# Hawaii's Proposal to Waive Certain Provisions of the Affordable Care Act Per Section 1332, Waivers for State Innovation

## Executive Summary

Hawaii shares the goals of the Patient Protection and Affordable Care Act ("ACA") to

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

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

### The Hawaii Prepaid Health Care Act

Since being exempted by the federal Employee Retirement Income Security Act of 1974 ("ERISA"), Prepaid has defined employer coverage if Hawaii. Prepaid has fundamentally shaped Hawaii'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 household income.
- The actuarial value of Prepaid plans for employee-only coverage is approximately 90%, the equivalent of an ACA "platinum" plan. The ACA allows employer coverage to be as little as "bronze," which has an actuarial value of 60%.
- Under Prepaid, employers may offer plans that are of lesser actuarial value (approximately at a "gold" or 80% value), but only if the employer contributes at least half of the cost of the coverage of dependents under such a plan.

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.

Because of its ERISA exemption, no part of Prepaid can be altered in any substantial way.

## Characteristics of Hawaii and Its Health Insurance Market

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

Reflecting its population size, Hawaii has a small insurance marketplace. Since the founding of the Hawaii Medial Service Association ("HMSA") in 1935 and the entry of Kaiser Foundation Health plan ("Kaiser") to the market in 1958, Hawaii 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 Hawaii that serve small employers - University Health Alliance, Hawaii Management Alliance Association, Family Health Hawaii, Kaiser, and HMSA - are not-for-profit organizations.

Underpinning Hawaii's unique market structure is the 40-year-old Prepaid, which requires nearly all employers to provide a uniformly high level of coverage for their employees. It also requires employees to accept the offered coverage unless they can demonstrate 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 making those packages the floor for benefit coverage. As a result, the benefit plans sold to employers in the state have an average actuarial value of 90% (essentially equivalent to a platinum plan in ACA parlance). Even with these robust benefit plans, employees enjoy protection from significant premium contributions as Prepaid limits premium contributions to only 1.5% of the employees' wages for employee-only coverage. While employer-based coverage in Hawaii is richer than required under the ACA and employer contributions are smaller, 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. Hawaii's health care system does suffer 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 with the state's small market and limited number of insurers, have combined to increase system stability and predictability while limiting entrepreneurial medical care that adds cost with little value to the health care market.

Besides employer-based insurance, Hawaii has sought to ensure coverage by means of progressive public insurance strategies. In the early 1990s, Hawaii created a basic State Health Insurance Program ("SHIP") for the insurance "gap group," and, in 1994, Hawaii received one of the first section 1115 Medicaid waivers that incorporated the SHIP program and ambitiously aimed at universal insurance coverage. Although the 1115 waiver was not able to achieve this 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, Hawaii'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, Hawaii's uninsured rate is thought 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 Hawaii's superior performance, as compared to the national measures sampled below:

- 10% lower employer-sponsored premiums for families (2013)[1]
- 93% of residents with a usual source of care (2012)[2]
- 43% fewer hospitalizations per 100,000 adults (2011)[3]
- 32% fewer emergency room visits per 1000 (2011)[4]
- Healthiest state in the nation (2015) and among the top ten since surveying began in 2008[5]

The following table illustrates how Hawaii residents are covered by health insurance type.

| Insurance Coverage by Type | Percentage of Population |
|---|---|
| Employer-sponsored – Private Sector | 29% |
| Employer-sponsored – State/County | 13% |
| Medicaid/CHIP | 23% |
| Medicare | 16% |
| Tricare and Military | 12% |
| Individual | 3-4% |
| Uninsured | 3-5% |

## Implementation of a State-Based Marketplace and Lessons Learned

With Hawaii'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, the efforts of the non-profit corporation formed to establish the marketplace, years of significant work contributed by public-sector employees from at least five departments, and a supportive legislature, the Hawaii Health Connector ("Connector") was not sustainable. As a result of our lessons learned:

- With the November 2015 open enrollment period, Hawaii became a Supported State-Based Marketplace
- Hawaii's SHOP infrastructure was shut down, and small employers enrolled directly with health plans as of June 2015
- Hawaii is seeking to waive SHOP in 2017

Specific lessons learned from our experience are the following:

1. Start-up and upkeep too expensive for small market. As events proved, Hawaii's population was not large enough to make the development and upkeep of its own marketplace financially viable. With 1.4 million total residents, Hawaii'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.

[1] Medicaid Expenditures Panel Survey-Insurance Component. Average annual family premiums for Hawaii and the US were $14,382 and $16,029, respectively.
[2] State Health Access Data Assistance Center ("SHADAC") analysis of restricted National Health Interview Survey (NHIS) data.
[3] SHADAC analysis of Healthcare Cost and Utilization Project (HCUP) data.
[4] Kaiser State Health Facts analysis of American Hospital Association data.
[5] Gallup-Healthways Physical Well-being Index.

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. It was able to improve its customer-facing services, but was never able to effectively manage "back-office" functions, which created coverage lags and significant frustration for both consumers and insurers. The Connector was able to increase its volume of individual enrollees somewhat during the second year of business, but it was never able to persuade even 1% of eligible small businesses to use its services.

3. Small businesses purchased coverage as they always had done 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 via agents or brokers, there was little interest in testing a new route.
    - Initially two and then 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. Hawaii's other commercial plans were not incentivized to participate in the Connector because of the premium fees and the additional filings and reporting.

## Proposed Waiver: Conforming the Small Employer Marketplace to Prepaid

Hawaii proposes to adjust its health insurance marketplace by means of the proposed waiver to align the ACA and Prepaid for small employers. Hawaii 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.

As noted above, Prepaid provides predictable coverage and relatively stable prices for small businesses and their employees. Employees enjoy significantly greater benefits under Prepaid than required under the ACA. Among the differences:

| Prepaid | ACA |
|---|---|
| • Employers with even a single permanent employee must provide coverage.<br>• Permanent employees are eligible for coverage if they work 20 hours or more per week.<br>• The actuarial value of Prepaid plans averages 90%, and may not dip below 80%. | • Only large employers must provide employee coverage.<br>• Permanent employees are eligible for coverage if they work 30 hours or more per week.<br>• Employers may offer plans with an actuarial value as low as 60%. |

- Employees cannot be made responsible for premium costs that exceed 1.5% of wages.
- Employees may pay as much as 9.5% of household income.

Under 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%.

**The State emphasizes the two following facts that should be given significant consideration by the Secretary:**

1. **In contrast to the ACA, small employers in Hawaii do provide employee coverage, which includes the EHBs and additional mandated services, and employees pay little of the cost. SHOP adds nothing in terms of value or incentives 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 superior benefits for employees required by Prepaid, Hawaii 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.**

The specific sections for which Hawaii 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 | While Hawaii supports this provision for the individual marketplace, 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. | Hawaii 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. |
| **§1304 (b)(4)(D)(i) and (ii)** Continuation of participation for growing small employers | As Hawaii 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. |
| **§1311 (b)(1)(B)** The establishment of a Small Business Health Options Program (SHOP Exchange) | Hawaii proposes to waive SHOP for three important reasons:<br>1. In order to make clear to all small employers in the state the necessity to continue to meet Prepaid rather than ACA requirements; and<br>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 Hawaii marketplace, and, in fact, imperils the success of Hawaii's cost-effective system; and<br>3. To relieve small employers of the added premium costs related to purchasing ACA plans on the SHOP.<br>While Hawaii values the opportunity to partner with the federal exchange to ensure individual coverage, the unique requirements of Prepaid cannot be adequately supported by the federal exchange infrastructure. |
| **§1311 (f)(3)(B)**<br>Eligible entity authorized to carry out exchange responsibilities | Hawaii 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. |
| **§1312 (a)(2)**<br>Employer may specify level and employee may choose plans within a level | Hawaii proposes to waive the consumer choice provision defined in this section in conjunction with waiving SHOP. Supporting reasons are:<br>1. Assuring such choice for employees of small businesses requires an on-going investment in technical infrastructure disproportionate to the benefits for Hawaii's small market.<br>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. 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.<br>3. In Hawaii'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.<br>4. 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. |
| **§1312 (f)(2)(A)**<br>Definition of "qualified employer" | As Hawaii proposes to waive SHOP, there will be no "qualified employers" that may elect to make employees eligible to purchase insurance coverage through the exchange. |
| **[Section Citation]**<br>Definition of eligible employee as one who works 30/more hours/week | Hawaii proposes to waive the ACA definition of "full-time" employee in favor of the definition in Prepaid. The ACA defines such employers as those working at least 30 hours per week while Prepaid covers those regularly working 20 or more hours per week. |

## Description of Waiver Program

In describing the proposed waiver, the State is describing how Hawaii's small employer market functions in accordance with Prepaid, which requires all businesses with at least one employee working a minimum of 20 hours per week to provide health insurance. It should be emphasized that Hawaii's employer-

sponsored health insurance market is the only market regulated by Prepaid. 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 uptake (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)

Prepaid 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 outlined below:

**The Insurance Commissioner/Insurance Division**. The Insurance Commissioner ("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 Hawaii'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**. 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.

DLIR also administers a Premium Supplementation Fund established as part of Prepaid to provide financial assistance to small businesses that employ fewer than eight employees. This program is described in greater detail below

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

*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.

## Tax Credit Proposal

**In lieu of the ACA's small business employer tax credit described in ACA Section 1421, the State proposes that funds amounting to $46 million for the five year waiver period be paid to Hawaii.** Such funds will be deposited in Hawaii's Premium Supplementation Fund established by Prepaid (HRS §393-41). While the State's fund is more narrowly restricted, it serves the same purpose as the ACA's small business tax credits and, as it will be locally administered, it is more likely to be used by Hawaii's small business community.

The following table highlights the differences between the ACA's small business tax credit program and the Prepaid Premium Supplementation Fund:

| ACA Small Business Tax Credit Eligibility | Prepaid Premium Supplementation Fund Eligibility |
|---|---|
| • Small business employs 25 or fewer employees.<br>• Business covers at least 50% of employee-only insurance cost.<br>• Employees must have average annual wages of less than $50,000 (as adjusted for inflation beginning in 2014).<br>• The maximum credit is 50 percent of premiums paid for small business employers and 35 percent of premiums paid for small tax-exempt employers.<br>• The credit is limited to two consecutive taxable years to eligible employers. | • Employer employs less than eight employees entitled to coverage under Prepaid.<br>• Employer's share of premium costs exceeds 1.5% of total wages for such employees.<br>• The amount that exceeds 1.5% of wages is greater than 5% of the employer's income before taxes directly attributable to the business in which such employees are employed.<br>• The amount of the supplementation is that part of the employer's share of the premium cost which exceeds the specified 1.5% of wages limitation. |

We propose the following methodology to calculate the value of the tax credit to be provided to the State:

## Small Business ACA Tax Credit Methodology

***The total market value of the credits:*** *The estimated value of the small business tax credit since from 2010 is estimated to be $182 million based on full utilization by all eligible employers identified in 2014 data from the DLIR. This is based on the maximum annual value of the credits for each employer multiplied by the number of years for which they can be eligible (2 years).*

***Average Premium:*** *Approximately $400 per member per month, or $4,800 per year*

***Credit value 2017 to 2021:*** *Approximately $9 million per year, or $46 million total (This assumes a 5-15% uptake for the credit on an annual basis, simplified by using an average of 10%. While the credit is only available to each employer for 2 years, this analysis assumes an even distribution of participation across the 5 year waiver period with no specific regard to timing.)*

*This analysis assumes that uptake prior to the waiver period was negligible due to administrative barriers (time, know-how) and an exchange in which few eligible businesses participated. Accordingly, the amount of credits that small businesses could have expected to receive over a five year period from a well-functioning exchange is estimated to be $46.*

*Elements used to develop these estimates included employment data from DLIR, valuation estimates from the Lewin Group for Families USA and the Small Business Majority,[6] and the federal tax credit formula in 79 FR 36640 (2014). Using the DLIR market size data and the Lewin Group's estimates for credit eligibility, we determined a distribution for employers based on the number of full time equivalent ("FTE") employees and average salaries. The Lewin Group*

[6] Families USA and Small Business Majority, "Good Business Sense: The Small Business Health Care Tax Credit in the Affordable Care Act," 2012.

*provided an estimate for the percentage of eligible employers likely to qualify for the maximum 50% tax credit, which is shown below in the box below corresponding to "<=10 FTE" and "$25,000 average annual wage." Further, the DLIR data indicated that 88% of the relevant groups employed ten or fewer employees, for which wages were evenly distributed among the remaining levels for ten or fewer FTEs. The remaining groups were assigned based on a weighted distribution similar that of the credit eligibility, trailing off as the number of FTEs increased.*

### Number of Eligible Groups by FTE Count and Average Salary

| | No. of FTE | | | | | |
|---|---|---|---|---|---|---|
| **Average annual wage** | **<=10** | **13** | **16** | **19** | **22** | **25** |
| **$ 25,000** | 5,741 | 128 | 102 | 77 | 51 | 0 |
| **$ 27,500** | 1,031 | 128 | 102 | 77 | 51 | 0 |
| **$ 30,000** | 1,031 | 128 | 102 | 77 | 0 | 0 |
| **$ 32,500** | 1,031 | 128 | 102 | 77 | 0 | 0 |
| **$ 35,000** | 1,031 | 128 | 102 | 0 | 0 | 0 |
| **$ 37,500** | 1,031 | 128 | 102 | 0 | 0 | 0 |
| **$ 40,000** | 1,031 | 128 | 0 | 0 | 0 | 0 |
| **$ 42,500** | 1,031 | 128 | 0 | 0 | 0 | 0 |
| **$ 45,000** | 1,031 | 0 | 0 | 0 | 0 | 0 |
| **$ 47,500** | 1,031 | 0 | 0 | 0 | 0 | 0 |
| **$ 50,000** | 0 | 0 | 0 | 0 | 0 | 0 |

This employee/wage distribution matrix was paired with the allowable credit per employee and the average employee count for each position in the matrix. This allowed us to determine the total value of the credit after the 2010 implementation.

### Average employee counts

| ***Employee count grouping*** | ***<=10*** | ***13*** | ***16*** | ***19*** | ***22*** | ***25*** |
|---|---|---|---|---|---|---|
| Average # of employees | 2.7 | 11.5 | 14.5 | 17.5 | 20.5 | 23.5 |

### Maximum Credit per Employee[7]

| | No. of FTE | | | | | |
|---|---|---|---|---|---|---|
| Average annual wage | 10 | 13 | 16 | 19 | 22 | 25 |
| $ 25,000 | $2400 | $1920 | $1440 | $960 | $480 | $0 |
| $ 27,500 | $2160 | $1680 | $1200 | $720 | $240 | $0 |
| $ 30,000 | $1920 | $1440 | $960 | $480 | $0 | $0 |
| $ 32,500 | $1680 | $1200 | $720 | $240 | $0 | $0 |

[7] The following is an example for how to determine the maximum credit per employee for a group with 16 employees and an average salary of $35,000: Maximum available credit rate [50%] * Average annual employee premium [$4,800] * (1 - ((FTEs [16]– 10)/15) + ((Average salary [35,000] -25,000)/25,000)) = $480 per employee

| | | | | | | |
|---|---|---|---|---|---|---|
| $ 35,000 | $1440 | $960 | $480 | $0 | $0 | $0 |
| $ 37,500 | $1200 | $720 | $240 | $0 | $0 | $0 |
| $ 40,000 | $960 | $480 | $0 | $0 | $0 | $0 |
| $ 42,500 | $720 | $240 | $0 | $0 | $0 | $0 |
| $ 45,000 | $480 | $0 | $0 | $0 | $0 | $0 |
| $ 47,500 | $240 | $0 | $0 | $0 | $0 | $0 |
| $ 50,000 | $0 | $0 | $0 | $0 | $0 | $0 |

## Affected Population and Demographics

The population affected by Hawaii's proposal to waive the SHOP exchange is defined as small employers with 50 or fewer employees and their employees. There are 29,419 such employers with 169,273 employees. Looking at the expanded definition of small employer, i.e. those with 100 or fewer employees, the total number of employers rises only by 782 to 30,201 while the number of employees increases by 55,387 to 224,660.[8]

| Employer Type | Number of Employers | Number of Employees | % of Prvt Mkt | % of TOTAL |
|---|---|---|---|---|
| Small, 50/fewer | 29,419 | 169,273 | 33.2% | 28.2% |
| Small, 100/fewer | 30,201 | 224,660 | 44.1% | 37.4% |
| Large, > 100 | 749 | 284,859 | 55.9% | 47.4% |
| **Private Market Total** | **30,950** | **509,519** | **100%** | **84.7%** |
| State | 1 | 73,157 | | 12.2% |
| County | 4 | 18,626 | | 3.1% |
| **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, but there is no significant demographic difference between them and the rest of working adults in the state.[9]

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

[8] Employment sector data as reported by State DLIR for quarter ending March 2015.
[9] Ibid.

The general demographics of Hawaii's population that would be expected to be equally true for employees of small businesses is shown below:

| 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 |
| Hawaii | 190,821 |
| Maui | 160,202 |
| Kauai | 69,512 |
| **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 |

## Effect on Residents' Ability to Get Care Out of State

Hawaii'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 mandate, under which all plans provide for covered services that might be required by beneficiaries if they happen to be in another state.

## Description of Post-Waiver Marketplace

[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.

The post-waiver health insurance marketplace is expected to be as follows:

- **Supported State Based Marketplace**. 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. Enrollment for Medicaid-eligible individuals and families will be managed by the State Department of Human Services Med-QUEST Division. Individuals not eligible for other public or private coverage will be able to complete enrollment in a participating QHP at the federal site.
- **Small employers and their employees**. Small employers will 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 what choices or options will be available to employees. Eligible small employers are more likely to take advantage of the local premium subsidy program in lieu of tax credits as requested in the waiver. The five not-for-profit health plans serving the small employer market will not be affected by the waiver.
- **Large employers**. There will be no change in the insurance market for large employers since, by complying with Prepaid, they comply with ACA requirements.

## Number of Employers Offering Coverage Before and After Waiver

Hawaii's expects no change in the number of employers offering coverage as a result of its proposed waiver. Hawaii is seeking to waive SHOP requirements, in part, to ensure that all Hawaii employers understand their obligations to provide employee health insurance benefits according to Prepaid. Since these obligations were established more than forty years ago and will continue after any waiver is granted, there would be no reason for coverage to change. In fact, if ACA SHOP provisions replaced Prepaid, Hawaii would expect a DECREASE in the number of small employers providing employee coverage.

## Impact on Insurance Coverage in the State

Hawaii'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 Hawaii SHOP provided coverage to less than 1% of eligible employers and employees (246 employers and 1,139 employees).

The Hawaii 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 Hawaii that it can for other states. Under a waiver, Hawaii's market 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.

Hawaii'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 contradistinction, 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

Hawaii 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**. 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 applications, enrollment, and payment were not managed correctly. 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 Hawaii 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 Hawaii 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 Prepaid, with its employer mandates and methods for adding or changing benefits. 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 Hawaii 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 with Prepaid by ensuring that both plans and employers meet all requirements. It also continues to administer the Prepaid Premium Supplementation Fund. DLIR is identified as the agency that will provide required reports to HHS. We strongly advocate for streamlined

reporting appropriate to Hawaii'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 Hawaii's Prepaid requirements
- No necessity to review, approve, and pay out small employer tax credits
- No need to ensure business compliance in purchasing ACA-compliant coverage (the State DLIR does that)

## 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, Hawaii's ability to retain Prepaid in full force and without ambiguity via a waiver will serve to ensure that virtually all permanent employees in Hawaii 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. Hawaii's proposal to waive SHOP while retaining Prepaid 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

**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, as noted below and at https://www.cms.gov/CCIIO/Resources/Data-Resources/Downloads/hawaii-ehb-benchmark-plan.pdf:

| ACA EHB Category | Hawaii EHB Benefit |
|---|---|
| 1. Ambulatory patient services | • Vasectomy<br>• Surgery: operating room, recovery and treatment rooms<br>• Anesthesia<br>• Pathology<br>• Chemotherapy<br>• Radiation therapy<br>• Diagnostic colonoscopy |

| ACA EHB Category | Hawaii EHB Benefit |
|---|---|
| | • Dialysis and home dialysis services, supplies, and equipment<br>• Blood and plasma<br>• Medical and surgical supplies<br>• Oxygen<br>• Nuclear medicine<br>• Infertility services<br>• Genetic screening and testing<br>• Genetic counseling<br>• Outpatient surgery<br>• Urgent care visits<br>• Physician office visits<br>• Diagnostic imaging<br>• Home health visits<br>• Skilled nursing facility care<br>• HIV/AIDS treatment<br>• Certain treatment of diabetes<br>• Diagnosis of TMJ dysfunction<br>• Home hospice care<br>• Coverage for certain clinical trials<br>• Medical foods |
| 2. Emergency services | • Emergency room services<br>• Ambulance services |
| 3. Hospitalization | • Room and board<br>• Nursing<br>• Complications of pregnancy<br>• Pathology services<br>• Radiology services<br>• Anesthesia<br>• Medical supplies<br>• Prosthetics<br>• Drugs<br>• Blood<br>• Transplants<br>• Reconstructive breast surgery following a mastectomy<br>• Surgery to correct congenital anomalies<br>• Other reconstructive surgery<br>• Bariatric surgery<br>• Tubal ligation<br>• Inpatient hospice<br>• Vision procedures<br>• Inpatient visits<br>• Inpatient surgery |
| 4. Maternity and newborn care | • Coverage for newborns and foster children<br>• Minimum inpatient stays following delivery of a baby<br>• Treatment of maternity as any other illness when maternity is provided<br>• Prenatal care<br>• Nurse midwife services |
| 5. Mental health and substance abuse disorder services, including behavioral health treatment | • Treatment for mental illnesses<br>• Treatment for alcoholism and drug abuse |
| 6. Prescription drugs | • Injectable drugs<br>• Retail and mail-order prescription drugs<br>• Prescription contraceptives<br>• Smoking and tobacco cessation prescription drugs |

| ACA EHB Category | Hawaii EHB Benefit |
|---|---|
| 7. Rehabilitative and habilitative services | • Durable medical equipment<br>• Inpatient rehab services<br>• Cardiac rehab<br>• Pulmonary rehab<br>• Physical therapy<br>• Occupational therapy<br>• Speech therapy<br>• IV/infusion therapy<br>• Hyperbaric oxygen therapy<br>• Hearing aids<br>• Speech generating devices<br>• Diagnosis and treatment of autism<br>• Orthodontic treatment of orofacial anomalies resulting from birth defects |
| 8. Laboratory services | • Laboratory services |
| 9. Preventive and wellness services and chronic disease management | • Adult routine physical exams<br>• Well-baby and well-child exams<br>• Immunizations<br>• Routine mammography screening<br>• HPV and cervical cancer screening<br>• Newborn hearing screening<br>• Newborn screening – other<br>• Pediatric hearing screening<br>• Prostate cancer screening<br>• Colorectal cancer screening<br>• Depression screening<br>• Diagnostic bone mass measurement/density screening<br>• Colonoscopy screening<br>• Allergy testing<br>• Diabetes screening<br>• Screening for sexually-transmitted infections – HIV<br>• Screening for sexually-transmitted infections – other<br>• Anemia screening for pregnant women<br>• BRCA screening and counseling about genetic testing<br>• Folic acid supplements for women who may become pregnant<br>• Hepatitis B screening for newly pregnant women<br>• Rh incompatibility screening for all pregnant women and follow-up testing for women at higher risk<br>• Allergy injections<br>• Smoking and tobacco cessation counseling<br>• Diabetes education<br>• Diabetes monitoring<br>• Breastfeeding and lactation counseling<br>• Nutritional counseling<br>• HPV vaccine<br>• Flu vaccines |
| 10. Pediatric services, including oral and vision care | • Anesthesia and hospital care for dental procedures for children under age 9 with serious mental, physical, or behavioral problems<br>• Pediatric vision screening<br>• Pediatric eyeglasses and contact lenses<br>• Pediatric dental<br>• Routine hearing exams |

As noted on https://www.cms.gov/CCIIO/Resources/Data-Resources/Downloads/hi-state-required-benefits.pdf, Hawaii'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 |
| Habilitative | Autism diagnosis and treatment | 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<br>432:1<br>432D-23 |

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

The infrastructure to support Hawaii's proposed waiver is already fully in place and, as it currently operates, requires no additional public funds from either the Federal or State government. Over the forty years of administering Prepaid, cooperative systems have developed between the State's Insurance Division and the State DLIR. The Insurance Division ensures compliance with federal and state insurance regulations, approves rate changes to ensure consumer protections and financial viability, provides for benefit and rate transparency, and adjudicates consumer complaints. DLIR supports the Prepaid Health Care Advisory Council, and manages compliance with Prepaid, both in ensuring that plans comply with Prepaid requirements and that employers are providing mandated coverage via approved plans. DLIR also operates the Premium Supplementation Fund. Otherwise, insurers, employers, agents, and brokers carry out the business of marketing, enrollment, payment, and reporting.

The proposed waiver will actually *reduce* costs for employers because they will not be burdened with the fee added to premiums for coverage purchased on or off the exchange by participating insurers.

The State requests funds in lieu of small business tax credits to be administered by DLIR through the Prepaid Premium Supplementation Fund. Hawaii's tax credit formula is intended to be budget neutral, requesting an amount that does not exceed the sum that could potentially be paid to small employers by the Treasury.

## Assuring Compliance, Reducing Waste and Fraud

The DLIR has responsibility for assuring compliance related to small employer coverage under the waiver, as follows. DLIR:

- Plans to leverage its Prepaid health Care penalties and injunctions capabilities[13]

[13] Hawaii'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

- 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 sections
- 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.

The State Department of Commerce and Consumer Affairs through its Insurance Division has the 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. Hawaii 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

Hawaii 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. As result, the State contends that implementation of the waiver can be done immediately upon notification that it has been granted. The process will include providing public information about the waiver and the expectation of continuing to enroll directly or through agents and brokers. In addition, if the small employer tax credit is provided to the State for administration, the State DLIR will do small business outreach to ensure that qualified employers are aware of the opportunity available.

(§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.

## Reporting Responsibilities

As required, Hawaii 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 Hawaii 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, Hawaii 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 Hawaii'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.

## 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

Hawaii'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 Hawaii 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 Hawaii, sharing the federal technology in a supported marketplace provides cost-effective access for individual consumers. A SHOP exchange for Hawaii is not economically viable, and the unique requirements of Prepaid make sharing the federal marketplace for SHOP untenable.

## PART I – ESTABLISHMENT OF QUALIFIED HEALTH PLANS

### Section 1301: Definition of Qualified Health Plans

| Key ACA Provisions | Hawaii Proposal |
|---|---|
| *The definition of "Qualified Health Plan" including providing EHB, and offering plans conforming to metal levels (bronze, silver, gold, and platinum)* | Hawaii 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.<br><br>**For the Individual Market**. Hawaii proposes retaining the general terms specified for "qualified health plan."<br><br>**For the Small Employer Market**. Hawaii proposes:<br>• Maintaining the EHB<br>• Waiving SHOP and the metal-level requirement for QHPs offering plans to small businesses. Instead, Hawaii 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 Hawaii 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 | Hawaii Proposal |
|---|---|
| *Inclusion of Co-Op and Multi-State Plans* | Hawaii 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. |
| *Treatment of Qualified Direct Primary Care Medical Home Plans* | Hawaii proposes to retain these provisions. |
| *Exceptions for Self-Insured Plans and MEWAS (multiple employer welfare arrangements)* | Hawaii proposes to retain these provisions. |

**Section 1302: EHB Requirements**

| Key ACA Provisions | Hawaii Proposal |
|---|---|
| *Defines EHB* | Hawaii proposes that the EHBs be retained. |
| *Annual limitations on cost-sharing* | Hawaii 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. |
| *Annual limitations on deductibles for employer-sponsored plans* | Hawaii 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. |
| *Definition of metal levels by actuarial value* | **For the Individual Market**. Hawaii proposes to retain the levels of coverage and actuarial values described for bronze, silver, gold, and platinum plans.<br><br>**For the Small Business Market**. Hawaii proposes to waive the metal-level requirements for small businesses. Instead, Hawaii will maintain Prepaid requirements under which all eligible employers purchase 7(a) and 7(b) plans. |
| *Availability of catastrophic plans* | Hawaii proposes to retain these provisions. |
| *Availability of child-only plans* | Hawaii proposes to retain these provisions. |
| *Defines payment to federally-qualified health centers* | Hawaii proposes to retain these provisions. |

**Section 1303: Special Rules Related to Abortion Services**

| Key ACA Provisions | Hawaii Proposal |
|---|---|
| *Details special rules related to abortion services* | Hawaii 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 1304: Definitions of Markets and Rules Large and Small Employers**

| Key ACA Provisions | Hawaii Proposal |
|---|---|
| *Defines and details rules for "small" and "large" group markets* | Hawaii 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.<br><br>The task force proposes this waiver because all businesses in Hawaii, 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. |
| *Specifies rules for aggregation treatment of employers, employers not in existence in preceding year, and predecessor employers* | Hawaii proposes to retain these provisions. |
| *Defines when a "growing" small employer that purchased employee coverage through SHOP may continue to do* | Hawaii proposes to waive this section to be consistent with its recommendation to waive SHOP. |

## PART II – CONSUMER CHOICES AND INSURANCE COMPETITION THROUGH HEALTH BENEFIT EXCHANGES

**Section 1311: Providing Consumers a Health Insurance Exchange**

| Key ACA Provisions | Hawaii Proposal |
|---|---|
| *Requires establishment of an American Health Benefit Exchange, and details responsibilities of the exchange* | Hawaii proposes to retain the individual exchange via a Supported State-Based Marketplace. |
| *Provides for the establishment a SHOP exchange* | Hawaii 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. |

| | |
|---|---|
| | 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. |
| *Specifies which entities are eligible to carry out responsibilities of the Exchange* | Hawaii 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 | Hawaii Proposal |
|---|---|
| *Details provisions for consumer choice among QHPs through an exchange* | Hawaii proposes to waive the consumer choice provision defined in this section in conjunction with waiving SHOP. Some of the reasons are as follows:<br>• Assuring such choice for employees of small businesses requires an on-going investment in technical infrastructure disproportionate to the benefits for Hawaii's small market.<br>• 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.<br>• In Hawaii'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.<br>• 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. |
| *Establishes that all enrollees in the individual market are in a single risk pool* | Hawaii proposes to retain these provisions. |
| *Establishes that all enrollees in the small group market are in a single risk pool* | Hawaii proposes to retain these provisions. |
| *Allows states to merge individual and small group insurance in a single risk pool if the state deems it appropriate* | Hawaii proposes to retain these provisions. |
| *Prevents state law from requiring grandfathered* | Hawaii proposes to retain these provisions. |

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

**Section 1313: Financial Integrity**

| Key ACA Provisions | Hawaii Proposal |
|---|---|
| *Details financial management and protections* | Hawaii proposes to retain these provisions. |

| | |
|---|---|
| *against fraud and abuse for an exchange* | |

## PREMIUM TAX CREDITS AND REDUCED COST-SHARING

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

| Key ACA Provisions | Hawaii Proposal |
|---|---|
| *Details provisions and eligibility for reductions in cost-sharing and out-of-pocket costs for individuals who enroll in a QHP* | Hawaii proposes to retain these provisions. |

## INDIVIDUAL AND EMPLOYER RESPONSIBILITY REQUIREMENTS

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

| Key ACA Provisions | Hawaii Proposal |
|---|---|
| *Defines and details requirements for offering health insurance coverage by large employers and responsibilities of employees for enrolling* | Hawaii 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: The Hawaii Prepaid Health Care Act

Originally enacted in 1974, the Hawaii Prepaid Health Care Act was the first in the nation to set minimum standards of health care benefits for workers. Employers, excluding Federal, State and City government and other categories specifically excluded by the law (sections 393-3, 393-5 and 393-6), are required to provide Hawaii employees, who suffer a disability due to non-work related illness or injury, with adequate medical coverage for non-work related illness or injury, protecting them from the high cost of medical and hospital care.

Employers must provide health care coverage to employees who work at least twenty (20) hours per week and earn 86.67 times the current Hawaii minimum wage a month (as of January 1, 2015, $7.75 x 86.67 = $672). 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.

The following is the full text of the law:

**CHAPTER 393**
**PREPAID HEALTH CARE ACT**

## 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:

"Department" means the department of labor and industrial relations.

"Director" means the director of labor and industrial relations.

"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:

(1) The State, any of its political subdivisions, or any instrumentality of the State or its political subdivisions;
(2) The United States government or any instrumentality of the United States;
(3) Any other state or political subdivision thereof or instrumentality of such state or political subdivision;
(4) 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.

"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.

"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.

"Prepaid health care plan" means any agreement by which any prepaid health care plan contractor undertakes in consideration of a stipulated premium:

(1) 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
(2) To defray or reimburse, in whole or in part, the expenses of health care.

"Prepaid health care plan contractor" means:

(1) Any medical group or organization which undertakes under a prepaid health care plan to provide health care; or
(2) 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
(3) Any insurer who undertakes under a prepaid health care plan to defray or reimburse in whole or in part the expenses of health care.

"Recipient of social service payments" includes:

(1) A person who is an eligible recipient of social services such as attendant care and day care services; and
(2) A corporation or private agency that contracts directly with the department of human services to provide attendant care and day care authorized under the Social Security Act, as amended.

"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.

"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. [L 1974, c 210, pt of §1; am L 1976, c 78, §1; gen ch 1985; am L 2007, c 259, §5]

**§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. [L 1974, c 210, pt of §1]

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

(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 in-home and community-based services for persons with developmental and intellectual disabilities under the medicaid home and community-based services program pursuant to title 42 Code of Federal Regulations sections 440.180 and 441.300, and title 42 Code of Federal Regulations, part 434, subpart A, as amended, or when provided through state funded medical assistance to individuals ineligible for medicaid, and identified as chore, personal assistance and habilitation, residential habilitation, supported employment, respite, and skilled nursing services, as the terms are defined and amended from time to time by the department of human services, performed by an individual whose services are contracted by a recipient of social service payments and who voluntarily agrees in writing to be an independent contractor of the recipient of social service payments; and
(8) Domestic services, which include attendant care, and day care services authorized by the department of human services under the Social Security Act, as amended, or when provided through state-funded medical assistance to individuals ineligible for medicaid, when performed by an individual in the employ of a recipient of social service payments. For the purposes of this paragraph only, a "recipient of social service payments" is a person who is an eligible recipient of social services such as attendant care or day care services.

**§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; provided that a person representing a health maintenance organization under chapter 432D, a mutual benefit society issuing individual and group hospital or medical service plans under chapter 432, or any other health care organization shall not be a member. 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 depositary 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 depositary bank. Such moneys shall be secured by the depositary bank to the same extent and in the same manner as required by the general depositary 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.