serves as the principal investigator for the State Planning Grant. Family Health Services Division (FHSD) is the Departmental lead for assurance of services for the safety net population of Hawaii. FHSD is the agent for Primary Care and Title V activities within the state. As in the past the Department will contract out the majority of the funding to its primary partners, UH SSRI, HHIC, and HIPA, to continue the data analysis and policy development.

The HHIC provides access to CMS and medical utilization data as well as the cleaning and processing of that data as well as survey data from the Hawaii Department of Health. The UH SSRI provides comprehensive analysis of the Current Population Survey, Annual Social and Economic Supplement (1996-2003), Hawaii Health Survey 1996-2002, the Behavioral Risk Factor Surveillance System Survey and the Medicaid data.

A major effort was made to ensure that the core of volunteer leaders in the project's work groups represent a diversity of perspectives and interests. Policy ideas and potential solutions are shared and analyzed by more than 60 organizations, whose goal is to design equitable plans for health coverage expansion. HIPA will continue to manage the five stakeholder work groups to address the issues of the uninsured for the employed but uninsured, the Medicaid eligible but un-enrolled, including children, and the safety net population. In addition other stakeholder group examined the issues of the Hawaii Prepaid Health Care Act, and members of the Compact of Freely Associated States.

A leadership group was formed to provide guidance and community support for the project. Stakeholders include a broad cross section of the community: health care providers, heath care insurers, labor unions and trade organizations, small and large business, academia, nonprofit and community organizations, government officials, and consumers. A listing of the members of the leadership group and work groups can be found in Appendix I.

Public Input and Awareness. In order to educate key stakeholders and build public awareness and support, the project has approached reporting and communications in a number of ways.

- **Community Relations.** A comprehensive plan was completed, and has included activities involving the media and participation in Cover the Uninsured Week 2004, including proclamations from the Governor and Mayors of all four Hawaii counties. A report to the community, "*On Common Ground,"* was published and released in April 2003, summarizing the work of the project, outlining key issues, and suggesting strategies for improved coverage. This report was distributed to key community stakeholders, opinion leaders, and policy makers, and a copy is attached as Appendix J.

- **Public Forums.** A major stakeholder gathering was held on October 29, 2003 and was attended by nearly 200 statewide leaders, including the Governor, members of her cabinet, and members of the Hawaii State Legislature. Advocates, care providers, insurers, state agencies, academia, labor, and business were all represented. It featured research presentations on Hawaii's uninsured, a showcase of national health policy experts, and presentations on policy scenarios.

  On October 13, 2004, a public policy forum on health care, "The Costs and Benefits of Health Care Coverage in the 21st Century," targets business and health care industry leaders to provide details about and receive response from business and community leaders about proposals to address the working uninsured.

- **Briefings.** In the first quarter of 2003, the project team met with the Governor's senior policy advisor, who expressed support for the project's intent. Informational briefings were also conducted in February 2003 and April 2004 to key legislative committees in the State House of Representatives and Senate.

- **Newsletter.** In April 2003, we published our first community newsletter to educate the community of our work and focus. Several editions of the newsletter have been distributed on a quarterly basis.

- **Technical Workshops.** Six technical workshops have been held to report research findings to community leaders, work group members, and government officials. The most recent workshop was held on September 17, 2004.

- **Website.** As a means to share information about the progress of the project and educate the community, a website was established in June 2003: www.healthcoveragehawaii.org.

Section 6
LESSONS LEARNED AND RECOMMENDATIONS TO STATES

Importance of State-Specific Data and Qualitative Research. The award of continuation funds and a no-cost extension makes it possible to complete activities involving broad-based community collaboration and commitment to develop policies to increase health insurance coverage in Hawaii. The Hawaii Uninsured Project will be conducting meetings of stakeholders and the community to disseminate information and further consensus. In addition, other partners, SSRI and HHIC, will continue data analysis and dissemination of results.

A hallmark of the HRSA SPG as executed in Hawaii is broad-based policy deliberations founded on fact and reason. An important input into those deliberations has been research results produced by the University of Hawaii in collaboration with the Hawaii Health Information Corporation, under the direction of the Hawaii Department of Health and in consultation with the Hawaii Uninsured Project. During the first two years of the Hawaii HRSA SPG research was conducted to characterize the uninsured and to model the impact of various proposed and existing public policies designed to extend or maintain health insurance coverage. A wide variety of research methods were employed including ethnographic research based on one-on-one interviews with uninsured individuals, statistical and econometric analysis of survey, health plan and hospital discharge data, theoretical analysis of labor market and health insurance interactions, and economic experiments conducted in a laboratory setting to micro-simulate employer mandates. Results were presented to the Hawaii Uninsured Project work groups and leadership group meetings and at other community venues as policy deliberations proceeded.

During the continuation period September 1, 2004 – August 31, 2005, updated survey data, including the Current Population Survey, Annual Social and Economic Supplement (Demographic Supplement) public use version March 2004, Hawaii Health Survey confidential version 2003, and the Behavioral Risk Factor Surveillance System confidential version 2003, will become available for analysis. These updated data are expected to reflect an improving Hawaii economy, favorable labor market conditions and successful enrollment of SCHIP eligible children. Policymakers, community leaders, and key stakeholders all demand the latest information available on the number and characteristics of the uninsured as well as the demographic and economic impacts of past and proposed policy changes. During the no-cost extension period, a pending application to access the National Health Interview Survey confidential version with state identifiers will also come to fruition. This will further enhance the project's analytical capabilities with regard to health status, utilization and coverage and provide an instrument for further validating other survey estimates.

In addition to analysis of these survey data, a no-cost extension will provide time to conduct modeling based on Hawaii's Medicaid Analytical Extract (MAX) Files made available through a special data use agreement with the Centers for Medicare & Medicaid Services (CMS) with the support of HRSA. These include the entire set of records on enrollment, utilization and claims

for all Hawaii Medicaid, QUEST and SCHIP beneficiaries and provide the foundation for simulating the expected expenditures associated with proposed public insurance expansions. Thus far, the Hawaii Health Information Corporation (HHIC) has received Hawaii Medicaid data for 1999. However, updated analysis will include micro-level Medicaid data through 2002, which is scheduled for availability during the 2004-2005 continuation period. Similar health plan data from Hawaii's two largest private insurers is slated for continued analysis and will support costs simulations under privately financed scenarios. The project has received unprecedented access to confidential and proprietary health plan data which affords policymakers information on health insurance generally unavailable for discussion and decision making. Updated and enhance analysis will be undertaken during the 2004-2005 project continuation and no-cost extension period.

With the cooperation of federal and state agencies, private insurers, community groups and partner organizations the HRSA SPG project in Hawaii has acquired and analyzed a vast array of data. This data base will be further enhanced and updated (under the Continuation Grant funds) and analysis will be undertaken during the no-cost extension period on the following sources.

- Current Population Survey (CPS), March Demographic Supplements, 1988-2004.
- Hawaii Health Survey (HHS) 1997-2003.
- Behavioral Risk Factor Surveillance System (BRFSS) Survey 1994-2003.
- National Health Interview Survey (NHIS) 1997-2002.
- Pregnancy Risk Assessment Monitoring System (PRAMS) Survey 2000-2002.
- State and Local Area Integrated Telephone Survey (SLAITS) 2000-2002.
- CMS Medicaid MAX Files Hawaii 1999-2002.
- Private Health Plan Data 1999-2000.
- Community Health Centers' UDS data 1999-2002.
- Medical Expenditure Panel Survey – Insurance Component (MEPS-IC) 1999-2002.

These data will support further characterization of the uninsured population in Hawaii and provide the raw input for economic models and micro-simulation of proposed policy scenarios. Under the direction and leadership of the Hawaii Department of Health, the Hawaii Uninsured Project has set five priorities for 2004-2005. These are health insurance coverage for every child; enrollment of adults who are eligible for public insurance; expansion of coverage for adults where justified; creation of affordable options for uninsured workers; and improved capacity of the safety net. Data analysis has been critical to the formulation of these priorities, particularly policies aimed at expanding insurance for children and adults. An extension will permit refinement and enhancement of information as the policy debate evolves.

With regard to children's coverage, the continuation funds will support updated and revised estimates of expansion of the State Children's Health Insurance Program (SCHIP). This will include a retrospective analysis of the July 1, 2000 expansion which increased eligibility to 200% of the federal poverty level for children aged 0-18 years. Enrollment under SCHIP continues to expand under existing eligibility criteria and updated data will permit revised estimates of public insurance take-up and private insurance crowd-out rates. In addition data analysis will be undertaken to simulate expansion of the SCHIP eligibility to 300% of the federal poverty level and will include projections of enrollment, crowd-out, and costs to federal and state

taxpayers. Technical briefings will be undertaken September thru December 2004 to disseminate results.

Analysis of coverage options for adults under public financing includes two categories, those policies which targets adults with children and those policies designed for adults in general. The University of Hawaii, Social Science Research Institute (SSRI) has simulated continuous income measures for use with the HHS and BRFSS surveys which will be updated through 2003. This permits micro-based population estimates of the number of uninsured adults eligible for free medical assistance, with a level of precision and across survey conformity heretofore unavailable. This updated and enhanced data base will be used to simulate an expansion of coverage to adults of SCHIP eligible children and a general Medicaid (QUEST) expansion to 200% and 300%, respectively. Although a broad consensus to expand public insurance eligibility for adults has not been reached, careful advanced planning and research will allow the project to exploit educational opportunities which arise during the 2005 Hawaii state legislative session. Real (inflation-adjusted) personal income in Hawaii is projected to grow at 2.8% in 2004 and 3.6% in 2005. Resultant increases in family income, private insurance coverage and state tax revenues, may render a Medicaid expansion more attractive to policymakers in 2005. The project will be prepared to provide the latest simulated estimates on coverage, crowd-out, costs, and tax burden should the opportunity arise. Preparation of accurate and timely information is the key to success.

Private coverage options for working adults will be a high priority for research and policy formulation in 2004-2005. Exploiting information of the wage earners portion of the Current Population Survey developed by the Bureau of Labor Statistics in cooperation with the Census Bureau, estimates of the insurance status of self-employed, part-time and full-time workers and their families will be estimated and updated through March 2004. With the addition of this most recent data, a total of 11-years of CPS data on labor market activity, industry of employment and insurance coverage of Hawaii's workers will be available to policymakers, community leaders and key stakeholders. With continued support from HRSA, the project will be able to expand and maintain the most extensive analysis of workers and coverage available in Hawaii.

Technical workshops have been conducted and further are planned to disseminate research findings and receive input from community leaders, stakeholders, government officials and policy-makers as well as other interested parties. A total of six half-day technical workshops have been completed. The schedule through September 2004 is as follows:

- Technical Workshop I, 18 October 2002, University of Hawai`i at Mānoa, Saunders Hall
- Technical Workshop II, 7 February 2003, East-West Center, Hawaii Imin International Conference Center, Jefferson Hall
- Technical Workshop III, 23 May 2003, East-West Center, Hawaii Imin International Conference Center, Jefferson Hall
- Technical Workshop IV, 26 September 2003, East-West Center, Hawaii Imin International Conference Center, Jefferson Hall

- Technical Workshop V, 29 March 2004, University of Hawai`i at Mānoa, Saunders Hall

- Technical Workshop VI, 17 September 2004, East-West Center, Hawaii Imin International Conference Center, Jefferson Hall

A series of technical reports and research papers documenting the various research findings is also in preparation. These are as follows.

- Wood, D. William, Carol Murry, and Heather Young Leslie. July 2004. "Listening to the Uninsured in Hawai`i: A Qualitative Research Report," [report attached as Appendix C].

- Fuddy, Loretta J., Gerard Russo, Lawrence Nitz, Sang-Hyop Lee. Abdul Jabbar, Thamana Lekprichakul and Rui Wang "Hawai'i's Uninsured Population: An Overview," [in progress].

- Forbes, Susan and Jill Miyamura "Hawai'i's Uninsured Population—Estimates from Emergency Department and Hospital Discharge Data," [in progress]

- Russo, Gerard, Lawrence Nitz, Sang-Hyop Lee Abdul Jabbar, and Thamana Lekprichakul "Hawai'i's Uninsured Population—Children Aged 0-18 Years: Estimates from the CPS and HHS," [in progress].

- Russo, Gerard, Lawrence Nitz, Sang-Hyop Lee, Abdul Jabbar, Thamana Lekprichakul and Rui Wang "Hawai'i's Uninsured Population—Children Aged 0-17 Years, Estimates from the CPS, HHS and SLAITS," [in progress].

- Nitz, Lawrence, Gerard Russo, Sang-Hyop Lee, Abdul Jabbar, Thamana Lekprichakul and Rui Wang "Hawai'i's Uninsured Population—Adults Aged 19-64 Years: Estimates from the CPS, HHS and BRFSS," [in progress].

- Russo, Gerard, Sang-Hyop Lee, Lawrence Nitz and Abdul Jabbar "Hawai'i Workers without Health Insurance—Self Employed, Part-Time and Full-Time: Estimates from the Current Population Survey (CPS) 1994-2003," [in progress].

- Lee, Sang-Hyop, Gerard Russo, Lawrence Nitz and Abdul Jabbar. Revised September 2004 "The Effect of Mandatory Employer-Sponsored Insurance (ESI) on Health Insurance Coverage and Employment in Hawai'i: Evidence from the Current Population Survey (CPS) 1994-2003," [technical working paper attached as Appendix K].

- Sherstyuk, Katerina, Yoav Wachsman and Gerard Russo. Revised September 2004. "The Labor Market Effects of Employer-Provided Health Insurance: Theoretical and Experimental Results with Flexible Wages," [technical working paper attached as Appendix L].

- Sherstyuk, Katerina, Gerard Russo, Dolgosuren Dorj and Tomomi Tanaka "Health Insurance and Labor Markets with Wage Rigidities: Insights from Experiments," [in progress].

- Russo, Gerard, Lawrence Nitz, Sang-Hyop Lee, Thamana Lekprichakul, Abdul Jabbar and Kathleen Baker "An Analysis of the Hawai'i State Children's Health Insurance Program (SCHIP) Expansion—Children Aged 0-18 Years: Estimates from the CPS and HHS," [in progress].

- Nitz, Lawrence, Gerard Russo and Sang-Hyop Lee "An Analysis of Medicaid and QUEST Expansion Options for Adults," [in progress].

Key lessons about insurance market and employer community. Due to Hawaii's unique Prepaid Health Care Act, most Hawaii residents are fortunate to have health care coverage. While many Hawaii's employers are small businesses, they are also health care consumers. Thus, while these small businesses are truly challenged by the higher contribution rate they must pay to provide coverage to their employees at the same time they enjoy the benefits of the substantial prevailing health plan required under the PHCA. Therefore, most agree that any change to the PHCA must be done very carefully and with consensus amongst both employers and employees. Beginning in April of 2004, the Hawaii Medical Services Association has begun to offer a catastrophic plan for sole proprietors not required to obtain coverage under the PHCA. It is anticipated that this catastrophic plan would also fit with the HSA option being proposed by some proponents on the national and state level. However, the Prepaid Heath Care Council has yet to approve this as an option within the requirements of the PHCA.

Policy planning process and political and economic environment. Hawaii's policy planning process, no matter what the issue, is deeply rooted in a consensus-driven model. Due to our diverse, multi-ethnic population, many individuals must be consulted and options explore before a significant shift in public policy can occur. While our state's political environment did shift after the 2002 elections, and issues have been more publicly debated, involving the grassroots and community leaders is still very critical to moving forward on public policy. One of the lessons from Hawaii might be that geographic isolation can lead to self-sufficiency and adopting public policy that may not be viewed as popular in the other states. Another lesson from Hawaii is that due to our close proximity to each other, we have access through our daily activities to many community and business leaders and government officials. Thus, we will often take the opportunity to "talk story" and educate them when the opportunities arise, which is perceived by some as a more effective means of approaching public policy issues than the large-scale broad-based campaigns often used on the mainland.

During 2004, Hawaii has led the country with the lowest unemployment rate amongst the states. However, it is also a well-known fact among local economists, that Hawaii has a higher rate of underemployment, with many individuals working multiple jobs in order to accommodate the higher cost of living reflected by above average housing and transportation costs. However, since Hawaii's health insurance coverage is largely employer-based, statistics for 2004 might reflect a slight decrease in the uninsured rate due to higher levels of employment.

Change in Project Goals. While we had originally planned to approach expansion of adult and children's coverage under government programs through separate work groups and initiatives, we have determined that they are too interrelated, and thus have collapsed the work groups into one "complete enrollment" work group. We have also determined that within this group, this

primary target should be children who presently qualify under QUEST or SCHIP, but who are not enrolled, rather than proposing an increase in the federal poverty level (FPL) qualifications. Data analysis on SCHIP enrollment indicates that if we are successful in enrolling all children presently qualified, the additional federal match would substantially assist us in then seeking additional state funds for qualified adults who are not presently enrolled.

With regard to uncovered workers, the federal CPS data indicates that many uncovered workers should qualify for employer-sponsored insurance through the PHCA. However, due to the limitations of the federal data, we cannot determine why this is occurring and to what groups. The State Department of Labor, which is responsible for enforcement of the PHCA, does not have complaints indicating non-compliance that mirror the CPS data. Thus, we will need to determine how to collect an alternative but representative sample of data about the uninsured status of workers that can offer another picture of what might be occurring. At the same time, we are proceeding with development of two policy options, related to uncovered workers, that will involve both government and private insurance programs.

Next Steps. The Hawaii Uninsured Project (HUP), one of the partners on this effort, has also received Robert Wood Johnson funds to continue the community collaboration and education portion of this project. The HUP Leadership Group will be developing policy positions for each work group – Complete Enrollment, Expansion of the Safety Net, Uncovered Workers, Compact of Free Association, and the Prepaid Health Care Act – by the end of 2004. These positions will be communicated to community and business leaders and government officials through informational briefings and community outreach.

Section 7
RECOMMENDATIONS TO THE FEDERAL GOVERNMENT

The project recommends the following:

- Continued support of federally qualified health centers, since a strong and viable safety net is critical to reaching a large segment of the uninsured population with primary and preventive services.

- The population of Hawaii is ethnically diverse. No single ethnic group comprises a majority. The Departments of Health and Business, Economic Development, and Tourism estimated that in 2001, 22.8 percent of the state's population was Hawaiian or part-Hawaiian, 22 percent Caucasian, 16 percent Japanese 11 percent Filipino, 3 percent Chinese, 16 percent mixed. The U.S. Census Bureau, Bureau of Labor Statistics provides Current Population Survey data that does not provide detailed ethnic/racial information that would be helpful in our efforts.