EXECUTIVE CHAMBERS

HONOLULU

BENJAMIN J CAYETANO
GOVERNOR

January 31, 2001

Mr. Ferdinand Aranza
Director, Officer of Insular Affairs
U.S. Department of the Interior
Office of the Secretary
Washington, D.C. 20240

Dear Mr. Aranza:

I am again sending you my views on the impact of the Compact of Free Association with the Federated States of Micronesia (FSM) and the Republic of the Marshall Islands (RMI), for your transmittal to Congress in accordance with section 104(e)(3) of P.L. 99-239, as amended by P.L. 106-504.

First, I would like to make you aware of my strong disagreement with the decision of the U.S. Department of Health and Human Services (DHHS) that the State is not entitled to federal financial participation to defray the State's Medicaid costs for Compact migrants. On March 3, 2000, DHHS, through its agency the Health Care Financing Administration (HCFA), directed the State to cease claiming federal financial participation in the State's program for providing non-emergency health care services to Compact migrants. Although we appreciated DHHS's willingness to temporarily suspend that directive to re-evaluate its legality, we were most disappointed in DHHS's final decision to adhere to its original position.

It is imperative that we obtain relief from DHHS's interpretation of the 1996 welfare reform act. As you know, the Personal Responsibility and Work Opportunity Act of 1996 (PRWORA) restricts non-citizens' eligibility for federal public benefits. However, two of the primary rationales underlying PRWORA's restrictions are completely inapplicable to Compact migrants.

First, PRWORA was designed to discourage illegal immigration. Migration to the United States pursuant to the Compact's generous entry rights is not only legal, but a cornerstone of the United States' foreign and defense policy. Second, PRWORA's denial of benefits to aliens who have been in the United States for five years or less is based on the idea that aliens' eligibility should turn on the strength of their ties to the United States. However, Compact migrants have stronger ties with the United States than *any* other aliens because they come from one of the three

countries in the world that are perpetually bound to the United States in free association.

If the executive branch of the federal government is unwilling to change its position on this Medicaid issue, it is imperative that we obtain some relief from Congress. Last November Congress passed P.L. 106-504, once again making Compact migrants eligible for federal housing programs, as they had been before PRWORA. The fact that Congress did not also restore such eligibility to immigrants from other countries shows that it recognizes that it can make principled distinctions between Compact migrants' and other aliens' eligibility for federal public benefits. Congress should apply the same principle it applied in P.L. 106-504, to restore Compact migrants' Medicaid eligibility.

Our health care system simply cannot absorb the costs of providing medical care to migrants. In FY 2000, the State paid medical providers about $3.7 million for such medical services (Exhibit A). Despite these payments, our hospitals and other healthcare institutions are losing millions of dollars a year as a result of unrecovered costs for medical care for Compact migrants. Queens Hospital, one of our main hospitals, reports a projected loss of $15 million for the year just for medical care for Compact migrants. See "Free Association: Impact on Hawaii," prepared by the Communicable Disease Division of the Department of Health, July 17, 2000, p. 10 (Exhibit B). No hospital can sustain losses of this magnitude without cutting services. Our whole community is harmed by such extraordinary losses.

Our educational costs are just as serious. Since the Compact went into effect in 1986, we have spent over $64 million to educate Compact migrants and their children in our public schools. Last year alone, we spent over $10 million (Exhibit C).

I am pleased that the magnitude of these problems is slowly getting more attention in Washington, and that we will be getting more help from the federal government in assessing the impact of the Compact. As you know, the Chairman and Ranking Minority Member of the House Committee on International Relations, Subcommittee on Asia and the Pacific, have asked the U.S. General Accounting Office to review Micronesian migration to the United States and its territories and possessions. We warmly welcome the GAO representatives who will be in Hawaii later this month to meet with various representatives of the public and private sectors.

We would like GAO to have the U.S. Census Bureau's full analysis of the data gathered during the 1997 and 1998 census of Micronesians in Hawaii. I have been told that your office has funded a contract with the Census Bureau to complete its analysis, and I hope that we will get the full results shortly.

Finally, I urge you to help redress the unfairness of the Clinton administration's increasing Guam's annual Compact impact reimbursement from $4.58 million to $10 million at a time when the State of Hawaii has never received any reimbursement whatsoever. We do appreciate the

efforts of the State Department's Office of Compact Negotiations to address this disparity in the context of the Compact negotiations. So long as the United States allows migrants such free entry, the nation as a whole has a duty to honor its pledge to redress the adverse effects of such migration to Hawaii. I urge you to join me in addressing these many issues in the coming year.

With warmest personal regards,

Aloha,

Benjamin J. Cayetano

BENJAMIN J. CAYETANO

Department of Human Services
Data on Recipients from Micronesia, the Marshall Islands, and Palau
State Funding Only
FY 2000 Annual Figures
(From average monthly figures for the period August 1999 to June 2000 excluding December 1999)

1. Estimated Average Monthly Recipients

| | State Aged,Blind,or Disabled Program | State TAONF Program (formerly part of AFDC) | State General Assistance Program | Medicaid-Only Program | TOTAL |
|---|---|---|---|---|---|
| Micronesia | 85 | 1,012 | 43 | 336 | 1,476 |
| Marshall Islands | 34 | 770 | 10 | 292 | 1,106 |
| Palau | 2 | 13 | 0 | 5 | 20 |
| TOTAL | 121 | 1,795 | 53 | 633 | 2,602 |

2. Estimated Annual Money Payments (Welfare Checks)

| | State Aged,Blind,or Disabled Program | State TAONF Program (formerly part of AFDC) | State General Assistance Program | TOTAL |
|---|---|---|---|---|
| Micronesia | $212,604 | $1,505,940 | $188,484 | $1,907,028 |
| Marshall Islands | $86,172 | $1,145,208 | $45,288 | $1,276,668 |
| Palau | $3,804 | $18,900 | $0 | $22,704 |
| TOTAL | $302,580 | $2,670,048 | $233,772 | $3,206,400 |

3. Estimated Annual Medicaid Payments (Payments to Medical Providers)

| | State Aged,Blind,or Disabled Program | State TAONF Program (formerly part of AFDC) | State General Assistance Program | State Funding for Medicaid-Only Program | TOTAL |
|---|---|---|---|---|---|
| Micronesia | $511,272 | $1,217,208 | $48,288 | $393,096 | $2,169,864 |
| Marshall Islands | $213,192 | $892,332 | $11,496 | $342,624 | $1,459,644 |
| Palau | $8,148 | $14,796 | $0 | $7,128 | $30,072 |
| TOTAL | $732,612 | $2,124,336 | $59,784 | $742,848 | $3,659,580 |

The State's Aged, Blind, or Disabled Program is funded entirely by the State. This program was created to assist individuals and couples with little or no income who are not eligible for federally-funded Supplemental Security Income (SSI) or eligible only for partial SSI payments.

The State's TAONF (Temporary Assistance to Other Needy Families) Program is funded entirely by the State. It was created to assist other needy families, such as those with two parents and those with non-citizens, who are not eligible for the federally-funded TANF (Temporary Assistance to Needy Families) Program.

The State's General Assistance Program is funded entirely by the State. This program was created to assist individuals and couples with little or no income who have a temporary, incapacitating medical condition.

The State's Medicaid Program provides healthcare to eligible recipients under Fee-For-Service and Managed Care Plans. Recipients in the Aged, Blind, or Disabled Program have their medical bills paid under fee-for-service to their medical providers. Recipients in the other programs are enrolled in the managed care medical plans where the State pays premiums to the plans. The plans then reimburse the medical providers with their payments. Recipients who receive Medicaid without a welfare check are in the Medicaid-Only Program. The State's Medicaid program is funded with approximately one-half federal and one-half state funds. Effective April 1, 2000, however, federal funds may not be used in Medicaid expenditures for recipients under the Compact of Free Association.

Estimated Average Monthly Recipients were based on the average number of monthly recipients for the indicated period.

Estimated Annual Money Payments were calculated by multiplying average monthly money payments by 12.

Estimated Annual Medicaid Payments were calculated by multiplying average monthly medicaid payments by 12. Dental was included. Average monthly medicaid payments were calculated using the average monthly fee-for-service cost for the Aged, Blind, or Disabled Program and the average monthly medical plan premium payment for the other programs.

EXHIBIT A

# Compact of Free Association:

# Impact on Hawai'i

**Hawai'i Department of Health**

**Division of Communicable Diseases**

**July 17, 2000**



**EXHIBIT B**

## Background

The 1986 Compact of Free Association (CoFA) assured citizens of the Freely-Associated States (FAS), comprised of the Federated States of Micronesia (FSM), the Republic of the Marshall Islands (RMI), and the Republic of Palau (ROP), certain rights and privileges in the creation of "mutually beneficial relationships." (CoFA, p. 89) The Compact allows FAS citizens unrestricted entry to the U.S. and access to residence, education, and employment.

In 1996, the Personal Responsibility and Work Opportunities Reconciliation Act (PRWORA) of 1996, determined that FAS migrants were no longer eligible for federal means-tested public benefits including DHHS programs such as Medicare, Medicaid, State Children's Health Insurance Program or Temporary Assistance to Needy Families. Herein lies the dilemma. If FAS citizens have unrestricted access to US public services but are no longer eligible for Medicaid, the State of Hawaii is in the precarious position of having to finance the repercussions of a Federal level international agreement. Without financial assistance from the Federal government, the situation will become a potential public health threat to both Hawaii and the mainland United States.

This report compiles and presents the impact of the Compact of Free Association on the State of Hawaii since 1996. These data are the most accurate assessments currently available. Because FAS citizens require no documentation upon entry to and exit from the U.S., accurate counts of the number of FAS citizens currently residing in Hawaii remain elusive. What data sources are available, however, are referenced within this document.

## Scope of the Problem

### Migration

Since 1980, there has been increasing migration to Hawaii from the FSM, RMI, and ROP. The rise in migration is particularly evident from FSM and RMI after 1986, when the Compact came into effect.[1] (See Figure 1) Some areas of the state have been particularly affected by the influx. Figure 2 shows the dramatic increase in population of Marshall Islanders living in Kona, on the Big Island of Hawaii, since the implementation of the Compact in 1986.[2] During a 1997 screening of Pacific Islanders for Hansen's disease, 75% of persons screened had arrived in Hawaii only within the previous five years. This demonstrates an increasing trend in the number of migrants over the last few years.[3]

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[1] The Status of Micronesian Migrants in 1998: A Study of the Impact of the Compacts of Free Association based on Censuses of Micronesian Migrants to Hawaii, Guam, and the Commonwealth of the Northern Mariana Islands. Funded by the Bureau of Census and Office of Insular Affairs.

[2] Hansen's Disease Branch, Communicable Diseases Division, Hawaii Department of Health.

[3] Hansen's Disease Branch, Division of Communicable Diseases, Hawaii Department of Health, 1997.

An estimated 610 FAS citizens migrated to Hawaii before the Compact and 5,509 since. The proportions of FAS migrants coming from each state have also changed since 1986. In fact, fewer Palauans have actually migrated to Hawaii after the Compact than before its implementation. (Figure 3)

The number of children from FAS populations enrolled in Hawaii Schools has also increased dramatically since the initiation of the Compact in 1986. (See Figure 4)

**Population demographics**

Along with the growth of the FAS population in Hawaii comes the change in the demographics of this population as well. A demographic profile comparing FAS migrants before and after implementation of the Compact is provided in Table 1. A smaller proportion of FAS citizens migrating to Hawaii after the Compact are in the labor force, speak English, or have telephones than their pre-Compact counterparts. These factors can significantly hinder the state of Hawaii's ability to access this population for public health and education purposes. Additionally, more of the recent migrants are residing in domiciles without adequate water and sanitation facilities, potentially placing them at increased risk for disease.[4]

Table 1.

**Demographic profile of Pre- and Post-Compact FAS migrants to Hawaii***

| | Pre-Compact | Post-Compact |
|---|---|---|
| % in labor force | 58.1 | 44.6 |
| % Primary language at home is not English | 40.1 | 59 |
| % Speak English at home | 35.5 | 22.1 |
| % without telephone | 22.8 | 41.1 |
| % without toilet/outhouse | 6 | 9.1 |
| % without sewer/septic tank | 3.7 | 7.8 |
| % without piped water | 2 | 4.3 |

* The Status of Micronesian Migrants in 1998: A Study of the Impact of the Compacts of Free Association based on Censuses of Micronesian Migrants to Hawaii, Guam, and the Commonwealth of the Northern Mariana Islands. Funded by the Bureau of Census and Office of Insular Affairs.

[4] The Status of Micronesian Migrants in 1998: A Study of the Impact of the Compacts of Free Association based on Censuses of Micronesian Migrants to Hawaii, Guam, and the Commonwealth of the Northern Mariana Islands. Funded by the Bureau of Census and Office of Insular Affairs.

The average per capita income of post-Compact migrants is considerably lower than that of pre-Compact migrants. (See Table 2)

Table 2.
**Per capita income of pre- and post-Compact FAS migrants in Hawaii***

| | TOTAL | FSM | RMI | ROP |
|---|---|---|---|---|
| Post-Compact migrants and children | $3,759 | $4,213 | $2,977 | $4,688 |
| Pre-Compact migrants | $13,622 | $17,629 | $6,770 | $15,372 |

* The Status of Micronesian Migrants in 1998: A Study of the Impact of the Compacts of Free Association based on Censuses of Micronesian Migrants to Hawaii, Guam, and the Commonwealth of the Northern Mariana Islands. Funded by the Bureau of Census and Office of Insular Affairs.

Unemployment, defined as persons over 16 years old actively looking for work, has increased since the Compact. (See Table 3)

Table 3.
**Percent unemployment among pre- and post-Compact FAS migrants 16 years or older in Hawaii***

| | TOTAL | FSM | RMI | ROP |
|---|---|---|---|---|
| Post-Compact migrants and children | 16.9 | 12.8 | 28.0 | 30.2 |
| Pre-Compact migrants | 7.7 | 6.0 | 15.8 | 4.5 |

* The Status of Micronesian Migrants in 1998: A Study of the Impact of the Compacts of Free Association based on Censuses of Micronesian Migrants to Hawaii, Guam, and the Commonwealth of the Northern Mariana Islands. Funded by the Bureau of Census and Office of Insular Affairs.

The reasons for migrating to Hawaii have also changed. Since 1986, the *proportion* of all FAS citizens who state they are coming to Hawaii for medical reasons has almost tripled. However, the estimated *number* coming to Hawaii for medical reasons has actually increased more than 20 fold. (See Figure 5)

## Public Health Impact on Hawaii

The countries making up the FAS have very different health statistics than the United States. Because FAS citizens have unrestricted access to the U.S., we must be aware of the country-specific disease profiles from which this migrant population is coming. Diabetes rates in the Pacific are seven times higher than in the U.S. Specific infectious disease rates are described below. Hawaii must be prepared to assist the FAS migrant population with their health and social service needs. It is important to note that the information provided below can only present the actual costs and disease burden within the FAS migrant population of Hawaii. It does not quantify the potential additional impact of transmission of communicable diseases such as tuberculosis or hepatitis to and from other residents of HI and the U.S. mainland through the facility of transoceanic transportation. It also does not quantify the amount of missed time from work and school.

Regarding the Compact's impact on specific costs to the state of Hawaii, data continue to be gathered. Table 4 shows the cumulative figures for 1996 – 1999 for the Hawaii Department of Health by disease-specific programs. The total cost thus far has been estimated to be around $850,000. FAS-population specific figures are not available from some programs such as immunizations and sexually transmitted diseases (STD), because services provided to the FAS population are not documented separately. As a result, the figures presented are most likely substantial underestimates of true expenditures. Table 5 shows the estimated annual costs to each communicable disease-prevention program for providing services to FAS populations in Hawaii.

Table 4.

**Program-specific Compact costs to the Hawai'i Department of Health (HDOH) Communicable Diseases Division, 1996 –1999**

| | # cases | Cost |
|---|---|---|
| **Communicable Diseases Division[#]** | - | **>$843,306** |
| Tuberculosis control[~] | 15 | $295,350 |
| Hansen's Disease | 151* | $296,266 |
| Sexually transmitted diseases (STD)[^] | 101 | - |
| Chlamydia | 56 | - |
| Gonorrhea | 30 | - |
| Syphilis | 6 | - |
| Congenital syphilis | 3 | - |
| Non-gonococcal urethritis/cervicitis | 6 | - |
| Hepatitis[@] | 48 | $42,531 |
| Investigations (Pertussis outbreak) | 62 | $21,085 |
| Public Health Nursing[~] | - | $188,074 |

[#]Sum total of figures reported by the disease-specific programs of the Hawai'i Department of Health, HDOH.
[~]Does not include 1999 cases. Costs include skin tests, Chest X-rays, INH preventive therapy, directly observed therapy (DOT), physician consultations, sputum tests, liver function blood tests for 1833 persons screened and the subsequent detected cases.
*Number of cases of persons born in RMI or FSM, 1992-99. Cost data for 1996/97 not yet available and therefore not included. Data reported by Hansen's Disease section, DOH.
[^]1995-1998 data reported to DOH, STD/HIV section. Cost figures for FAS population only are not available.
[@]Cost figures are up to 9/30/99.
[~]Cost figures for 1996-97 not yet available and therefore not included.

Table 5.

| Estimated annual cost by communicable disease-prevention program servicing the FAS population, 1999 | |
|---|---|
| **Department of Health, Communicable Diseases Division** | **$786,522** |
| Public Health Nursing | $665,352 |
| Tuberculosis Control | $90,500 + meds, skin tests, syringes (figures pending) |
| Hansen's disease elimination | $239,100 + translators at $50/hr + funds to primary health clinics (particularly Mililani Clinic) |
| Hepatitis | $67,600 + funds to Salvation Army Clinic & Kona Community Hospital |
| STD/AIDS | $0* |
| Immunizations | $0* |

*Data are not available for estimating FAS-population program costs. Current funds appear to be sufficient for providing coverage to FAS populations

**Impact on the Hawaii Department of Public Health Communicable Diseases Division**

Hansen's Disease Branch

According to the World Health Organization, the 1997 Hansen's disease prevalence rates in FSM and RMI were the highest in the world at 35 cases/10,000 and 15 cases.10,000 respectively. For the same year, Hawaii's rate of Hansen's disease was 0.28/10,000, the highest in the nation. The first case of Hansen's disease among the Marshall Islanders in Hawaii was identified in November 1996. By the end of 1999, 181 cases had been detected among the Marshall Islanders and Micronesians in Hawaii. A large number of cases have been concentrated on the Big Island of Hawaii among the Marshallese community there, where an outbreak of Hansen's Disease occurred just 5 years ago. Public health nurses are closely following cases and contacts as well as educating community members about the disease. Continuing surveillance and follow-up of cases

with long-term therapy are ongoing activities of the Hansen's disease section within the HDOH.

Tuberculosis Branch

Imported cases of tuberculosis remains a large public health problem for the state of Hawaii. The 1996 incidence of tuberculosis in FSM was 163/100,000 population, more than 20 times higher than that of the U.S. for the same time period. Of the 181 tuberculosis (TB) cases detected in Hawaii in 1998, 79% were foreign born, 6% were Marshall Islanders, and 6% were born in former trust territories. Although cases were found in all four counties, most (82%) were detected in Honolulu county, Oahu.

The TB control program has been extremely active in targeting the Marshall Islander population in Kona through the Kona public health nurses who provide skin test screening, chest X-ray referrals, and follow-up.

Epidemiology Branch

Over the past few years, several outbreaks involving pertussis and Hepatitis A have occurred within the FAS-population communities in Hawaii. Such outbreaks of communicable diseases are not only a threat to the health and well being of FAS migrants and other residents of Hawaii, they are also a threat to the US mainland public at large. Because there are no current health screening or registration requirements when FAS citizens enter or leave Hawaii, it is essentially impossible to track potentially infectious individuals travelling to the mainland US.

Immunizations Section

Separate FAS population-specific data are not available for immunizations as activities targeting these migrants are incorporated into overall immunization programs. However, accessing and immunizing these children remain a clear public health priority because the reported immunization coverage rates in FSM and RMI have been as low as 64%. These children are therefore at risk for contracting vaccine preventable diseases such as pertussis and measles. They, in turn, are a potential public health risk to the general population of Hawaii and the mainland US.

Hepatitis Section

The hepatitis control section has carried out active screening for Hepatitis B among 309 Marshall Islanders in Kona. Of those screened, 40 were found to be non-immune therefore vaccinated. Another 48 were found to be either infectious or carriers, indicating previous infection.

In March 2000, 3 recent cases of Hepatitis A were identified within the Marshall Island population in Kona. The public health nurses conducted a hepatitis A vaccination campaign targeting 2-17 year old children. Vaccine was provided by the HI DOH Immunizations section. It was evident that more public health nurses are needed out in the field. Additionally, bilingual outreach workers and translators are much needed and currently lacking.

STD/AIDS Branch

The number of cases of sexually transmitted diseases (STDs) among the FAS population in Hawaii is increasing and remains a public health issue. (See Figure 6) Screening, treatment and contact tracing are major priorities for the STD/AIDS branch for the FAS population in Hawaii. The branch has expressed a need for urine tests for chlamydia as well as bilingual translation services for counseling and testing in this population. At present the STD/AIDS branch asserts that they have sufficient staff and funds to maintain current programs

Public Health Nursing Branch

Public health nurses are critical in successful implementation and maintenance of public health programs. They are the individuals interfacing with the FAS communities. It is the public health nurses who encourage and educate FAS migrants on basic health practices and to obtain vaccinations. Unfortunately, public health nurses are few in number and over worked, particularly on the outer islands. The language barriers are also difficult for them to bridge without bilingual interpreters and outreach workers.

Hawaii State Primary Care Association

The Hawaii State Primary Care Association, a collection of ten primary health centers and clinics throughout the state, provides outpatient services to FAS migrants. Between 1996-97 and 1998-99 there was a 51% increase in "Pacific Islanders," which also includes non-FAS citizens, using health centers in Hawaii. For 1999, the Association reports over 3,000 visits by FAS migrants and their children. Although the total costs for services would have been much more after this population was deemed ineligible for Medicaid, the unrecovered costs for 1999 was estimated at $420,160. Projected costs for outreach and transportation for 1999-2000 are an estimated $360,000 targeting approximately 2,000 FAS migrants in catchment areas. Without Medicaid assistance, the overall projected cost for health services to FAS migrants for1999-2000 is $6,598,800. This demonstrates that Medicaid funds provide a large amount of support for healthcare in this population.

Uncompensated costs to health centers will increase significantly once public coverage through Medicaid is eliminated. Currently, over 400 Marshallese in Kona are probably covered by QUEST, Hawaii's Medicaid program. The Kalihi-Palama Health Center (KPHC) has 41 Micronesian women and many more Marshall Islanders in their perinatal program who are currently covered by QUEST. Of note, FAS women comprise 25% of KPHCs perinatal caseload. According to Beth Giesting, executive director of the Primary Care Association, "many of Hawai'i's FAS residents have significant health problems, including communicable diseases such as tuberculosis, Hansen's Disease, and hepatitis. These problems are exacerbated by poverty, lack of English language facility and work skills, sub-standard living conditions, and patterns of transience. The experience and capabilities of community health centers make them ideal agencies to do outreach and provide health care. However, the high cost of meeting the needs of these migrants and the lack of payment for services makes it difficult for health centers to take up these roles

effectively."[5] With the elimination of federal funds for healthcare coverage for FAS populations, the financial burden to the state of Hawaii will increase substantially. The projected costs for primary care and outreach services for habitual residents from Compact nations are based on current and past expenditures.

**Impact on Mutual Benefit Healthcare Providers**

Hawaii has a classification of "mutual benefit" healthcare institutions that are characterized by both private and public components. Mutual benefit hospitals such as Queen's Hospital, the major trauma and tertiary care center for the state, Kapi'olani Medical Center, which provides a substantial amount of the obstetric and pediatric care for FAS migrants, and Kona Community Hospital, which serves the Marshall Islander population there, have all been significantly financially impacted by the Compact and the subsequent Welfare Reform Act (PRWORA).

Queen's Hospital reports $6-7 million loss for 1995-96, a $15 million loss for 1998-99, and is currently losing $1.5 million per month for 1999-2000. The latter results in a projected loss, in terms of unrecovered costs, of $15 million for the year pertaining to care for FAS migrants alone. FSM, mostly Chuuk, accounts for $3 million of Queen's unrecuperated costs.

Kona Community Hospital is in a unique situation of servicing a large community of Marshall Islanders. Data reveal that 48% of Marshall Islanders accessing outpatient or inpatient services at the hospital are between 19 and 34 years of age with almost twice as many women as men accessing services. Close to 50% of Marshall Islanders come to the hospital through the Emergency Department during regular business hours. Another 25% seek health services through the Obstetrics/Gynecology department.

The Hawaii Management Alliance Association (HMAA) is currently in a contractual agreement with the government of RMI to provide health care coverage for Marshall Islanders in Hawaii. Information on diagnoses and healthcare costs from both HMAA and Kona community hospital is still forthcoming.

According to these healthcare institutions, reinstating Medicaid eligibility to this population will actually do little to address the financial losses associated with inpatient care for FAS migrants because Medicaid only reimburses $0.31 for every dollar. Therefore, other routes of reimbursement must also be explored.

**Impact on other State Agencies**

The Compact's impact on Hawaii extends beyond the realm of health and public health. The Departments of Education and Corrections are also affected. (See Table 6)

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[5] Personal communication to Bruce Anderson, Ph D , Director, Hawaii Department of Health, February 8, 2000.

Table 6.
**Other Compact costs to the State of Hawaii, 1996 – 1999**

| | 1996 | 1997 | 1998 | 1999 |
|---|---|---|---|---|
| Health related | | | | |
| Medicaid/Assistance | | $3,300,000 | $2,347,000 | $3,191,148 |
| Social services | | | | |
| Education | | $6,000,000 | $8,000,000 | $9,000,000 |
| Corrections | | $205,000 | $229,600 | |
| Other Services* | | | $206,700 | |
| Annual totals | $7,000,000 | $9,505,000 | $10,783,300 | $12,191,148 |
| **Total (including DOH costs, excluding uncompensated costs)** | | | **$40,422,885** | |

Blanks are left where figures are not yet available.
*Includes programs for job training and family development services for immigrants.

**Addressing Public Health Issues Among Hawaii's FAS Population**

The above information briefly describes the general health and public health problems faced by the FAS migrant communities in Hawaii and the financial impact borne by the state over the years. The direct and indirect costs of this burden will undoubtedly increase with Medicaid ineligibility. Should supplemental funds become available to assist Hawaii's Department of Health in providing care and services to FAS migrants, specific needs have been clearly identified.

The primary problem lies in the disease prevalence in the originating countries of FAS citizens. The state of Hawaii unquestioningly supports improvement of the health care infrastructure within these countries of origin. However, once FAS citizens migrate or travel to Hawaii with their individual health needs, it is up to the state to assist them while safeguarding the health of the general public. As a result barriers to health care and public health promotion must be overcome. Traditionally the main barriers for FAS migrants have been minimal English language skills, unfamiliarity with the social services and health care systems in Hawaii, and lack of trust in the state system. With the Personal Responsibility and Work Opportunities Reconciliation Act (PRWORA) of 1996 comes the additional barrier of cost. In order to address these barriers, the state is proposing the following use of supplemental funds.

There is a clear need for additional field staff who can communicate with and educate the FAS community. The Communicable Disease Division (CDD) of the HI Department of Health (HDOH) proposes to hire additional public health nurses (PHNs), bilingual/bicultural health educators, and outreach workers. They are crucial in accessing

the communities, educating residents about proper public health practices, and encouraging them to obtain preventive and curative health care services such as immunizations and treatment for communicable diseases such as tuberculosis. Over time they can develop a relationship of trust with the communities. Outbreaks with high profile media coverage have understandably made the Marshallese community in Kona weary of public health officials in state vehicles. Each disease-specific branch in CDD (Hansen's disease, tuberculosis, hepatitis, immunizations, STD/AIDS) and the public health nursing program have expressed the need for more public health nurses and bilingual outreach workers.

These additional staff will provide outreach, education, and preventive interventions on a myriad of diseases and public health issues. Being bilingual educators, they will breach the language barrier and relay the information on hygiene and public health practice necessary to increase awareness about disease prevention, improve community attitudes, and hopefully change behaviors. Culturally sensitive and relevant education programs need to be created and supported. Identifying and training community representatives who then go back to educate their community is another strategy that has been successful in improving public health services in other settings. Public health nurses on Kona are currently doing this while continuing to strengthen the relationships between the local department of health and these communities. Additional funds will be necessary to offset the inpatient health care costs of primary health centers and hospitals such as Kona Community Hospital, which services a large proportion of FAS migrants on the Big Island of Hawaii.

**Proposed Budget**

The general proposed budget for additional staff, development of FAS community-specific programs, and support for medical services follows. (Table 7)

Table 7.
**Budget to Address the Public Health Needs of FAS Migrants, Hawaii**

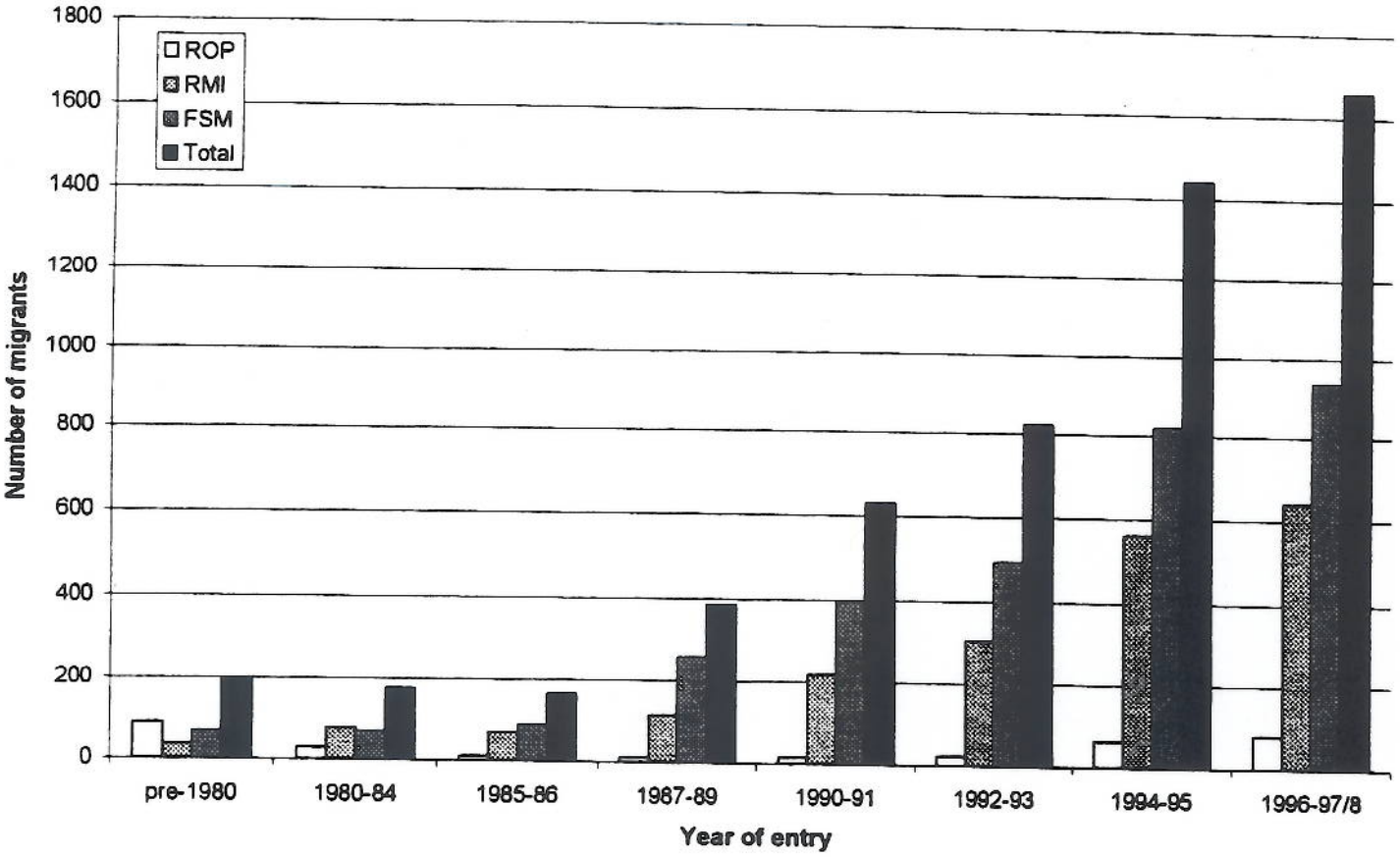
| | Cost (US $) |
|---|---|
| Personnel | |
| 5 Public Health Nurses ($47,820/yr) | $239,100 |
| - Oahu (2) | |
| - Hawaii (2) | |
| - Maui (1) | |
| 3 Public Health Educators ($32,700/yr) | $98,100 |
| - Oahu (1) | |
| - Hawaii (1) | |
| - Maui (1) | |
| 3 Bilingual Outreach Workers ($19,800/yr) | $59,400 |
| - Oahu (2) | |
| - Hawaii (1) | |
| Operating Costs | |
| Health education materials (printing, production, etc) | $3,000 |
| **Total** | **$399,600** |

This estimated budget is solely for the CDD, HDOH to appropriately serve the FAS population in Hawaii. As previously described, the projected unrecuperated costs for 1999-2000 to primary health centers and hospitals providing health care services to FAS citizens is significant approaching $6.6 million for primary health centers and $15 million for Queen's hospital alone.

The impact of the Compact of Free Association on Hawaii is significant and increasing without the support of federal funds through Medicaid as a result of the Personal Responsibility and Work Opportunities Reconciliation Act (PRWORA) of 1996. We hope the information submitted is helpful in clarifying and quantifying the impact. It is evident that the state of Hawaii is in need of federal assistance in order to continue providing public health, health, and social services for the FAS migrant population.

Figure 1.

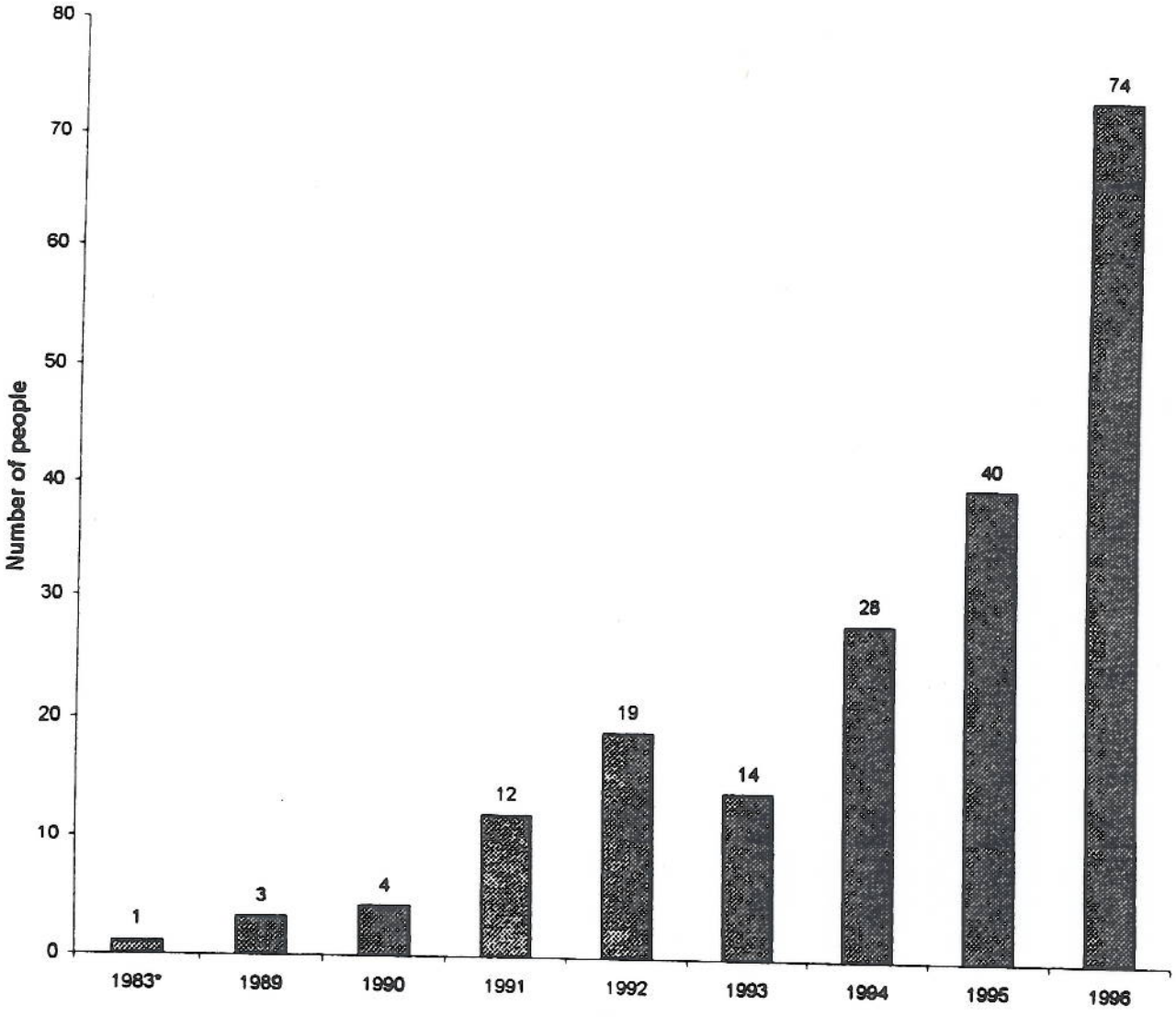
**Migrants from FAS countries to Hawaii by year of entry through 1997/98 (Total = 6,119)***




* The Status of Micronesian Migrants in 1998: A Study of the Impact of the Compacts of Free Association based on Censuses of Micronesian Migrants to Hawaii, Guam, and the Commonwealth of the Northern Mariana Islands. Funded by the Bureau of Census and Office of Insular Affairs.

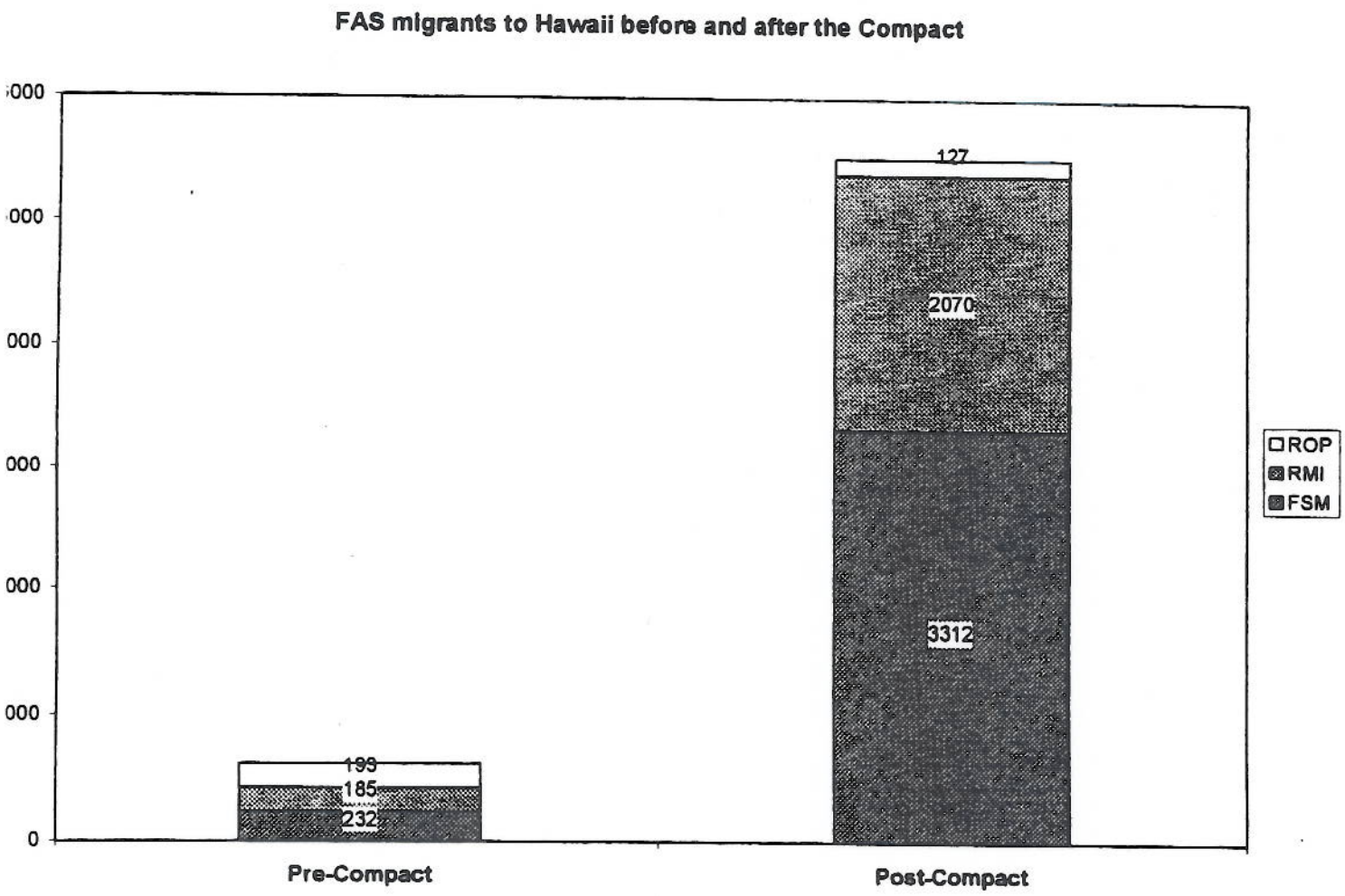
Figure 2.

**Population of Marshall Islanders on Kona by year of arrival to Hawaii, 1997**



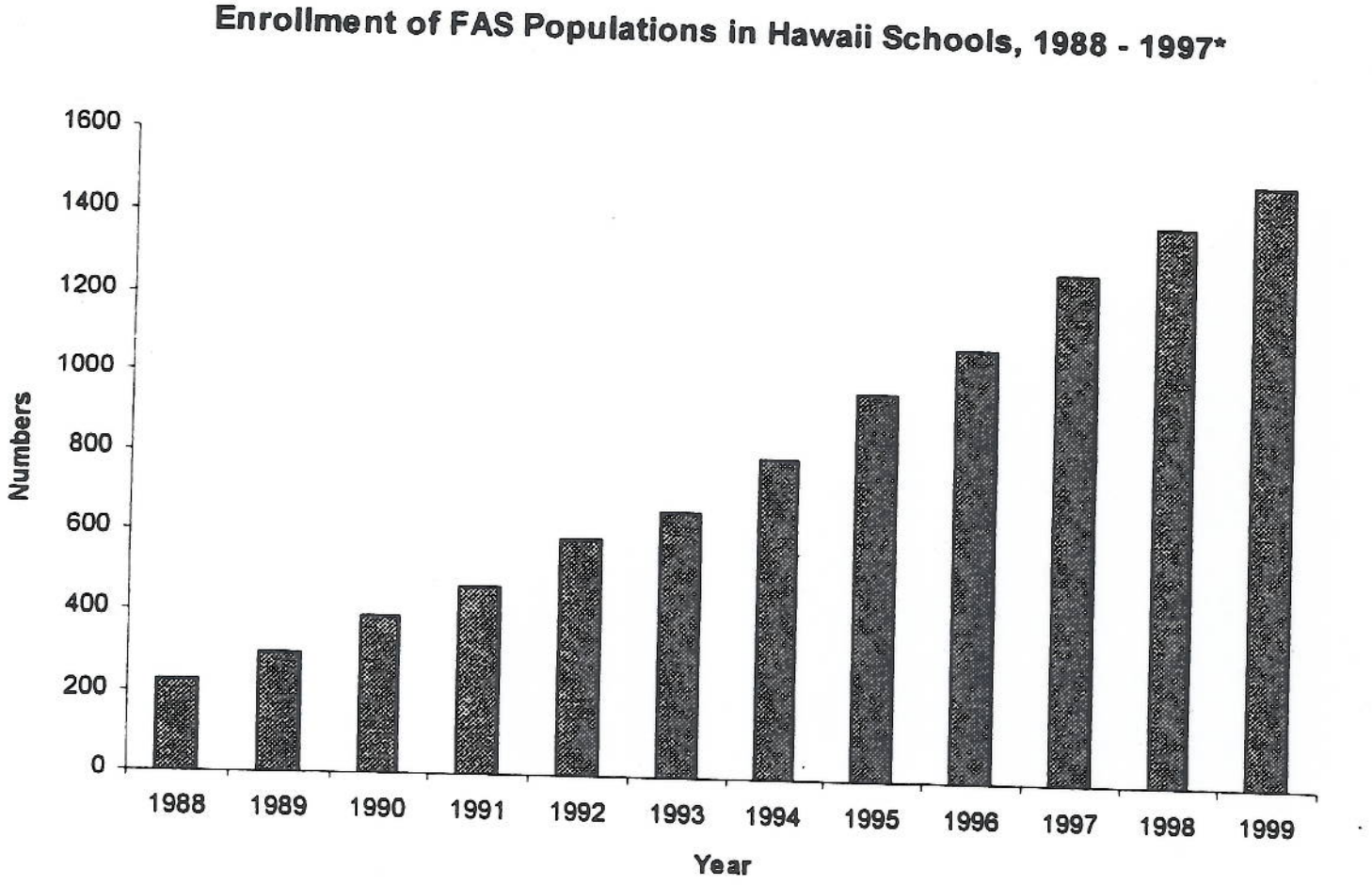

*The Compact of Free Association became effective in 1986.

Figure 3.



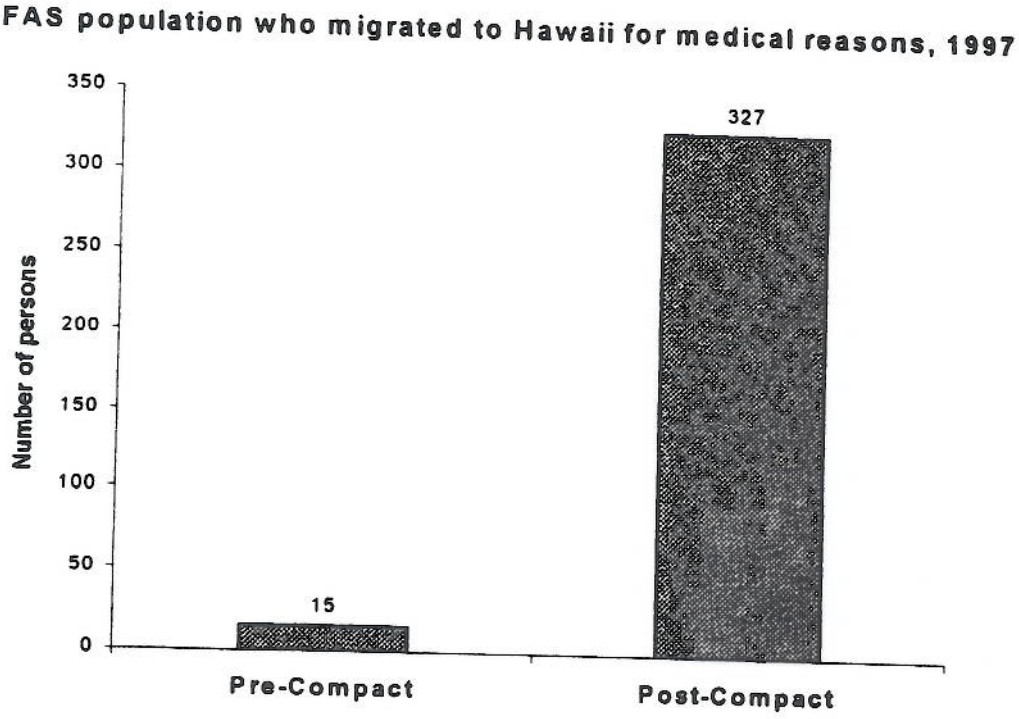

* The Status of Micronesian Migrants in 1998: A Study of the Impact of the Compacts of Free Association based on Censuses of Micronesian Migrants to Hawaii, Guam, and the Commonwealth of the Northern Mariana Islands. Funded by the Bureau of Census and Office of Insular Affairs.

Figure 4.



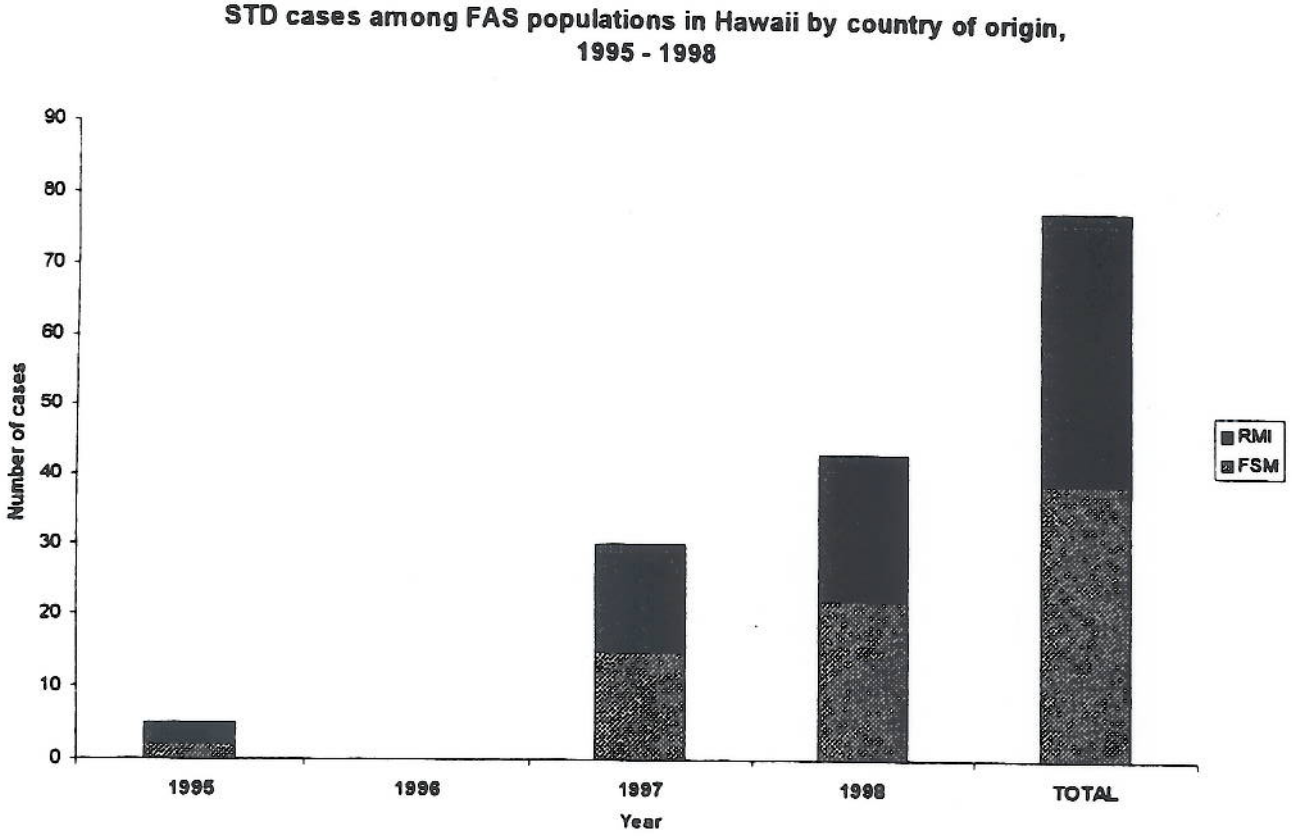

* Hawaii Department of Education

Figure 5




* The Status of Micronesian Migrants in 1998: A Study of the Impact of the Compacts of Free Association based on Censuses of Micronesian Migrants to Hawaii, Guam, and the Commonwealth of the Northern Mariana Islands. Funded by the Bureau of Census and Office of Insular Affairs.

Figure 6.




*STD/AIDS Branch, Hawaii Department of Health (no data on the Republic of Palau).

## Cumulative Impact of Compact Immigration on the Department of Education

| Year | No. of Students | Per Pupil Cost | Total Impact Cost | Percent of Increase |
|---|---|---|---|---|
| 1988 | 227 | $3,580.55 | $812,784.85 | |
| 1989 | 294 | $3,826.41 | $1,124,964.54 | 38.4% |
| 1990 | 389 | $4,176.78 | $1,624,767.42 | 44.4% |
| 1991 | 467 | $4,943.65 | $2,308,684.55 | 42.1% |
| 1992 | 588 | $5,170.22 | $3,040,089.36 | 31.7% |
| 1993 | 656 | $5,445.81 | $3,572,451.36 | 17.5% |
| 1994 | 798 | $5,684.30 | $4,536,071.40 | 27.0% |
| 1995 | 967 | $5,763.72 | $5,573,517.24 | 22.9% |
| 1996 | 1090 | $5,694.40 | $6,206,896.00 | 11.4% |
| 1997 | 1283 | $5,763.72 | $7,394,852.76 | 19.1% |
| 1998 | 1407 | $5,962.15 | $8,388,745.05 | 13.4% |
| 1999 | 1521 | $6,031.34 | $9,173,668.14 | 9.4% |
| 2000 | 1565 | $6,772.66 | $10,599,212.90 | 15.5% |
| | | | | |
| | | TOTAL | $64,356,705.57 | |

EXHIBIT C