

**Hawai'i's Proposal to Waive
Certain Provisions of the Patient Protection
& Affordable Care Act**

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Hawai'i's Proposal to Waive Certain Provisions of the Patient Protection & Affordable Care Act

Per Section 1332, Waivers for State Innovation

Executive Summary

Hawai'i shares the goals of the Patient Protection and Affordable Care Act ("ACA") to

- Expand access to affordable, high quality health care via meaningful insurance, especially for vulnerable populations
- Protect consumers from predatory insurance practices
- Reduce health care and insurance costs

Hawai'i has long boasted low uninsured rates due to rigorous employer coverage requirements and progressive Medicaid eligibility policy. The State embraced the opportunities provided by the ACA to expand Medicaid eligibility, improve an already well-performing insurance environment, and create a pathway for affordable individual coverage. Where Hawai'i diverges from the ACA is in employer-based insurance regulation. As detailed in this proposal, Hawai'i's private sector workforce has enjoyed progressive health coverage policy since 1974 when the Hawai'i Prepaid Health Care Act ("Prepaid") went into effect. Prepaid, both simpler and more sweeping than the ACA, has shaped Hawai'i's health insurance landscape in numerous positive ways. **As a result, the State seeks to maintain all aspects of the innovative Hawai'i Prepaid Health Care Act and proposes to waive provisions in Sections 1301, 1304, 1311, and 1312 of the Affordable Care Act that could diminish it. Hawai'i will, instead, maintain the "Prepaid Employee Coverage Marketplace."**

The Hawai'i Prepaid Health Care Act

Since its 1974 passage and exemption from the federal Employee Retirement Income Security Act ("ERISA") in 1983, Prepaid has defined employer coverage in Hawai'i. Prepaid has fundamentally shaped Hawai'i's health insurance market while it meets or exceeds the goals of the ACA for employer-sponsored health coverage.

Specifically:

- Prepaid requires virtually every employer with at least one permanent full-time employee to purchase employee health insurance coverage. *Prepaid defines a "permanent" worker as one who is not engaged in seasonal labor and who has been employed for four consecutive weeks, and "full-time" as working 20 or more hours per week.* This compares with the ACA requirement that only large employers purchase coverage for employees who work at least 30 hours per week.
- Under the provisions of Prepaid, employers cannot recoup more than 1.5% of employee wages for employer-only premiums. Comparatively, under the ACA, employees may pay as much as 9.5% of income for coverage.
- The actuarial value of Prepaid plans for employee-only coverage is approximately 90%, the equivalent of an ACA "platinum" plan. Prepaid allows employers to offer plans that are of lesser actuarial value (approximately at a "gold" or 80% level), but only if the employer contributes at least half of the cost of the coverage of dependents under such a plan. The ACA allows employer coverage to be as little as "bronze," which has an actuarial value of 60%.

Prepaid is administered and enforced by the State Department of Labor and Industrial Relations ("DLIR") while the State's Insurance Division is responsible for insurance and rate regulation.

As a result of Hawai'i's Prepaid ERISA exemption, no part of the law can be altered in any substantial way.

Assurances

Hawai'i's proposed waiver intends to preserve and strengthen the employee protections provided by the state's Prepaid Health Care Act. Prepaid sets a higher bar for employer-sponsored insurance than does the ACA. Its coverage, benefits, and costs to employees apply to all regardless of income, age, race and ethnicity, or any other demographic characteristic. Hawai'i does not seek to waive any aspect of the ACA that would diminish access to meaningful, affordable insurance for any resident and does not contemplate changes to the Medicaid program or individual exchange with this proposal. Nothing in this proposal is expected to increase costs or reduce revenues for the federal government.

The State of Hawai'i provides the following assurances:

- A. **Comparable Coverage.** The State's proposed waiver meets the "comparability" test in that there will be no decrease in the number of Hawai'i residents covered, nor will there be any changes in coverage for vulnerable populations by coverage category, health status, age, geographic location, or any other demographic characteristic due to the waiver.
- B. **Affordability.** The State's proposed waiver meets the "affordability" test in that it will not change the cost of health care coverage for state residents, on average, nor will it result in any differences in affordability for individuals with large health care spending burdens, for vulnerable groups, or at-risk populations. There will be no pre- and post-waiver differences in net out-of-pocket expenses, deductibles, co-pays, co-insurance, or premium contributions.
- C. **Comprehensiveness.** The State's proposed waiver will retain the scope of benefits for the affected program and population, including requiring the provision of the ten essential health benefits, as identified in the state-selected benchmark plan. It will not result in a decrease in the number of individuals with coverage that meets the EHB requirements or in any way diminish benefits currently provided by Medicaid or employers.
- D. **Deficit Neutrality.** The State's proposed waiver will result in no increased spending or administrative or other expenses to the federal government, nor will it reduce federal income, payroll or excise tax, or any other revenue.
- E. **Pass-Through Funding.** The State's proposed waiver requests no pass-through funding.
- F. **Effect on Federally-Facilitated Exchanges.** The State's proposed waiver requests no consideration of any kind for state-specific changes to federally-facilitated exchanges or marketplaces.
- G. **Public Input.** The State's proposed waiver has been publicly posted, public hearings have been held, and public comment has been solicited in compliance with 31 CFR 33.112 and 45 CFR 155.1312. Postings on-line meet national standards to assure access to individuals with disabilities.

Impact if Waiver is Not Granted

Hawai'i's Prepaid law helps meet the ACA's goals and is good for the federal government.

Without Prepaid:

- **Small employers in Hawai'i might not provide employee coverage and many of those employees would get subsidies through the individual marketplace**
- **Low income employees who might be qualified for federally-funded Medicaid benefits are, instead, covered by employer-sponsored plans**
- **More employees would become uninsured and under-insured**
- **Uncompensated care would increase resulting in economic stress to individuals and to the medical system**

Since Hawai'i's waiver proposal seeks to assert the continued authority of Prepaid for employers, failure would result in ambiguity and possible challenges to the system that has served Hawai'i so well for so long. If a waiver is not granted, Hawai'i will be left with a choice of 1) building a functional web-based SHOP to accommodate the unique dual-rules environment needed for Prepaid, or 2) having a federally-facilitated SHOP. Either of these choices would be counter to the goals of the ACA and of Hawai'i to maximize meaningful insurance coverage. Based on our experience, rebuilding an ACA-compliant SHOP would be expensive and take a long time to perfect, only to be sparsely used by employers. If, instead, Hawai'i used the federally-facilitated exchange, Prepaid could be undermined by employers that purchase non-Prepaid compliant plans or fail to recognize their responsibilities under State law.

The predicted negative consequences of either option would be:

If Hawai'i Rebuilds State-Based SHOP

- Effective, reliable technical platform would be costly to build, maintain, and upgrade.
- The timeframe to build a reliable technology system would be lengthy
- There is no evidence of demand for such a system so would likely be little used by businesses
- Costs would be passed on to tax-payers, employers, insurers, and all consumers
- Federal agencies would have on-going oversight responsibilities

If Hawai'i uses Federally-Facilitated SHOP

- Since the federal platform cannot support Prepaid rules non-Prepaid-compliant plans would be made available to Hawai'i employers
- Hawai'i employees protections under Prepaid would be eroded or could disappear
- DLIR would have to increase its oversight – and costs – to ensure employer compliance
- Costs would be passed on to tax-payers, employers, insurers, and all consumers
- Federal government shares cost of maintaining SHOP platform

Characteristics of Hawai'i and Its Health Insurance Market

With an ethnically diverse 1.4 million population spread across six main islands, Hawai'i is one of the smaller and most geographically isolated states in the nation. Tourism, government, and military activity are dominant elements in Hawai'i's economy. While more individuals are employed by large employers, the vast majority of employers are small businesses with fewer than 50 employees.

Reflecting its population size, Hawai'i has a small insurance marketplace. Since the founding of the Hawai'i Medial Service Association ("HMSA") in 1935 and the entry of Kaiser Foundation Health plan ("Kaiser") to the market in 1958, Hawai'i has been a unique marketplace for health insurance carriers. Adding to the state's singular character is the fact that all five of the health plans in Hawai'i that serve small employers - University Health Alliance, Hawai'i Management Alliance Association, Family Health Hawai'i, Kaiser, and HMSA - are not-for-profit organizations.

Underpinning Hawai'i's exceptional market structure is the 40-year-old Prepaid, which requires nearly all private employers to provide a uniformly high level of medical coverage for their employees. It also requires employees to accept the offered coverage unless they can show evidence of coverage from another source (a spouse's plan, for example). The Prepaid model manages the richness of benefits by identifying the prevalent PPO and HMO benefit packages in the state and setting those packages as the floor for benefit coverage. As a result, the benefit plans sold to private employers in the state have an average actuarial value of 90%, the equivalent of a platinum plan in ACA parlance. Even with these robust benefit plans, employees enjoy protection from significant out-of-pocket costs because Prepaid limits premium contributions to only 1.5% of the employees' wages for employee-only coverage. While employer-based coverage in Hawai'i is richer than required under the ACA with lesser employee contributions, small employers and their employees are also protected by the state's rating approval process and the Prepaid requirement that carriers cannot refuse to insure an employer group. Hawai'i's health care system suffers from some of the same concerns related to access, quality, and cost as the rest of the country; however, the regulatory consistency of benefits under Prepaid has contributed significantly to system stability and predictability.

Besides private employer-based insurance, Hawai'i has sought to ensure coverage by means of progressive public insurance strategies. In the early 1990s, Hawai'i created a basic State Health Insurance Program ("SHIP") for the insurance "gap group,"¹ and, in 1994, the State received one of the first section 1115 Medicaid waivers. The waiver, which explicitly aimed at universal insurance coverage, allowed Hawai'i to combine SHIP with the Medicaid program and had no asset test. Although the 1115 waiver was not able to achieve its universal coverage goal, the State has taken advantage of the ACA to expand eligibility, and strongly advocates for individuals not otherwise covered to obtain affordable insurance through a Supported State-Based Marketplace. Before 2014 when ACA coverage became available, Hawai'i's uninsured rate was estimated to be 100,000 people, mostly non-elderly adults. Now, having the experience of two years of expanded ACA enrollment opportunities, Hawai'i's uninsured rate is estimated to be less than half that number.

Health insurance coverage and Prepaid are not the only factors that contribute to a healthier population and more efficient system but we believe they are linked to Hawai'i's superior performance, as compared to the national measures sampled below:

¹ The "gap group" in the early 1990s was made up largely of part-time workers who did not qualified for Prepaid coverage and other low-income adults who were ineligible for Medicaid coverage.

- 10% lower employer-sponsored premiums for families (2013)²
- 93% of residents with a usual source of care (2012)³
- 43% fewer hospitalizations per 100,000 adults (2011)⁴
- 32% fewer emergency room visits per 1000 (2011)⁵
- Healthiest state in the nation (2015) and among the top ten since surveying began in 2008⁶
- Third best in the nation on the Commonwealth Fund’s “Scorecard on State Health Performance” (2015)⁷

The following table illustrates how Hawai’i residents are covered by health insurance type. There are more than 760,000 Prepaid-covered lives.

Insurance Coverage by Type	Percentage of Population*
Employer-sponsored – Public and Private Sector	54%
Medicaid/CHIP	23%
Medicare	16%
Tricare and Military	12%
Individual	3-4%
Uninsured	3-5%

**Percentages exceed 100% because of duplicate and dependent coverage.*

Implementation of a State-Based Marketplace and Lessons Learned

With Hawai’i’s progressive agenda for full insurance coverage and its long-standing success with Prepaid, the State was among the first to declare its intent to create an ACA state-based marketplace. Despite substantial federal investment in technology and assistance, years of significant work contributed by public sector employees from at least five departments, a supportive legislature, and the efforts of the non-profit corporation formed to establish the marketplace, the Hawai’i Health Connector (“Connector”) was not sustainable. As a result of our lessons learned:

- With the November 2015 open enrollment period, Hawai’i became a state based exchange on the federal platform
- Hawai’i’s SHOP infrastructure was shut down, and small employers enrolled directly with health plans as of June 2015
- Hawai’i is seeking to waive SHOP in 2017

Specific lessons learned from our experience are the following:

² Medicaid Expenditures Panel Survey-Insurance Component. Average annual family premiums for Hawaii and the US were \$14,382 and \$16,029, respectively.

³ State Health Access Data Assistance Center (“SHADAC”) analysis of restricted National Health Interview Survey (NHIS) data.

⁴ SHADAC analysis of Healthcare Cost and Utilization Project (HCUP) data.

⁵ Kaiser State Health Facts analysis of American Hospital Association data.

⁶ Gallup-Healthways Physical Well-being Index.

⁷ Commonwealth Fund, http://www.commonwealthfund.org/~media/files/publications/fund-report/2015/dec/2015_scorecard_v4.pdf?la=en

1. Start-up and upkeep too expensive for small market. As events proved, Hawai'i's population was not large enough to make the development and upkeep of its own marketplace financially viable. With 1.4 million total residents, Hawai'i's uninsured population was estimated to be only 100,000 in 2013, and fewer than 170,000 people worked for small employers (50 employees or fewer). The Connector, of necessity, was technically complex and expensive to develop and maintain; consequently, its infrastructures costs could not be scaled down to fit a limited market.
2. Connector systems too complex and susceptible to errors. As a "start-up" effort, the Connector was unable to inspire confidence in its operations for individual consumers, employers, or insurers. While it improved its customer-facing services, it was never able to effectively manage "back-office" functions, which created coverage lags and frustration for both consumers and insurers. Fewer than half the individuals who enrolled in insurance under the ACA did so through the Connector and less than 1% of eligible small businesses used its services.
3. Small businesses purchased coverage as they always had under Prepaid. Notwithstanding outreach, marketing, and a significant effort among business organizations to educate small employers about potential tax credits, fewer than 250 small employers enrolled through the Connector. This amounts to less than 1% of employers with 25 or fewer employees. Small employers did not make the switch because:
 - Unlike in the rest of the country, small employers were already buying coverage for their employees due to Prepaid requirements. After years of purchasing directly from plans or with the assistance of agents or brokers, there was little interest in testing a new route.
 - Initially two and later only one insurer offered plans on the Connector SHOP marketplace. Meanwhile, outside of the Connector, small employers had the choice of five commercial plans selling the same products.
4. No competition. The Connector was unable to foster competition among carriers. Only two of five commercial insurers initially offered individual plans and, in the second year, only one insurer provided small business plans in SHOP. Hawai'i's other commercial plans were discouraged from participating by premium fees and additional filings and reporting.

Proposed Waiver: Conforming the Small Employer Marketplace to Prepaid

Hawai'i proposes to align the ACA with Prepaid while administering the Prepaid Employee Coverage Marketplace (hereafter called the "Prepaid Marketplace") for both large and small businesses. Hawai'i does not propose any changes to the marketplace for individuals, who will continue to have full access to coverage and any subsidies to which they are entitled in a Supported State-Based Marketplace.

Hawai'i's consumers enjoy the expectation of good health insurance coverage while our health care system depends on a largely insured population and the predictability of payment through the combination of Prepaid, Medicare, and Medicaid that insulates consumers from large out-of-pocket costs. With the passage of the Affordable Care Act, Prepaid's status became ambiguous and the provisions of the SHOP exchange added potential threats to ensuring small employer compliance. Among the differences between Prepaid and the ACA:

Prepaid

- Employers with even a single permanent employee must provide coverage.

ACA

- Only large employers must provide employee coverage.

- Permanent employees are eligible for coverage if they work 20 hours or more per week.
- The actuarial value of Prepaid plans averages 90%, and may not dip below 80%.
- Employee contributions for employee-only premiums cannot exceed 1.5% of wages.
- Permanent employees are eligible for coverage if they work 30 hours or more per week.
- Employers may offer plans with an actuarial value as low as 60%.
- Employees may pay as much as 9.5% of income.

In the State’s proposal, both individual and small business coverage would retain the Essential Health Benefit package. Individuals would have a greater array of options to meet their needs including the gamut of metal levels, bronze through platinum, catastrophic plans for eligible individuals, and child-only plans while small employers, conforming to Prepaid, would continue to offer plans with an average actuarial value of at least 80%. Large employers will continue to be subject to the requirements of Prepaid, which provide superior consumer protections compared to the ACA. The state Department of Labor and Industrial Relations (DLIR) will be principally responsible for the Prepaid Marketplace.

The State emphasizes three particulars that should be given significant consideration by the Secretary:

- 1. Hawai’i’s requirement for small employers to sponsor insurance, where coverage includes the EHBs and additional mandated services and employees pay little of the cost far exceeds that of ACA. SHOP does not add value or incentives to employers and has served only to increase small business insurance costs.**
- 2. Prepaid works and has been working for more than forty years with minimal public investment in infrastructure for data collection, monitoring, reporting, and penalties. Besides maintaining the benefits for employees required by Prepaid, Hawai’i requests a SHOP waiver to ensure the effective cooperation among insurers, employees, employers, and State agencies that has enjoyed an exemplary level of compliance without adding significantly to administrative costs.**
- 3. Creating the ACA-required infrastructure for SHOP is not cost-effective but joining the federal platform for the SHOP exchange is not feasible because the federal exchange cannot accommodate Prepaid’s coverage mandates.**

The specific sections for which Hawai’i requests a waiver and the reason for each request are outlined below:

ACA Section	Reason Waiver is Sought
§1301 (a)(1)(C)(ii) Qualified health insurance issuer must offer at least one qualified health plan in the silver level	Hawai’i supports this provision for the individual marketplace, but requiring a qualified health plan to provide a silver level plan is not consistent with Prepaid and therefore not consistent with our request to waive SHOP.
§1301 (a)(2) Inclusion of co-op and multi-state qualified health plans.	Hawai’i proposes to waive this section since it is doubtful that co-op and multi-state plans can conform to the requirements of Prepaid. In addition, plans would be harder to regulate and monitor for compliance than state-based plans.

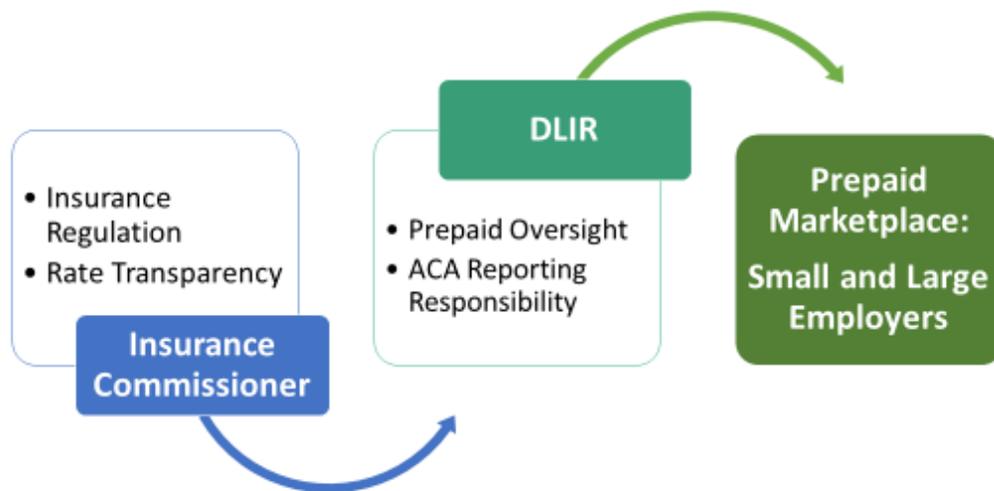
<p>§1304 (b)(4)(D)(i) and (ii) Continuation of participation for growing small employers</p>	<p>Hawai'i is proposing to waive SHOP so it follows that the State proposes to waive this provision, which would allow a "growing small employer" to continue to enroll employees through the exchange.</p>
<p>§1311 (b)(1)(B) The establishment of a Small Business Health Options Program (SHOP Exchange)</p>	<p>Hawai'i proposes to waive SHOP for three important reasons:</p> <ol style="list-style-type: none"> 1. In order to make clear to all small employers in the state the necessity to continue to meet Prepaid rather than ACA requirements. 2. To eliminate the burdensome expensive, unnecessary infrastructure required by the ACA for SHOP functions. Maintaining these state-based SHOP functions is not economically feasible, fails to add value to the Prepaid Marketplace, and, in fact, imperils the success of Hawai'i's cost-effective system. 3. To relieve small employers of the added premium costs related to purchasing ACA plans on the SHOP. 4. While Hawai'i values the opportunity to partner with the federal exchange to ensure individual coverage, the unique requirements of the Prepaid Marketplace cannot be adequately supported by the federal exchange infrastructure.
<p>§1311 (f)(3)(B) Eligible entity authorized to carry out exchange responsibilities</p>	<p>Hawai'i proposes to waive these sections to permit flexibility as to which state agencies, in addition to the Medicaid agency, can carry out responsibilities for the individual exchange.</p>
<p>§1312 (a)(2) Employer may specify level and employee may choose plans within a level</p>	<p>While acknowledging the attractiveness of employees having the ability to choose their health plans, Hawai'i proposes to waive the consumer choice provision defined in this section in conjunction with waiving SHOP. Supporting reasons are:</p> <ol style="list-style-type: none"> 1. Assuring such choice for employees of small businesses requires an on-going investment in technical infrastructure disproportionate to the benefits for Hawai'i's small market. 2. The cost to comply with the technical infrastructure necessary to offer consumer choice for insurers offering coverage to businesses would result in the smaller insurers departing the market and so achieve the unintended consequence of reduced competition and choice. In fact, during the second year of Hawai'i Health Connector's SHOP exchange, only Kaiser Permanente participated, rendering "consumer choice" meaningless. 3. In Hawai'i's Prepaid environment, consumer choice is relatively insignificant because employers are required to purchase employee coverage with uniformly comprehensive benefits with very little of the cost passed on to employees. 4. Offsetting any consumer disadvantages is the fact that employee coverage, benefits, and cost-sharing are significantly better under Prepaid than under ACA provisions.
<p>§1312 (f)(2)(A) Definition of "qualified employer"</p>	<p>As Hawai'i proposes to waive SHOP, there will be no "qualified employers" that may elect to make employees eligible to purchase insurance coverage through the exchange.</p>

Description of Waiver Program

Hawai'i's Waiver Program is the Prepaid Marketplace in which all businesses with at least one employee working a minimum of 20 hours per week provide health insurance. This Prepaid Marketplace is responsible for regulating employer-sponsored health insurance exclusively and does not address the individual market. Prepaid is consistent with or exceeds the ACA in all the following aspects:

- Strong employee protections from out-of-pocket costs
- Employer participation from the smallest to the largest businesses
- A forum in which employers can select from among competing health plans
- Standardized, meaningful benefit requirements
- Actuarial values for plans that meet or exceed ACA requirements
- Minimal risk of adverse selection due to Prepaid's broad coverage mandate and long history of up-take (in fact, a SHOP exchange environment likely presents a greater risk of uncertainty, adverse selection, and a corresponding need for risk corridor payments in the small group market)

The Prepaid Marketplace works because of the cooperative interactions of the parties involved, including employers and employees, insurers, and regulatory agencies, notably the DLIR and the State's Insurance Division. As shown below, the Insurance Commissioner ("Commissioner") in the Department of Commerce and Consumer Affairs regulates insurance to ensure compliance with state and federal law, including the provision of EHB and other ACA requirements. The Division makes premium for qualified health plans publicly available on its website. The DLIR certifies QHPs and maintains the Prepaid Marketplace for small and large businesses and manages the Supported State-Based Marketplace for individuals in partnership with DHHS.



The Insurance Commissioner/Insurance Division. The Commissioner is responsible for reviewing health insurance plans to ensure that their benefit structures comply with applicable state and federal law, including providing state-mandated benefits and Essential Health Benefits for ACA-compliant plans, both for the individual market and for the small employer market.

The Commissioner also reviews and rules on health insurance rate proposals according to the process prescribed in Hawai'i's insurance code. Plans are required to file with the Commissioner every rate, charge, classification, schedule, practice or rules, and any modification thereof it proposes to use, along with supporting documentation. Mandatory information to be incorporated in the rate filing includes:

- Medical and prescription drug utilization and claims experience
- Premium and demographic information
- Index rate development

Rate filings are open to public inspection during the review period before a filing is approved. The review period, during which the Commissioner may request additional information, is at least 60 days. A rate becomes effective if approved by the Commissioner or upon expiration of the review period the Commissioner did not disapprove. If a filing is disapproved by the Commissioner, a petition for a contested case hearing may be filed with the Commissioner within 30 days of the decision. The petitioner has the burden of proving that the disapproval of the filing is not justified. The Commissioner must affirm, reverse, or modify the previous decision. This, in turn, can be appealed to the Circuit Court and, subsequently, to the State Supreme Court.

The Commissioner accepts and adjudicates health insurance complaints. For more information see section below, "Assuring compliance, reducing waste and fraud."

The Commissioner contributes to transparency and competition by maintaining and posting a listing of premium rates for all plans offered to small businesses at <http://cca.hawaii.gov/ins/small-group-premium-comparison/>.

DLIR and the Prepaid Council. DLIR is the principal agency responsible for the Prepaid Marketplace. The Prepaid statute requires plans to be reviewed for compliance by the Prepaid Healthcare Council ("Council"), a committee of community members who offer recommendations for plan approval to the Director of DLIR. The Council ensures conformity to the medical and hospital benefits offered by the plan that has the largest number of subscribers in the state. The meetings of the Council are subject to the state's open meetings law, which requires public notice of all meetings and allows for public input on all matters before the Council. This review is comparable to the certification process for QHPs offered through an Exchange.

Employer participation. The following excerpt from DLIR's website provides guidance to employers for purchasing employee coverage in the Prepaid Marketplace:

Employers can choose one of the following three ways to provide the mandated coverage to their employees.

- *Purchase an approved plan [the website provides a link to the list of already approved plans]. In Hawaii, insurance companies, mutual benefit societies and health maintenance organizations can sell health care plans to Hawaii employers directly. These plans must be reviewed by the PHC Advisory Council and approved by the Director of the Department of Labor and Industrial Relations (DLIR) before they can be marketed to employers.*
- *Purchase an insured plan of employers' choice. Some employers with corporate offices located outside of Hawaii purchase a health care plan and offer such plan to their employees on a nationwide basis. Employers that choose this option must*

submit their plan to DLIR for review by the PHC Advisory Council and approval by the Director to ensure the benefits are comparable to plans sold in Hawaii.

- *Provide a health care plan that is funded by the employer. As a self-insurer, the employer must show proof of financial solvency and ability to pay benefits by furnishing DLIR with the latest audited financial statements for review. Following the initial approval, the audited financial statements must be filed annually for continued approval. Employers choosing this option must complete an application for self-insurance [a link to Form HC-61 is included here] as well as submit a copy of their health care plan to DLIR for review by the PHC Advisory Council and approval by the Director to ensure the benefits are comparable to plans sold in Hawaii.*

All health care plans, whether sold by health care contractors or submitted by employers, must be approved by DLIR as meeting the prescribed minimum standards. Such determination is made by the Director under the advisement of a seven-member PHC Advisory Council consisting of representatives from the medical and public health care professions, from consumer interests, and from the prepaid health care protection industry. Upon approval, plans are designated as 7(a) or 7(b) plans. Plans designated as 7(a) are equal to or better than the benefits offered by the plan with the largest number of subscribers (also known as the prevalent plan) in the State of Hawaii. (See the summary of benefits offered by the PPO and HMO prevalent plans.) Plans designated as 7(b) provide for sound basic hospital, surgical, medical, and other health care benefits; however, plan's benefits, such as, the deductible, out of pocket limit, lifetime maximum benefit, benefit level and copayments, may be more limited than the benefits provided by plans qualifying as 7(a). Plans qualifying as 7(b) require the employer to pay one-half of the cost for dependents' coverage.

Employers may elect to pay the entire monthly premium or share the cost with their employees. Employers must pay at least 50% of the premium cost, but the employees' share cannot exceed the lesser of 50% of the premium cost or 1.5% of the employees' monthly gross earnings. Cost sharing for dependents is determined by plan type. If employers purchase an approved plan, the health care contractor is responsible for informing the employers whether they are responsible for contributing toward dependents' coverage. If employers submit a plan for approval, DLIR is responsible for informing the employers of their plan approval designation and whether they are responsible for contributing toward dependents' coverage.

There are situations where employees can waive the mandated coverage. These include being covered by a federally established health insurance, such as, Medicare and Medicaid, covered as a dependent under a qualified plan, recipient of public assistance and covered by state-legislated health plan, covered under their own personal health insurance policy or a follower of a religious group who depends for healing upon prayer or other spiritual means. Employees are required to complete "Employee Notification to Employer" [a link to Form HC-5 is included here] every calendar year to validate the exemption so that employers are relieved of the responsibility for providing the mandated health care coverage.

Unless specifically excluded under the law or a Notice to Employer to waive coverage is filed with the employers, all employees who meet the eligibility requirements are entitled to health care coverage through employer-based group policies. Complaints [a link to Form DC-54 is included here] related to non-coverage by employers can be filed with the Investigation Section in Honolulu or on the neighbor-island, the Department of Labor and Industrial Relations District Office nearest the complainant for assistance. Complaints related to benefits of the plan are usually filed directly with the health care contractors who are regulated by the Department of Commerce and Consumer Affairs, Insurance Division.

Insurers, agents, and brokers. Small employers may obtain employee insurance directly from the five insurers offering coverage. Alternatively, all but HMSA work with agents and brokers who also support employers for plan choice and employee enrollment.

Small business employer tax credits. While Hawai'i proposes to waive the SHOP marketplace, we would retain the availability of the small business tax credit for eligible employers. Our expectation is that small employers purchasing coverage directly would be able to apply for tax credits in the same manner available to them now.

Affected Population and Demographics

Hawai'i's waiver proposal seeks to clarify and maintain coverage responsibilities and the marketplace for small employers with 50 or fewer employees and their employees. The waiver will not reduce coverage, affordability, or comprehensiveness, nor will it affect the federal deficit. As described elsewhere in this document, the proposal waives ACA SHOP technical requirements while reinforcing the obligations of small employers to their employees under Prepaid but does not actually change any of aspects of coverage, affordability, or comprehensiveness.

There are 29,419 small employers with 50 or fewer employees, which employ a total of 169,273 Hawai'i residents. Comparatively, large employers with more than 50 employees, numbers only 1,531 private sector and five non-federal public sector employers but employs more than 432,000 people.⁸

Employer Type	Number of Employers	Number of Employees	% of Pvt. Mkt.	% of TOTAL
Small, 50 or fewer	29,419	169,273	33.2%	28.2%
Large, more than 50	1,531	340,246	66.8%	56.5%
Private Market Total	30,950	509,519	100%	84.7%
State	1	73,157		12.2%
County	4	18,626		3.1%
All Sector Total	30,955	601,302		

As might be expected, the average income for employees in small businesses is slightly lower than that of larger employers and the public sector, as shown below.⁹

⁸ Employment sector data as reported by State DLIR for quarter ending March 2015.

⁹ Ibid.

Employer Type	Annualized Wages	% of Average – Pvt. Mkt.	% of Average – All Sectors
Small, 50 or fewer	\$ 40,280	93.9%	91.8%
Small, 100 or fewer	\$ 40,496	94.4%	92.3%
Large, more than 100	\$ 44,769	104.4%	102.1%
Private Market Ave.	\$ 42,885		97.8%
State	\$ 45,973		104.8%
County	\$ 62,200		141.8%
All Sector Ave.	\$ 43,859		

The general demographics of Hawai'i's population, as shown below, is expected to be the same for large and small employers:

Race/Ethnicity (2013)	
African-American/Black	2.2%
Asian	37.8%
Hispanic/Latino (any race)	9.8%
Native American/Alaska Native	0.2%
Native Hawaiian and Pacific Islander	9.8%
White	25.6%
Multiple Races	23.5%
Other	1.0%
Age (adults only) (2013)	
19-25	10.4%
26-44	25.6%
45-54	12.7%
55-64	12.7%
65+	15.5%
Population by County (2013)	
Honolulu	983,429 (70%)
Hawai'i	190,821 (14%)
Maui	160,202 (11%)
Kaua'i	69,512 (5%)
Total State Population	1,403,964 (100%)
Income and Health Care Spending	
Median Household Income (2009-13)	\$67,402
Per Capita Income (2009-13)	\$29,305
Average Employer-Sponsored Premium (2013) – Individual ¹⁰	\$5,103
Average Employer-Sponsored Premium (2013) – Family ¹¹	\$14,382
Average out of pocket spending, (2011-2012) ¹²	\$2,001

¹⁰ Medical Expenditure Panel Survey - Insurance Component. Reflects total premium (both employee and employer share).

¹¹ Ibid.

¹² SHADAC analysis of Current Population Survey (CPS). Out of pocket spending includes spending for premiums and other costs such as co-pays.

Effect on Residents' Ability to Get Care Out of State

Hawai'i's proposed waiver will have no effect on residents' ability to obtain care out of state. The State proposes to waive the SHOP exchange, and retain the full effects of the Prepaid Marketplace, under which all plans provide for covered services required by beneficiaries if they happen to be in another state.

Description of Post-Waiver Marketplace

The post-waiver Prepaid Marketplace will be as follows:

- **State-Based Exchange on the Federal Platform.** Individuals and families will receive assistance in applying at www.healthcare.gov where eligibility for Medicaid, tax credits, or cost-sharing reductions will be completed. Individuals not eligible for other public or private coverage will be able to complete enrollment in a participating QHP at the federal site. Hawai'i does not propose to change the SSBM with this waiver submission.
- **Prepaid Marketplace: Small employers and their employees.** DLIR and the Prepaid Marketplace will ensure that small employers continue to obtain Prepaid- and ACA-compliant plans for their employees by enrolling directly with health plans or with support from agents and brokers. Employees will have coverage that is robust and affordable for the employee. The sponsoring employer will determine which health insurer(s)'s plans will be available to employees. The five not-for-profit health plans serving the small employer market will not be affected by the waiver.
- **Prepaid Marketplace: Large employers.** There will be no change in the insurance market for large employers since, by complying with the Prepaid Marketplace, they comply with the ACA.

Number of Employers Offering Coverage Before and After Waiver

Hawai'i is seeking to waive SHOP requirements, in part, to ensure clarity for Hawai'i employers about their obligations to provide employee health insurance benefits as required in the Prepaid Marketplace. Accordingly, Hawai'i expects no change in the number of employers offering coverage as a result of its proposed waiver. In fact, if ACA SHOP provisions replaced Prepaid, Hawai'i would expect a DECREASE in the number of small employers providing employee coverage.

Impact on Insurance Coverage in the State

Hawai'i's proposed waiver of SHOP will not affect coverage in the marketplace, quite simply, because SHOP did not bring added value to the marketplace and employers did not choose to use it. A year and a half after "go-live," the Hawai'i SHOP provided coverage to less than 1% of eligible employers and employees (246 employers and 1,139 employees).

The Hawai'i insurance environment is unique. Benefit packages are expected to remain relatively rich, premiums relatively low, employees make only modest contributions to premium costs, and small employers are mandated by state law to provide coverage. This uniqueness made it quite unlikely that SHOP could ever deliver the value for Hawai'i that it can for other states. Under a waiver, Hawai'i's Prepaid Marketplace will continue to operate as it did prior to the opening of the SHOP, with richer benefits, covering more lives, and lower cost-sharing than required under the ACA.

Hawai'i's proposal to waive SHOP will also not adversely affect competition in the state. For the first year of operations, only two carriers participated in the SHOP and, in the second, only one did. Groups that wished to purchase from the SHOP, therefore, had none of the benefits of competition. In contrast, the

marketplace outside the SHOP continues to thrive as smaller carriers, including a new entrant to the market, continue to grow through direct enrollment. This is yet another demonstration of employer groups' preference to purchase coverage directly from issuers.

Increase/Decrease in Administrative Burden

Hawai'i anticipates that the proposed waiver will result in a *decrease* in administrative burden for all relevant parties, as outlined below:

For small employers and their employees. In the Prepaid Marketplace overseen by DLIR, employers will continue to offer and directly purchase Prepaid-approved plans for employees as they have for more than 40 years. The State Insurance Division has significantly increased insurance premium transparency by posting rates for all available small business plans at <http://cca.hawaii.gov/ins/small-group-premium-comparison/>. Both employers and employees will be able to obtain information about benefits and enrollment directly through the plans or agents and brokers.

Conversely, using the SHOP Exchange for purchasing coverage introduced an additional level of confusion and uncertainty as it muddied accountability when errors occurred in applications, enrollment, and payment. Small businesses and their employees are firmly opposed to replacing a simple, straight-forward enrollment system with one whose expensive complexity gets added to the cost of premiums.

For insurers. Under the proposed waiver, insurers will continue to manage insurance enrollment and benefits for small businesses as they have done since 1974, and which they have continued to do for 99% of small businesses in Hawai'i since the implementation of the SHOP exchange. A waiver of SHOP will result in a decrease rather than an increase in administrative burdens.

The work and cost related to building a SHOP exchange far exceeded the federal dollars expended by the Hawai'i Health Connector; the issuers that decided to participate also spent millions of dollars to try to accommodate SHOP requirements. In addition, because of largely inoperable Connector technology, the plans had to develop work-arounds and augment assistance center staff to assist confused consumers and correct inaccurate application and enrollment information. The additional burden on insurers, not counting lost opportunity costs, were not offset by any increased benefits to the issuers themselves or to eligible small businesses, very few of which purchased coverage on the exchange.

For consumers and advocates. Under the proposed waiver, consumers and advocates for insurance and coverage will be relieved to continue to work in the familiar framework of the Prepaid Marketplace, with its employer mandates and methods for adding or changing benefits overseen by DLIR. As noted above, employees will be able to continue to work directly with their health plan representatives to answer any questions. Advocates can continue to work through the legislature on evolving benefits. Business and human resources organizations will not have to address new health insurance requirements for members. It should be noted that the Hawai'i Chamber of Commerce, its affiliates, and other business and HR organizations sponsored an average of four forums per year between 2010 and 2014 to educate small businesses and their accountants about the potential of the small employer premium tax credit.

For state agencies. The proposed waiver would not substantially add to the work of state agencies, namely DLIR and the Insurance Division.

DLIR will continue to enforce compliance through the Prepaid Marketplace by ensuring that both plans and employers meet all requirements. DLIR is identified as the agency that will provide required reports to HHS. We strongly advocate for streamlined reporting appropriate to Hawai'i's intent to preserving a simple, straight-forward system that does not add administrative burdens to the state.

The State Department of Commerce and Consumer Affairs' Insurance Division would not be required to add to or subtract from its administrative responsibilities as a result of the proposed waiver.

For federal agencies. Under the proposed waiver, the federal government's administrative burden will be reduced the most. Cases in point:

- No oversight required for a state-based SHOP exchange
- No oversight or on-going costs to develop and/or fix technology capable of managing the complexities of SHOP plan selection, enrollment, and premium aggregation
- No additional burden for a federally-facilitated SHOP exchange, including accommodating Hawai'i's Prepaid requirements

Effect on Sections of ACA that are Not Proposed to be Waived

The State can identify no section of the ACA that would be adversely affected by the proposed waiver. If anything, Hawai'i's ability to retain Prepaid in full force and without ambiguity via a waiver will serve to ensure that virtually all permanent employees in Hawai'i working twenty or more hours per week, even if for a small employer, will enjoy robust, affordable health insurance coverage.

Comparability: Data and Analysis, Actuarial Certifications, Assumptions, Targets

The State asserts that its proposed waiver will comply with the coverage requirements for scope and comprehensiveness, as well as the affordability requirement. Hawai'i's proposal to waive SHOP technical requirements while supporting the Prepaid Marketplace means that all small businesses will purchase Prepaid compliant plans, that

- Include the ten EHBs as well as state-mandated benefits
- Have an average actuarial value of 90% for employee-only plans and 80% for employee plus dependent plans
- Have employee contributions to premiums capped at 1.5% of wages
- Have annual out-of-pocket cost limits as follows:
 - \$2000 for an individual/\$6000 for a family in a 7(a) plan, and
 - \$3000 for an individual/\$9000 for a family in a 7(b) plan

Prepaid's superior coverage requirements will be preserved, not changed, by the proposed waiver.

Scope and Comprehensiveness of coverage. All plans sold for employees of small businesses include the ten Essential Health Benefits as well as state-mandated benefits. None of these benefits will change under the waiver. State-mandated benefits are noted below and at

<https://www.cms.gov/CCIIO/Resources/Data-Resources/Downloads/hawaii-ehb-benchmark-plan.pdf>:

ACA EHB Category	Hawai'i EHB Benefit
1. Ambulatory patient services	<ul style="list-style-type: none"> • Vasectomy • Surgery: operating room, recovery and treatment rooms • Anesthesia • Pathology

ACA EHB Category	Hawai'i EHB Benefit
	<ul style="list-style-type: none"> • Chemotherapy • Radiation therapy • Diagnostic colonoscopy • Dialysis and home dialysis services, supplies, and equipment • Blood and plasma • Medical and surgical supplies • Oxygen • Nuclear medicine • Infertility services • Genetic screening and testing • Genetic counseling • Outpatient surgery • Urgent care visits • Physician office visits • Diagnostic imaging • Home health visits • Skilled nursing facility care • HIV/AIDS treatment • Certain treatment of diabetes • Diagnosis of TMJ dysfunction • Home hospice care • Coverage for certain clinical trials • Medical foods
2. Emergency services	<ul style="list-style-type: none"> • Emergency room services • Ambulance services
3. Hospitalization	<ul style="list-style-type: none"> • Room and board • Nursing • Complications of pregnancy • Pathology services • Radiology services • Anesthesia • Medical supplies • Prosthetics • Drugs • Blood • Transplants • Reconstructive breast surgery following a mastectomy • Surgery to correct congenital anomalies • Other reconstructive surgery • Bariatric surgery • Tubal ligation • Inpatient hospice • Vision procedures • Inpatient visits • Inpatient surgery
4. Maternity and newborn care	<ul style="list-style-type: none"> • Coverage for newborns and foster children • Minimum inpatient stays following delivery of a baby • Treatment of maternity as any other illness when maternity is provided • Prenatal care • Nurse midwife services
5. Mental health and substance abuse disorder services, including behavioral health treatment	<ul style="list-style-type: none"> • Treatment for mental illnesses • Treatment for alcoholism and drug abuse
6. Prescription drugs	<ul style="list-style-type: none"> • Injectable drugs • Retail and mail-order prescription drugs

ACA EHB Category	Hawai'i EHB Benefit
	<ul style="list-style-type: none"> • Prescription contraceptives • Smoking and tobacco cessation prescription drugs
<p>7. Rehabilitative and habilitative services</p>	<ul style="list-style-type: none"> • Durable medical equipment • Inpatient rehab services • Cardiac rehab • Pulmonary rehab • Physical therapy • Occupational therapy • Speech therapy • IV/infusion therapy • Hyperbaric oxygen therapy • Hearing aids • Speech generating devices • Diagnosis and treatment of autism • Orthodontic treatment of orofacial anomalies resulting from birth defects
<p>8. Laboratory services</p>	<ul style="list-style-type: none"> • Laboratory services
<p>9. Preventive and wellness services and chronic disease management</p>	<ul style="list-style-type: none"> • Adult routine physical exams • Well-baby and well-child exams • Immunizations • Routine mammography screening • HPV and cervical cancer screening • Newborn hearing screening • Newborn screening – other • Pediatric hearing screening • Prostate cancer screening • Colorectal cancer screening • Depression screening • Diagnostic bone mass measurement/density screening • Colonoscopy screening • Allergy testing • Diabetes screening • Screening for sexually-transmitted infections – HIV • Screening for sexually-transmitted infections – other • Anemia screening for pregnant women • BRCA screening and counseling about genetic testing • Folic acid supplements for women who may become pregnant • Hepatitis B screening for newly pregnant women • Rh incompatibility screening for all pregnant women and follow-up testing for women at higher risk • Allergy injections • Smoking and tobacco cessation counseling • Diabetes education • Diabetes monitoring • Breastfeeding and lactation counseling • Nutritional counseling • HPV vaccine • Flu vaccines
<p>10. Pediatric services, including oral and vision care</p>	<ul style="list-style-type: none"> • Anesthesia and hospital care for dental procedures for children under age 9 with serious mental, physical, or behavioral problems • Pediatric vision screening • Pediatric eyeglasses and contact lenses • Pediatric dental • Routine hearing exams

As noted on <https://www.cms.gov/CCIIO/Resources/Data-Resources/Downloads/hi-state-required-benefits.pdf>, Hawai'i's mandated services are as follows:

Benefit	Name of Required Benefit	Market Applicability	Statutory Authority
Hospice Services	Hospice care	Individual, small group, large group, HMO	431:10A-119; 432:1-608; 432D-23
Infertility Treatment	In-vitro fertilization	Individual, small group, large group, HMO	431:10A-116.5 432:1-604 432D-23
Delivery and All Inpatient Services for Maternity Care	Newborn children	Individual, small group, large group, HMO	431:10A-115 432:1-602 432D-23
Mental/Behavioral Health Outpatient Services	Mental illness, alcohol, and drug dependence	Individual, small group, large group, HMO	431M-4 432D-23
Substance Abuse Disorder Outpatient Services	Mental illness, alcohol, and drug dependence	Individual, small group, large group, HMO	431M-4 432D-23
Substance Abuse Disorder Inpatient Services	Mental illness, alcohol, and drug dependence	Individual, small group, large group, HMO	431M-4 432D-23
Specialty Drugs	Chemotherapy services	Individual, small group, large group, HMO	432:1-616
Preventive Care/ Screening/ Immunization	Mammography	Individual, small group, large group, HMO	43110A-116 432:1-605 432D-23
Preventive Care/ Screening/ Immunization	Contraceptive services	Individual, small group, large group, HMO	431:10A-116.6 431:10A-116.7 432:1-604.5 432D-23
Preventive Care/ Screening/ Immunization	Child health supervision service	Individual, small group, large group, HMO	431:10A-115.5 432:1-602.5 432D-23
Preventive Care/ Screening/ Immunization	Colorectal screening	Individual, small group, large group, HMO	431:10A-122
Diabetes Care Management	Diabetes	Individual, small group, large group, HMO	431:10A-121 432:1-612 432D-23
Inherited Metabolic Disorder – PKU	Medical foods and low protein modified food products	Individual, small group, large group, HMO	431:10A-120 432:1-609 432D-23
Prescription Drugs Other	Chemotherapy services	Individual, small group, large group, HMO	432:1-616
Autism spectrum disorders	Applied behavioral analysis services	Individual, small group, large group, HMO	431:10 432:1 432D-23

Orofacial anomalies	Orthodontic treatment for orofacial anomalies resulting from birth defects	Individual, small group, large group, HMO	431:10 432:1 432D-23
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Plans available for purchase by small employers are defined under Prepaid as 7(a) and 7(b) plans (see *Attachment 3* for a text of the Prepaid Health Care Act, §393-7 Required health care benefits). If employers purchase coverage for employees only, they must choose a 7(a) plan, which has an average actuarial value of 90%, the equivalent of an ACA platinum plan. The employer may instead choose a lower value 7(b) plan but only if the employer contributes at least half of the cost of the coverage of dependents under such plan. The actuarial value of 7(b) plans averages 80%, or gold level.

Affordability of coverage. Prepaid prohibits employers from recouping more than 1.5% of any employee’s gross wages to pay for employee-only insurance premiums. Annual out of pocket payments are capped at \$2000/individual and \$6000/family in a 7(a) plan and \$3000/individual and \$9000/family in 7(b).

10-Year Waiver Budget Projection – Budget Neutrality

Since Hawai’i is proposing to maintain the Prepaid Marketplace that has been in operation for more than forty years, there has been and will be no negative cost or revenue implications for the federal government related to this waiver proposal. Accordingly, we believe that actuarial or economic analysis is not applicable to the circumstances. The infrastructure to support Hawai’i’s proposed waiver and the Prepaid Marketplace is already fully in place. The DLIR manages the Prepaid Marketplace with no federal oversight or responsibility. As noted in the section above on “Administrative Burden,” granting Hawai’i’s waiver request is expected to eliminate any federal costs that would be associated with overseeing a state SHOP marketplace or supporting SHOP through the federal platform.

Assuring Compliance, Reducing Waste and Fraud

With responsibility for assuring compliance related to small employer coverage under the waiver, DLIR:

- Leverages its Prepaid health Care penalties and injunctions capabilities¹³
- Monitors employer compliance through its Disability Compensation Information System that tracks employers’ health care coverage of their employees
- Conducts random compliance checks of employers by the Disability Compensation Division’s Audit and Investigation section
- Investigates employers on-site when identified through its Delinquent/Non-Compliant Employer reports
- Maintains a hotline for employees or others to report employers who fail to comply with Prepaid

In addition, the State relies on issuers and their internal systems to monitor and curb waste, fraud, and abuse by subscribers and to report suspicious activity to the Department.

¹³ Hawai’i’s Prepaid Health Care Act (Chapter 393, Hawaii Revised Statutes) allows the director to assess penalties and enjoin employers from carrying on their business if the employer fails to comply with Prepaid coverage requirements (§393-33 and 393-34, HRS). Furthermore, employers that do not provide health care insurance to their eligible employees are liable to pay for their employees’ medical expenses.

The State Department of Commerce and Consumer Affairs, through its Insurance Division, has responsibility for regulating and ensuring compliance and solvency of health insurers, including health maintenance organizations and mutual benefit societies. The Health Insurance Branch reviews health insurance contracts and forms to ensure readability and the disclosure of required information. The Branch also reviews premium rate filings of managed care plans. Hawai'i has an effective rate review program.

The Health Insurance Branch also receives inquiries and complaints pertaining to federal and state laws governing health insurance that has resulted in consumer saving in the thousands of dollars per year. In addition, the Branch assists consumers, healthcare providers, and health insurance professionals with informal inquiries, and conducts independent external reviews of managed care plan coverage decisions that are appealed by plan members that has likewise resulted in consumer savings of thousands of dollars per year.

The Insurance Fraud Investigations Branch conducts a statewide program for the prevention, investigation, and prosecution of insurance fraud cases and complaints relating to all lines of insurance (except workers' compensation). The Fraud Branch reviews referrals submitted by the insurance industry, other agencies, and members of the public, and employs special deputy attorneys general.

Violations of the insurance code can result in loss of license, injunction, penalty, fines, restitution, and civil and criminal prosecution.

Implementation Timeline and Process

Hawai'i is currently using direct enrollment for SHOP and proposes to waive SHOP entirely, which will result in continued direct enrollment in health plans for small employers. DLIR currently maintains oversight for the Prepaid Marketplace that replaces SHOP, supported by the Insurance Division that regulates insurance plans and facilitates rate transparency. As result, the State contends that implementation of the waiver can be done immediately upon notification that it has been granted, or by January 1, 2017, whichever is later. The process will include providing public information about the waiver and the expectation of continuing to enroll directly or through agents and brokers.

Reporting Responsibilities

As required, Hawai'i will hold public forums six months after the proposed waiver is granted and annually thereafter. The date, time, and location of each forum will be posted on the Hawai'i government electronic calendar of public events, on websites maintained by the Governor's Office, DLIR, and the Insurance Division, and shared with consumer and business advocacy organizations. Each forum will be conducted at a site that offers both in-person and interactive video attendance to accommodate state residents across islands.

While the State is open to providing quarterly reports to the Secretary, the proposed waiver does not seem to warrant such scrutiny. Alternatively, Hawai'i proposes to report upon the completion of the first six months of the waiver and annually thereafter 90 days after the anniversary of the date on which the waiver was granted. The State will, of course, cooperate fully with any independent evaluation conducted by the Secretary or the Secretary of the Treasury.

In its reports, the State proposes to include:

- Evidence of compliance with public forum requirements, including date, time, place, description of attendees, and the substance of public comment and the State’s response, if any.
- Information about any challenges the State may face in implementing and sustaining the waiver program and its plan to address the challenges.
- A description of any substantive changes in Hawai‘i’s insurance landscape such as the number of insurers serving small employers and any changes in benefits or actuarial values related to plans purchased by small employers.
- The number of small business applicants to and payments made by the Premium Supplementation Fund.
- Any other information consistent with the terms and conditions in the State’s approved waiver.

Waiver Development Process

Hawai‘i Waiver Task Force. Hawai‘i’s State legislature recognized the potential for a Section 1332 waiver in 2014 and, in Act 158 (HB 2581 HD3, SD2, CD1), Regular Session 2014, created a task force “to develop a health care reform plan that meets requirements for obtaining a state innovation waiver.” The waiver task force considered every aspect of the ACA subject to potential waiver and agreed on the provisions specified in the proposed waiver.

The task force was convened regularly after its initial meeting in September 2014 and, per legislation, will be dissolved on June 30, 2017. Subject to Hawai‘i’s open meeting laws, all meetings were publically posted at least one week in advance and members of the public were invited to both attend and comment at every meeting. The task force also submitted an annual report to the legislature summarizing its actions and recommendations. All task force meeting agendas, minutes, presentations, and reports are posted on the Governor’s website at <http://governor.hawaii.gov/healthcareinnovation/healthcare-transformation/>.

Public Hearings. As required in §1332(a)(4)(B)(i), when the task force had agreed upon a draft proposal, public hearings were held in accordance with CFR §33.112 and §155.1312, which address state public notice requirements. Public hearing notices and the written draft proposal were duly posted on the Governor’s website on August 31, 2015, and information was distributed to the media and interested parties at least two weeks before hearings commenced. The public comment period remained open until October 31, 2015. Task force chair, Beth Giesting, was interviewed on-air by Hawai‘i Public Radio about the waiver and scheduled public hearings.

In order to accommodate Hawai‘i’s diverse island geography, hearings were held in seven locations on six islands, as follows:

Kaua‘i	September 14, 2015, 2:00 p.m. – 4:00 p.m. Kaua‘i Community College Cafeteria 3-1901 Kaunuali‘i Highway Lihu‘e, Hawai‘i
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Maui	September 18, 2015, 10:00 a.m. – noon J. Walter Cameron Center Auditorium 95 Mahalani Street Wailuku, Hawai'i
Kona	September 21, 2015, 10:00 a.m. – noon County Council Chambers at the West Hawaii Civic Center, Building A 74-677 Kealakehe Pkwy Kailua-Kona, Hawai'i
O'ahu	September 23, 2015, 2:00 – 4:00 p.m. The Queen's Conference Center, Room 200 1301 Punchbowl Street Honolulu, Hawai'i
Hilo	September 25, 2015, 10:00 a.m. – noon University of Hawai'i at Hilo, College of Hawaiian Language, Hale'ōlelo, Lumi Pāhiahia (Performing Arts Hall) 200 West Kawili Street Hilo, Hawai'i
Lana'i	September 29, 2015, 1:00 – 3:00 p.m. Lana'i Senior Center 309 7th Street Lana'i City, HI
Moloka'i	October 2, 2015, 10:00 a.m. – 12:00 noon Kaunakakai Civic Center, Room 105 Corner of Maka'ena and Ala Malama Kaunakakai, HI

To augment communication and enhance interest in the hearings, the Governor's Office organized them to include an overview and in-depth discussion of three important executive-level Affordable Care Act-related initiatives:

1. The proposed Hawai'i ACA Waiver.
2. The strategies being developed as part of a State Innovation Models (SIM) Planning grant supported by the Centers for Medicare and Medicaid Innovation.
3. A "No Wrong Door" three-year plan supported by the federal Agency for Community Living intended to enhance access to services for the elderly, people with disabilities, and veterans (due to grant constraints this plan was not included in the public hearings on Lana'i and Moloka'i).

A copy of the combined presentations is also posted at <http://governor.hawaii.gov/healthcareinnovation/healthcare-transformation/>.

The Governor’s Office hosted the public hearings with Deputy Chief of Staff, Laurel Johnston, serving as convener and task force chair, Beth Giesting, presenting the ACA Waiver Proposal.

Attendance for all seven public hearings totaled 163 with considerable variation by island, as follows:

Kaua’i	15	Hilo	10
Maui	40	Lana’i	25
Kona	9	Moloka’i	9
Honolulu	55	TOTAL	163

At the four public hearings where topics were discussed in break-out groups, a total of thirteen people participated in the ACA waiver discussions. In the three public hearings where all topics were discussed in one large group, few questions or comments were directed to the waiver proposal. A summary of the ACA Waiver proposal discussion reflects:

- Agreement with aligning ACA requirements with those of the Prepaid Health Care Act, and
- Strong support for maintaining all of the Essential Health Benefits, noting specifically the importance of prescription drug coverage and dental care for children.

Legislation. As required under §1332(a)(1)(B)(i), the 2016 State legislature authorized the proposed waiver in S/HB ____, which was enacted as Act ____ upon signature of Governor David Ige on _____, 2016. A copy of Act ____ can be found in Attachment 4.

Attachment 1: Sections Waivable in §1332

Provisions of the Affordable Care Act that may be Waived under Section 1332

Offering Qualified Health Plans ("QHPs") and required Essential Health Benefits ("EHB")

- Section 1301: Definition of **QHPs**
- Section 1302: **EHB** requirements, including
 - Identifying EHBs
 - Annual limitations on cost-sharing
 - Annual limitations on deductibles for employer-sponsored plans
 - Levels of coverage as currently defined by metal levels (platinum, gold, silver, bronze)
 - Catastrophic plans
 - Child-only plans
- Section 1303: **Special rules** related to abortion services
- Section 1304: **Definitions** related to
 - Group and individual markets
 - Large and small employers and rules related to determining the size of an employer

Providing consumers a health insurance exchange

- Section 1311: Affordable health plan choices via **establishing exchanges**
- Section 1312: **Consumer choice**
 - Employee choice
 - Single risk pool
 - Markets outside of exchanges
 - Individual choice to enroll in a QHP or participate in the exchange
 - Limitations on access to exchanges to citizens and lawful residents
 - Ability of exchanges to offer coverage to large employers starting in 2017
- Section 1313: **Financial integrity** expectations that exchanges will keep accurate accounts of receipts and expenditures

Premium tax credits and reduced cost-sharing

- Section 1402: **Cost-sharing reductions** via enrollment in QHPs
- Section 36B of the IRS Code: **Refundable credits/premium assistance** for coverage in a QHP

Individual and employer responsibility requirements

- Section 4980H of the IRS Code: **Shared responsibility** for employee health insurance
 - Penalties for large employers (more than 100 employees) if not providing coverage
 - Penalties for large employers if coverage offered but employees still access premium tax credits or cost-sharing
 - Definition of Full Time Employee ("FTE") as at least 30 hours per week employment
 - Exemption for certain employees: FTEs who work seasonally or 120 or fewer days/year
 - Definition of seasonal workers
 - Rules for determining employer size
- Section 5000A of the IRS Code: Requirement to **maintain minimum coverage (Section 1501)**
 - Penalties
 - Exemptions
 - Definition of minimum essential coverage

Attachment 2: Section by Section Consideration of Waivable Provisions

Hawai'i's waiver proposal outlined by section below is founded on:

- **The goal of universal health insurance coverage.** To that end, the State proposes to continue to participate in a Supported State-Based Marketplace, and strongly advocate for individual choice and access to affordable coverage.
- **Retaining the benefits of Prepaid.** Eliminating SHOP makes it clear to Hawai'i employers that Prepaid is the single mandate for employer coverage.
- **Ensuring sustainability and eliminating infrastructure and costs that do not add value.** While an independent state-based marketplace is not viable in Hawai'i, sharing the federal technology in a supported marketplace provides cost-effective access for individual consumers. A SHOP exchange for Hawai'i is not economically viable, and the unique requirements of Prepaid make sharing the federal marketplace for SHOP untenable.

ESTABLISHMENT OF QUALIFIED HEALTH PLANS

Section 1301: Definition of Qualified Health Plans

Key ACA Provisions	Hawai'i Proposal
<p><i>The definition of "Qualified Health Plan" including providing EHB, and offering plans conforming to metal levels (bronze, silver, gold, and platinum)</i></p>	<p>Hawai'i proposes that DLIR serve as the certifying authority for qualified health plans. All plans will be required to be ACA QHPs as determined by the Insurance Commissioner.</p> <p>For the Individual Market. Hawai'i proposes retaining the general terms specified for "qualified health plan."</p> <p>For the Small Employer Market. Hawai'i proposes:</p> <ul style="list-style-type: none"> • Maintaining the EHB • Waiving SHOP and the metal-level requirement for QHPs offering plans to small businesses. Instead, Hawai'i will maintain requirements under Prepaid that all eligible employers purchase 7(a) and 7(b) plans, as defined in Prepaid and certified by DLIR.¹⁴

¹⁴ The following Hawai'i Revised Statutes excerpt from the Prepaid Health Care Act defines 7(a) and 7(b) plans:

§393-7 Required health care benefits. (a) *A prepaid health care plan shall qualify as a plan providing the mandatory health care benefits required under this chapter if it provides for health care benefits equal to, or medically reasonably substitutable for, the benefits provided by prepaid health plans of the same type, as specified in section 393-12(a)(1) or (2), which have the largest numbers of subscribers in the State. This applies to the types and quantity of benefits as well as to limitations on reimbursability, including deductibles, and to required amounts of co-insurance.*

The director, after advice by the prepaid health care advisory council, shall determine whether benefits provided in a plan, other than the plan of the respective type having the largest numbers of subscribers in the State, comply with the standards specified in this subsection.

(b) A prepaid group health care plan shall also qualify for the mandatory health care benefits required under this chapter if it is demonstrated by the health care plan contractor offering such coverage to the satisfaction of the

Key ACA Provisions	Hawai'i Proposal
<i>Inclusion of Co-Op and Multi-State Plans</i>	Hawai'i proposes to waive this section as it is doubtful that co-op and multi-state plans can conform to the requirements of Prepaid. In addition, plans would be harder to regulate and monitor for compliance than state-based plans.
<i>Treatment of Qualified Direct Primary Care Medical Home Plans</i>	Hawai'i proposes to retain these provisions.
<i>Exceptions for Self-Insured Plans and MEWAS (multiple employer welfare arrangements)</i>	Hawai'i proposes to retain these provisions.

Section 1302: EHB Requirements

Key ACA Provisions	Hawai'i Proposal
<i>Defines EHB</i>	Hawai'i proposes that the EHBs be retained.
<i>Annual limitations on cost-sharing</i>	Hawai'i proposes to retain these provisions. Currently, cost-sharing in Prepaid plans is more advantageous to employees but, should that change, the ACA limits would serve as a ceiling.
<i>Annual limitations on deductibles for employer-sponsored plans</i>	Hawai'i proposes to retain these provisions. Currently, deductibles in Prepaid plans are more advantageous to employees but, should that change, the ACA limits would serve as a ceiling.
<i>Definition of metal levels by actuarial value</i>	<p>For the Individual Market. Hawai'i proposes to retain the levels of coverage and actuarial values described for bronze, silver, gold, and platinum plans.</p> <p>For the Small Business Market. Hawai'i proposes to waive the metal-level requirements for small businesses. Instead, Hawai'i will maintain Prepaid requirements under which all eligible employers purchase 7(a) and 7(b) plans.</p>
<i>Availability of catastrophic plans</i>	Hawai'i proposes to retain these provisions.
<i>Availability of child-only plans</i>	Hawai'i proposes to retain these provisions.
<i>Defines payment to federally-qualified health centers</i>	Hawai'i proposes to retain these provisions.

director after advice by the prepaid health care advisory council that the plan provides for sound basic hospital, surgical, medical, and other health care benefits at a premium commensurate with the benefits included taking proper account of the limitations, co-insurance features, and deductibles specified in such plan. Coverage under a plan which provides aggregate benefits that are more limited than those provided by plans qualifying under subsection (a) shall be in compliance with section 393-11 only if the employer contributes at least half of the cost of the coverage of dependents under such plan.

Section 1303: Special Rules Related to Abortion Services

Key ACA Provisions	Hawai'i Proposal
<i>Details special rules related to abortion services</i>	Hawai'i proposes to retain these provisions.

Section 1304: Definitions of Markets and Rules Large and Small Employers

Key ACA Provisions	Hawai'i Proposal
<i>Defines and details rules for "small" and "large" group markets</i>	<p>Hawai'i proposes to waive the requirement to define a "large employer" as one with at least 101 employees while a "small employer" is one with between one and 100 employees. Instead, the task force endorses maintaining the threshold between large and small employers at 50, i.e. small businesses will be defined as those with 50 or fewer employees while large businesses will be those with 51 or more employees, unless the threshold of 101 becomes effective on January 1, 2016.</p> <p>The task force proposes this waiver because all businesses in Hawai'i, large and small, are subject to Prepaid, but only small businesses are subject to additional ACA provisions related to EHBs and premium rating. Minimizing the number of businesses that must meet these additional ACA requirements ensures that most businesses – and their employees – are subject to the same benefits, requirements, and rating arrangements.</p>
<i>Specifies rules for aggregation treatment of employers, employers not in existence in preceding year, and predecessor employers</i>	Hawai'i proposes to retain these provisions.
<i>Defines when a "growing" small employer that purchased employee coverage through SHOP may continue to do</i>	Hawai'i proposes to waive this section to be consistent with its recommendation to waive SHOP.

**CONSUMER CHOICES AND INSURANCE COMPETITION
THROUGH HEALTH BENEFIT EXCHANGES**

Section 1311: Providing Consumers a Health Insurance Exchange

Key ACA Provisions	Hawai'i Proposal
<i>Requires establishment of an American Health Benefit Exchange, and details</i>	Hawai'i proposes to retain the individual exchange via a Supported State-Based Marketplace.

<i>responsibilities of the exchange</i>	
<i>Provides for the establishment a SHOP exchange</i>	<p>Hawai'i proposes to waive the SHOP requirement. As noted above, Prepaid better meets the goals of the ACA in ensuring small business employee coverage than SHOP.</p> <p>In lieu of the tax credits for qualified small businesses that purchase employee coverage as described in IRS Code §1421, the State seeks payment from the Treasury to deposit in the Premium Assistance fund already established as part of Prepaid. The task force purposes a methodology and application of such payment as described below.</p>
<i>Specifies which entities are eligible to carry out responsibilities of the Exchange</i>	Hawai'i proposes to waive this section to allow state agencies, in addition to the state Medicaid agency, to carry out certain Exchange responsibilities.

Section 1312: Consumer Choice

Key ACA Provisions	Hawai'i Proposal
<i>Details provisions for consumer choice among QHPs through an exchange</i>	<p>Hawai'i proposes to waive the consumer choice provision defined in this section in conjunction with waiving SHOP. Some of the reasons are as follows:</p> <ul style="list-style-type: none"> • Assuring such choice for employees of small businesses requires an on-going investment in technical infrastructure disproportionate to the benefits for Hawai'i's small market. • The cost to comply with the technical infrastructure necessary to offer consumer choice for insurers offering coverage to businesses would result in the smaller insurers departing the market and so achieve the unintended consequence of reduced competition and choice. It should be noted that when the Connector supported the SHOP exchange, it included only Kaiser small business plans, so consumer choice was foiled by the lack of competitors. • In Hawai'i's Prepaid environment, consumer choice is relatively insignificant because employers are required to purchase employee coverage with uniformly comprehensive benefits with very little of the cost passed on to employees. • Offsetting any consumer disadvantages is the fact that employee access to coverage, benefits, and cost-sharing are significantly better under Prepaid than under the ACA provisions.
<i>Establishes that all enrollees in the individual market are in a single risk pool</i>	Hawai'i proposes to retain these provisions.
<i>Establishes that all enrollees in the small group market are in a single risk pool</i>	Hawai'i proposes to retain these provisions.
<i>Allows states to merge individual and small group</i>	Hawai'i proposes to retain these provisions.

Key ACA Provisions	Hawai'i Proposal
<i>insurance in a single risk pool if the state deems it appropriate</i>	
<i>Prevents state law from requiring grandfathered plans to be in the individual or small group risk pool</i>	Hawai'i proposes to retain these provisions.
<i>Allows health issuers to offer coverage outside an exchange, and allows individuals and qualified employers to purchase coverage outside an exchange</i>	Hawai'i proposes to retain these provisions.
<i>Maintains state control of plans outside of the exchange</i>	Hawai'i proposes to retain these provisions.
<i>Provides choice to qualified individuals as to whether or not to enroll via an exchange and which plan to choose</i>	Hawai'i proposes to retain these provisions.
<i>Describes health plan choices for members of Congress and Congressional staff</i>	Hawai'i proposes to retain these provisions.
<i>Ensures that individuals who cancel enrollment on the exchange in favor of employer coverage will not be penalized</i>	Hawai'i proposes to retain these provisions.
<i>Allows enrollment through agents and brokers</i>	Hawai'i proposes to retain these provisions.
<i>Limits enrollment through an exchange to citizens and lawful residents</i>	Hawai'i proposes to retain these provisions.
<i>Excludes incarcerated individuals</i>	Hawai'i proposes to retain these provisions.
<i>Allows coverage via the exchange for the large group market</i>	Hawai'i proposes to waive this section to be consistent with its recommendation to waive SHOP.
<i>Provides that access to coverage through an exchange may be denied to those who are not lawful residents for the entire enrollment period</i>	Hawai'i proposes to retain these provisions.

Section 1313: Financial Integrity

Key ACA Provisions	Hawai'i Proposal
<i>Details financial management and protections against fraud and abuse for an exchange</i>	Hawai'i proposes to retain these provisions.

PREMIUM TAX CREDITS AND REDUCED COST-SHARING

Sections 1402/36B – Premium Tax Credits and Cost Sharing

Key ACA Provisions	Hawai'i Proposal
<i>Details provisions and eligibility for reductions in cost-sharing and out-of-pocket costs for individuals who enroll in a QHP</i>	Hawai'i proposes to retain these provisions.

INDIVIDUAL AND EMPLOYER RESPONSIBILITY REQUIREMENTS

IRC Sections 4980H and 5000A: Individual and Employer Responsibility

Key ACA Provisions	Hawai'i Proposal
<i>Defines and details requirements for offering health insurance coverage by large employers and responsibilities of employees for enrolling</i>	Hawai'i proposes to retain these provisions, which impose IRS penalties for large employers who fail to meet requirements to provide adequate health insurance coverage.

Attachment 3: Q & A about the Hawai'i Prepaid Health Care Act

History and Overview. The Hawai'i Prepaid Health Care Act ("Prepaid") was the first in the nation to set minimum standards of health care benefits for workers. Employers, excluding Federal, State and City government and several others specifically excluded by the law, are required to provide Hawai'i employees, who suffer a disability due to non-work related illness or injury, with adequate medical coverage, protecting them from the high cost of medical and hospital care. Detailed in Chapter 393, Hawai'i Revised Statutes, Prepaid became law and was exempted from the federal Employee Retirement Income Security Act ("ERISA") by Congress¹⁵ in 1983. Because Prepaid is sanctioned by a Congressional ERISA exemption, any substantive change in the Act's provisions would void the entire law.

The following table contrasts key employer/employee provisions contained in Prepaid and in the ACA:

Prepaid	ACA
<ul style="list-style-type: none"> • Employers with even a single permanent employee must provide coverage. • All employees are eligible for coverage if they work 20 hours or more per week. • The actuarial value of Prepaid plans averages 90%. • Employees cannot be made responsible for premium costs that exceed 1.5% of wages. 	<ul style="list-style-type: none"> • Only large employers must offer employee coverage. • Permanent employees are eligible for coverage if they work 30 hours or more per week. • Employers may offer plans with an actuarial value as low as 60%. • Employees may pay as much as 9.5% of W-2 earnings.

Simply put, Prepaid mandates almost all employers with employees who work in Hawai'i to provide meaningful health care coverage for these employees. The full act, which is a concise ten pages, is attached.

Questions & Answers about the Hawai'i Prepaid Health Care Act

Question 1. Which employees and employers are subject to the Prepaid mandate?

Answer 1. Employers must provide health care coverage to employees who work at least 20 hours per week and earn 86.67 times the current Hawai'i minimum wage per month, which, as of January 1, 2015, equaled \$672 (\$7.75 x 86.67). Coverage commences after four (4) consecutive weeks of employment or the earliest time thereafter at which coverage can be provided by the health care plan contractor, which is usually the first of the month.¹⁶

¹⁵ P.L. No. 97-473, §301 (29 U.S. C. §1144(b)(5))

¹⁶ <http://labor.hawaii.gov/dcd/about-phc/>

“Employer,” for purposes of Prepaid, does **not** include the United States Government, the State of Hawai‘i or any of its political sub-divisions, any other state, or any foreign government.¹⁷

Question 2. Does Prepaid have an effect on collective bargaining agreements?

Answer 2. Prepaid is explicit in stating that it does not interfere with any collective bargaining agreement that provides equal or better employee health care benefits. §393-2 reads:

This chapter shall not be construed to interfere with or diminish any protection already provided pursuant to collective bargaining agreements or employer-sponsored plans that is more favorable to the employees benefited thereby than the protection provided by this chapter or at least equivalent thereto, provided that presently existing collective bargaining agreements shall not be affected by the provisions of this section.

Question 3. What if an employee works for two or more employers?

Answer 3. The employer responsible for providing coverage will be the one that pays the most wages, assuming the employee works for that employer for 20 or more hours per week. If another employer regularly employs the individual for at least 35 hours per week but does not pay the most wages, the employee can designate which of the two employers will be responsible for providing coverage. This designation may be changed on an annual basis.

Prepaid does not require coverage for an employee who has two or more part-time jobs where each is less than 20 hours per week.

Question 4. Are any regular employees exempt from Prepaid coverage?

Answer 4. A regular employee is exempt from coverage by his or her employer if the employee is:

- a) Already enrolled in another health insurance or Prepaid health care plan
- b) Covered as a dependent under a Prepaid health care plan
- c) A recipient of public insurance such as Medicaid or Medicare or some other public health care assistance plan
- d) A spouse, child, or parent employed by the employer
- e) A seasonal (agricultural) worker
- f) An insurance agent or real estate broker working on commission
- g) A domestic worker who provides attendant and day care services in the employ of a recipient of social service payments.¹⁸

¹⁷ §393-3 (3)

¹⁸ §393-5

In the event that the circumstances supporting an exemption end, the employer must enroll the employee in a Prepaid plan as provided in the Act, usually the first of the month following the reported change.¹⁹

Self-employed individuals without employees are not eligible for Prepaid coverage.

Question 5. How is the cost of the premium shared between employer and employee?

Answer 5. Except as negotiated under collective bargaining agreements, the employer must pay at least half of the cost of the premium but, “in no case shall the employee contribute more than 1.5% of the employee’s wages...”²⁰ In effect, employers are currently paying an estimated 85% of the cost of employee premiums.

Question 6. Who chooses the insurer and plan type?

Answer 6. The employer chooses the insurer and plan type.

Question 7. What types of health care benefits are required by Prepaid?

Answer 7. The benefits identified in Prepaid²¹ include:

- a) Hospital benefits
- b) Out-patient care
- c) Surgical benefits
- d) Medical benefits
- e) Diagnostic laboratory, x-ray, and radio-therapeutic services
- f) Maternity benefits
- g) Substance abuse benefits

Also covered by Prepaid but not codified in the statute are all additional benefits mandated in the insurance code as changed from time to time under State legislation. A list of such benefits is attached below. It should be noted that prescription drug coverage, while widely offered by employers, is not a Prepaid benefit.

Question 8. How are Prepaid-compliant health plans determined?

Answer 8. All health care plans, whether sold by health care contractors or submitted by employers, must be approved by the state Department of Labor and Industrial Relations (“DLIR”) as meeting the prescribed minimum standards. Such determination is made by the Director with the advice of a seven-member Prepaid Health Care Advisory Council consisting of representatives from the medical and public health care professions, from consumer interests, and from the Prepaid health care protection industry.

Upon approval, plans are designated as 7(a) or 7(b) plans. Plans designated as 7(a) are equal to or better than the benefits offered by the plan with the largest number of subscribers (also known as

¹⁹ §393-17

²⁰ §393-13

²¹ §393-7 (c)

the “prevalent plan”) in the State of Hawai‘i. Plans designated as 7(b) provide for sound basic hospital, surgical, medical, and other health care benefits; however, the plan’s benefits, such as the deductible, out of pocket limit, benefit level and copayments, may be more limited than the benefits provided by plans qualifying as 7(a). Employers that choose more robust – and more expensive – 7(a) plans must provide coverage to employees only. If a 7(b) plan is chosen, the employer must pay one-half of the cost for dependents’ coverage in addition to covering the employee with no more than a 1.5% of wages contribution.²²

Question 9. How do employers ensure their health plans are compliant with Prepaid?

Answer 9. Employers can choose one of the following three ways to provide the mandated coverage to their employees.

- a) Purchase an [approved plan](#) (the DLIR website provides a link to the list of already approved plans). In Hawai‘i, insurance companies, mutual benefit societies and health maintenance organizations can sell health care plans to Hawai‘i employers directly. These plans must be reviewed by the [Prepaid Health Care Advisory Council](#) and approved by the Director of the DLIR before they can be marketed to employers.
- b) Purchase an insured plan of the employer’s choice. Some employers with corporate offices located outside of Hawai‘i purchase a health care plan and offer it to their employees on a nationwide basis. Employers that choose this option must submit their plan to DLIR for review by the Prepaid Health Care Advisory Council and approval by the Director to ensure the benefits are comparable to plans sold in Hawai‘i.
- c) Provide a health care plan that is funded by the employer. A self-insured employer must show proof of financial solvency and ability to pay benefits by furnishing DLIR with the latest audited financial statements for review. Following the initial approval, the audited financial statements must be filed annually for continued approval. Employers choosing this option must complete an application for self-insurance as well as submit a copy of their health care plan to DLIR for review by the Prepaid Health Care Advisory Council and approval by the Director to ensure the benefits are comparable to plans sold in Hawai‘i.²³

Question 10. How many Hawai‘i residents are covered because of Prepaid?

Answer 10. Prepaid’s influence on coverage and consumer expectations is the single most significant aspect of health insurance in Hawai‘i. More than 760,000 people, or 54% of the state’s 1.4 million population, have Prepaid insurance coverage. This number includes both public and private sector employees and their dependents.

²² <http://labor.hawaii.gov/dcd/about-phc/>

²³ <http://labor.hawaii.gov/dcd/about-phc/>

Question 11. How is Prepaid enforced with employers?

Answer 11. The DLIR has responsibility for assuring employer compliance with Prepaid. DLIR has the authority to:

- Exert its Prepaid health care penalties and injunctions capabilities. Employers that do not provide health care insurance to their eligible employees are liable to pay for their employees' medical expenses²⁴
- Monitor employer compliance through its Disability Compensation Information System that tracks employers' health care coverage of their employees
- Conduct random compliance checks of employers by the Disability Compensation Division's Audit and Investigation sections
- Investigate employers on-site when identified through its Delinquent/Non-Compliant Employer reports
- Maintain a hotline for employees or others to report employers who fail to comply with Prepaid

Question 12. How are insurers monitored for compliance with Prepaid?

Answer 12. The Insurance Division in the State Department of Commerce and Consumer Affairs has responsibility for regulating and ensuring compliance and solvency of health insurers, including health maintenance organizations and mutual benefit societies. The Health Insurance Branch reviews health insurance contracts and forms to ensure readability and the disclosure of required information. The Branch also reviews premium rate filings of managed care plans. Hawai'i has an effective rate review program.

The Health Insurance Branch also receives inquiries and complaints pertaining to federal and state laws governing health insurance that has resulted in consumer saving in the thousands of dollars per year. In addition, the Branch assists consumers, healthcare providers, and health insurance professionals with informal inquiries, and conducts independent external reviews of managed care plan coverage decisions that are appealed by plan members that has likewise resulted in consumer savings of thousands of dollars per year.

The Insurance Fraud Investigations Branch conducts a statewide program for the prevention, investigation, and prosecution of insurance fraud cases and complaints relating to all lines of insurance (except workers' compensation). The Fraud Branch reviews referrals submitted by the insurance industry, other agencies, and members of the public, and employs special deputy attorneys general.

Violations of the insurance code can result in loss of license, injunction, penalty, fines, restitution, and civil and criminal prosecution.

²⁴ Hawai'i's Prepaid Health Care Act (Chapter 393, Hawai'i Revised Statutes) allows the director to assess penalties and enjoin employers from carrying on their business if the employer fails to comply with Prepaid coverage requirements (§393-33 and 393-34, HRS).

**CHAPTER 393
PREPAID HEALTH CARE ACT**

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PART I. SHORT TITLE; PURPOSE; DEFINITIONS

§393-1 Short title. This chapter shall be known as the "Hawaii Prepaid Health Care Act".

§393-2 Findings and purpose. The cost of medical care in case of sudden need may consume all or an excessive part of a person's resources. Prepaid health care plans offer a certain measure of protection against such emergencies. It is the purpose of this chapter in view of the spiraling cost of comprehensive medical care to provide this type of protection for the employees in this State. Although a large segment of the labor force in the State already

enjoys coverage of this type either by virtue of collective bargaining agreements, employer-sponsored plans, or individual initiative, there is a need to extend that protection to workers who at present do not possess any or possess only inadequate prepayment coverage.

This chapter shall not be construed to diminish any protection already provided pursuant to collective bargaining agreements or employer-sponsored plans that is more favorable to the employees benefited thereby than the protection provided by this chapter or at least equivalent thereto, provided that presently existing collective bargaining agreements shall not be affected by the provisions of this section.

§393-3 Definitions generally. As used in this chapter, unless the context clearly requires otherwise:

- (1) "Department" means the department of labor and industrial relations.
- (2) "Director" means the director of labor and industrial relations.
- (3) "Employer" means any individual or type of organization, including any partnership, association, trust, estate, joint stock company, insurance company, or corporation, whether domestic or foreign, a debtor in possession or receiver or trustee in bankruptcy, or the legal representative of a deceased person, who has one or more regular employees in the employer's employment. "Employer" does not include:
 - (A) The State, any of its political subdivisions, or any instrumentality of the State or its political subdivisions;
 - (B) The United States government or any instrumentality of the United States;
 - (C) Any other state or political subdivision thereof or instrumentality of such state or political subdivision;
 - (D) Any foreign government or instrumentality wholly owned by a foreign government, if (A) the service performed in its employ is of a character similar to that performed in foreign countries by employees of the United States government or of an instrumentality thereof, and (B) the United States Secretary of State has certified or certifies to the United States Secretary of the Treasury that the foreign government, with respect to whose instrumentality exemption is claimed, grants an equivalent exemption with respect to similar service performed in the foreign country by employees of the United States government and of instrumentalities thereof.
- (4) "Employment" means service, including service in interstate commerce, performed for wages under any contract of hire, written or oral, expressed or implied, with an employer, except as otherwise provided in sections 393-4 and 393-5.
- (5) "Premium" means the amount payable to a prepaid health care plan contractor as consideration for the contractor's obligations under a prepaid health care plan.
- (6) "Prepaid health care plan" means any agreement by which any prepaid health care plan contractor undertakes in consideration of a stipulated premium:
 - (A) Either to furnish health care, including hospitalization, surgery, medical or nursing care, drugs or other restorative appliances, subject to, if at all, only a nominal per service charge; or
 - (B) To defray or reimburse, in whole or in part, the expenses of health care.
- (7) "Prepaid health care plan contractor" means:
 - (A) Any medical group or organization which undertakes under a prepaid health care plan to provide health care; or
 - (B) Any nonprofit organization which undertakes under a prepaid health care plan to defray or reimburse in whole or in part the expenses of health care; or
 - (C) Any insurer who undertakes under a prepaid health care plan to defray or reimburse in whole or in part the expenses of health care.
- (8) "Regular employee" means a person employed in the employment of any one employer for at least twenty hours per week but does not include a person employed in seasonal employment. "Seasonal employment" for the purposes of this paragraph means employment in a seasonal pursuit as defined in section 387-1 by a seasonal employer during a seasonal period or seasonal periods for the employer in the seasonal pursuit or employment by an employer engaged in the cultivating, harvesting, processing, canning, and warehousing of pineapple during its seasonal periods. The director by rule and regulation may determine the kind of employment that constitutes seasonal employment.

(9) "Wages" means all remuneration for services from whatever source, including commissions, bonuses, and tips and gratuities paid directly to any individual by a customer of the individual's employer, and the cash value of all remuneration in any medium other than cash.

The director may issue regulations for the reasonable determination of the cash value of remuneration in any medium other than cash.

If the employee does not account to the employee's employer for the tips and gratuities received and is engaged in an occupation in which the employee customarily and regularly receives more than \$20 a month in tips, the combined amount received by the employee from the employee's employer and from tips shall be deemed to be at least equal to the wage required by chapter 387 or a greater sum as determined by regulation of the director.

"Wages" does not include the amount of any payment specified in section 383-11 or 392-22 or chapter 386.

§393-4 Place of performance. "Employment" includes an individual's entire service, performed within or both within and without this State if:

- (1) The service is localized in this State; or
- (2) The service is not localized in any state but some of the service is performed in this State and
 - (A) The individual's base of operation, or, if there is no base of operation, the place from which such service is directed or controlled, is in the State; or
 - (B) The individual's base of operation or place from which the service is directed or controlled is not in any state in which some part of the service is performed but the individual's residence is in this State.

§393-5 Excluded services. "Employment" as defined in section 393-3 does not include the following services:

- (1) Service performed by an individual in the employ of an employer who, by the laws of the United States, is responsible for care and cost in connection with such service;
- (2) Service performed by an individual in the employ of the individual's spouse, son, or daughter, and service performed by an individual under the age of twenty-one in the employ of the individual's father or mother;
- (3) Service performed in the employ of a voluntary employee's beneficiary association providing for the payment of life, sick, accident, or other benefits to the members of the association or their dependents or their designated beneficiaries, if:
 - (A) Admission to membership in the association is limited to individuals who are officers or employees of the United States government; and
 - (B) No part of the net earnings of the association inures (other than through such payments) to the benefits of any private shareholder or individual;
- (4) Service performed by an individual for an employer as an insurance agent or as an insurance solicitor if all service performed by the individual for the employer is performed for remuneration by way of commission;
- (5) Service performed by an individual for an employer as a real estate salesperson or as a real estate broker if all service performed by the individual for the employer is performed for remuneration by way of commission;
- (6) Service performed by an individual who, pursuant to the federal Economic Opportunity Act of 1964, is not subject to the provisions of law relating to federal employment, including unemployment compensation;
- (7) Domestic, which include attendant care, and day care services authorized by the department of human services under the Social Security Act, as amended, performed by an individual in the employ of a recipient of social service payments.

§393-6 Principal and secondary employer defined; coercion, interference, etc. prohibited. If an individual is concurrently a regular employee of two or more employers as defined in this chapter, the principal employer shall be the employer who pays the individual the most wages; provided that if one of the employers, who does not pay the most wages, employs the regular employee for at least thirty-five hours per week, the employee shall determine which of the employers shall be the employee's principal employer. The employee's other employers are secondary employers. An employer so designated as the principal employer shall remain as such principal employer for one year or until change of employment, whichever is earlier.

If an individual is concurrently a regular employee of a public entity which is not an employer as defined in section 393-3 and of an employer as defined in section 393-3 the latter shall be deemed to be a secondary employer.

An employer who, directly or indirectly, interferes with or coerces or attempts to coerce an employee in making a determination under this section shall be subject to the penalty provided under subsection 393-33(b).

§393-7 Required health care benefits. (a) A prepaid health care plan shall qualify as a plan providing the mandatory health care benefits required under this chapter if it provides for health care benefits equal to, or medically reasonably substitutable for, the benefits provided by prepaid health plans of the same type, as specified in section 393-12(a)(1) or (2), which have the largest numbers of subscribers in the State. This applies to the types and quantity of benefits as well as to limitations on reimbursability, including deductibles, and to required amounts of co-insurance.

The director, after advice by the prepaid health care advisory council, shall determine whether benefits provided in a plan, other than the plan of the respective type having the largest numbers of subscribers in the State, comply with the standards specified in this subsection.

(b) A prepaid group health care plan shall also qualify for the mandatory health care benefits required under this chapter if it is demonstrated by the health care plan contractor offering such coverage to the satisfaction of the director after advice by the prepaid health care advisory council that the plan provides for sound basic hospital, surgical, medical, and other health care benefits at a premium commensurate with the benefits included taking proper account of the limitations, co-insurance features, and deductibles specified in such plan. Coverage under a plan which provides aggregate benefits that are more limited than those provided by plans qualifying under subsection (a) shall be in compliance with section 393-11 only if the employer contributes at least half of the cost of the coverage of dependents under such plan.

(c) Subject to the provisions of subsections (a) and (b) without limiting the development of medically more desirable combinations and the inclusion of new types of benefits, a prepaid health care plan qualifying under this chapter shall include at least the following benefit types:

- (1) Hospital benefits:
 - (A) In-patient care for a period of at least one hundred twenty days of confinement in each calendar year covering
 - (i) Room accommodations;
 - (ii) Regular and special diets;
 - (iii) General nursing services;
 - (iv) Use of operating room, surgical supplies, anesthesia services, and supplies;
 - (v) Drugs, dressings, oxygen, antibiotics, and blood transfusion services.
 - (B) Out-patient care
 - (i) Covering use of out-patient hospital;
 - (ii) Facilities for surgical procedures or medical care of an emergency and urgent nature.
- (2) Surgical benefits:
 - (A) Surgical services performed by a licensed physician, as determined by plans meeting the standards of subsections (a) and (b);
 - (B) After-care visits for a reasonable period;
 - (C) Anesthesiologist services.
- (3) Medical benefits:
 - (A) Necessary home, office, and hospital visits by a licensed physician;
 - (B) Intensive medical care while hospitalized;
 - (C) Medical or surgical consultations while confined.
- (4) Diagnostic laboratory services, x-ray films, and radio- therapeutic services, necessary for diagnosis or treatment of injuries or diseases.
- (5) Maternity benefits, at least if the employee has been covered by the prepaid health care plan for nine consecutive months prior to the delivery.
- (6) Substance abuse benefits:
 - (A) Alcoholism and drug addiction are illnesses and shall receive benefits as such. In-patient and out-patient benefits for the diagnosis and treatment of substance abuse, including but not limited to alcoholism and drug addiction, shall be specifically stated and shall not be less than the benefits for any other illness, except as provided in this subsection. Medical treatment of substance abuse shall not be limited or reduced by restricting coverage to the mental health or psychiatric benefits of a

plan. However, any psychiatric services received as a result of the treatment of substance abuse may be limited to the psychiatric benefits of the plan.

(B) Out-patient benefits provided by a physician, psychiatrist, or psychologist, without restriction as to place of service; provided that health plans of the type specified in section 393-12(a) shall retain for the contractor the option of:

- (i) Providing the benefits in its own facility and utilizing its own staff, or
- (ii) Contracting for the provision of these benefits, or
- (iii) Authorizing the patient to utilize outside services and defraying or reimbursing the expenses at a rate not to exceed that for provision of services utilizing the health contractor's own facilities and staff.

(C) Detoxification and acute care benefits in a hospital or any other public or private treatment facility, or portion thereof, providing services especially for the detoxification of intoxicated persons or drug addicts, which is appropriately licensed, certified, or approved by the department of health in accordance with the standards prescribed by the Joint Commission on Accreditation of Hospitals. In-patient benefits for detoxification and acute care shall be limited in the case of alcohol abuse to three admissions per calendar year, not to exceed seven days per admission, and shall be limited in the case of other substance abuse to three admissions per calendar year, not to exceed twenty-one days per admission.

(D) Prepaid health plans shall not be required to make reimbursements for care furnished by government agencies and available at no cost to a patient, or for which no charge would have been made if there were no health plan coverage.

(d) The prepaid health care advisory council shall be appointed by the director and shall include representatives of the medical and public health professions, representatives of consumer interests, and persons experienced in prepaid health care protection. The membership of the council shall not exceed seven individuals.

PART II. MANDATORY COVERAGE

§393-11 Coverage of regular employees by group prepaid health care plan. Every employer who pays to a regular employee monthly wages in an amount of at least 86.67 times the minimum hourly wage, specified in chapter 387, as rounded off by regulation of the director, shall provide coverage of such employee by a prepaid group health care plan qualifying under section 393-7 with a prepaid health care plan contractor in accordance with the provisions of this chapter.

§393-12 Choice of plan type and of contractor. (a) Every employer required to provide coverage for the employer's employees by a prepaid group health care plan under this chapter shall elect whether coverage shall be provided by:

- (1) A plan which obligates the prepaid health care plan contractor to furnish the required health care benefits; or
- (2) A plan which obligates the prepaid health care plan contractor to defray or reimburse the expenses of health care.

The employer's election is binding for one year.

(b) Whether the employer elects a plan type described in subsection (a)(1) or in subsection (a)(2), the employer may elect the particular contractor but the employee shall not be obligated to contribute a greater amount to the premium than the employee would have to contribute had the employer elected coverage with the contractor providing the prevailing coverage of the respective type in the State.

Subject to the provision of section 393-20, the employer shall provide coverage with the prepaid health care plan contractor selected pursuant to this subsection for all the employer's employees in the State electing this type of coverage who are covered by the provisions of this chapter, except for employees covered by the health care provisions of an applicable collective bargaining agreement as provided in section 393-19(b) first sentence.

§393-13 Liability for payment of premium; withholding; recovery of premium. Unless an applicable collective bargaining agreement specifies differently every employer shall contribute at least one-half of the premium for the coverage required by this chapter and the employee shall contribute the balance; provided that in no case shall the employee contribute more than 1.5 per cent of the employee's wages; and provided that if the amount of the

employee's contribution is less than one-half of the premium, the employer shall be liable for the whole remaining portion of the premium.

The employer shall withhold the employee's share from the employee's wages with respect to pay periods as specified by the director.

If an employee separates from the employee's employment after the employee's employer has prepaid the employee's share of the cost of providing health care coverage, the employer may deduct an amount not to exceed one-half of the premium cost but without regard to the 1.5 per cent limitation, from the last salary or wages due the employee, or seek other appropriate means to recover the premium.

§393-14 Commencement of coverage. The employer shall provide the coverage required by this chapter for any regular employee, who has been in the employer's employ for four consecutive weeks, at the earliest time thereafter at which coverage may be provided with the prepaid health care plan contractor selected pursuant to this chapter.

§393-15 Continuation of coverage in case of inability to earn wages. If an employee is hospitalized or otherwise prevented by sickness from working, the employer shall enable the employee to continue the employee's coverage by contributing to the premium the amounts paid by the employer toward such premium prior to the employee's sickness for the period that such employee is hospitalized or prevented by sickness from working. This obligation shall not exceed a period of three months following the month during which the employee became hospitalized or disabled from working, or the period for which the employer has undertaken the payment of the employee's regular wages in such case, whichever is longer.

§393-16 Liability of secondary employer. An employer who has been notified by an employee, in the form prescribed by the director, that the employer is not the principal employer as defined in section 393-6 shall be relieved of the duty of providing the coverage required by this chapter until the employer is notified by the employee pursuant to section 393-18 that the employer has become the principal employer. The employer shall notify the director, in the form prescribed by the director, that the employer is relieved from the duty of providing coverage or of any change in that status.

§393-17 Exemption of certain employees. (a) In addition to the exemption specified in section 393-16, an employer shall be relieved of the employer's duty under section 393-11 with respect to any employee who has notified the employer, in the form specified by the director, that the employee is:

- (1) Protected by health insurance or any prepaid health care plan established under any law of the United States;
- (2) Covered as a dependent under a prepaid health care plan, entitling the employee to the health benefits required by this chapter;
- (3) A recipient of public assistance or covered by a prepaid health care plan established under the laws of the State governing medical assistance.

(b) Employers receiving notice of a claim of exemption under this section shall notify the director of such claim in the form prescribed by the director.

§393-18 Termination of exemption. (a) If an exemption which has been claimed by an employee pursuant to section 393-17 terminates because of any change in the circumstances entitling the employee to claim such exemption, the employee shall promptly notify the principal employer of the termination of the exemption and the employer thereupon shall provide coverage as required by this chapter.

(b) If because of a change in the employment situation of an employee or a redetermination by an employee as provided in section 393-6, a principal employer becomes a secondary employer or a secondary employer becomes the principal employer, the employee shall promptly notify the employers affected of such change and the new principal employer shall provide coverage as required by this chapter.

§393-19 Freedom of collective bargaining. (a) In addition to the policy stated in section 393-2, nothing in this chapter shall be construed to limit the freedom of employees to bargain collectively for different prepaid health care coverage, if the protection provided by the negotiated plan is more favorable to the employees benefited than the protection provided by this chapter or at least equivalent thereto, or for a different allocation of the costs thereof. A

collective bargaining agreement may provide that the employer oneself undertakes to provide the health care specified in the agreement.

(b) If the employees rendering particular types of services are not covered by the health care provisions of the applicable collective bargaining agreements to which their employer is a party, the provisions of this chapter shall be applicable with respect to them. An employer or group of employers shall be deemed to have complied with the provisions of this chapter if they undertake to provide health care services pursuant to a collective bargaining agreement and the services are available to all other employees not covered by such agreement.

§393-20 Adjustment of employer-sponsored plans. Where employees subject to the coverage of this chapter are included in the coverage provisions of an employer-sponsored prepaid health care plan covering similar employees employed outside the State and the majority of such employees are not subject to this chapter, the benefits applicable to the employees covered by this chapter shall be adjusted within one year after the effective date of this chapter so as to meet the requirements of this chapter.

§393-21 Individual waivers; additional withholding for dependents. (a) An employee may waive individually all of the required health care benefits pursuant to this chapter by:

- (1) Requesting the waiver by a writing submitted to the employer; and
- (2) Receiving approval of the waiver from the director upon the director determining that the employee has other coverage under a prepaid health care plan which provides benefits that meet the standards prescribed in section 393-7.

(b) The employer who receives from an employee a written request for a waiver under this section shall transmit to the director a copy of the waiver, on a form prescribed by the director, and a copy of the prepaid health care plan on the basis of which the waiver is requested.

(c) A waiver under this section is binding for one year and is renewable for subsequent one-year periods.

(d) An employer who, directly or indirectly, coerces or attempts to coerce an employee in making a waiver under this section shall be subject to the penalty provided under section 393-33(b).

(e) An employee may not agree to pay a greater share of the premium for such benefits than is required by this chapter.

(f) Subject to section 393-7(b), an employee may consent to pay a greater share of the employee's wages and to a withholding of such share by the employer for the purpose of providing prepaid health care benefits of the employee's dependents under the plan providing such benefits for the employee's self.

§393-22 Exemption of followers of certain teachings or beliefs. This chapter shall not apply to any individual who pursuant to the teachings, faith, or belief of any group, depends for healing upon prayer or other spiritual means.

§393-23 Joint provision of coverage. Employers may form associations for the purpose of jointly providing prepaid health care protection under this chapter for their employees with the contractors authorized to provide such coverage in the State.

§393-24 Noncomplying employer held liable for employee's health care costs. Any employer who fails to provide coverage as required by this chapter shall be liable to pay for the health care costs incurred by an eligible employee during the period in which the employer failed to provide coverage.

PART III. ADMINISTRATION AND ENFORCEMENT

§393-31 Enforcement by the director. Except as otherwise provided in section 393-7 the director shall administer and enforce this chapter. The director may appoint such assistants and such clerical, stenographic, and other help as may be necessary for the proper administration and enforcement of this chapter subject to any civil service act relating to state employees

§393-32 Rulemaking and other powers of the director. The director may adopt, amend, or repeal, pursuant to chapter 91, such rules and regulations as the director deems necessary or suitable for the proper administration and enforcement of this chapter.

The director may round off the amounts specified in this chapter for the purpose of eliminating payments from the premium supplementation fund in other than even dollar amounts or other purposes.

The director may prescribe the filing of reports by prepaid health care plan contractors and prescribe the form and content of requests by employers for premium supplementation and the period for the payment thereof.

§393-33 Penalties; injunction. (a) If an employer fails to comply with section 393-11, 393-12, 393-13, or 393-15 the employer shall pay a penalty of not less than \$25 or of \$1 for each employee for every day during which such failure continues, whichever sum is greater. The penalty shall be assessed under rules and regulations promulgated pursuant to chapter 91 and shall be collected by the director and paid into the trust fund for premium supplementation established by section 393-41. The director may, for good cause shown, remit all or any part of the penalty.

(b) Any employer, employee, or prepaid health care plan contractor who willfully fails to comply with any other provision of this chapter or any rule or regulation thereunder may be fined not more than \$200 for each such violation.

(c) Any employer who fails to initiate compliance with the coverage requirements of section 393-11 for a period of thirty days, may be enjoined by the circuit court of the circuit in which the employer's principal place of business is located from carrying on the employer's business any place in the State so long as the default continues, such action for injunction to be prosecuted by the attorney general or any county attorney if so requested by the director.

§393-34 Penalties. (a) Any person who, after twenty-one days written notice and the opportunity to be heard by the director, is found to have violated any provision of this chapter or rule adopted thereunder for which no penalty is otherwise provided, shall be fined not more than \$250 for each offense.

(b) All fines collected pursuant to this chapter shall be deposited into the [premium supplementation trust fund] created by section 393-41.

PART IV. PREMIUM SUPPLEMENTATION

§393-41 Establishment of premium supplementation trust fund. There is established in the treasury of the State, separate and apart from all public moneys or funds of the State, a trust fund for premium supplementation which shall be administered exclusively for the purposes of this chapter. All premium supplementations payable under this part shall be paid from the fund. The fund shall consist of (1) all money appropriated by the State for the purposes of premium supplementation under this part and (2) all fines and penalties collected pursuant to this chapter.

§393-42 Management of the fund. The director of finance shall be the treasurer and custodian of the premium supplementation fund and shall administer the fund in accordance with the directions of the director of labor and industrial relations. All moneys in the fund shall be held in trust for the purposes of this part only and shall not be expended, released, or appropriated or otherwise disposed of for any other purpose. Moneys in the fund may be deposited in any depository bank in which general funds of the State may be deposited but such moneys shall not be commingled with other state funds and shall be maintained in separate accounts on the books of the depository bank. Such moneys shall be secured by the depository bank to the same extent and in the same manner as required by the general depository law of the State; and collateral pledged for this purpose shall be kept separate and distinct from any other collateral pledged to secure other funds of the State. The director of finance shall be liable for the performance of the director of finance's duties under this section as provided in chapter 37.

§393-43 Disbursements from the fund. Expenditures of moneys in the premium supplementation fund shall not be subject to any provisions of law requiring specific appropriations or other formal release by the state officers of money in their custody. All payments from the fund shall be made upon warrants drawn upon the director of finance by the comptroller of the State supported by vouchers approved by the director.

§393-44 Investment of moneys. With the approval of the department the director of finance may, from time to time, invest such moneys in the premium supplementation fund as are in excess of the amount deemed necessary for the payment of benefits for a reasonable future period. Such moneys may be invested in bonds of any political or municipal corporation or subdivision of the State, or any of the outstanding bonds of the State, or invested in bonds or

interest-bearing notes or obligations of the State (including state director of finance's warrant notes issued pursuant to chapter 40), or of the United States, or those for which the faith and credit of the United States are pledged for the payment of principal and interest, or in federal land bank bonds or joint stock farm loan bonds. The investments shall at all times be so made that all the assets of the fund shall always be readily convertible into cash when needed for the payment of benefits. The director of finance shall dispose of securities or other properties belonging to the fund only under the direction of the director of labor and industrial relations.

§393-45 Entitlement to premium supplementation. (a) An employer who employs less than eight employees entitled to coverage under this chapter and who provides coverage to such employees pursuant to section 393-7(a) shall be entitled to premium supplementation from the fund if the employer's share of the cost of providing such coverage as determined by sections 393-13 and 393-15 exceeds 1.5 per cent of the total wages payable to such employees and if the amount of such excess is greater than five per cent of the employer's income before taxes directly attributable to the business in which such employees are employed.

(b) The amount of the supplementation shall be that part of the employer's share of the premium cost which exceeds the limits specified in subsection (a).

§393-46 Income directly attributable to the business. (a) "Income directly attributable to the business" means gross profits from the business minus deductions for:

- (1) Compensation of officers;
- (2) Salaries and wages, except wages paid by an individual proprietor to oneself;
- (3) Repairs;
- (4) Taxes on business and business property;
- (5) Business advertising;
- (6) Amounts contributed to employee benefit plans;
- (7) Interest on business indebtedness;
- (8) Rent on business property; and
- (9) Other expenses necessary for the current conduct of business.

(b) Deductions shall not include:

- (1) Bad debts;
- (2) Contributions or gifts, other than those listed under subsection (a)(6);
- (3) Amortization and depreciation; or
- (4) Losses by fire, storm, casualty, or theft.

(c) The director may promulgate rules and regulations necessary to define income directly attributable to business for the purpose of section 393-45.

§393-47 Claim of premium supplementation. An employer entitled to premium supplementation shall file a claim therefor in the manner provided by regulation of the director. The employer shall have the burden of proof of establishing the employer's entitlement.

§393-48 Prepaid health care benefits to be paid from the premium supplementation fund; recovery of benefits. Prepaid health care benefits shall be paid from the premium supplementation fund to an employee who is entitled to receive prepaid health care benefits but cannot receive such benefits because of bankruptcy of the employee's employer or because the employee's employer is not in compliance with this chapter. Benefits paid from the premium supplementation fund to such employee may be recovered from the employee's bankrupt or noncomplying employer. The director shall institute administrative and legal actions as provided in section 393-33 to effect recovery of such benefits.

Attachment 4: Authorizing Legislation

____.B. NO. ____

A BILL FOR AN ACT

RELATING TO THE AFFORDABLE CARE ACT SECTION 1332 WAIVER.

BE IT ENACTED BY THE LEGISLATURE OF THE STATE OF HAWAII:

SECTION 1. The legislature finds that the federal Patient Protection and Affordable Care Act, P. L. 111-148 of 2010, as amended ("Affordable Care Act"), encourages states to develop innovative approaches to insuring their populations by authorizing states to apply for waivers from certain requirements of the Affordable Care Act.

The purpose of this Act is to authorize the State to submit a waiver proposal and to implement such waiver upon approval by the federal government.

SECTION 2. The State is authorized to submit a waiver proposal to the United States Secretary of Health and Human Services to waive certain provisions of the Affordable Care Act, as provided under Section 1332 of the federal act, and upon approval by the Secretary, to implement the waiver on or after January 1, 2017.

SECTION 3. This Act shall take effect upon its approval.

INTRODUCED BY: _____

Report title:

Affordable Care Act Waiver; Authorization

Description:

Authorizes the State to submit and implement a waiver from certain provisions of the Patient Protection and Affordable Care Act of 2010. Effective upon approval.

The summary description of legislation appearing on this page is for informational purposes only and is not legislation or evidence of legislative intent.

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