



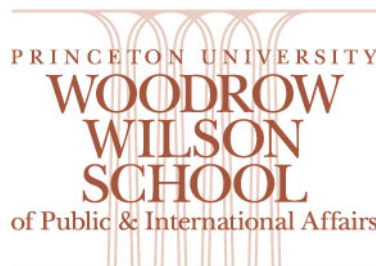
# Hawaii's COFA Islanders: Improving Health Access and Outcomes

*A report for the Governor of Hawaii, David Ige*

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Artwork in this report was created by youth from Kokua Kalihi Valley.

Photographs in this report were taken by Bethany Atkins.



## I. Executive Summary

At the request of the Office of the Governor, the graduate student consulting team from Princeton University's Woodrow Wilson School of Public and International Affairs spent Fall 2016 studying the provision of health care to residents of Hawaii originating from the Federated States of Micronesia, the Republic of the Marshall Islands, and the Republic of Palau. Under the Compact of Free Association (COFA), citizens of these nations—whose territories were used by the United States for nuclear weapons testing and remain a U.S. strategic asset—were granted visa-free migration to the United States. Many choose to settle in Hawaii seeking economic opportunities and advanced health care unavailable in their home islands.

Unfortunately, accessing adequate, affordable health care in the United States remains a challenge for COFA islanders. Their unique immigration status makes COFA islander adults ineligible for Medicaid, and the state of Hawaii only finances care for children, pregnant women, and the aged, blind, or disabled. COFA adults can purchase health insurance through the Affordable Care Act (ACA) exchange. However, as non-native English speakers and immigrants without normal documentation, they face financial, linguistic, cultural, and administrative barriers beyond those of average exchange consumers. Our team was tasked with finding ways to improve the current situation. Our full report details the complex issues faced by COFA islanders residing in Hawaii and proposes a series of actions to address these issues. The problems and solutions fall into three branches of action: administrative and implementation changes, state-level policy, and federal policy options.



## Summary of Options

### Administrative and Implementation Changes

Current practices around data collection, the challenge of establishing official identity, and the lack of outreach from insurance companies prevent efficient insurance enrollment and care delivery. All stakeholders we met with during our research in Hawaii lacked access to accurate and up-to-date information about the individuals who migrated to Hawaii under the COFA agreement. Absent more reliable data, it is impossible to assess specific needs or provide targeted care practices to improve the welfare of these residents. Under current ACA legislation, people who have immigrated to the United States under COFA are required to have an I-94 immigration form to purchase insurance in the exchange. Especially for people who entered the United States before I-94 forms were entered into a digital record, these documents can be easily lost and are expensive to replace. Even with the correct documents, COFA islanders might not have the resources to enroll in the appropriate plans to receive the maximum available subsidies. Our administrative and implementation solutions focus on promoting ease of access to insurance while encouraging efficiency. Hawaii leadership should:

#### *1. Enhance data collection practices.*

- Better identify members of the COFA population by asking specific questions during health care or social service intake processes (ex: “what is your country of origin?”).
- Improve collection and analysis of federal data by expanding the census data points to include questions about country of origin, languages spoken other than English, and disaggregating the Asian American Pacific islander designation to track each ethnic group.
- Consolidate data and improve communication between stakeholders by assigning data collection responsibilities to one agency.

#### *2. Change provider and state government practices to accommodate the population’s needs.*

- Encourage FQHCs to use more diverse information sources to contact COFA islanders receiving care; allow COFA islanders to use non-traditional documents to establish residency.
- Prompt all agencies to more actively engage in determining the COFA population’s needs.

#### *3. Encourage insurance companies to facilitate outreach and remove barriers to participation.*

- Create a partnership with FQHCs and nonprofits that have experience working with COFA islanders; appoint an official liaison position at insurance company to collaborate with FQHCs and nonprofits to conduct informed outreach.
- Incentivize insurance companies to decrease co-pay amounts, or increase subsidies for the COFA population to eliminate cost-sharing and administrative burdens on enrollees.

#### *4. Establish a low-burden vehicle through which COFA islanders can establish an official presence:*

- Work with Experian to incorporate Hawaii state identification numbers into the ACA identity-proofing database.
- Update Hawaii’s state identification card requirements to make it easier for COFA islanders and other residents with incomplete documentation to establish their official identities as Hawaii state residents.

## State Policy Avenues

Inflexibility within the standard ACA exchange leaves coverage and accessibility gaps that impact the COFA islander population. The current structure of the ACA poses various restrictions for people who have moved to the United States under the COFA agreement. Due to their unique residency status, COFA islanders are only eligible for a slim combination of affordable benefits and the one-size-fits-all enrollment practices create additional difficulties in receiving even this level of support. State-level policy solutions could create flexibility that would provide COFA residents of Hawaii with increased reach and access. Possible state policy options include:

1. *Implement a Basic Health Plan (BHP) under Section 1331:* A BHP as outlined under Section 1331 in the ACA could allow Hawaii to provide a simple Medicaid-like system to low-income individuals who are ineligible for the formal Medicaid program.
2. *Apply for a State Innovation Waiver under Section 1332 that would create:* A BHP for only COFA islanders; BHP for the entire exchange population, Medicaid, and state employees; or a single-player plan for individuals in the state.

## Federal Policy Options

Hawaii legislators have a history of advocating on behalf of vulnerable populations. Our Federal level options are meant to further expand existing advocacy efforts. Increased efforts:

1. *Reinstate Medicaid benefits for COFA islanders.* Advance reinstatement of Medicaid benefits for COFA islanders as part of a larger legislative package.
2. *Promote immigration reform to normalize COFA islander immigration status.* Use public relations campaign or interest group advocacy strategy to increase awareness of and support for reforming the immigration status of COFA islanders.
3. *Expand COFA Impact Aid provided to states hosting COFA populations.* Lobby federal government for increased Federal Compact Aid.

## Final Recommendations

### RECOMMENDATION PACKAGE 1: Short-Term and Feasible

Administrative:

- Allow community center or church addresses to serve as points of contact for primary care.
- Reduce patient cost burdens with increased access to Premium Assistance Program.
- Require providers to collect more data on COFA patients.
- Increase funding for culturally appropriate outreach to the COFA islander population.

Federal Policy: Advocate for increased funding for COFA impact aid.

### RECOMMENDATION PACKAGE 2: Long-Term and Ambitious

State Policy: Establish a Basic Health Plan, using one of the flexibility options we outline.

Federal Policy:

- Lobby Congress to restore COFA islanders to Medicaid.
- Normalize COFA islander immigration status through an immigration reform bill.



## II. Problem Statement

Providing affordable, effective, and comprehensive health coverage for COFA islanders is a complex undertaking. On their home islands, their health is threatened by the legacy of U.S. nuclear weapons testing, with contaminated soil and water altering their traditional diets and lifestyles. As immigrants to the United States, they face legal and cultural barriers to accessing quality, accessible health care. In the decades since the Compact of Free Association (COFA) was established, policy changes and tumultuous legal battles created a legacy of confusion and mistrust among both COFA islanders and those responsible for providing health care coverage to this high-need population. Current policy creates challenges for patients, insurers, providers, and the state. Looking forward, uncertainty looms over the future of the Affordable Care Act (ACA) and Medicaid.

Despite future uncertainty, the urgent needs of these legal residents of Hawaii demand that the state consider every possible avenue for expanding health care access for COFA islanders. Our report suggests policy, regulatory, and statutory options to alleviate obstacles to COFA islander care, as well as opportunities to use the ACA to create a more sustainable health care system for COFA islanders in the long-term.

## Background

### History of Compact of Free Association

The U.S. signed the Compact of Free Association (COFA) with the Federated States of Micronesia (FSM) and the Marshall Islands in 1986, and with the Republic of Palau in 1994. COFA established a unique relationship between the U.S. and these Freely Associated States (FAS). It allowed the United States to maintain its military presence in the region and formalized the U.S. role in developing the independent island-nations. The compact enables COFA islanders to freely live, work, or study in the United States. Hawaii, Guam, the Mariana Islands, and American Samoa receive federal funds to offset the cost of providing services and benefits to this population, known as Compact Impact Aid. FAS nations also receive federal funding under the COFA agreement. The terms and benefits of the agreement are set to be renegotiated in 2023.

Precise demographic information about COFA islanders in the United States is difficult to obtain because much of this population is transient. It is estimated that roughly 32,000 COFA islanders resided in Guam, Hawaii, and the Northern Mariana Islands, as of 2008. After Guam, Hawaii hosts the second largest population of COFA islanders, estimated to total approximately 12,000 in 2005-2009. Compared to the general U.S. population, COFA islanders who come to the U.S. are on average younger, have lower educational attainment, and higher rates of poverty.<sup>i</sup> An estimated 1,150 COFA islanders in Hawaii are homeless.<sup>ii</sup>

The U.S. military legacy has left an indelible mark on the islands and their residents. Beginning in the 1950s, the United States used the islands for weapons testing, contributing to nuclear contamination, loss of land, and economic stagnation. Loss of land has limited agriculture on the islands. COFA islanders have had to replace their traditional diets with imported, highly-processed food products. This diet has contributed to high rates of obesity, diabetes, and heart complications.<sup>iii</sup> Most COFA islanders come to the United States in search of work and educational opportunities. Others migrate to seek care for illnesses that require advanced medical procedures unavailable at home. Yet when COFA islanders reach American soil, they continue to face prohibitive barriers to health care access.

Language and cultural barriers are some of the factors that complicate access to health care for COFA islanders. While the island nations are home to a diverse mix of ethnicities, many of the migrants to Hawaii share common cultural characteristics. In our conversations with Chuukese advocates, we learned that they come from an oral communication culture, where the strength of verbal agreements obviate the need for paper forms, photo identification, contracts, documents, and email. This poses significant challenges for enrollment in insurance and access to care. Furthermore, critical health documents are usually not translated into the native languages of the COFA islander populations. This further exacerbates the challenge in reaching and serving this high-need population.

In addition, like many immigrant populations, COFA islanders must reconcile their traditional family structure and cultural values with those of their new home. Chuukese deeply value large families with communal upbringing of children, which comes at odds with the push for family planning in our current health care system. They also come from a matriarchal society, where decision-making is often communal, and led by the elder women. Respected “aunties” can act as bridges or guides to those trying to navigate unfamiliar American systems. Understanding these dynamics is instrumental in disseminating information and resources about health care. Federally qualified health centers (FQHCs) have strategically worked with advocates from the community to help navigate these cultural and language barriers, but their capacity is limited.

**A note on terminology:** COFA encompasses relationships between the U.S. and the island nations of the Federated States of Micronesia (FSM), the Marshall Islands, and the Republic of Palau. These nations comprise the Freely Associated States (FAS) of Micronesia. Citizens from these island nations have diverse ethnic identities: Marshallese, Chuukese, Yapese, to name a few. In Hawaii, most this population identifies as ethnically Chuukese, from the Federated States of Micronesia. For the purposes of this report, we will refer to these populations together as COFA islanders. Although they do not self-identify as COFA islanders, the term broadly encompasses all ethnicities and refers to the agreement that governs their unique status as residents of the United States.



## History of Health Coverage for COFA Population

Since the COFA was signed in 1986, state and federal policy changes have continued to impact COFA islanders' access to health care. These changes created confusion and uncertainty among COFA islanders, exacerbated by the urgent medical needs and language barriers described above. As seen in Figure 1, each policy change led to shifts in coverage for COFA islanders, including loss of coverage for a significant portion of the population.

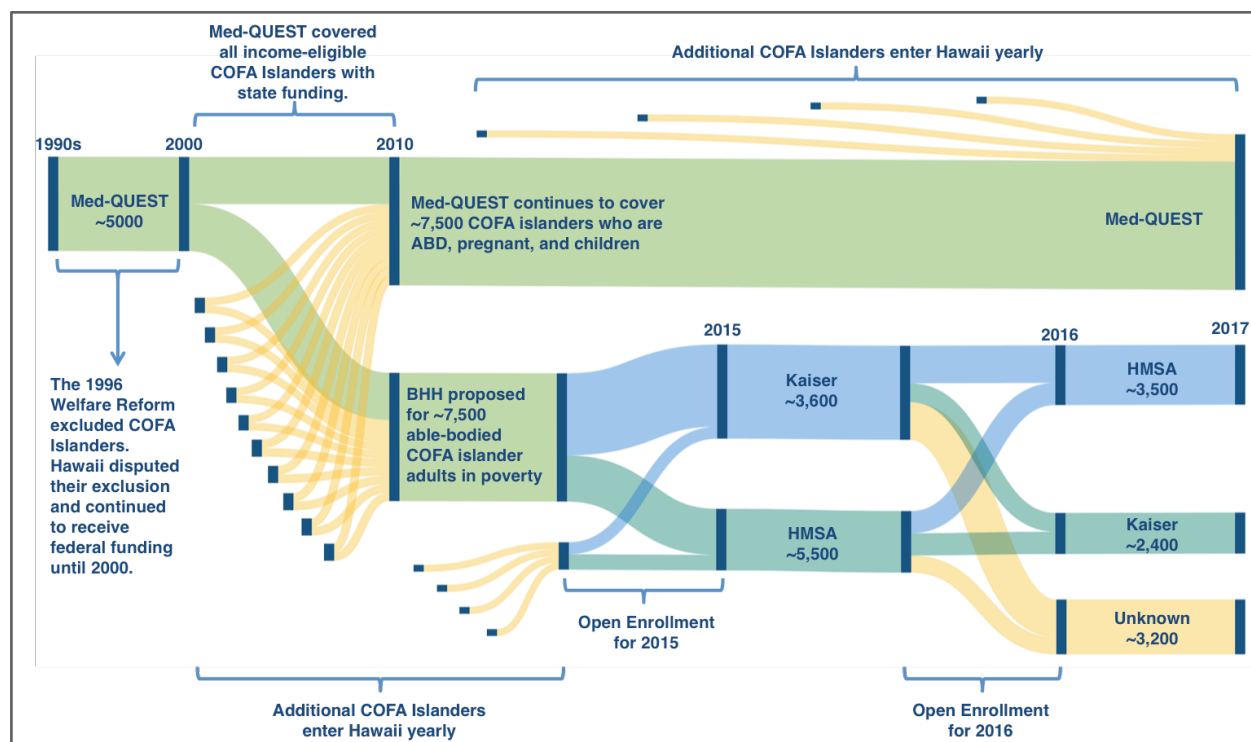


Figure 1. Flow of COFA islander population between insurance coverage categories. Population estimates are based on a combination of GAO reports and interviews with the Med-QUEST director, HMSA staff, and Kaiser staff.

In 1996, the U.S. Congress passed the Personal Responsibility and Work Opportunity Reconciliation Act (PRWORA), known as welfare reform, which stripped COFA islanders of their eligibility for most federal benefits. The act required lawful immigrants to meet a five-year residency requirement to access Medicaid, but barred most COFA islanders from any Medicaid benefits by placing them under a special immigration status. The State of Hawaii disputed the exclusion of COFA islanders from Medicaid and continued to submit claims and receive federal funding for those patients until April 2000.<sup>1</sup> After 2000, Hawaii continued to cover COFA islander individuals for more than a decade with a state-funded Medicaid-like health insurance program. This insurance was provided through Hawaii's state Medicaid system, Med-QUEST, and was funded without matching federal funds.

In 2009, the Children's Health Insurance Program Reauthorization Act (CHIPRA) gave states the option to provide federally-matched Medicaid to all pregnant women, even if they did not meet residency requirements. Hawaii opted to cover pregnant COFA islanders under this plan.

In 2010, Hawaii attempted to reduce the cost of covering COFA islanders by moving some COFA islanders insured through Med-QUEST to a new program called Basic Health Hawaii (BHH). The plan cut costs by limiting annual doctor visits and access to certain services such as dialysis. Community organizations representing the affected patients banded together to fight against the

plan. A legal aid organization, now known as Hawaii Appleseed, filed a federal lawsuit on behalf of the COFA islanders. The U.S. District Court for the District of Hawaii held that the state had unconstitutionally discriminated against the COFA islanders and enjoined Hawaii from implementing BHH.<sup>iv</sup> Hawaii chose to appeal the District Court's decision.

In April 2014, the U.S. Court of Appeals for the Ninth Circuit vacated the lower court's decision, holding that Hawaii was not constitutionally obligated to provide health insurance to COFA islanders with benefits equivalent to those provided under Medicaid.<sup>v</sup> Hawaii Appleseed appealed the decision to the U.S. Supreme Court, but the Supreme Court declined to hear the case. This effectively upheld the Appeals Court's ruling.

While the lawsuit was underway, COFA islanders continued to receive care under Med-QUEST, but in 2015 the state ended this coverage for adult COFA islanders who were not pregnant, aged, blind, or disabled. Under the ACA, these individuals were required to purchase health insurance through the insurance exchange, the Hawaii Health Connector. During open enrollment for plan year 2015, federal funding provided for two classes of navigator assistance (known as "kōkua"), to assist with outreach and enrollment of the COFA islander population. The outreach kōkua went out into the COFA communities, going door to door to locate individuals being moved Med-QUEST to the exchange. Once located, transitioning individuals worked with enrollment kōkua to navigate the enrollment process using the Hawaii Health Connector. For 2015 only, Med-QUEST instituted auto-enrollment to ensure that no patients were dropped from insurance entirely. Those whose eligibility for Med-QUEST had been eliminated and who had not actively enrolled in a Kaiser or Hawaii Medical Service Association (HMSA) plan were split between the two insurers.

The rollout of the state exchange faced significant technical challenges, and Hawaii Health Connector eventually closed down in 2015, replaced by a federally managed exchange. Those enrolled in exchange insurance – including COFA islanders – had to re-enroll using the federal exchange website, Healthcare.gov, only months after the first enrollment period.

During open enrollment for plan year 2016, federal funding for kōkua went to enrollment assistance only, and outreach efforts were provided on a volunteer basis. All patients had to actively re-enroll using the Healthcare.gov or lose their insurance. The closure of the state-run exchange also meant that applicants needing help had to reach out to the federal call center, which may have presented additional barriers to non-native English speakers, including COFA islanders. Without outreach kōkua, and with this being the first active enrollment period for some COFA islanders, it is likely some of the "unknown" status COFA islanders in figure 1 lost insurance entirely. Some patients chose to switch from Kaiser to HMSA upon re-enrollment, so they could continue receiving care at the FQHCs where they already had established relationships with providers. Some may have also switched from HMSA to Kaiser, although lacking firm data we can only assume that through conjecture.

As of 2016, COFA islanders under 100 percent of the U.S. federal poverty level who do not qualify for Medicaid qualify for the state-funded Premium Assistance Program (PAP). This benefit covers qualifying individuals' share of the premium for health insurance plans bought in the Healthcare.gov exchange. The PAP process begins when HMSA and Kaiser flag enrollees that fit the PAP criteria—they send the list to the State and Hawaii pays the premiums for those individuals. The insurance companies do not bill their enrollees for premiums, although the enrollees are still responsible for any co-pay, co-insurance, or deductible payments. Current policy essentially began in plan year 2015.

COFA islanders are subject to the ACA's individual mandate, which requires all citizens and lawfully present residents to have minimum essential coverage or pay a penalty. COFA islanders who are Aged, Blind, or Disabled (ABD) remain on Medicaid-like, state-funded Med-QUEST insurance. Pregnant COFA islanders may receive federally-matched Medicaid under the 2009 CHIPRA changes.

Below, we outline the navigational experience for a COFA islander new to the health insurance exchange, and discuss pain points from the perspective of insurers, providers, and the state.

## **The Patient Experience**

Patients have three main stages to navigate: determining whether they need to enroll (or re-enroll), navigating the exchange, and accessing care.

### **Eligibility Identification**

In 2017, COFA islanders will navigate enrollment system largely without kōkua support, as federal funding for this role has declined each year. Re-enrollment in the exchange was required for 2017 as Hawaii switched from a state-based exchange to Healthcare.gov. Given the linguistic barriers and differing cultural understanding of insurance faced by many COFA islanders, failure to enroll is a risk.

Beginning in the 2017 plan year, there is a possibility that COFA islanders will be denied eligibility to an Advanced Premium Tax Credit (APTC) if they did not file taxes in 2016. This is a major point of confusion with COFA islanders with incomes below the normal tax filing requirement threshold. Typically, low-income COFA islanders do not file tax returns, so it is not intuitive that they should do so in order to receive their health insurance tax credit. However, if they do not file a tax return, the system will mark the applicant as ineligible for an APTC and inform them they must pay the full insurance premium cost out of pocket. This so-called reconciliation process may then prevent more COFA islanders from obtaining health insurance coverage for 2017. Such an outcome could hurt the state budget through additional emergency department utilization by newly uninsured COFA islanders and require FQHCs and hospitals to provide more un-reimbursed health care.

### **Plan Enrollment**

Since its conception, the ACA enrollment process created substantial confusion for COFA enrollees. Community groups reported to us that the community had relatively strong understanding of their eligibility when COFA islanders were largely covered by Med-QUEST. However, the BHH proposal and subsequent court case caused confusion, and misinformation spread widely through informal community channels regarding eligibility. The three different enrollment processes used during the last three exchange plan years further exacerbated the misinformation issue.

More fundamentally, under Med-QUEST the COFA islanders did not face premiums, co-pays, co-insurance, or deductibles. These cost sharing mechanisms are unfamiliar to the COFA islanders. One Chuuk community advocate explained to our team that their language does not have applicable terms to explain medical cost-sharing. We were told that some insured COFA islanders avoid going to the doctor because they were embarrassed about not being able to afford these expected out-of-pocket costs. For low-income COFA islanders, even small costs can present a large financial burden, and many are unfamiliar with available co-pay assistance programs, such as those offered by Kaiser. Administratively, there are technological and documentation barriers as well:

- Patients are required to have an email address to use the Hawaii Health Connector and later Healthcare.gov. Many COFA islanders then must create an email address to access care, but



they may not have the linguistic skills, technological access, or cultural familiarity to maintain an active email address.

- To verify their eligibility for an APTC, COFA islanders need to establish their identity and legal status within the United States. However, under the COFA agreement, they are not required to have a visa, current passport, or any formal documentation. Those who immigrated prior to the establishment of the digital I-94 form were provided with a paper I-94 form upon entry, but if this has since been lost, they must pay \$330 for a replacement before they can enroll in health insurance. If they brought a passport to the United States that has since expired, they must also apply for a new passport to prove their identity. This presents a financial burden and a logistical delay that could prevent them from completing their application in the open enrollment period. See Section 4 for further recommendations on this issue.
- When selecting a plan on the exchange, if a COFA islander selects the right combination of plans and APTC, they will be automatically flagged by the insurance companies to enroll in the Premium Assistance Program (PAP) described in the previous section. This means that COFA islanders can continue to receive health insurance without out-of-pocket premium costs. Even with these subsidies our interviewees expressed concern that the cost sharing mechanisms would be unaffordable to many COFA islanders. Additionally, if the islanders select any plan other than the Silver 94 within the exchange, and/or do not accept the full APTC value offered to them, the insurance companies will not flag them for PAP enrollment. Thus, they will have no monetary support beyond the amount of APTC that they accept. One possible explanation for the “unknown” wedge of COFA islanders in Figure 1 is that they did not select the options that would make them identifiable as COFA islanders for the PAP. This could result in them losing care if they fail to pay their premiums, or it could mean they are paying out of pocket costs that are eligible for subsidy.

## Accessing Care

Once enrolled in a plan on the exchange, COFA islanders receive coverage from either HMSA or Kaiser. Depending on which insurer they selected (or were automatically assigned, as was the case for many in the 2015 plan year), they experience different challenges in accessing care.

### Kaiser

For many of those who gained coverage through Kaiser, the concept of a managed care network is unfamiliar. Kaiser hospital locations lack historic ties to the COFA islander community and may be geographically distant from COFA patients, who typically access health care in an FQHC near to where they live. Kaiser’s non-profit wing (the Kaiser Foundation) has a Medical Financial Assistance (MFA) program that supplements the state PAP. For patients who receive PAP, Kaiser offers a wrap-around service that eliminates the cost-sharing requirements for that patient. If the patient does not get flagged as PAP eligible, however, they will also not receive MFA.

Even if a patient is directed to MFA, it is only available to them when the patient accesses care from a Kaiser provider, so it does not apply to FQHC or non-Kaiser provided emergency room services. Kaiser also issues a monthly bill for their insurance, which is sent to an enrollee even if they are not obligated to pay because of the PAP and MFA programs. For COFA islanders who may already be unfamiliar with medical billing practices, the arrival of a paper bill—even one marked “Do Not Pay”—can create additional confusion and reluctance to seek out care, even if it is provided at no cost.

## HMSA

For COFA islanders who are accustomed to accessing care through FQHCs, transitioning to HMSA from Med-QUEST allows them to continue seeing their familiar FQHC provider. However, under HMSA they are now required to pay co-pay fees to their provider. Research has shown that even very low cost-sharing amounts can negatively impact how low income patients use health services.<sup>vi</sup> For example, patients sometimes delay or avoid medically needed care due to cash flow concerns, which can mean waiting until a condition is enough of a crisis to become an emergency, rather than making use of proactive and preventative health care services which benefit health outcomes and cost containment. HMSA is beginning a pilot program to subsidize the out of pocket costs for a small portion of the COFA islander population beginning in 2017.

When other immigrant families living in the same neighborhood as COFA islanders with similar incomes go the FQHC and have no out-of-pocket costs because their care is covered by Med-QUEST, this creates a perception of discrimination, which further undermines COFA islander trust in the health care system. An immigrant family who has been in the United States for five or more years from a non-COFA country is eligible for Med-QUEST at no cost, while COFA islanders have no path to ever gain eligibility.

## The Insurer and Provider Perspectives

Insurers and providers must contend with the cost, administrative burden, and health outcomes related to providing COFA islander care.

Our research found that HMSA and Kaiser have a difference of opinion on whether the COFA islanders are a more expensive (less healthy) population to insure from a medical perspective. Neither tracks ethnicity or citizenship for their patients, so it is difficult to conduct meaningful analysis on their health costs. Instead, we must rely on proxy signals to identify which patients are COFA islanders, such as whether the patient is eligible for PAP (discussed above). Absent a cohesive method to identify COFA islander patients, assessments of their access to services, health outcomes, and difference (or lack thereof) in cost is impossible. Kaiser—both an insurer and a provider—does flag files with primary language information once a patient who needs an interpreter uses medical services, but this remains only a partial method to track COFA islander patients.

Providers receive reimbursements on a fee-for-service basis from insurance plans. Market-rate plans (such as those sold on Healthcare.gov) tend to reimburse at a higher amount per service than Med-QUEST does. This suggests that enrolling COFA islanders in commercial insurance coverage should improve the financial state of private providers. This may not be the case for FQHCs, however, which are often the first stop for COFA islanders in need of care. Several FQHC locations are near to neighborhoods where COFA islanders live, and have staff members and volunteers who speak some of the COFA islander languages. Thus, some COFA islander patients feel more comfortable seeking care at an FQHC than other alternatives.

FQHCs are committed to serving anyone who walks through their doors, regardless of insurance status. However, Kaiser's business model is a closed network, in which only Kaiser health care providers are covered by insurance for most services. So, Kaiser does not reimburse FQHCs for services provided to Kaiser enrollees at health centers. Kaiser and FQHCs did come to a short-term agreement to handle reimbursements in the months following the COFA transition to the exchange, but that has since lapsed. Kaiser and the FQHCs do not agree on the extent to which this is an

ongoing problem, but FQHCs do continue to see patients who used to be covered by Med-QUEST but now are not—whether they are now covered by Kaiser or are simply uninsured is unclear.

Insurers and providers of all stripes acknowledged to us that there is a shortage of funds and staff for interpretation and translation services. This may lead patients to underuse preventive care services and overuse emergency services, to the detriment of health outcomes and cost containment.

## The State Perspective

The State of Hawaii provides Hawaii residents of all kinds with an array of services—including education, transportation, and other social services, such as those surrounding the issue of homelessness. While COFA islanders represent a small portion of the overall Hawaii population, their particular legal status and cultural and linguistic profile make them an important group to consider when designing or refining programming. Furthermore, as climate change continues to impact their islands of origin, and with the prospect of Compact Aid ending in 2023, the presence of COFA islanders in Hawaii is likely to grow over the next decade.

As part of the COFA agreement, the U.S. Department of Interior (DOI) allocated \$30 million in mandatory and \$3 million in discretionary Compact Impact aid in FY 2014. The mandatory appropriation will continue through FY 2023. The Compact Impact funds are split proportionately between affected jurisdictions.<sup>vii</sup> However, the level of funding has been, in the DOI's own words, insufficient.<sup>viii</sup> In 2014, Hawaii received \$12 million in Compact Impact funds, more than one third of the total Compact Impact funds. However, these funds covered only a small fraction of the total cost that Hawaii reported from hosting COFA islanders, estimated at \$163 million. The majority of state expenditures on services for COFA islander are related to education (53 percent) and health and social services (44 percent). All DOI Compact Impact funds received by Hawaii are currently allocated to the Department of Human Services to offset the cost of state-funded medical services.

For the State of Hawaii, the precise financial effect of moving half of the COFA islanders from Med-QUEST to the exchange is unknown. The anticipated fiscal impact predicted a savings of \$27 million for the state, with the Premium Assistance Program (PAP) meant to ameliorate the financial burden for COFA islanders.<sup>ix</sup> Although the PAP program was projected to cost \$3.3 million annually, uptake has been lower than expected. The lower enrollment in PAP likely has two causes—some COFA islanders are now uninsured, and others may not have selected all the necessary options when they enrolled through the exchange that would allow insurers to correctly identify their eligibility for PAP.

One possible effect of COFA islanders losing insurance coverage (or having insurance coverage with cost-sharing requirements) is increased use of emergency services. Emergency departments file for reimbursement from the state to recoup some portion of their unpaid services. While this information was not available to our research group, the state could compare shifts in emergency department funding requests since the transfer of COFA islanders to the ACA exchange to identify if the policy choice had unintended consequences for the state budget.

## Challenges: Data Collection

All stakeholders we met mentioned the lack of available data on the COFA islanders as a major hurdle in measuring the efficacy of current health care policy. Simple measures, including the number of COFA islanders currently in Hawaii, as well as more complex information like their current health insurance status, are not reliably available. COFA islanders receive care from a variety of sources with separate and distinct tracking systems, which further complicates data collection. Data is too often fragmented in state and federal silos, or not collected at all. Below is a brief summary of those data collection sources that currently do exist:

- **Med-QUEST and CHIPRA at the Department of Human Services.** Of all the state agencies, the Department of Human Services, as the administrator of Med-QUEST and CHIPRA, collects the most comprehensive data on COFA islander health, although this population is not specifically identified as different from other enrollees. The data collected includes COFA islanders who are on the state's ABD program as well as pregnant women who become eligible for Med-QUEST during their pregnancies. Med-QUEST also receives the data of those COFA islanders eligible for PAP. However, COFA islanders are only eligible for PAP if they correctly enroll through the exchange.
- **Hospitals.** Hospitals do not formally track COFA islanders but do keep track of those who access care but are unable to pay, regardless of ethnicity. Hospitals use this data to receive reimbursement under their Charity Care program.
- **Insurance companies.** HMSA and Kaiser have information about individuals who received insurance through the exchange, but they do not track members by ethnic origin. The estimates of the needs and cost of this population's health care are imprecise. However, when justifying its premium increase of 49.1%, HMSA explicitly mentioned the cost of caring for COFA patients with health conditions and expensive prescription medicine.x
- **Federally Qualified Health Centers.** FQHCs collect specific data on the health and income of the COFA islanders they serve. While they are designated as "Pacific Islander" in annual reports, specific information on country of origin may be broken down at the community centers.
- **Other state government agencies.** Data collection occurs at the agency level although this data isn't generally categorized by ethnicity in a manner that would allow for COFA islanders to be clearly identified. Hawaii's Department of Human Services collects data on homelessness, including a category for those who identify as Micronesian. However, this data comes from surveys taken at point of access for services and is sometimes imprecise or inconsistently gathered.
- **Federal Government.** Federal government agencies have information about COFA islanders, including dates of entry into the country, but accessing that data is often a lengthy and challenging process. To get client-level data on housing and services for the homeless, for example, Hawaii's Homelessness Coordinator must request data from the Continuum of Care, a Federal Department of Housing and Urban Development program that funds homelessness initiatives for nonprofits, state, and local governments.

## Emerging Challenges

Looking forward, it is reasonable to assume the COFA islander population in Hawaii will continue to grow. As climate change makes their home countries ever more vulnerable, citizens from COFA nations may find moving to the United States an even more appealing opportunity. Those with the greatest health care needs will continue to see migration to the United States as a life-saving necessity. As we get closer to the expiration of the compact in 2023, fears that Compact aid will expire or the migration policy may be rescinded may lead to further spikes in immigration.

At the national level, the outcome of the 2016 presidential election creates additional uncertainty for the U.S. health care system as a whole and for services to support COFA islanders in particular. The political will within the U.S. Congress to renew or increase Compact Impact Aid funding after its slated sunset in 2023 remains unclear.

Given President-elect Trump's campaign promises to repeal the Affordable Care Act and the continuing Republican majority in the House and Senate, substantial policy revisions to national health care policy are likely. For example, federal funding for state Medicaid programs may be capped in a Trump administration, which would further restrict the state's budget and therefore its ability to continue providing COFA islander care.





### III. Approach to Assessing Policy Options

This section describes our assessment framework for policy options—administrative actions, state policy options, and federal policy options—in terms of 1) feasibility and 2) ability to improve health care for COFA islanders in Hawaii. In the remainder of the report we apply this framework to our proposals and recommendations. Our aim was to construct a framework that served the purposes of this report and could be applied by state policymakers to assess new proposals as they emerge.

The primary reason for creating a framework, as opposed to simply ranking the policy options in the report, is flexibility. Our report is static, but the context it speaks to is not. The 2016 election has already created tremendous uncertainty around the future of the ACA and government's role in health care provision more generally. The coming months and years will likely bring significant changes, but there is no consensus yet on what they will be. In any case, we anticipate that new laws and industry practices might suggest changes to the proposals here – or even entirely new approaches. We wanted to provide a tool that will help the Governor's office evaluate such future options alongside (or in place of) the ones detailed here.

A second reason for the framework is transparency. It offers a systematic way to view policy options against the specific challenges COFA islanders in Hawaii face in accessing health care (as identified in Section 2). As such, it connects our proposed solutions with the problems they intend to address.

A third reason is consistency. Our proposed policy options range in scope and character, including both short- and long-term approaches, immediate tactical steps and broad strategies. Given the range of options, assessing different proposals by different standards is somewhat unavoidable, but we attempted to apply the same fundamental level of scrutiny to each proposal.

#### Framework Part 1: Feasibility

The first part of the framework addresses political and administrative feasibility. Each policy option we proposed includes a call-out box that considers three aspects of feasibility that emerged as key considerations for the Governor's office. We expanded each aspect with qualitative questions:

## Cost

- How will this impact the state budget?
- Is this a one-time investment, or does it require ongoing expenditure?
- Could an investment by the state leverage other resources (e.g., federal matching or other federal funding, private-sector resources through partnerships)

## Stakeholder analysis

- We considered the major players with an interest in this space: COFA islanders and advocates; health care providers, insurers, state government, and federal government
- Which stakeholders or stakeholder groups would likely support this action? Oppose it?
- How strongly would they support/oppose?
- What capacity do these groups have to organize behind support/opposition?

## Implementation

- Does this policy option require buy-in/participation from many different actors/sectors?
- Complexity: How much ongoing coordination and effort would be needed? To what extent could the Governor's office steward the process to success?
- What is the time horizon for implementation?

### Feasibility Scorecard (applied to each policy option in Section 4)

Cost	Stakeholders	Implementation
<ul style="list-style-type: none"><li>▪ <i>State budget impact?</i></li><li>▪ <i>Any other funding to leverage?</i></li></ul>	<ul style="list-style-type: none"><li>▪ <i>Who is likely to support?</i></li><li>▪ <i>Who is likely to resist / oppose?</i></li></ul>	<ul style="list-style-type: none"><li>▪ <i>Complexity</i></li><li>▪ <i>Time horizon</i></li></ul>

## Framework Part 2: Policy Impact

The second part of the framework speaks to the degree to which policy options address the underlying challenge that motivates this project: providing adequate and appropriate health care for COFA islanders in Hawaii, given the unique needs and status of that population.

We see two distinct paths in this challenge: 1) expanding coverage so more COFA islanders can access care; and 2) addressing administrative and practical hurdles that encumber COFA islanders' appropriate use of care. The second component of the framework has two corresponding paths: Coverage and Addressing Pain Points. Note that the pain points align with the problems in Section 2.

The Policy Impact part of the framework appears in Section 5, where we assess packages of policy options that could be pursued simultaneously. A set of policies taken together can comprise a comprehensive response to the challenge even if the individual policies have targeted scope. We address these topics with the same qualitative questions used to assess recommended packages.

## Coverage

- Overall headcount: How does this policy affect the total number of COFA islanders eligible for some support in getting health care?



- Does this policy imply big changes in eligibility for specific subgroups of the COFA islander population (e.g. pregnant women, aged/blind/disabled)?
- Do any other (non-COFA) groups see a change in eligibility for assistance?

### Addressing Pain Points

- How does this option make it easier to **identify who is eligible** for assistance, or otherwise increase the likelihood that eligible individuals are aware of available benefits?
- How does this option **address barriers to enrollment** (in insurance coverage and/or other programs like premium-assistance plans) faced by COFA islanders?
- How does this option ultimately make appropriate health care more **accessible**?
  - Changing/expanding the set of benefits covered
  - Helping connect patients with timely care in appropriate settings (e.g., avoiding emergency room care when possible)
  - Limiting or otherwise controlling the cost of appropriate care for patients

### Policy Impact Scorecard (applied to recommendations in Section 5)

Coverage		Addressing Pain Points		
<b>Headcount</b> <i>How many people are eligible?</i>	<b>Demographic</b> <i>Specific subgroups (e.g. ABD, poor)</i>	<b>Eligibility Identification</b>	<b>Plan Enrollment</b>	<b>Accessing Care</b> <ul style="list-style-type: none"> <li>▪ Benefits available</li> <li>▪ Appropriate utilization</li> <li>▪ Cost to patients</li> </ul>

### A Few Caveats

The spirit of the framework is simple and schematic. We chose a qualitative approach given (1) the exploratory nature of this project, and (2) the diversity of options put forward. Our intention is to help compare options at a high level to inform the Governor’s choice of an approach to the challenge of COFA islander health care. The considerable tasks of detailed costing, feasibility studies, and impact assessments are important next steps but are beyond the scope of this report. Consistent with this spirit, three notes about how the framework is used:

- The general framing is: How does this option compare to the status quo? Rather than seeking “absolutes” (e.g., What is the total budget; How many people would enroll), we focus on relative changes (e.g. Would the state spend increase or decrease; Would this help boost enrollment compared to current level).
- When applying the framework to policy options, for each category we include both brief qualitative comments and, where appropriate, a rough “overall score” of High / Medium / Low.
- In creating recommended packages of policy options (see Section 5) we weighted the framework categories roughly equally. Depending on the Governor’s priorities and constraints, it might be appropriate to prioritize certain categories over others (e.g. We *must* be able to implement in the next year); doing so could lead to different policy recommendations.



## IV. Policy Options

### Administrative and Implementation Changes

Regardless of forthcoming changes in the Affordable Care Act, or the level of appetite at the federal level for alleviating the burden of COFA impact on the states, our research in Hawaii allowed us to identify several administrative changes we recommend the state consider. These are actions that could be taken immediately to ease some of the current pain points experienced by patients, providers, and the state in providing health care to the COFA islander population. These options could be undertaken alone, or in conjunction with a more ambitious state- or federal-level remedy.

#### Data Collection

Haphazard data collection has serious consequences for the COFA population's health and makes it difficult for the state, federal government, or insurers to remedy health care gaps. The lack of data on health care utilization, including plan enrollment and emergency room visits, undermines the state's case for more federal funding or examining alternative health care options under the ACA.

#### Better identification of COFA population with providers

A major barrier to identifying the COFA population in health care data is that current data collection methods either do not ask for identifying factors or are too general. COFA islanders may respond incorrectly to commonly used pan-ethnic terms like "Pacific Islander" or "Asian." In Hawaii, where many residents, including Native Hawaiians, could be captured under these terms, data collected at the "Asian/Pacific Islander" level does not sufficiently disaggregate populations with possibly vastly different health profiles. Asking for country of origin or ethnic group with specific classifications (e.g. Marshallese, Chuukese, Yapese, Palauan) will more accurately identify this COFA population.

Agencies can improve data collection by asking specific questions. Including a section on intake forms for state services requesting country of origin would help identify COFA islanders. The state can also mandate that health care providers, emergency rooms, social service agencies, and schools include this question in intake forms. Accurately measuring COFA islanders would help identify trends in this population's health care and allow social service agencies to better provide for their needs.

## FEASIBILITY CONSIDERATIONS

Cost	Stakeholders	Implementation
<i>State budget impact? Any other funding to leverage?</i>	<i>Who is likely to support? Who is likely to resist / oppose?</i>	<i>Complexity Time horizon</i>
Low - Can be integrated into current processes and included during next materials update	Supporters - COFA islander advocacy groups, FQHCs Opposition - Agencies may view as extra work	Complexity - Low Time horizon - 1-3 years, depending on current timeline for material, process updates

### Improving collection and analysis of federal data

Increasing COFA islanders' participation in the census is crucial for their inclusion in federal-level data. Census data allows the federal government to identify vulnerable populations that might be at "risk of experiencing limitations in health care access, poor health quality, and suboptimal health outcomes."<sup>xi</sup> There are three questions on the census where COFA islanders can self-identify—country of origin, race, and language spoken at home:

- **"Where was this person born?"** Respondents can write in the name of their home country.
- **"What is Person 1's race? (Mark [X] one or more boxes)"** Respondents have the option "Other Pacific Islander" and to use a write-in option to specify Micronesian, Palauan, or Marshallese.
- **"Does this person speak a language other than English at home? What is that language?"** COFA respondents can identify themselves by writing in the language they speak at home.

The White House Initiative on Asian Americans and Pacific Islanders (AAPI) provides recommendations on gathering data to highlight different ethnicities within the AAPI community. This disaggregation of data ensures that diverse ethnic groups are not seen as homogenous in terms of their health, education, and social service needs. The census provides an ideal opportunity for highlighting the needs of the COFA population and the White House Initiative recommendations can be modified for Hawaii's unique situation.

- **Prepare COFA community for census participation.** Community and health centers should encourage their kōkua to work in the census. Increasing representation of surveyors familiar with the COFA population would allow this group to help respondents complete census forms correctly.
- **Overcoming language and other barriers.** Surveyors who speak COFA languages and understand their culture will be able to seek out accurate responses from those they survey. Enlisting surveyors directly from the COFA population will be critical.
- **Report specific ethnicities.** Encouraging COFA islanders to report their specific location of birth, race, and language helps disaggregate them from the general Pacific Islander population.<sup>xii</sup>

## FEASIBILITY CONSIDERATIONS

Cost	Stakeholders	Implementation
<i>State budget impact?</i> <i>Any other funding to leverage?</i>	<i>Who is likely to support?</i> <i>Who is likely to resist / oppose?</i>	<i>Complexity</i> <i>Time horizon</i>
Medium - Funding needed to for additional training to recruit COFA islander census workers and train them in approaching the community; federal funds will be provided for census outreach workers	Support - State government agencies interested in data on COFA population  Oppose - State agencies not interested in singling out population	Complexity - Medium - Developing and funding training

### Consolidating data and improving communication between stakeholders

Ideally, one state government agency would take an active role in collecting data on the health needs of all COFA islanders in Hawaii, perhaps through the existing working group of stakeholders organized by DHS. This agency would become a repository of data, compiling information across agencies to provide a comprehensive picture of the COFA population's insurance status and health needs. The Governor's Office currently compiles information on this population yearly for the Department of the Interior and the development of a repository in one agency could strengthen this reporting process.

The role of this agency would be bringing together stakeholders and collecting the data they have on COFA islanders. In consolidating this disparate information, the agency would be able to identify trends in data especially related to health. The Department of Human Services (DHS) is best positioned for this role. The Med-QUEST office within DHS, with access to data on COFA islanders who are ABD, pregnant, enrolled in PAP, and accessing emergency rooms, has the widest sample of accessible data on this population.

An addendum to this proposal would be to re-start the process of developing Hawaii's All-Payer Claims Database (APCD). The APCD, usually administered by the Insurance Commissioner's Office, would provide information on claims data so that the insurance office could get baseline estimates of certain service costs. This information could be used to develop programs to prevent difficult and expensive health cases. Development of the APCD slowed in the legislature in 2010 because of concerns about cost.<sup>xiii</sup>

## FEASIBILITY CONSIDERATIONS

Cost	Stakeholders	Implementation
<i>State budget impact?</i> <i>Any other funding to leverage?</i>	<i>Who is likely to support?</i> <i>Who is likely to resist / oppose?</i>	<i>Complexity</i> <i>Time horizon</i>
Low, if process can be streamlined into current work of an agency  High, as APCD will require funding from the state	Support - Med-QUEST, makes it easier to submit annual report to federal government  Oppose - groups that have difficulty collecting and accessing data	Complexity - Low  Time horizon - Short



## Changing practices to accommodate population specific needs

Several government officials we interviewed shared the belief that additional targeted services geared toward the COFA islander population could cause discord among the general population and suggest unequal treatment. While well intended, some attempts to provide uniform treatment have ignored the presence of unique barriers the population members face because of their position in Hawaii and migrant status. Most obviously, the insurance enrollment system has assumed internet access, English fluency, and the primacy of written documents among other qualifications. As mentioned in the problem statement, these assumptions come into direct conflict with COFA islander culture and their limited access to resources in the United States. Differences in the quality of care accessed and received by COFA islanders and other populations in Hawaii suggests the need for targeted interventions. One step towards this would be for the state to encourage practices more culturally appropriate for COFA islanders.

## Encourage FQHCs to use diverse information sources to contact COFA islanders

FQHCs should be encouraged to collect more diverse sources of contact information for COFA islanders during health care intake processes, similar to the ones used in New York City's municipal identification program. Typical contacts like phone numbers and home addresses may not be useful for reaching this population as many may suffer from housing instability or live in multigenerational housing, with more than one person in residence per address or phone number. Email contact can also be problematic as COFA islanders may not have the technological access or cultural incentive to check email frequently. Using contact points that are less likely to change in the short-run – such as church affiliation or child's school – could increase FQHC initial contact and follow-up success rates.

## FEASIBILITY CONSIDERATIONS

Cost	Stakeholders	Implementation
<i>State budget impact?</i> <i>Any other funding to leverage?</i>	<i>Who is likely to support?</i> <i>Who is likely to resist / oppose?</i>	<i>Complexity</i> <i>Time horizon</i>
Low - Burden on the FQHCs would be minimal, this would be voluntary information provided at the patient's discretion	Supporters - COFA advocacy groups, FQHCs	Complexity - Low Time horizon - 6-12 months, depending on what FQHC intake forms would need adaptation

## Prompt government agency engagement to determine the vulnerable populations' needs

Agencies we interviewed looked toward the Department of Human Services to take responsibility for the COFA islander population as it is the agency that receives the most federal Compact Impact Aid and has the most direct access to COFA populations through Med-QUEST and CHIPRA. Yet for COFA islanders to be fully integrated into the citizenry of Hawaii, concern about this population should be widely shared among stakeholder agencies, including the Department of Health, Department of Education, and the Governor's coordinator on homelessness. The state should consider encouraging all agencies to consider the particular needs of the COFA population when creating programs and delivering services. Any practices adopted could be applied to other populations who may need additional support.

## FEASIBILITY CONSIDERATIONS

Cost	Stakeholders	Implementation
<i>State budget impact? Any other funding to leverage?</i>	<i>Who is likely to support? Who is likely to resist / oppose?</i>	<i>Complexity Time horizon</i>
Low - Changes in agency culture would have a minimal impact on budget	Supporters - COFA advocacy groups, FQHCs	Complexity - Medium Time horizon - 6-15 months, depending on robustness of efforts

### Insurance take-up and enrollment

While we lack firm data on COFA islander insurance enrollment, approximate data and testimonies from insurance companies and local organizations indicate that enrollment and access to health insurance for COFA islanders continues to be a struggle. Insurance companies face two primary barriers to increased insurance take-up and enrollment of COFA islanders: 1) a lack of cultural competency within insurance companies and 2) structural properties that disincentivize the COFA population from properly accessing care. To ameliorate these barriers, the state can encourage insurance companies to create a cultural liaison position and promote structural changes within agencies to improve proper access of care by COFA islanders.

#### **Create a formal outreach position in each of Hawaii's insurance companies that partners with FQHCs and nonprofits that have already worked directly with COFA islanders**

Insurance providers find it difficult to increase enrollment of COFA islanders because of cultural barriers. While on the exchange, both Kaiser and HMSA must work within the confines of Healthcare.gov. This platform cannot be adapted to serve this population's language needs. Furthermore, neither insurance provider has an institutionalized way to perform outreach or communicate the enrollment process to this population that is informed by their cultural needs.

Kaiser has held sporadic enrollment sign up events with translators, but there is no annually scheduled time when this sign up takes place. HMSA experienced some success increasing the number of COFA islander enrollees by partnering its sales team with translators to explain coinsurance, premiums, and enrollment processes. During the second ACA enrollment period, however, HMSA experienced a decline in enrollees. FQHC staff and supporters attempted to fill in this gap with enrollment outreach but could only do so in an informal or voluntary basis.

Furthermore, once COFA islanders are enrolled in a plan, insurance companies don't have an institutionalized way of explaining how to navigate their insurance plan specifically to this population. Some difficulties include translating the meaning of copays to COFA islanders, how to manage chronic care, and explaining which assigned plans cover what facilities.

Although FQHCs may have the most in person contact with COFA islanders, they have limited ability to enroll patients into Kaiser and HMSA. HMSA previously had one person who spearheaded COFA islander outreach, but because this role was not institutionalized, outreach to local COFA islanders suffered during staff turnover. If the state could provide funding to agencies for an official liaison position between FQHCs and insurance companies, this partnership would enable insurance companies to disseminate necessary information via a trusted person from either a health center or from the local community.

Insurance companies would need to do the following to make sure this outreach position meets the cultural needs of the population and has the intended effects on increasing COFA Islander enrollment:

- **Appoint someone as the outreach liaison.** Insurance companies can appoint someone who has work experience with the COFA islander. This can be someone who has either worked at an FQHC or a vetted grassroots organization and is known by the community.
- **Conduct Outreach.** The liaison would ideally divide their time between the insurance company and a few FQHCs, and have access from Kaiser or HMSA on enrollment eligibility, copays and locations where this insurance can be used. Having previous experience working with the population, this liaison could explain these processes in the COFA islanders' native language by speaking to people who frequent FQHCs, visiting churches, or attending community events that would be conducive to the enrollment of multiple people.
- **Evaluate Impact.** To see the impact this outreach has had on enrollment, there should be both qualitative and quantitative evaluation. First, in the liaison's regularly scheduled visits to FQHCs and community centers, the liaison should attempt to ask about the burdens experienced by workers in FQHCs and whether the majority of the patients coming in are still uninsured. Additionally, the insurance company should use enrollment data to assess whether there has been an increase in uptake of insurance a year after the outreach position.

Allocating state funding to help with grassroots outreach could encourage insurance companies to nurture these relationships. Having multiple community doctors and hospital workers endorse the use of private insurance for example, may improve take-up of insurance benefits. The organizations that interface with COFA islanders are more equipped to explain special programs like Kaiser's co-pay assistance, especially since the idea of co-pays is foreign to this population. Funding should emphasize oral advertising for enrollment over a written campaign. Outreach through churches and schools could also encourage uptake.

Insurance companies should consider expanding methods for communicating accurate and easily accessible information to the COFA population to guarantee enrollment and correct utilization. With the variety of language and transient nature of the population, insurance companies will need to make frequent and regular attempts to reach the COFA islander population. Connecting with grassroots workers who not only speak the language but are plugged into the community will likely increase the productivity of enrollment attempts.

## FEASIBILITY CONSIDERATIONS

Cost	Stakeholders	Implementation
<i>State budget impact?</i> <i>Any other funding to leverage?</i>	<i>Who is likely to support?</i> <i>Who is likely to resist / oppose?</i>	<i>Complexity</i> <i>Time horizon</i>
Medium - Insurance companies would need funding to pilot this partnership. This may need to come from state dollars to incentivize the creation of this partnership.	Support - Organizations that want insurance accountability with outreach  Resist - Insurance companies that would have to do the onboarding, recruitment, and compensation for grassroots organizations.	Complexity - High, would require buy in from grassroots groups and insurance companies. Relationships are tense between direct service providers and insurance companies.  Time Horizon - Long, the state would need to mandate or incentivize insurance companies to make an outreach position. Companies would identify partners, delegate outreach tasks, and monitor the position's effectiveness.



**Ensure that COFA islanders are not disincentivized from using preventative health services by expanding the current cost-sharing assistance program and lowering the burdens to access care**

Current insurance plans are structured in a way that discourages COFA islanders from using primary care and insurance properly. The transition from Med-QUEST to the exchange introduced copays that can deter enrollees from seeking preventative care. Additionally, having coverage for facilities that are distant from COFA islander neighborhoods also discourages an already burdened population from finding care.

The state could incentivize insurance companies to change certain aspects of their insurance plans to incentivize COFA islanders to use the primary care they are enrolled in. The state could promote structural changes by having grant funding for insurance companies that eliminate copays, conducting a separate assessment of the physical barriers preventing enrollees from accessing care, and/or assessing network adequacy.

The state should do the following to restructure parts of insurance plans so that COFA islanders are incentivized to use preventative health services:

- **Encourage insurance companies to lower or eliminate co-pays for COFA islanders.** The elimination of co-pays is generally associated with higher rates of preventative care usage, which is crucial for the COFA islander population. Although insurance providers may push back on a plan that increases the use of medical services – and therefore drives up immediate costs – offering payment options that encourage the use of preventative care would help insurers spend less in the long-run. Lower cost sharing is associated with higher compliance with drugs for hypertension, diabetes and other chronic diseases, which also affect COFA islanders in high numbers. Those who are less active in the health care system are more sensitive to prices and likely to forgo expensive care if they believe there is no immediate medical need.  
  
If the state created an incentive mechanism that offers more funding for insurers and lower copays, insurers may in turn see greater uptake of all services, including preventative care. This leads to healthier outcomes for Hawaii's COFA residents, and saves insurance providers money on costly long-term care. Kaiser has eliminated co-pays for low income enrollees, but the benefit can only be used at Kaiser Permanente hospitals. This restriction creates a barrier to preventative care use.
- **Conduct an inquiry about COFA islander care utilization.** The state should follow up with Kaiser, HMSA, FQHCs, and local community groups to verify whether COFA islanders are properly accessing care via their health plans. The state could conduct an inquiry examining how often enrolled COFA islanders use primary care physicians, or other preventative care services.
- **Assess the network adequacy of a specific insurance company.** For COFA Islanders, who rely heavily on FQHCs for care, co-pay elimination may not be the best way improve insurance up-take, especially if designated care facilities are inaccessible to areas with high concentrations of COFA islanders. For example, while Kaiser has a no co-pay model, it only covers hospitals, not the FQHCs that are closer and more familiar to COFA islanders. The current exclusion of FQHC care from Kaiser's insurance model complicates the ability to expand health care access. These centers are the main locations where COFA islanders interact with medical services.

States may not be able to alter the entire operation of one insurance organization, but they can inform insurers that successful care models used for other customer populations may not be appropriate for COFA islanders. The state could conduct a third-party assessment to determine what facilities are closest to areas with a high COFA islander population and what facilities COFA islander enrollees can use. These findings should be made transparent and used to keep insurance companies accountable for providing suitable service to this population.

The state should continue to monitor and let insurance companies know that this information will be made transparent. To make sure COFA enrollees are properly accessing primary care, the state should persuade insurance companies to meet these goals as meeting them will contribute to improving the chronic health problems experienced by COFA islanders and growing emergency care costs.

#### FEASIBILITY CONSIDERATIONS

Cost	Stakeholders	Implementation
<i>State budget impact? Any other funding to leverage?</i>	<i>Who is likely to support? Who is likely to resist / oppose?</i>	<i>Complexity Time horizon</i>
Medium - Would still rely on state funding to cover the costs of the population who specifically uses copays. State funding would also be required to conduct network adequacy assessments.	Support - Insurance companies, COFA islanders, grassroots organizations, hospitals/clinics.  Resist - Insurance companies if the restructuring approach from the state includes eliminate copays and/or expose any shortcoming within their business model.	Complexity - Medium, the plan would require adjusting the current insurance system, specifically for HMSA. While Kaiser has done some work already to eliminate copays, HMSA has only piloted this program.  Time Horizon – Long, would require a change within the insurance company.

#### Improve COFA islander's ability to establish official presence.

One of the challenges COFA islanders face in accessing health care and other services is the lack of official identity documents. Micronesians, Marshallese, and Palauans immigrating to Hawaii do not need valid passports to either make the trip or remain in the United States. Those who entered prior to the establishment of the electronic I-94 system may have lost the paper I-94 that establishes their legal arrival. They may not have brought personal documentation, like official birth certificates, with them to Hawaii. Even documents establishing place of residence – such as a utility bill or lease – may be unavailable if the immigrant is homeless or living in a multi-generational housing situation.

The lack of official identity makes it difficult for the state to reliably measure how many COFA islander adults are present in Hawaii. Without accurate population estimates, and some way to clearly identify what services they use, it is impossible to know how effective the state is at reaching the COFA community.

Specific to health care delivery, COFA islanders without the means to establish an official identity cannot establish an account to purchase health insurance through Hawaii's ACA exchange. We learned in our meetings with community advocates that COFA applicants are often unable to prove their identity through the Experian identity proofing system used by the ACA to verify account holders

are who they say they are. The Experian system uses identity checks such as credit databases to verify the identification of applicants creating online accounts, but COFA islanders, especially the newly arrived, often do not show up in these databases. If they wish to create ACA accounts, they must mail whatever identification they possess to a processing center in Kentucky. Community advocates also reported to us that documents are frequently misplaced by the processing center during review, making it impossible for people to register for health care even if they wish to do so. In addition, COFA islanders may have no affordable way to replace lost identification documents, leaving them permanently without official identification.

If Hawaii could integrate its state ID database into the Experian database, COFA islanders may be able to use Hawaii State IDs to establish identity and access ACA accounts. The state database could also be modified to note country of origin, which would allow the state to collect demographic data on the COFA islanders present in Hawaii and compare that data against the uptake of COFA-specific programming.

However, getting COFA islanders to establish identity using the Hawaii State ID program will require modifications to the program. The current documentary requirements to receive a Hawaii State ID are strict and may pose barriers to residents without certain kinds of official documentation.<sup>xiv</sup> Hawaii could consider adjusting the Hawaii State ID program, perhaps using New York City's IDNYC program as a model. IDNYC is specifically designed with the needs of immigrants without official identity documents in mind, but can be accessed by any resident of New York City.<sup>xv</sup> The IDNYC program allows residents to access a broad range of services while also helping the city better understand the needs of its residents.

IDNYC can be used in the New York State health insurance exchange as proof of official identity.<sup>xvi</sup> It can also be used as a registration card when using public hospitals or patient care facilities.<sup>xvii</sup> Care provided to a registered IDNYC holder in a public hospital, clinic, or other public facility is recorded in a single file associated with the user's IDNYC number, making it easier for health care workers and patients to access vital medical records. IDNYC can also be used as a membership card for ActionHealthNYC, a city-run organization that helps low income New York City residents access low-cost and coordinated health care.

Beyond health benefits, IDNYC can be used as official identity when interacting with police, accessing city buildings, enrolling a child in city schools and summer camps, opening an account at a bank or credit union, enrolling in public universities, and it provides free entry to cultural institutions in New York City.

**Modify the documentary proof requirements for Hawaii State ID to encourage more residents, especially COFA islanders to get official identification. Work with Experian to incorporate data into Healthcare.gov identity proofing.**

The current requirements for a Hawaii State ID require documentary proof of three separate categories (Name and Date of Birth, Social Security Number, and proof of legal presence) as well as two documents proving principal residence. Expired foreign passports or foreign birth certificates cannot be used.

Comparatively, the IDNYC program in New York City allows applicants to use a much broader range of documents to prove both residency and identity. For example, an applicant can use an expired passport (if it expired within three years); a foreign passport; or foreign birth certificate to prove

identity. They also can use a letter from their child’s school principal or from their religious institution to prove residency.<sup>xviii</sup>

The state will also need a plan to encourage uptake of the identity cards under the new requirements. Hosting “ID Days” events at schools, or in conjunction with FQHCs or COFA community institutions like churches, should allow state officials to reach a significant portion of the population lacking official identification. Offering a state or city-sponsored give away could further encourage uptake.

Helping COFA islanders establish official ID does not just benefit the immigrant population in Hawaii, but will also help the state in its effort to better document other Hawaii residents who may be invisible to the official record because of homelessness or immigration status. We recommend modifying the state ID database to allow for designations including Chuuk, Yap, and Marshallese, as part of its demographic collections. The state could use the ID card process to improve its data collection practices.

The key to making these changes worthwhile for the state and those residents seeking ID, is to link the ID card to easier provision of essential services, including health care. The state must work with Experian to get Hawaii State ID numbers included in the identity proofing database as acceptable proof of identity for creating health care exchange accounts. Since Hawaii’s exchange is federally managed, there may be additional barriers to establishing this link not experienced by New York’s state-run marketplace. Still if the state can make this connection viable, it would ease a major pain point to ACA enrollment for the COFA population and reduce some burden in providing health care for this high-need population.

It is reasonable to assume having reliable IDs could have other benefits for both COFA islanders and the state of Hawaii. For example, a state-sanctioned ID could allow a newly arrived migrant to open a bank account – as it does in New York City – or access employment. This could reduce some of the financial burdens on the state from being a COFA host. However, this is likely to have a smaller impact on overall COFA islander quality of life or state finances than easing the difficulty of ACA identity proofing through Experian.

## FEASIBILITY CONSIDERATIONS

Cost	Stakeholders	Implementation
<i>State budget impact? Any other funding to leverage?</i>	<i>Who is likely to support? Who is likely to resist / oppose?</i>	<i>Complexity Time horizon</i>
<p>Medium: State would need to provide IDs (potentially several thousand new ones) at no or low cost, along with incentives to encourage take-ups.</p> <p>Low: State would need to devote staff time to working with Experian to use State ID in the system.</p>	<p>Supporters: FQHCs, COFA islanders, lawmakers who want islanders shifted fully to ACA</p> <p>Oppose: state legislature (funding concerns)</p>	<p>High: This issue is not strongly worth pursuing unless Experian is willing to incorporate state ID numbers into their database. Healthcare aside, the system could make it easier for COFA islanders to engage in economic activity and provide the state with better data about the population.</p>

## State Policy Avenues

### Basic Health Plan

A Basic Health Plan (BHP) is outlined in the ACA under Section 1331 as an option for states to provide Medicaid-like coverage to low-income individuals who would otherwise be eligible to purchase coverage through the health insurance exchange.<sup>xi</sup> States finance the BHP using federal dollars that would have been paid to insurers (as premium tax credits and cost-sharing reductions) on behalf of those individuals. Below we outline the key features of a BHP and what a BHP might look like in Hawaii. This option assumes that the general structure of the ACA, including the 1331 waiver process will remain in effect through any future changes (including a potential replacement bill should the original law be repealed in 2017). While we cannot know what the future will bring, the recommendations below represent the available options for the state, given current federal health care guidelines.

### Eligibility

Through a BHP, states can provide coverage to individuals with incomes up to 200 percent of the federal poverty level (FPL) who would otherwise qualify for subsidies in the exchange.<sup>xx</sup> This means individuals must be state-residents, under age 65, and must be ineligible for other minimum essential coverage, including Medicaid, CHIP, and affordable insurance offered by an employer (i.e. it cannot cost more than 9.5 percent of household income for self-only coverage).<sup>xxi</sup>

Most individuals who would be covered through a BHP are adults with incomes between 138 and 200 percent FPL. However, COFA islanders and other lawfully present immigrants whose incomes are below 138 percent FPL, but who do not qualify for Medicaid because of their immigration status, would also be eligible for a BHP.

In 2016, 61 percent of the roughly 13,000 individuals enrolled in qualified health plans (QHPs) through Hawaii's Insurance Exchange had incomes below 250 percent FPL.<sup>xxii</sup> We assume that roughly 50 percent of individuals in the exchange had incomes below 200 percent FPL, and therefore estimate that between 6,000 and 10,000 individuals in Hawaii would qualify for a BHP. This large range allows for the possibility that a number of individuals who do not currently have coverage under the exchange because of the cost or difficulty of signing up for coverage would enroll in a BHP. As discussed in section 2.2, given the lack of reliable data on the COFA islander population, we do not have a good sense of the number who currently do not have health care coverage but who would be eligible to enroll in a BHP.

### Benefits and Costs for Consumers

A BHP must be at least as comprehensive as coverage in the exchange. This means that a BHP must cover at least the ten Essential Health Benefits required of QHPs in the exchange. These benefits include ambulatory, emergency, and hospital care; treatment for physical and mental illness; maternity, newborn, and pediatric care; prescription drugs; and more.<sup>1</sup>

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<sup>1</sup> See complete list of the Essential Health Benefits: What Marketplace health insurance plans cover. (n.d.). Retrieved December 12, 2016, from <https://www.healthcare.gov/coverage/what-marketplace-plans-cover/>

A BHP must also be at least as affordable for customers as subsidized coverage in the exchange. In other words, consumers' total out-of-pocket costs (i.e. deductibles, copays, and coinsurance) for a BHP cannot exceed what they *would have been* had they purchased the second-lowest-cost silver plan in the exchange. This takes into account all federal subsidies and cost-sharing payments. For 2017, that benchmark—the maximum out-of-pocket costs for exchange customers between 100-200 percent FPL—is \$2,350 per individual, or \$4,700 per family.<sup>xxiii</sup>

A state designing a BHP has discretion to set consumers' premiums and out-of-pocket costs (even to zero), or set up a sliding payment scale based on income. Either way, a BHP would almost certainly be less costly for enrollees than private coverage available through the insurance exchange. For example, total out-of-pocket expenditures for New York's BHP are 50-95 percent lower than for the state's benchmark silver plan, and enrollees under 150 percent FPL pay no monthly premium.<sup>xxiv</sup> (See "BHPs in Practice: New York and Minnesota" callout box below for more detail.)

Eliminating, or significantly decreasing, premiums and copayments would also reduce confusion and difficulty of utilizing coverage. As discussed above, this is particularly important for the COFA islander population. The reduction in cost and the increased ease of use would likely lead more people to retain coverage under a BHP, relative to the exchange option.

Another benefit of a BHP, particularly for COFA islanders, is that it would not require consumers to reconcile APTCs on federal income tax returns. BHP enrollees do not receive tax credits directly and do not risk losing tax refunds or owing back taxes if they received excess subsidies during the year.

A BHP can also benefit individuals by reducing 'churning.' Moving from Medicaid to private insurance, or vice versa, can be very disruptive. Individuals may have to change their doctor and may be required to pay more or less in premiums and cost-sharing. Churning causes confusion for individuals and may lead people to drop their coverage. Although this issue is not as relevant for COFA islanders as they are not eligible for Medicaid, it is likely relevant for other adults who would be eligible for a BHP and it represents a significant benefit of a BHP.

BHP At-a-Glance: Consumers' Perspective	
<b>Coverage + Benefits</b> <ul style="list-style-type: none"> <li>• Would cover all Hawaii residents &lt;200% FPL who do not qualify for other coverage</li> <li>• Must include the 10 Essential Health Benefits</li> <li>• Does not include some current Medicaid benefits (e.g. non-emergency medical transport, long term care)</li> </ul>	<b>Consumer Costs</b> <ul style="list-style-type: none"> <li>• Premium can be uniform or sliding scale (including zero)</li> <li>• Maximum annual spending on deductible, copays, and coinsurance of \$2,350 per individual, or \$4,700 per family</li> </ul>

### Cost to the State

A state operating a BHP receives federal funding equal to 95 percent of the total amount that would have been paid in APTCs and CSRs if the BHP enrollees had instead enrolled in the second-lowest-cost silver plan on the state exchange. For each BHP enrollee, the amount of APTC and CSR due—and thus the amount the state can collect from the federal government on that enrollee's behalf—is determined by his/her county of residence, age range, income range, and household size.<sup>xxv</sup> COFA islanders and other lawfully-present individuals with incomes below 100 percent FPL are eligible for APTCs and CSRs as if they had incomes at 100 percent FPL.



Per capita amounts for each federal payment cell are set prospectively each year. The Centers for Medicare and Medicaid Services (CMS) provide quarterly payments to states based on projected enrollment into each payment cell and reconciles funding at the end of the year based on actual enrollment. If the federal dollars exceed the state's cost for the BHP, any surplus funds must be used to reduce premiums and cost sharing for eligible individuals or to provide additional benefits. If instead the state's costs exceed the federal payments, then the state must cover any additional funding. In that sense, states implementing a BHP take on the financial risk of high patient costs, which would otherwise be borne by the patient's insurer.

The fact that payments are based on prospective enrollment will likely be a challenge in Hawaii. As mentioned above, current estimates of the number of COFA islanders who lack insurance under the exchange but would be eligible for a BHP are somewhat rough. If there were a significant "welcome mat" effect—if a BHP's affordability and ease-of-use drove broad enrollment among the COFA islander population—actual enrollment could exceed projections. Although the final federal payment is adjusted at the end of the year based on actual enrollment, there is a risk that the state may have to cover a large portion of the cost initially.

Part of the idea behind a BHP is that states can achieve savings by using BHP's negotiating leverage to set reimbursement rates somewhere between Medicaid and QHPs. This enables them to provide better coverage at a lower cost to consumers.

States concerned about BHP costs exceeding federal funding can lower BHP costs by increasing consumer out-of-pocket cost sharing, limiting benefits, or raising premiums, as long as BHP coverage remains at least as generous and affordable as QHP plans. Both New York and Minnesota's BHPs charge a minimal premium based on income to help offset the cost of the program. States can also achieve state budget savings by structuring BHP benefits to substitute for state-funded services, including certain mental health and substance abuse treatment, that fall outside qualified health plan's commercial coverage.

In the case of Hawaii, it may be possible to save money by moving COFA islanders who are aged (but not Medicare-eligible), blind, and disabled individuals (ABDs) from Medicaid to a BHP. ABD COFA islanders are currently covered by Med-QUEST with 100 percent state funds. If these individuals were moved to a BHP, the state would receive additional federal subsidies. One concern with doing this could be that the coverage provided under the BHP would not include some of the services covered under Medicaid that are critical for this population, such as non-emergency transportation. However, it may be possible to set up a separate fund that cover the cost of services not provided under the BHP and still save the state money.

### **Administration**

A BHP can be administered by contracted HMOs, insurers, or other care managers, and could piggyback on Hawaii's existing Med-QUEST program. The state could work with existing Med-QUEST issuers to build BHP plans that met the minimum essential coverage requirements and offer them through the exchange.

One administrative challenge with a BHP is on the technology side. The two states currently operating BHPs have state-run exchanges. The ability to offer a BHP is therefore not currently built into Healthcare.gov. It is possible that HHS would agree to build BHP functionality into the website since the ACA statute allows any state (not just those operating their own exchanges) to offer BHPs. Given Healthcare.gov's current capabilities, it may only require some minor adjustments to be able to



shunt individuals who fall below 200 percent FPL into the BHP registration process. However, it is unclear exactly how easy this process would be or how long it would take.

Another challenge is that federal BHP funds cannot be used to finance BHP setup or administrative costs. However, states can fund these expenses by putting a surcharge on BHP plans and then use federal BHP funds to cover the resulting premium escalation.<sup>xxvi</sup>

A final note, any action on a BHP should seriously consider an alternative name. It would be wise to avoid referencing—and inviting comparisons with—the challenges of “Basic Health Hawaii.”

### **BHPs in Practice: New York and Minnesota**

Two states have already implemented the ACA’s BHP options. The Essential Plan, New York’s BHP, first launched in 2015 and currently has nearly 300,000 enrollees.<sup>xxvii</sup> Two features of the plan are worth noting. First, costs for consumers are low: the Essential Plan has no deductible, low copayments, and (depending on the consumer’s income) either zero or \$20 per month in premium. The result is that consumers’ out-of-pocket expenditures for the Essential Plan are 50-95 percent lower than for the state’s benchmark silver plan.<sup>xxviii</sup> Second, consumers still have options: New York worked with 13 insurers to develop their own separate versions of the Essential Plan. When eligible consumers shop on the state exchange, these appear as competitive coverage options.

New York’s example shows that states can save money while keeping consumer costs low. Prior to launching the Essential Plan, New York had a typical federal-match Medicaid program, and used exclusively state funds to extend similar coverage to individuals who were ineligible for Medicaid due to immigration status. With the Essential Plan, New York uses state funds on top of federal subsidies to keep prices low for consumers. Ultimately the state paid about 8 percent of the total cost of the BHP. The net result in the first year of the Essential Plan was \$1 billion in savings compared to the previous Medicaid arrangement.<sup>xxix</sup>

Minnesota has operated MinnesotaCare since 1992. The state-funded program offered health coverage to residents who didn’t qualify for Medicaid, with incomes up to 175 percent FPL for adults without children. In January 2015, Minnesota converted MinnesotaCare to a BHP, which allowed them to utilize federal funding to provide coverage that they were previously offering with state-funds. Federal funding covers approximately 43 percent of the program, with additional funding from a state tax on hospitals and health care providers.<sup>xxx</sup> As in New York, enrollees pay premiums on a sliding scale, with an average of about \$16 per month, ranging as high as \$80.<sup>xxxi</sup>

### **Implications for State Insurance Exchange**

If a state sets up a BHP, a number of individuals will likely move off the exchange. This could threaten the viability of the exchange if the resulting exchange population is too small. The stability of an insurance pool depends in part on the number of lives covered. A smaller risk pool means more variation in costs, which results in higher premiums. If the pool becomes too small, then it is at risk of collapsing.

Hawaii already has a relatively small individual risk pool as most residents of Hawaii have employer-sponsored insurance (ESI) thanks to the 1974 Hawaii Prepaid Health Care Act. We estimate that up to 50 percent of the individuals on the individual exchange may be eligible for a BHP. This would leave a very small individual risk pool on the exchange. However, this does not necessarily

represent a problem. The ACA requires that premiums are based on the risk level of the individual market as a whole, not just on the risk level of exchange enrollees. This creates an option to include BHP as part of individual risk pool, which means it would not destabilize the exchange.<sup>xxxii</sup> If Hawaii chooses to go forward with a BHP, it would be important to elect this option.

## FEASIBILITY CONSIDERATIONS

Cost	Stakeholders	Implementation
<i>State budget impact?</i> <i>Any other funding to leverage?</i>	<i>Who is likely to support?</i> <i>Who is likely to resist / oppose?</i>	<i>Complexity</i> <i>Time horizon</i>
Leverages federal funding, exact effect on state budget unclear	Support - COFA islanders, FQHCs, advocacy organizations, insurance companies  Oppose - potentially providers, legislators who are concerned about financial risks	Statutory program under ACA, precedent with NY and MN.  Could add onto existing Med-QUEST program  Should be feasible update to Healthcare.gov given website's existing capabilities

## ADDITIONAL PROS & CONS

### Pros

- Strong option in terms of coverage and benefits for COFA islanders. Will also likely lead more low-income individuals overall to obtain coverage.
- Administratively simpler for enrollees, particularly COFA islanders, and avoids the need to reconcile advance premium tax credits on federal income tax returns.
- Avoids costly administrative churn of policyholders between Medicaid and private insurance.

### Cons

- State takes on the financial risk if costs are larger than the federal subsidies.
- Federal subsidies based on prospective enrollment, which is difficult to calculate when it is unclear the exact number of COFA islanders who would enroll in a BHP.
- Federal funding equal to 95 percent of enrollees' APTC and CSR. A 1332 waiver approach, discussed below, could attract more federal funding (but unlikely).
- Unclear how providers will react to reimbursement rates below QHP-rates.

## State Innovation 1332 Waivers

States can apply for State Innovation 1332 Waivers to pursue strategies for providing residents with health insurance. Waivers can be requested for ACA requirements including benefits covered, QHP eligibility and how subsidies are paid. The proposed plan and requested waivers must provide coverage that is at least as comprehensive and affordable as ACA coverage without the waiver. It also must provide coverage to a comparable number of residents covered prior to the waiver and without increasing the federal deficit.<sup>xxxiii</sup>

Hawaii submitted a 1332 waiver to waive Small Business Health Options (SHOP) exchange requirements. Hawaii's Prepaid Health Care Act requires that employees provide coverage that

meets or exceeds ACA standards for employer-sponsored health coverage. Below are some of the key differences between Hawaii's Prepaid coverage and the ACA required coverage.<sup>xxxiv</sup>

Snapshot of ACA and Hawaii Prepaid Health Care Act	
ACA	Hawaii
Requires employers with 50 or more full-time employees to offer coverage to those who work at least 30 hours a week.	Requires all employers with at least one full-time employee to provide coverage to those who work at least 20 hours a week.
Allows employees to pay up to 9.5 percent of their income for coverage.	Only allows employees to pay up to 1.5 percent of their income for coverage.
Allows employers to offer "bronze" coverage plans, which have an actuarial value of 60 percent. It also requires that employers offer at least one "silver plan", or 70 percent actuarial value.	The average value of the average Hawaii Prepaid plans is "platinum" or 90 percent actuarial value.

The waiver also requests tax credits that would have gone to small business employers be paid to Hawaii. The funds will be deposited in Hawaii's Prepaid Premium Supplementation Fund and administered to qualified small businesses. HHS approved this 1332 waiver on December 30, 2016.

Hawaii could use a 1332 waiver to create insurance products that are more flexible than the BHP and more appropriate for its residents. Each 1332 waiver is unique to the state's needs. The timeline for implementation will be longer than the BHP process due to stakeholder and public comment periods and the required economic analysis. First we lay out a narrow BHP-like plan for only COFA islanders. Then we suggest two plans that allow for broader risk pools than the BHP and the exchange.

### Create a BHP-like plan for COFA islanders only

Hawaii can apply for a 1332 waiver to create a population specific BHP-like plan that exclusively includes COFA islanders. Eligibility for this plan would be COFA islanders' nonimmigrant, lawfully present immigration status. This option would request exemptions from how APTCs and CSRs are paid, and QHP eligibility. This would allow Hawaii to receive APTCs and CSRs to pay for a non-QHP BHP-like plan. Although there is not reliable income data for COFA islanders, we assume that most are below 200 percent FPL. Given the challenges cost sharing creates for COFA islanders currently, we suggest this plan include no copays or premiums. For COFA islanders who are above 200 percent FPL, Hawaii could decide to keep them on the exchange or raise the BHP-like eligibility standards to 250 percent, the limit for CSRs.

Healthcare.gov cannot send individuals to a BHP plan based on immigration status. A 1332 waiver cannot require customization of the federal site. This option would not require Hawaii to go back to a state-based exchange but would require the state to build a separate portal on top of Healthcare.gov to determine BHP-eligibility. The state would have to cover the full cost of building this portal site.

## FEASIBILITY CONSIDERATIONS

Cost	Stakeholders	Implementation
<i>State budget impact?</i> <i>Any other funding to leverage?</i>	<i>Who is likely to support?</i> <i>Who is likely to resist / oppose?</i>	<i>Complexity</i> <i>Time horizon</i>
Leverages federal funding (level likely equivalent to BHP, as Federal government has declared it is unlikely fund this type of 1332 waiver above 95% of APTC + CSR)  Exact effect on state budget unclear	Support: COFA islanders, FQHCs, advocacy organizations, insurance companies  Oppose: potentially providers and legislators who are concerned about financial risks and have limited appetite given non-voting constituency	Requires custom 1332 waiver proposal, with public comment period and federal review  1332 waiver proposal cannot include customization of Healthcare.gov  Could piggyback on Med-QUEST program

## ADDITIONAL PROS & CONS

The pros and cons for the BHP plan hold for the BHP-like plan with these additional considerations:

### Pros

- Plan materials can be created to directly target and address COFA islanders needs. Because they are the only population on this BHP-like plan, it can be created with their specific needs in mind.

### Cons

- Does not provide additional benefits to non-COFA, low-income individuals, unlike the BHP.
- This plan makes a special accommodation for COFA islanders which may exacerbate stigma and be politically difficult.

## Create a plan for the entire exchange population, Medicaid and state employees

Hawaii could apply for a 1332 waiver to create a plan that includes the entire exchange population in addition to state employees and those on Medicaid. This option would request exemptions from the exchange, how APTCs and CSRs are paid, and QHP eligibility. Hawaii would also need to obtain a Medicaid waiver to bring Medicaid beneficiaries into this risk pool. Individuals would have different levels of financial participation, but the coverage would be the same for everyone with the same benefits and reimbursements for providers.

If Hawaii combines state employee insurance and the employee retirement system, along with Medicaid, a substantial portion of the health care exchange would be cornered. With the addition of the exchange population, there would be large negotiating power with providers. Challenges to this option include push back from state employees unlikely to support moving to a “medicaid-like” plan and provider resistance because of potentially lower negotiated rates.

## Create a single-payer plan for all individuals in the state

Hawaii could also apply for a 1332 waiver to create a single-payer plan that includes all individuals in Hawaii: those on Medicaid, those currently in the individual market, and those with small group and employer plans. As with the option above, individuals would have different levels of financial

participation, but the coverage would be the same for everyone with the same benefits and reimbursements for providers. We believe a single-payer plan will be politically complicated to implement because it requires the dismantling of the prepaid employer market.

In 2010, Vermont Governor Peter Shulman conducted three external economic assessments of a single-payer plan. Although the assessments projected overall savings, it also called for tax increases for employers and individuals. Vermont ultimately determined the single-payer plan was politically unfeasible due to the risk of economic shock and mixed public support.<sup>xxxv</sup>

## Federal Policy Options

At the federal level, Hawaii's officials and representatives have proactively pursued various strategies to support health coverage for COFA islanders, primarily centered on reinstating Medicaid funding and expanding COFA Impact Aid. This section lays out recommendations for furthering those federal strategies and will also discuss long-term reform to the COFA islanders' immigration status.

### Reinstating Medicaid Benefits

Prior to 1996, COFA islanders living in the United States were eligible for Medicaid services as legally residing non-citizens. Enactment of the Personal Responsibility and Work Opportunity Reconciliation Act (PRWORA) however, stripped some legal immigrants, including COFA islanders, of their eligibility for most federal programs such as Medicaid. Since then, Hawaii has largely assumed the cost of providing health coverage for COFA islanders, straining the state's budget.

Since the passage of PRWORA, legislative efforts to reinstate Medicaid benefits have focused on making an exception for COFA islanders within the law's definition of "qualified aliens." Together with members from affected states and territories (e.g., Guam, Samoa, and California, Washington, and Oregon), Hawaii's Congressional delegation has repeatedly introduced legislation to restore Medicaid benefits for COFA islanders.

Most recently, Senator Hirono (D-HI) and Representative Gabbard (D-HI) introduced S.1301/H.R.2249, entitled "Restoring Medicaid for Compact of Free Association Migrants Act of 2015," which amends PRWORA to restore Medicaid benefits for COFA islanders.<sup>xxxvi</sup> Similar legislation was introduced in previous sessions but failed in committee.<sup>xxxvii</sup> Bills focusing specifically on COFA islanders have consistently lacked bipartisan support and attract a very narrow number of co-sponsors.

The most successful legislative effort to restore Medicaid benefits for all COFA islanders was through a comprehensive immigration reform bill in 2013, introduced by Senator Schumer (D-NY) and Representative Garcia (D-FL) and entitled the Border Security, Economic Opportunity, and Immigration Modernization Act (S.744/H.R.155).<sup>xxxviii</sup> The bill included a provision to restore Medicaid eligibility for legally residing COFA islanders. Notably, the bill had bipartisan support in the Senate, but ran into partisan barriers in the House: four out of seven co-sponsors in the Senate were Republicans, but only three out of 200 co-sponsors in the House were Republicans. While the final package passed in the Senate (68 to 32 votes), it failed in House committee.

### Advance Medicaid restoration for COFA islanders through a larger legislative package

It is important for the Hawaii delegation to continue pushing for reinstatement of Medicaid benefits for COFA islanders. The key question is *how* to successfully achieve that goal on the legislative front: through stand-alone legislation or as part of a larger bill. The Hawaii delegation has typically leveraged the former.



Based on prior legislative efforts however, one potentially effective strategy would be to move this issue through Congress as part of a larger bill or legislative package, with a provision attached to restore Medicaid benefits for COFA islanders. Doing so would broaden the support base for an issue that has traditionally received narrow attention from the small number of affected states and territories, maximizing its likelihood of passage. This approach is also critical to ensuring that any bill related to expanding federal benefits for certain immigrants would receive the supermajority support necessary to overcome a possible Presidential veto.

There are, however, several challenges to this strategy. Results from the 2016 Elections suggest a political climate that leans toward heavier restrictions placed on immigrants and rollbacks to funding for health care; the delegation must identify a viable legislative vehicle to attach COFA islanders onto that can succeed within this political context. Moreover, this federal strategy can be reversed at any time by legislation in the future that seeks to restrict federal benefits for noncitizens like COFA islanders, underscoring the broader need for immigration reform.

#### FEASIBILITY CONSIDERATIONS

Cost	Stakeholders	Implementation
<i>State budget impact? Any other funding to leverage?</i>	<i>Who is likely to support? Who is likely to resist / oppose?</i>	<i>Complexity Time horizon</i>
Leverages federal funding and reduces state costs	Support: Representatives and officials from states and territories with COFA populations (e.g., California, Washington, Oregon, Guam, and Samoa); health care providers; advocates for COFA islanders; Department of the Interior  Oppose: Senate and House Republicans with a track record of voting against expansion of federal public benefits, particularly for immigrants; advocates who are against expansion of rights and services for immigrants.	Complexity: Simple due to existing Medicaid system  Time horizon: Depends on final legislation (e.g., full implementation could be delayed)

#### Promoting Immigration Reform

Recent legislative attempts to ameliorate the condition of COFA islanders in the United States have focused on restoring access to social services and increasing federal funding to states and territories where migrants live. While these strategies can provide some immediate relief to states struggling to address the needs of COFA islanders, we suggest such efforts be augmented to include an immigration reform component.

Working with the federal government to establish a pathway to legal permanent resident status for COFA islanders could be one such long-term fix. If COFA islanders were permanent residents with normal immigrant status, they would automatically have access to Medicaid after a five-year waiting period, along with other federal programs open to permanent resident and have a greater degree of insulation from the political vicissitudes of Washington.

Not granting COFA islanders permanent resident status was a deliberate decision made by the federal government when the COFA agreement and its amendments were signed, and getting federal lawmakers to change course will not be easy given the duration of the existing agreements. Amplifying the challenge of immigration reform for COFA islanders is the current wave of anti-immigrant sentiment sweeping much of the nation.

### **Use Public Relations Campaign or Interest Group Advocacy Strategy to Increase Awareness of and Support for Reforming the Immigration Status of COFA islanders**

There are two primary strategies advocates for COFA islanders could take in achieving immigration reform: motivating public opinion and interest group advocacy.

While we were unable to locate credible polling data on public awareness of COFA islanders, it seems unlikely due to the size of their population, that their plight and historical relations with the United States are well known amongst the general population. Advocates could attempt a public awareness campaign by highlighting the gross injustices committed at the hands of the United States with regards to the stewardship of their countries and the exploitation of their natural resources by the United States. The message of the campaign would be that our national values require us to “do right” by the COFA islanders, who have suffered from U.S. military activity in their atolls. While plausible, a public relations campaign to garner popular support for legislation would require a national effort. Furthermore, due to their small geographic concentration a model such as interest group advocacy, which is often employed where benefits are concentrated and costs diffuse, would likely be more effective than waging a fight for the hearts and minds of the general public.

Interest group advocacy is a model that works behind the scenes in executive agencies and legislative committees. Crucial to this model is building strategic alliances with key stakeholders that can deliver a targeted message to a small but highly influential group of policymakers. Natural coalition allies may include the U.S. military, environmental organizations, and representatives from states with significant COFA populations. Given the military importance of the COFA islands, the high rates of COFA military and civilian employment in military service, and growing influence/overtures of China in the region, the U.S. military may be natural allies in advocating for more equitable treatment of COFA islanders. Additional coalition members may be states that also have large COFA islander populations, such as Arkansas and Oregon to create a united front for normalizing the immigration status of COFA islanders. The more this is seen as a national issue, not just an issue for Hawaii, the greater the chance of success. Building a target coalition of key insiders could help accomplish the goal to craft an amendment as part of a larger piece of legislation that would grant the COFA islanders the legal status they need to fully avail themselves of the resources and opportunities in the United States.

An important part of any public relations or direct advocacy effort will also be to highlight that COFA islanders make important positive contributions to both Hawaii and the United States in general all while being denied access to normal immigration status. COFA islanders have the option of serving in the U.S. Armed Forces and do so “at approximately double the per capita rate of U.S. citizens.”<sup>xxxix</sup> COFA islanders make rich and diverse cultural contributions to the Aloha State, but they also contribute in more mundane ways: they pay state and federal taxes, they work, and they purchase goods and services, bolstering Hawaii’s economy—despite daunting linguistic and social barriers. These are important messages to underscore in any effort to improve COFA islander status.

## FEASIBILITY CONSIDERATIONS

Cost	Stakeholders	Implementation
<i>State budget impact? Any other funding to leverage?</i>	<i>Who is likely to support? Who is likely to resist / oppose?</i>	<i>Complexity Time horizon</i>
Political time/capital to build coalitions  Lobbyist/Legal fees	Military, environmental groups, states with significant COFA populations  May encounter pushback from groups desiring a holistic approach to immigration reform for all migrants	Long term horizon, success hinges on political opportunism, i.e., attaching to large contentious bill that needs Hawaii delegation support.

### COFA Aid Expansion

The United States pays \$30 million each year to states and territories in Compact Impact Aid, of which Hawaii receives about \$11 million. Hawaii reported COFA expenditures for FY 2014 of \$163.3 million, about 15 times the amount received. The Department of the Interior “concurs that the current allocation of mandatory and discretionary funds [is] insufficient to meet the financial impact costs . . . associated with the Compact agreements[.]”<sup>xli</sup> The federal government should do more to support Hawaii and other jurisdictions where COFA has led to significant costs, particularly in the health care context.

Increasing federal aid to Hawaii is one option for alleviating the acute health care challenges COFA islanders face when they migrate to the United States. Increased funding would provide Hawaii flexibility to implement an appropriate solution tailored to the needs of COFA islanders.

Increasing federal aid to the Freely Associated States is another important option. Stronger investment in economic development and health care, particularly in Micronesia and the Marshall Islands, could improve the health and socioeconomic status of COFA islanders who choose to migrate to Hawaii.

Working with Hawaii’s federal delegation to press for increased aid, particularly in the context of COFA renewal negotiations, will help Hawaii better serve these residents and ensure the U.S. government is seen to honor its commitments.

An important point for the delegation to emphasize in its advocacy for greater federal aid is that fully meeting the financial burden for COFA islander care benefits not only Hawaii and COFA islanders living in Hawaii, but also U.S. national security interests in the Pacific. Maintaining access to the territorial waters of Micronesia, Palau, and the Marshall Islands is an important security priority, which hinges on the COFA agreement. As noted by Lieutenant Colonel Thomas Matelski, a U.S. Army War College Fellow at the Daniel K. Inouye Asia Pacific Center for Security Studies, “[i]f Washington fails to act in a timely manner to renew the sometimes troubled Compact relationship, it will inadvertently drive the Micronesians into the arms of China and simultaneously leave a gaping hole in strategic access.”<sup>xlii</sup> China has “invested hundreds of millions of dollars in developing its diplomatic relationship with the FSM[,]” primarily in “economic sectors that the United States-FSM

Compact intended to develop” and also into a trust fund designed to help support the FSM after the 2023 COFA expiration.<sup>xlii</sup>

As long as access to the waters around the Freely Associated States remains of strategic interest to the United States, the COFA agreements will remain essential. And as long as the COFA agreements are effective, Hawaii can expect to incur significant costs. Therefore, it is the decent and strategic course for federal lawmakers to increase aid to an appropriate level so Hawaii can fulfill its role as host to those COFA islanders wishing to exercise their right to migrate to the United States. Treating COFA islanders well and fairly is inextricably linked to the viability of the COFA agreements, and doing so requires adequate funding, for which the federal government should be responsible.

### Lobby Federal Government for Increased COFA Impact Aid Assistance

As the deadline for Compact renewal approaches, it is essential that the state focus its efforts on securing adequate aid to provide and expand services for COFA islanders living in Hawaii.<sup>2</sup> Such investment will pay dividends as COFA islanders are more seamlessly integrated into the cultural and economic landscape of the state. Providing for COFA islanders, especially by offering them essential health services—some designed to address health effects suffered due to U.S. nuclear testing—is not simply an act of charity. Nor is allowing COFA islanders to live and work in the United States a gift, but rather part of our international obligations under signed agreement. COFA islanders represent both an opportunity to enrich the cultural and economic lives of Americans and an important piece of a larger geopolitical puzzle, one with potential ramifications for our national security. Advocacy in support of COFA renewal and continued and increased aid to Hawaii should feature these facts prominently.

### FEASIBILITY CONSIDERATIONS

Cost	Stakeholders	Implementation
<i>State budget impact?</i> <i>Any other funding to leverage?</i>	<i>Who is likely to support?</i> <i>Who is likely to resist / oppose?</i>	<i>Complexity</i> <i>Time horizon</i>
Exclusively federal funding sought, but lobbying efforts will cost state money, in third-party contract or staff time	Support: Hawaii state legislature; Department of Interior COFA islander advocates; FQHCs; if aid can be extended to COFA island nations, then receiving islands.  Oppose: Anti-immigration or fiscally conservative federal lawmakers.	Complex negotiations leading up to current COFA expiration in 2023; broader geopolitical and national security concerns increase complexity; limited direct involvement in negotiations

<sup>2</sup> Of course, advocates need not limit themselves to negotiations around the 2023 COFA expiration to push for increased aid. Congresswoman Madeleine Z. Bordallo, for example, introduced a bill in January 2016 designed to increase aid: <https://bordallo.house.gov/media-center/press-releases/bordallo-introduces-compact-impact-relief-bill>.



## V. Recommendations

For many years, Hawaii’s state institutions have shouldered the burden of care for COFA islanders, taking on the health, educational, and housing needs of this population. This report’s goal is to find policy avenues that the Hawaii Governor’s office can pursue to provide adequate, appropriate and affordable health care for COFA islanders. Our recommendations join federal, state, and administrative avenues. The complex needs and migration status of this population led us to explore areas for improvement not only among current health care possibilities, but administrative areas as well.

We developed two packages of recommendations that choose policies to address two areas— the difficulties currently experienced by COFA islanders to accessing health care and the need to increase the number of those covered. Compared with the status quo, these policies should improve COFA islanders’ overall access to health care. Within the framework, these two areas are broken down into sections. “Addressing Pain Points” looks at how each policy increases accessibility, decreases barriers to enrollment, and improves eligibility identification compared to the status quo. “Coverage” looks at how policies increase the total number of COFA islanders enrolled and eligibility for COFA populations.

### Package 1: Short-Term and Feasible

The recommendations included in Package 1 can be implemented in the short-term, are politically and financially feasible, and place the relatively smallest burden on the state, all while improving access to care. The administrative recommendations address current areas of inefficiency and oversight, providing small fixes to the current system that we think will ease confusion and improve care. The Federal recommendation to advocate for increased funding for Compact Impact Aid would



complement the increased care by providing more financial resources for caring for COFA islanders. Taken together, this package of recommendations modestly increases coverage and addresses pain points.

#### Administrative

- Allow COFA islanders to use community center or church addresses for the purpose of receiving correspondence related to health care
- Increase access to PAP for COFA islanders to reduce patient cost burdens
- Require providers to collect data on COFA patients
- Increase funding for culturally appropriate outreach for FQHCs

#### Federal

- Advocate for increased funding for COFA impact aid

	Coverage		Addressing Pain Points		
	Headcount <i>How many people are eligible?</i>	Demographic <i>Specific subgroups (e.g. ABD, poor)</i>	Eligibility Identification	Plan Enrollment	Accessing Care - Benefits available - Appropriate utilization - Cost to patients
Updating Contact Rules			Identifies those eligible	Increases plan enrollment	
PAP Access	Fewer Exchange plans canceled for non-payment				Cutting patient cost
Provider Data collection		Increases identification of chronic illness to improve treatment			
Outreach Funding		Improved communication in native language	Increases identification of those eligible	Increases plan enrollment	Appropriate use
Impact Aid Funding					Adding funding could support broader benefits

## Package 2: Long-Term and Ambitious

The second package provides a more complex set of recommendations that would need to be implemented over a longer timeframe. Given available resources and the uncertain political climate, it would be more difficult to institute these recommendations immediately. However, the impact of this package is more ambitious and would lead to large improvements in the health of COFA islanders living in Hawaii.

### State Policy Avenues

- A Basic Health Plan

### Federal

- Granting COFA islanders Federal Medicaid eligibility as a part of a Medicaid bill or through other legislation

	Coverage		Addressing Pain Points		
	Headcount <i>How many people are eligible?</i>	Demographic <i>Specific subgroups (e.g. ABD, poor)</i>	Eligibility Identification	Plan Enrollment	Accessing Care - Benefits available - Appropriate utilization - Cost to patients
<b>Basic Health Plan</b>	Increase enrollment up to 200% FPL	Captures subgroups unaware of eligibility	Identifies those eligible	Increases plan enrollment	Less plan churn, easier to access care
<b>Re-Add COFA to Medicaid</b>	Increases enrollment up to 138% FPL	Captures subgroups unaware of eligibility	Identifies those eligible	Increases enrollment	Less plan churn, easier to access care

The avenues suggested above direct the Governor's Office to the most immediate, feasible, and cogent recommendations. While none of these recommendations alone, or even combined, can entirely solve this complex issue, it is necessary to break down the silos between stakeholders and view the problem as holistic. Through implementing these changes that address the roles of various stakeholders, Hawaii can ensure that the state's most vulnerable populations receive needed care.

## VI. Appendix

### Maps of Likely COFA Islander Neighborhoods

The ethnic and citizenship data publically available does not offer enough detail to identify populations that fall under COFA legal status. In both cases, the most specific category available is “Pacific Islander,” rather than something as specific as “Chuukese” for ethnicity or “Palau citizen” for citizenship.

Absent direct data, we chose to use two other characteristics as proxy indicators for the populations likely to include COFA islanders who were historically covered by Medicaid and who are now the focus of our consulting project. The locations that have **both** above-average rates of non-citizens and above-average rates of families living poverty are high-need neighborhoods, and—we theorize—are likely also house the COFA islander population of interest to our client.

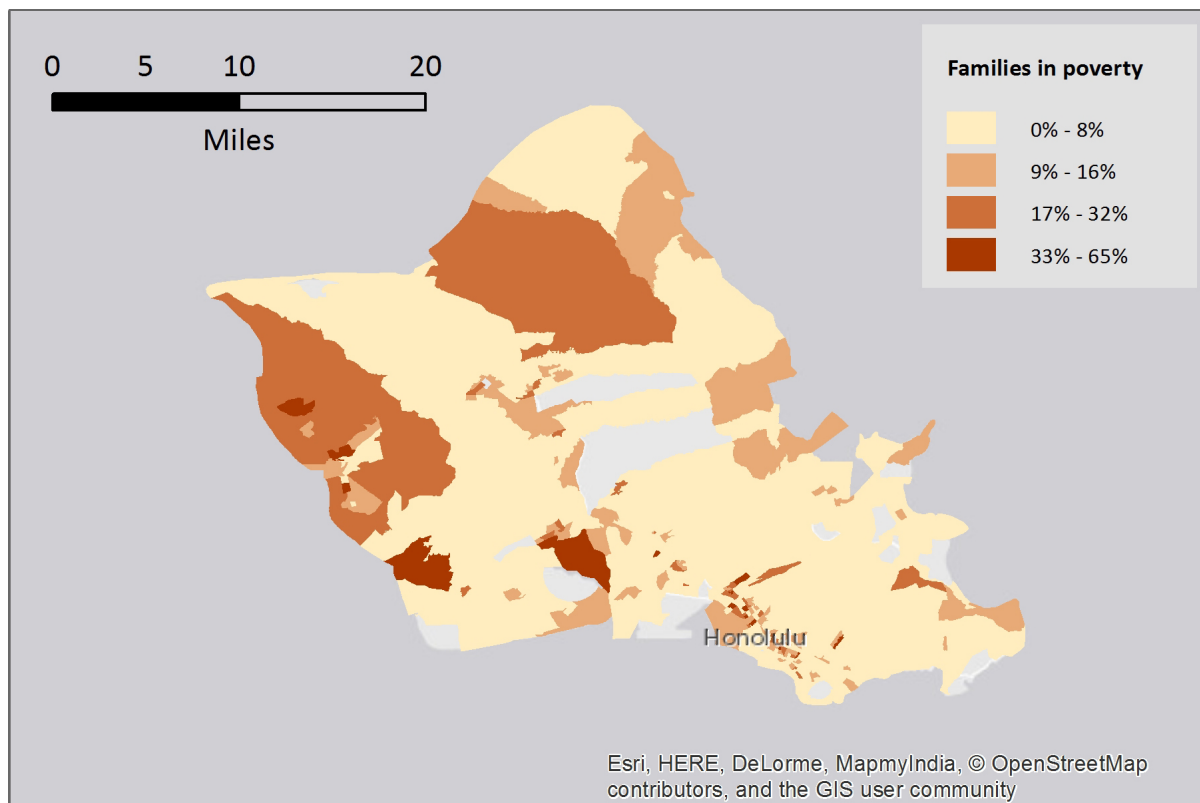
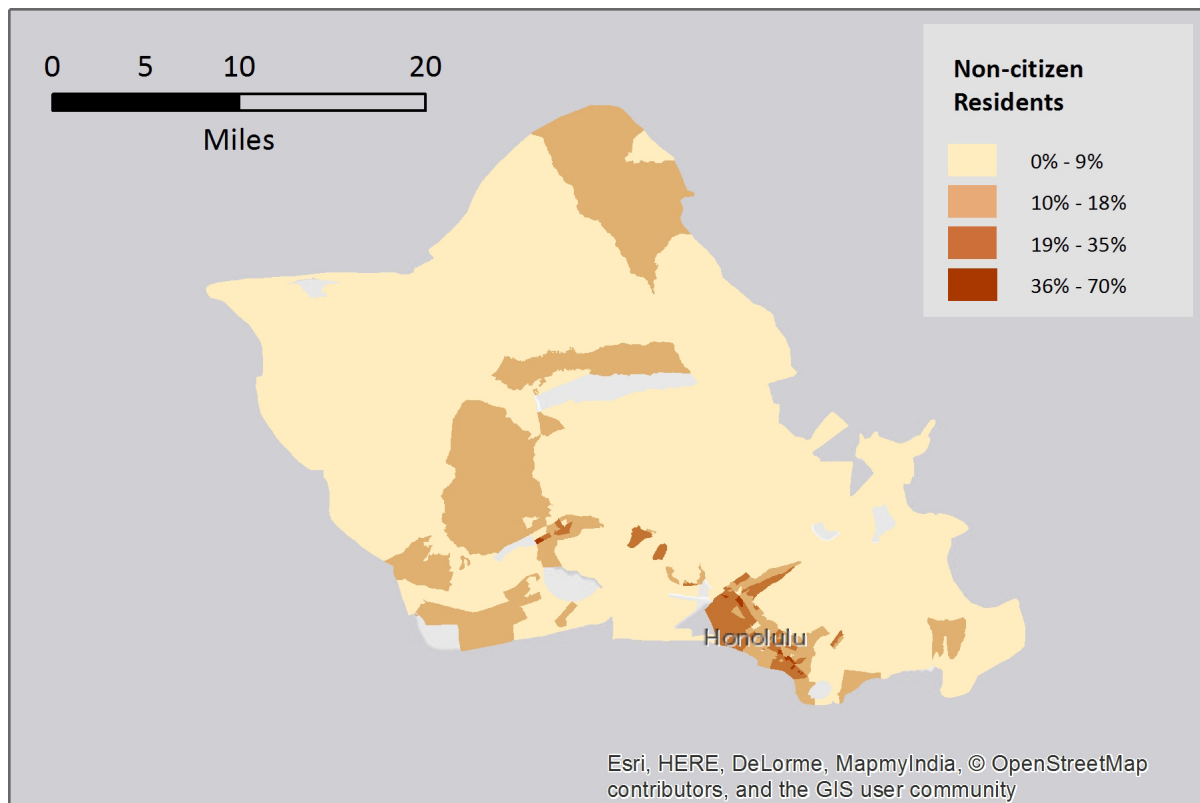
We used GIS mapping software to identify the census blocks that likely had high concentrations of COFA islanders. Of the 828 census blocks in Hawaii, the mean family poverty percentage was 8.1% (ranging from 0-61%) while the mean non-citizen percentage was 8.8% (ranging from 0-62%). By isolating the census blocks that had both a percentage of families in poverty over 8.1% and percentage of non-citizens over 8.8% simultaneously, the maps that follow illustrate census blocks with high probably of COFA islander residents. To examine if COFA islanders have additional burden trying to access hospitals and/or FQHCs, we calculated the distance from a COFA census block to the nearest hospital and FQHC.

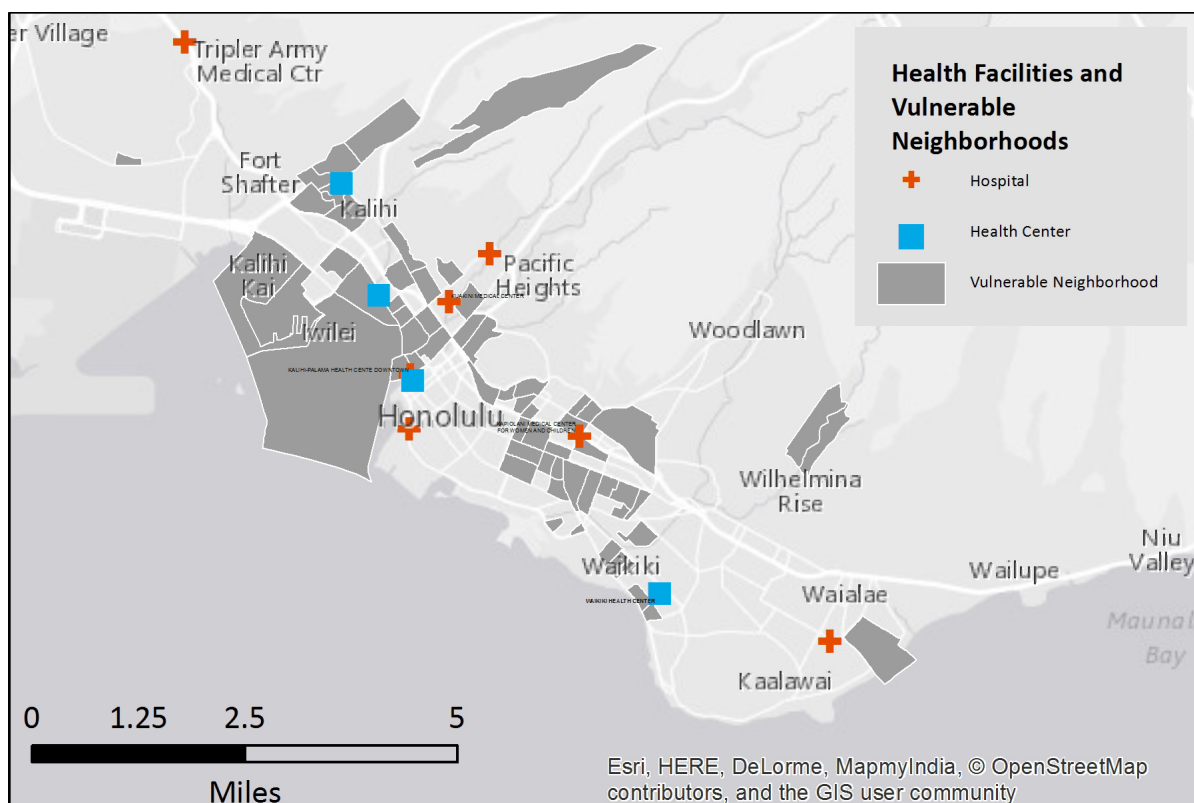
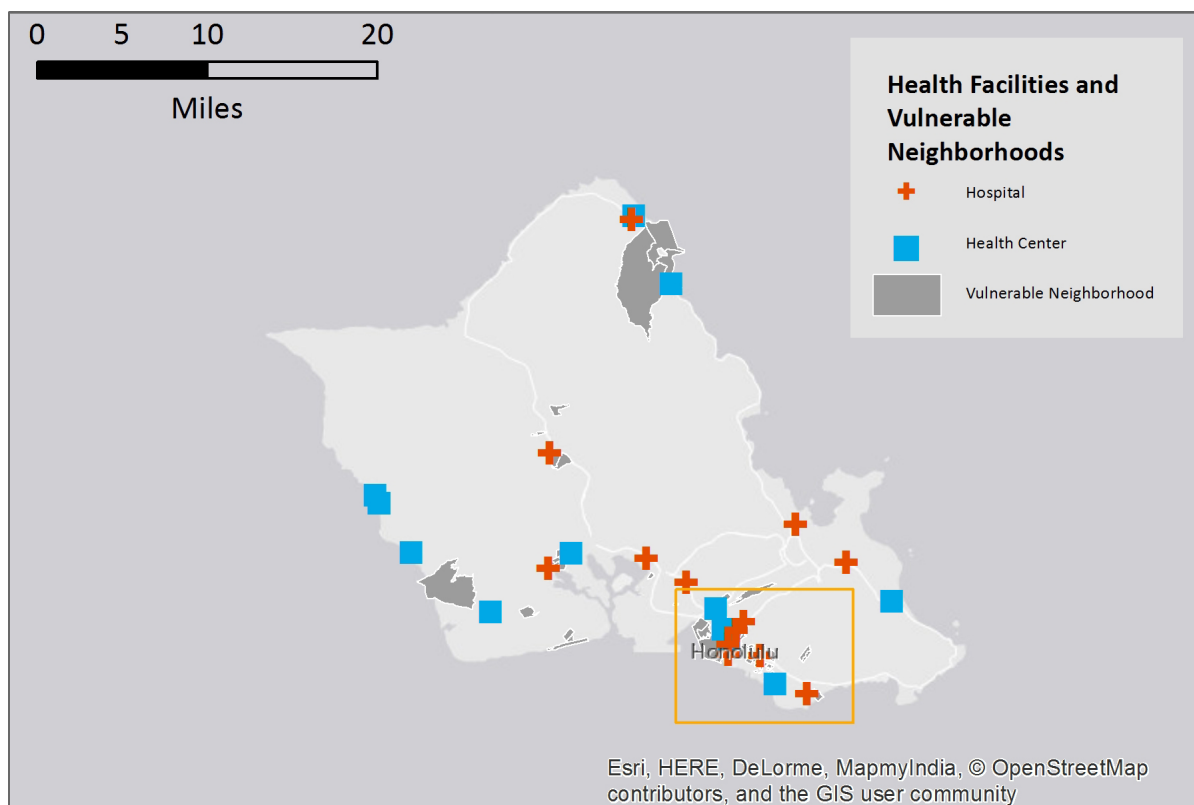
The following pages show maps depicting the islands of Oahu and Hawaii. For each island, we created:

- A map that shows the locations and concentrations of residents who are not citizens of the United States
- A map that shows the concentrations of families living below the poverty line
- Two maps that display those areas that are above average on both of the prior two metrics—one that shows the entire island and one focused on a neighborhood of interest. These final maps also show the locations of the hospitals and federally qualified health centers are located on the island.

Aggregating the populations using proximity information, we constructed a table of the health care facilities on the island of Hawaii, and their insurance affiliates. Similar methods identified that the Kalihi Palama Health Center Downtown and the Waikiki Health Center are the two clinics closest to the largest population from likely COFA islander neighborhoods on Oahu. The Kapiolani and Kuakini Medical Center are the two hospitals closest to the largest likely COFA islander population on Oahu.

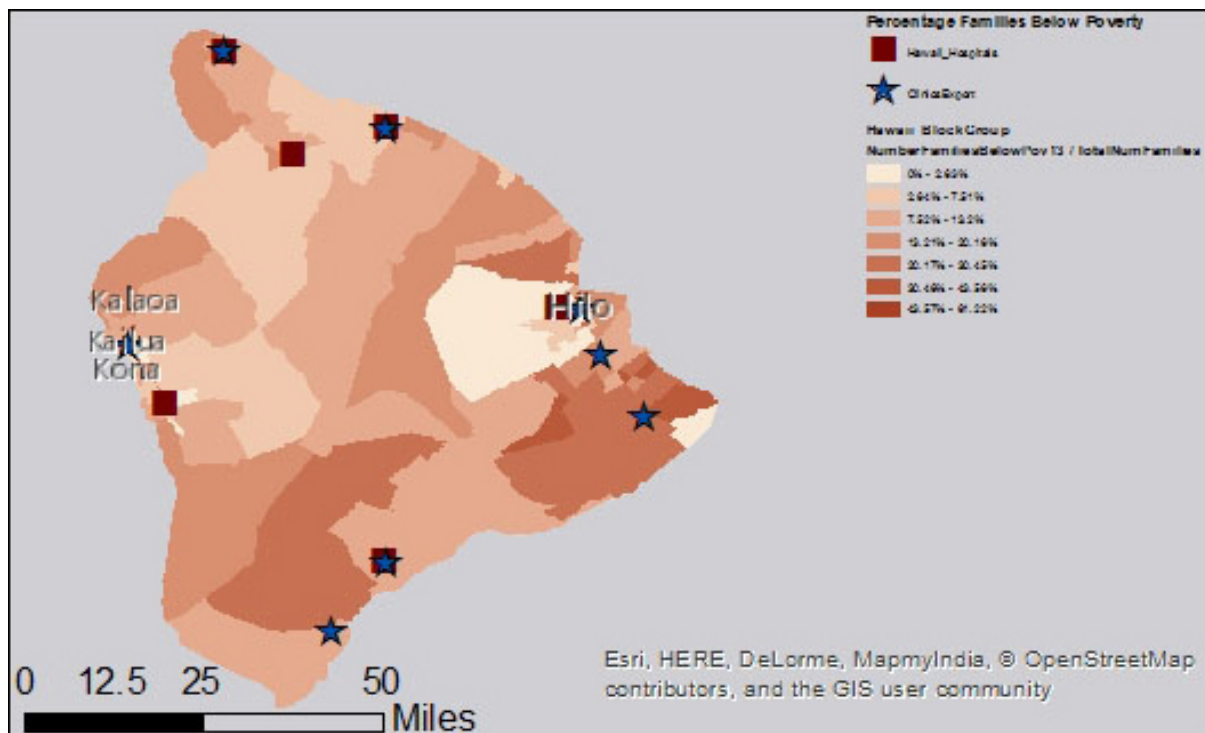
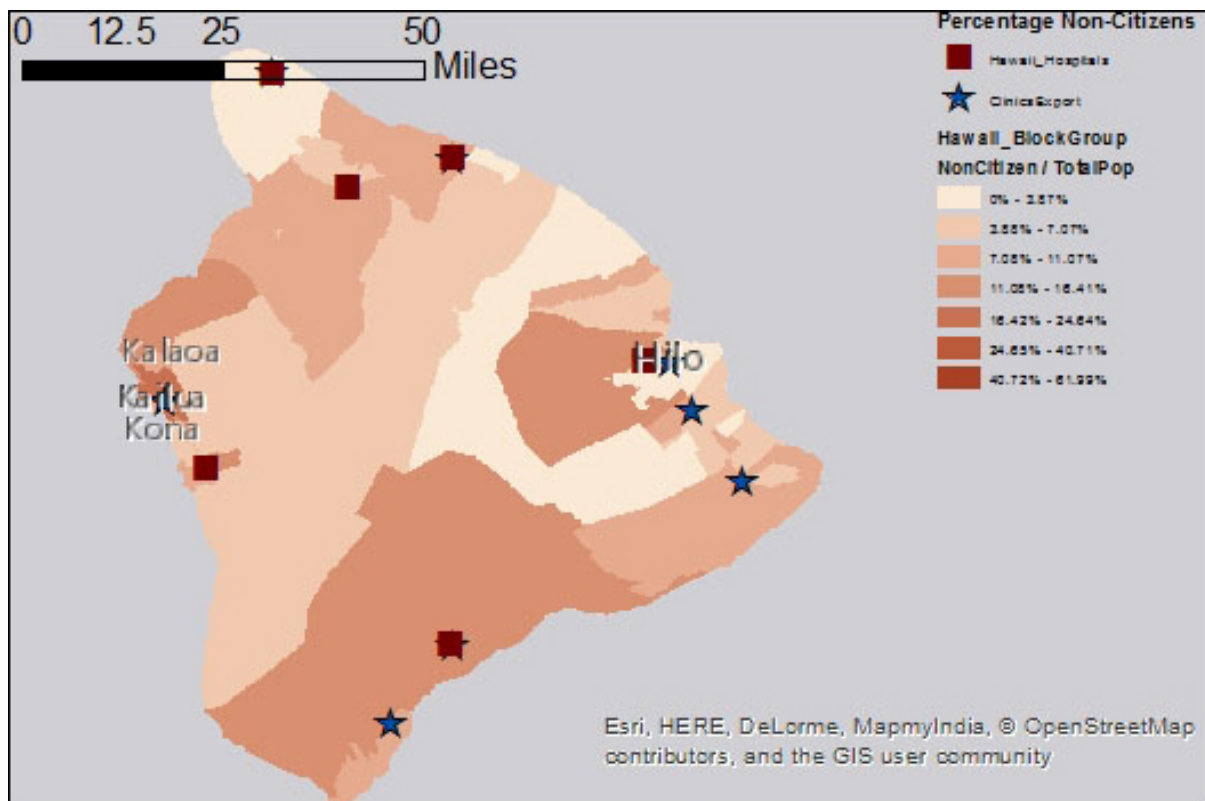
## Island of Oahu

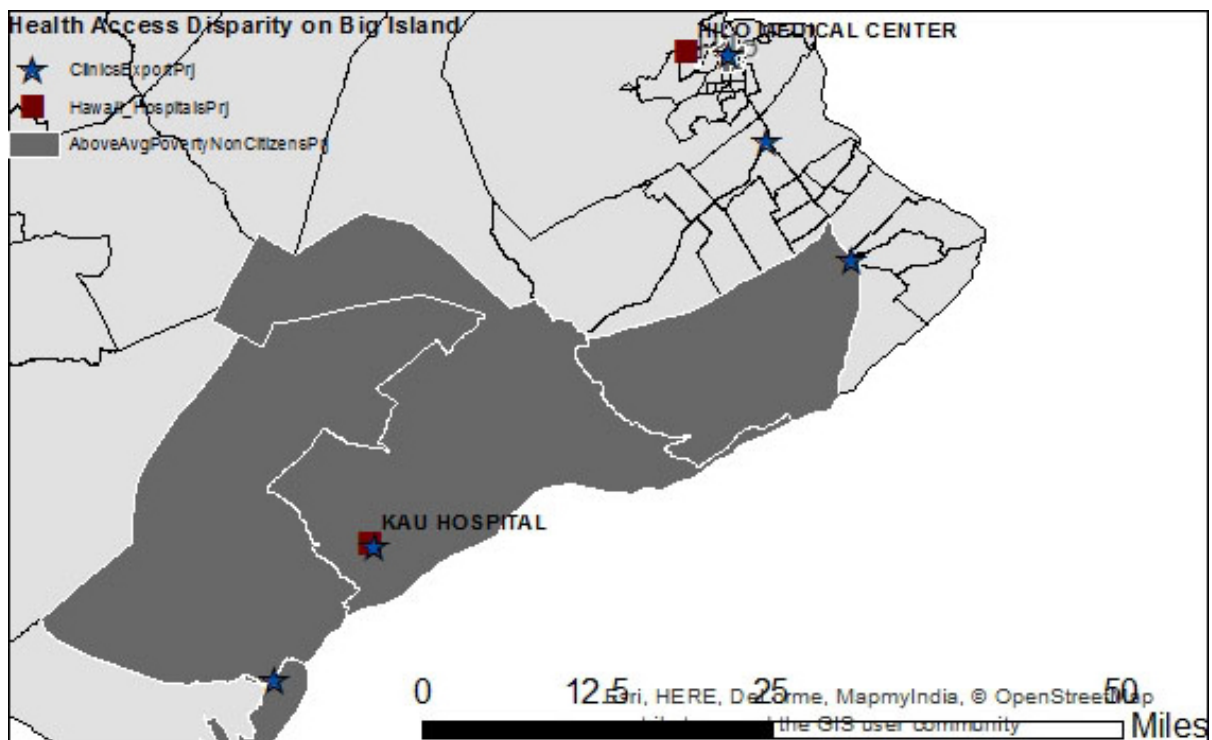
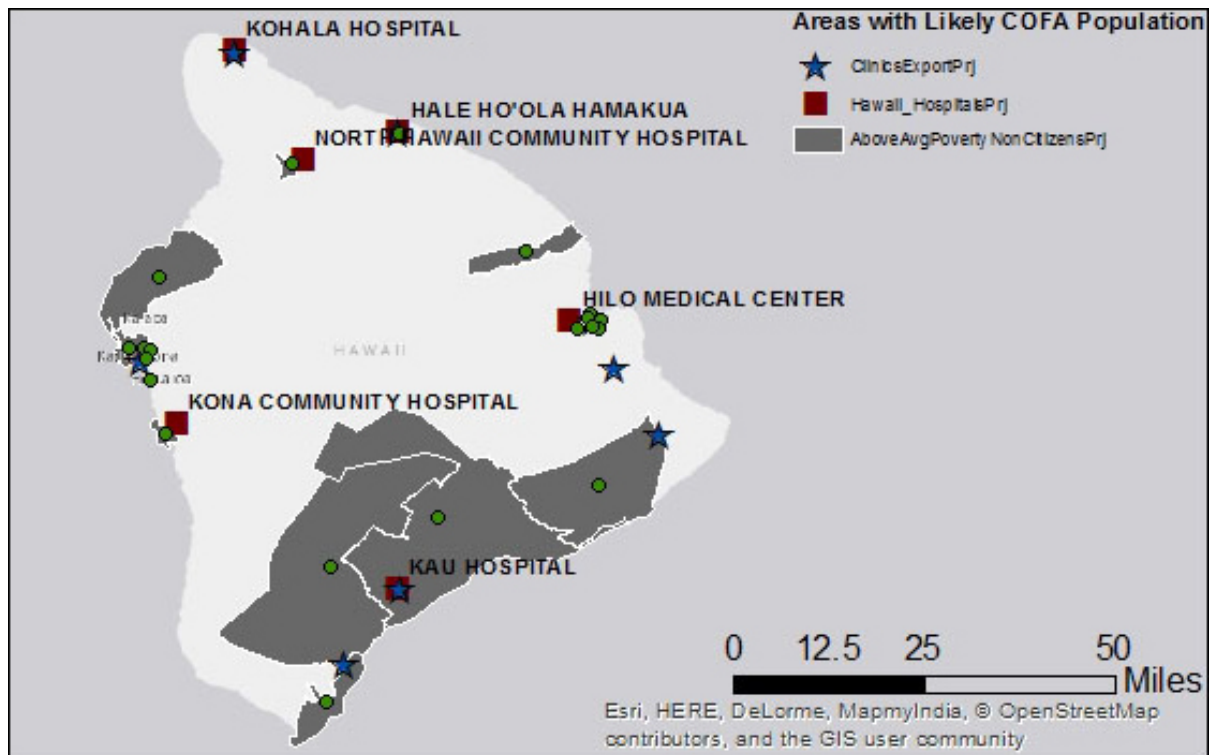






## Island of Hawaii





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