EXECUTIVE CHAMBERS
HONOLULU

DAVID Y. IGE
GOVERNOR

June 15, 2016

Secretary Sylvia Mathews Burwell
U.S. Department of Health & Human Services
200 Independence Avenue, S.W.
Washington, D.C., 20201

Re: Hawai'i Section 1332 Waiver Proposal

Dear Secretary Burwell:

Thank you for meeting with U.S. Senator Brian Schatz, U.S. Senator Mazie Hirono, and me on May 18, 2016. I believe that we all agree that Hawai'i has proven its commitment to affordable health care coverage through forty plus years of experience with our Prepaid Health Care Act and our expanded Medicaid programs.

Hawai'i has been a leader in policies that promote insurance coverage, having passed the Prepaid Health Care Act (Prepaid) in 1974. Besides this ERISA-waived employer mandate, Hawai'i has adopted Affordable Care Act (ACA) provisions for Medicaid expansion and continues to invest state resources and coordinate with your Department to ensure that all individuals and families have access to affordable robust insurance coverage. We are proud to say that Hawai'i's uninsured rate is estimated to be five percent or less, our employer health insurance premiums are the lowest in the nation for what they cover, and our system of care has produced a healthier population with among the lowest rates of in-patient and emergency service utilization.

As discussed during our meeting, the State of Hawai'i (State) is hereby submitting for your review and consideration, our 1332 waiver request for the Small business Health Options Program (SHOP). Enrollment in SHOP plans is approximately 1,000 employees through about 200 employers. Hawai'i's Prepaid Health Care Act provides health insurance coverage for the majority of Hawai'i's working population, approximately 742,000 employees.

Hawai'i's waiver proposal is fully in the spirit as well as the letter of the ACA in that it seeks to maintain coverage as it exists today, narrowly targeting ACA provisions that potentially weaken coverage required under Prepaid and unnecessarily increase insurance costs. Our waiver will not reduce coverage for any Hawai'i consumers, limit

benefits, increase costs, render coverage less affordable, or affect federal deficit neutrality.

We appreciate your expeditious consideration in processing our 1332 waiver in a timely manner, so as to not cause disruption in the upcoming Fall 2017 open enrollment. We will be pleased to provide your staff any additional information and clarifications they may require to ensure a timely and positive response to our waiver request.

With warmest regards,

David Y. Ige
Governor, State of Hawai'i

c: U.S. Senator Brian Schatz
U.S. Senator Mazie Hirono

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

June 15, 2016

David Y. Ige, Governor
Executive Chambers
415 S. Beretania St.
Honolulu, Hawai‘i 96813

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Executive Summary

Hawai‘i shares the goals of the Patient Protection and Affordable Care Act (“ACA”) to

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

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

The Hawai‘i Prepaid Health Care Act

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

Specific provisions:

- 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 offer 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 employee-only premiums. Comparatively, under the ACA, employees may pay as much as 9.5% of income for coverage.
- The actuarial value of average Prepaid plans for employee-only coverage is 90%, the equivalent of an ACA “platinum” plan. Prepaid allows employers to offer plans that are of lesser actuarial value (at an approximately 80% or “gold” level), but only if the employer contributes at least half of the cost of the coverage of dependents under such a plan. The ACA allows employer coverage to be as little as “bronze,” which has an actuarial value of 60%.

Prepaid is administered and enforced by the State Department of Labor & Industrial Relations (“DLIR”) while the Department of Commerce & Consumer Affairs’ Insurance Division is responsible for insurance and rate regulation.

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

Assurances

Hawai'i's proposed waiver intends to preserve and strengthen the employee protections provided by the state's Prepaid Health Care Act. Prepaid sets a higher bar for employer-sponsored insurance than does the ACA. Its coverage, benefits, and costs to employees apply to all regardless of income, age, race and ethnic group, or any other demographic characteristic. Hawai'i does not seek to waive any aspect of the ACA that would diminish access to meaningful, affordable insurance for any resident and does not contemplate changes to the Medicaid program or individual market or direct purchase with this proposal. The State of Hawai'i provides the following assurances:

A. **Comparable Coverage**. The State's proposed waiver meets the "comparability" test in that there will be no decrease in the number of Hawai'i residents covered, nor will there be any changes in coverage for vulnerable populations by coverage category, health status, age, geographic location, or any other demographic characteristic due to the waiver.

B. **Affordability**. The State's proposed waiver meets the "affordability" test in that it will not change the cost of health care coverage for state residents, on average, nor will it result in any differences in affordability for individuals with large health care spending burdens, for vulnerable groups, or at-risk populations. There will be no pre- and post-waiver differences in net out-of-pocket expenses, deductibles, co-pays, co-insurance, or premium contributions.

C. **Comprehensiveness**. The State's proposed waiver will retain the scope of benefits for the affected program and population, including requiring the provision of the ten Essential Health Benefits ("EHB"), as identified in the state-selected benchmark plan. It will not result in a decrease in the number of individuals with coverage that meets the EHB requirements or in any way diminish benefits currently provided by Medicaid or employers.

D. **Deficit Neutrality**. The State's proposed waiver will result in no increased spending or administrative or other expenses to the federal government, nor will it reduce federal income, payroll or excise tax, or any other revenue.

E. **Pass-Through Funding**. The State proposes that funds in lieu of the ACA small employer tax credit be passed through to the State to supplement the Prepaid Premium Supplementation Fund.

F. **Effect on Federal Operational Considerations**. The State's proposed waiver requests no consideration of any kind for state-specific changes to federally-facilitated exchanges or treatment by the Internal Revenue Service.

G. **Public Input**. The State's proposed waiver has been publicly posted, public hearings have been held, and public comment has been solicited in compliance with 31 CFR 33.112 and 45 CFR 155.1312. Postings on-line meet national standards to assure access to individuals with disabilities.

Summary of Hawai‘i Waiver Proposal

Rationale. Hawai‘i finds that ACA provisions related to the small business marketplace would undermine the long-standing Prepaid Health Care Act, upon which the state's health care system depends.

Prepaid requires all employers, small and large, to provide robust health insurance coverage to employees at minimal expense to the employees themselves; the ACA has no small employer requirements at all.

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

Sections Proposed for Waiver

SHOP Exchange. Hawai‘i proposes to waive hosting or participating in a web-based SHOP Exchange. Hawai‘i's experience with its state-based SHOP exchange demonstrated that it would be expensive, sparsely used, and increase costs while adding little value. Hawai‘i cannot use the ACA's federal SHOP because it does not inform Hawai‘i employers about their Prepaid-specific obligations and options. Proposed to be waived are:

§1311 (b)(1)(B). The establishment of a Small Business Health Options Program (SHOP) exchange

§1312(a)(2). Employee choice

§1312 (f)(2)(A). Definition of "qualified employer" that elects to use SHOP

§1304 (b)(4)(D)(i) and (ii). Continuation of participation in SHOP for growing small employers

Conforming Health Plans. Hawai‘i would waive the obligation to offer **silver-level** plans to small businesses since such plans do not conform to current Prepaid requirements and cannot be purchased by employers. Under this proposal, health insurers would retain the ability to offer silver-level plans in the rare event that employers seek them for Prepaid-exempt employees but the offering would be optional. Hawai‘i would also waive the requirement to accept **multi-state** plans, which are unlikely to comport with Prepaid and would be difficult to regulate. Proposed to be waived are:

§1301 (a)(1)(C)(ii). Requirement that QHPs include at least one silver level plan.

§1301 (a)(2). Inclusion of co-op and multi-state qualified health plans.

Housekeeping Measure. Hawai'i would seek flexibility to permit state agencies other than Medicaid to have a role in the exchange so would amend (**§1311 (f)(3)(B)**.)

Impact if Waiver is Not Granted

Hawai'i's Prepaid law contributes to meeting the ACA's goals and is good for the federal government.

Without Prepaid:

- **Not all small employers in Hawai'i would provide employee coverage and many of those employees would get subsidies through the individual marketplace**
- **More low income employees would enroll in the federally-funded Medicaid program instead getting employer-sponsored coverage**
- **Some employees would become uninsured and under-insured**
- **Uncompensated care would increase, resulting in economic stress to individuals and to the state's health care system**

Since Hawai'i's waiver proposal seeks to assert the continued authority of Prepaid for employers, failure would result in ambiguity and possible challenges to the system that has served Hawai'i so well for so long. If a waiver is not granted, Hawai'i will be left with a choice of 1) building a functional web-based SHOP to accommodate Prepaid rules, or 2) using the federally-facilitated SHOP, which does not support Prepaid rules. Either of these choices would be counter to ACA and Hawai'i goals to maximize meaningful insurance coverage and reduce costs. Based on our experience, rebuilding an ACA-compliant SHOP would be expensive and take a long time to perfect only to be sparsely used by employers. If, instead, Hawai'i used the federally-facilitated exchange, Prepaid would be undermined by employers misinformed about their responsibilities to provide coverage since the federal SHOP exchange cannot be customized to support Prepaid requirements for small employers. Appendix 4 shows excerpts from healthcare.gov's on-line advice to small businesses that run counter to Prepaid requirements.

The predicted negative consequences of either option would be:

If Hawai'i Rebuilds State-Based SHOP

- An effective, reliable technical platform would be costly to build, maintain, and upgrade
- The timeframe to build a reliable technology system would be lengthy
- Demand for such a system is insignificant so it would likely get little use
- Costs would be passed on to tax-payers, employers, insurers, and consumers
- Federal agencies would have on-going oversight responsibilities

If Hawai'i uses Federally-Facilitated SHOP

- Since the federal platform cannot support Prepaid rules, Hawai'i employers that used it would be misinformed about their coverage obligations and options
- Hawai'i employee protections under Prepaid would be eroded or could disappear
- DLIR would have to increase its oversight – and costs – to ensure employer compliance
- Costs would be passed on to tax-payers, employers, insurers, and consumers
- Federal government would incur cost for maintaining SHOP platform

Characteristics of Hawai‘i and Its Health Insurance Market

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

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

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

Besides private employer-based insurance, Hawai‘i has sought to ensure coverage by means of progressive public insurance strategies. In the early 1990s, Hawai‘i created a basic State Health Insurance Program (“SHIP”) for the insurance “gap group,”[1] and, in 1994, Hawai‘i was the second state in the nation to be granted a section 1115 Medicaid waiver. The waiver, which explicitly aimed at universal insurance coverage, was much like ACA Medicaid expansion, allowing Hawai‘i to combine SHIP with Medicaid and eliminate the asset test for non-disabled recipients. Although the 1115 waiver was not able to achieve its universal coverage goal, the State has taken advantage of the ACA to expand eligibility, and strongly advocates for individuals and families not otherwise covered to obtain affordable insurance through the Individual Marketplace. Before 2014 when ACA coverage became available, Hawai‘i’s uninsured population was estimated to be 100,000 people, mostly non-elderly adults. Now, having the experience of two years of expanded ACA enrollment opportunities, the number of uninsured residents in Hawai‘i is estimated to be half that number.

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

[1] The “gap group” at that time was made up largely of low-income adults who were ineligible for Medicaid coverage and part-time workers who did not qualified for Prepaid coverage.

- 10% lower employer-sponsored premiums for families (2013)[2]
- 93% of residents with a usual source of care (2012)[3]
- 43% fewer hospitalizations per 100,000 adults (2011)[4]
- 32% fewer emergency room visits per 1000 (2011)[5]
- Healthiest state in the nation (2015) and among the top ten since surveying began in 2008[6]
- Third best in the nation on the Commonwealth Fund's "Scorecard on State Health Performance" (2015)[7]

The following table illustrates how Hawai'i residents are covered by health insurance type. Between workers and dependents, there are more than 750,000 Prepaid-covered lives.

Insurance Coverage by Type	Percentage of Population*
Employer Based	52.5%
Government Coverage, including Military and VA	40.2%
Direct Purchased	3.2%
Uninsured	4.1%

**Oliver Wyman, Hawai'i 1332 Waiver, Actuarial Analyses and Certification, June 2016*

Implementation of a State-Based Marketplace and Lessons Learned

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

- With the November 2015 open enrollment period, Hawai'i became a state-based exchange using the federal platform for the individual market.
- Hawai'i's SHOP infrastructure was shut down, and small employers enrolled directly with health plans as of June 2015. Direct enrollment will continue.
- Hawai'i is seeking to waive participation in a SHOP exchange in 2017.

Specific lessons learned from our experience include the following:

1. Start-up and upkeep too expensive for small market. As events proved, Hawai'i's population was not large enough to make the development and upkeep of its own marketplace financially viable. With 1.4 million total residents, Hawai'i's uninsured population was estimated to be only 100,000 in 2013, and fewer than 170,000 people worked for small employers (50 employees or fewer).

[2] Medicaid Expenditures Panel Survey-Insurance Component. Average annual family premiums for Hawai'i and the US were $14,382 and $16,029, respectively.
[3] State Health Access Data Assistance Center ("SHADAC") analysis of restricted National Health Interview Survey (NHIS) data.
[4] SHADAC analysis of Healthcare Cost and Utilization Project (HCUP) data.
[5] Kaiser State Health Facts analysis of American Hospital Association data.
[6] Gallup-Healthways Physical Well-being Index.
[7] Commonwealth Fund, http://www.commonwealthfund.org/~/media/files/publications/fund-report/2015/dec/2015_scorecard_v4.pdf?la=en

The Connector, of necessity, was technically complex and expensive to develop and maintain; consequently, its infrastructures costs could not be scaled down to fit a limited market.

2. Connector systems too complex and susceptible to errors. As a "start-up" effort, the Connector was unable to inspire confidence in its operations for individual consumers, employers, or insurers. While it improved its customer-facing services, it was never able to effectively manage "back-office" functions, which created coverage lags and frustration for both consumers and insurers. Fewer than half the individuals who enrolled in insurance under the ACA did so through the Connector and less than 1% of eligible small businesses used its services, even though they continued to purchase coverage to meet their Prepaid obligations.

3. Small businesses purchased coverage directly, as they always had under Prepaid. Notwithstanding outreach, marketing, and a significant effort among business organizations to educate small employers about potential tax credits, fewer than 250 small employers enrolled through the Connector. This amounts to less than 1% of employers with 25 or fewer employees. Small employers did not make the switch because:
    - Unlike in the rest of the country, small employers were already buying coverage for their employees due to Prepaid requirements. After years of purchasing directly from plans or with the assistance of agents or brokers, employers had little interest in testing a new route, especially when media reports about the Connector's website problems cast further doubts.
    - Initially two and later only one insurer offered plans on the Connector SHOP marketplace. Meanwhile, outside of the Connector, small employers had the choice of up to five commercial plans selling the same products.

4. No competition. The Connector was unable to foster competition among carriers. Only two of five (now four)[8] commercial insurers initially offered individual plans and, in the second year, only one insurer provided small business plans in SHOP. Hawai'i's other commercial plans were discouraged from participating by premium fees and additional filings and reporting.

Proposed Waiver: Conforming the Small Employer Marketplace to Prepaid

Hawai'i proposes to align the ACA with Prepaid while administering the Prepaid Marketplace through direct enrollment for both large and small businesses. ***Hawai'i does not propose any changes to the marketplace for individuals, who will continue to have access to all coverage options and any subsidies to which they are entitled in a Federally-Facilitated Marketplace or may purchase coverage directly.***

Hawai'i's consumers enjoy the expectation of good health insurance coverage while our health care system depends on a largely insured population and the predictability of payment through the combination of Prepaid, Medicare, and Medicaid that insulates consumers from large out-of-pocket costs. Employer-sponsored insurance regulations included in the ACA are less robust than Prepaid's comprehensive mandates. The ACA's SHOP exchange requirements serve no purpose in Hawai'i except to add costs and threaten small employer compliance. Among the differences between Prepaid and the ACA:

[8] Family Health Hawai'i was ordered to liquidate and terminated all its plans as of May 6, 2016.

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

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

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

1. **Hawai'i's requirement for small employers to sponsor insurance is far more progressive than the terms of the ACA. SHOP does not add value or incentives to employers and has served only to increase small business insurance costs.**

2. **Prepaid works and has been working for more than forty years with minimal public investment in infrastructure for data collection, monitoring, reporting, and penalties. Besides maintaining the benefits for employees required by Prepaid, Hawai'i requests a SHOP waiver to continue the effective cooperation among insurers, employees, employers, and State agencies that has enjoyed an exemplary level of compliance without adding significantly to administrative costs.**

3. **Creating the ACA-required infrastructure for SHOP is not cost-effective but joining the federal platform for the SHOP exchange is not feasible because the federal exchange cannot accommodate Prepaid's coverage mandates.**

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

ACA Section	Reason Waiver is Sought
§1301 (a)(1)(C)(ii) Qualified health insurance issuer must offer at least one qualified health plan in the silver level	Hawai'i supports this provision for the individual marketplace, but would make it optional for employer-sponsored plans. Prepaid-compliant plans currently have an average actuarial value of gold or platinum; accordingly, silver plans cannot be purchased by employers to fulfill Prepaid obligations.
§1301 (a)(2) Inclusion of co-op and multi-state qualified health plans.	Hawai'i proposes to waive this section since multi-state plans are less likely to conform to the requirements of Prepaid and 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	Hawai'i proposes to waive the SHOP exchange so this provision, which would allow a "growing small employer" to continue to enroll employees through SHOP, would not be applicable.

§1311 (b)(1)(B) The establishment of a Small Business Health Options Program (SHOP Exchange)	Hawai'i proposes to waive the SHOP exchange for three important reasons: 1. To eliminate the burden of an expensive, unnecessary infrastructure for SHOP functions. Maintaining state-based SHOP functions is not economically feasible, fails to add value to the Prepaid Marketplace, and, in fact, imperils the success of Hawai'i's cost-effective system. 2. To relieve small employers of the added premium costs related to purchasing ACA plans on the SHOP. 3. To avoid participating in the Federal SHOP, which provides misleading information to any Hawai'i small employers as to its responsibilities to provide employee coverage.
§1311 (f)(3)(B) Eligible entity authorized to carry out exchange responsibilities	Hawai'i proposes to waive this section to permit flexibility as to which state agencies, in addition to the Medicaid agency, can carry out responsibilities for the exchange, as applicable.
§1312 (a)(2) Employer may specify level and employee may choose plans within a level	Currently, small employers in Hawai'i may select and pay for coverage at the level of a reference plan, giving employees a choice of specific options. This would continue as an option under Hawai'i's proposed waiver. Waiving *mandated* employee choice is necessary because: 1. Assuring such choice for employees of small businesses may require an on-going investment in technical infrastructure disproportionate to the benefits for Hawai'i's small market. 2. Only one Hawai'i plan participated in Hawai'i's SHOP exchange, rendering "consumer choice" meaningless. It is highly unlikely that any of the three other commercial insurers in Hawai'i will compete on SHOP in the future. 3. In Hawai'i's Prepaid environment, consumer choice is less significant because employers are required to purchase employee coverage with uniformly comprehensive benefits and can pass very little of the cost on to employees. 4. Employee coverage, benefits, and cost-sharing are significantly better under Prepaid than under ACA provisions.
§1312 (f)(2)(A) Definition of "qualified employer"	As Hawai'i proposes to waive SHOP, there will be no "qualified employers" that may elect to make employees eligible to purchase insurance coverage through the SHOP exchange.

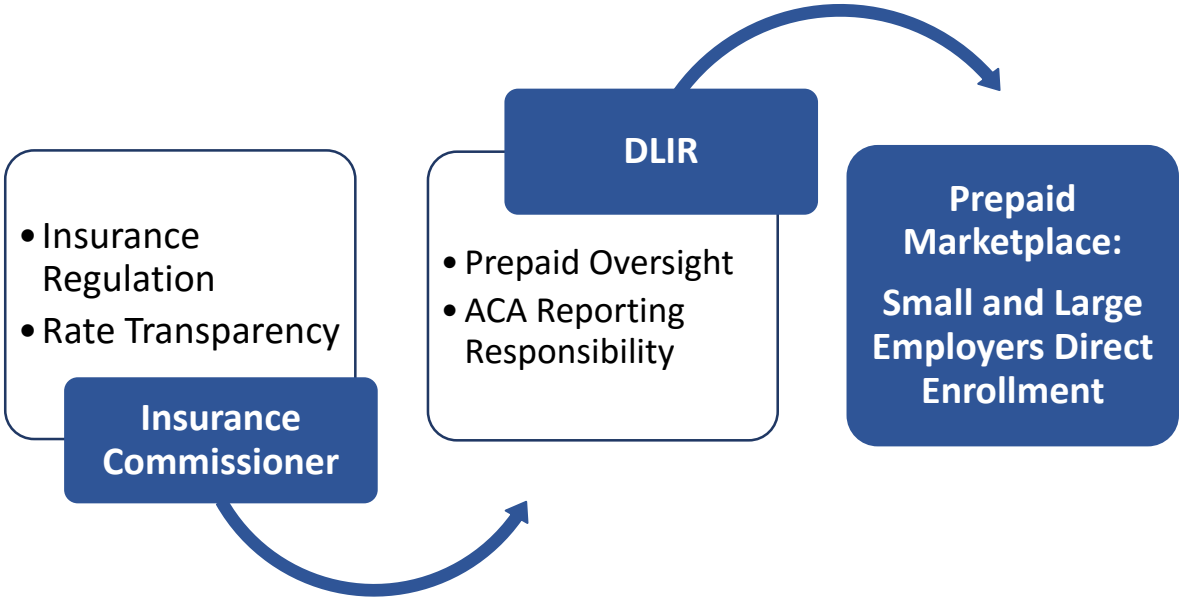
Description of Waiver Program

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

- Strong employee protections from out-of-pocket costs
- Employer participation from the smallest to the largest businesses
- A forum in which employers can select from among competing health plans
- Standardized, meaningful benefit requirements

- Actuarial values for plans that meet or exceed ACA requirements
- Minimal risk of adverse selection due to Prepaid's broad coverage mandate and long history of up-take (in fact, a SHOP exchange environment likely presents a greater risk of uncertainty, adverse selection, and a corresponding need for risk corridor payments in the small group market)

The Prepaid Marketplace works because of the cooperative interactions of the parties involved, including employers and employees, insurers, and regulatory agencies, notably the DLIR and the State's Insurance Division. As shown below, the Insurance Commissioner ("Commissioner") in the Department of Commerce and Consumer Affairs regulates insurance to ensure compliance with state and federal laws, including the provision of EHB and other ACA requirements in Qualified Health Plans. The Division supports transparency and competition by publishing information about benefits and premium rates for qualified health plans on its website. The DLIR certifies QHPs and maintains the Prepaid Marketplace for small and large businesses, which purchase coverage directly from insurers or through agents and brokers.



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

The Commissioner also reviews and rules on health insurance rate proposals according to the process prescribed in Hawai'i's insurance code. Plans are required to file with the Commissioner every rate, charge, classification, schedule, practice or rule, 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 if the Commissioner did not disapprove. If a filing is disapproved by the Commissioner, a petition for a contested case hearing may be filed with the Commissioner within 30 days of the decision. The petitioner has the burden of proving that the disapproval of the filing is not justified. The Commissioner must affirm, reverse, or modify the previous decision. This, in turn, can be appealed to the Circuit Court and, subsequently, to the State Supreme Court.

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

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

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

Employer participation. The following excerpt from DLIR's website at http://labor.hawaii.gov/dcd/about-phc/ provides guidance to employers for purchasing employee coverage in the Prepaid Marketplace:

> *Employers can choose one of the following three ways to provide the mandated coverage to their employees.*
>
> - *Purchase an approved plan [the website provides a link to the list of already approved plans]. In Hawaii, insurance companies, mutual benefit societies and health maintenance organizations can sell health care plans to Hawaii employers directly. These plans must be reviewed by the PHC Advisory Council and approved by the Director of the Department of Labor and Industrial Relations (DLIR) before they can be marketed to employers.*
> - *Purchase an insured plan of employers' choice. Some employers with corporate offices located outside of Hawaii purchase a health care plan and offer such plan to their employees on a nationwide basis. Employers that choose this option must submit their plan to DLIR for review by the PHC Advisory Council and approval by the Director to ensure the benefits are comparable to plans sold in Hawaii.*
> - *Provide a health care plan that is funded by the employer. As a self-insurer, the employer must show proof of financial solvency and ability to pay benefits by furnishing DLIR with the latest audited financial statements for review. Following the initial approval, the audited financial statements must be filed annually for continued approval. Employers choosing this option must complete an application for self-insurance [a link to Form HC-61 is included here] as well as submit a copy of their health care plan to DLIR for review by the PHC Advisory*

Council and approval by the Director to ensure the benefits are comparable to plans sold in Hawaii.

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

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

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

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

Insurers, agents, and brokers. Small employers may obtain employee insurance directly from the four insurers offering coverage. All but HMSA also work with agents and brokers who 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, Hawai'i proposes that during the five-year waiver period funds be paid to the State. Such funds will be deposited in Hawai'i's Premium Supplementation Fund established as part of Prepaid (HRS §393-41). While the State's fund is more narrowly restricted, it serves a similar purpose to the ACA's small business tax credits and, as it will be locally administered, may be more likely to be used by qualified small businesses.

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. • Business covers at least 50% of employee-only insurance cost. • Employees must have average annual wages of less than $50,000 (as adjusted for inflation beginning in 2014). • The maximum credit is 50 percent of premiums paid for small business employers and 35 percent of premiums paid for small tax-exempt employers. • The credit is limited to two consecutive taxable years to eligible employers.	• Employer employs less than eight employees entitled to coverage under Prepaid. • Employer's share of premium costs exceeds 1.5% of total wages for such employees. • 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. • 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:

Proposed Small Business Tax Credit Pass-Through

The total market value of the credits: The estimated value of the small business tax credit since 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 over five years. 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 five-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. The continued availability of "grandmothered" plans probably contributed to the lack of urgency for eligible employers. 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 million.

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,[9] 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 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

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

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[10]

	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
$ 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

Hawai‘i’s waiver proposal would relieve the State of the requirement to build a costly and unnecessary SHOP exchange and also keep Hawai‘i’s employers from using the federal SHOP, which materially contradicts the responsibilities that Hawai‘i’s small employers have under Prepaid. The waiver will enhance rather than reduce coverage, affordability, and comprehensiveness, and its approval will avoid possible ill-effects for the federal deficit. As described elsewhere in this document, the proposal waives ACA SHOP exchange technical requirements while reinforcing the obligations of small employers to their employees under Prepaid but does not change any aspects of coverage, affordability, or comprehensiveness.

In 2015, Hawai‘i had 29,419 small employers with 50 or fewer employees, which employed a total of 169,273 Hawai‘i residents. Comparatively, large employers with more than 50 employees, numbered only 1,531 private sector and five non-federal public sector employers but employed more than 432,000 people.[11]

[10] 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.

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

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

As might be expected, the average income for employees in small businesses is slightly lower than that of larger employers and the public sector, as shown below.[12]

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

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

Race/Ethnicity[13]	
African-American/Black	1.9%
Asian	38.6%
Hispanic/Latino (any race)	10.0%
Native American/Alaska Native	0.1%
Native Hawaiian and Pacific Islander	10.6%
White	24.1%
Two or more Races	23.8%
Other	1.0%
Age (percentage of total population)	
19-25	124,627 (8.9%)
25-34	199,498 (14.3%)
35-44	175,308 (12.6%)
45-54	185,369 (13.3%
55-64	179,032 (12.9%)
65-74	113,698 (8.2%)

[12] Ibid.

[13] American Fact Finder, US Census, 2014, http://factfinder.census.gov/faces/tableservices/jsf/pages/productview.xhtml?src=CF

Population by County, 2015[14]	
Honolulu	976,200 (69%)
Hawai‘i	202,700 (14%)
Maui	168,000 (12%)
Kaua‘i	71,400 (5%)
Total State Population	1,418,300 (100%)
Income and Health Care Spending	
Median Household Income	$68,201
Per Capita Income	$29,552
Average Employer-Sponsored Premium – Individual[15]	$5,316
Average Employer-Sponsored Premium – Family[16]	$14,848
Average out of pocket spending, (2011-2012)[17]	$2,001

Effect on Residents' Ability to Get Care Out of State

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

Description of Post-Waiver Marketplace

The post-waiver Prepaid Marketplace will be as follows:

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

Number of Employers Offering Coverage Before and After Waiver

Hawai‘i is seeking to waive SHOP requirements to ensure clarity for Hawai‘i employers about their obligations to provide employee health insurance benefits as required in the Prepaid Marketplace. Accordingly, Hawai‘i expects no decrease in the number of employers offering coverage as a result of its

[14] Hawai‘i Dept. of Business, Economic. Development & Tourism, "Population and Economic Projections for the State of Hawai‘i to 2040"

[15] "Average Single Premium per Enrolled Employee for Employer-Based Health Insurance (2014)," Kaiser Family Foundation, www.kff.org/other/state-indicator/single-coverage/.

[16] "Average Family Premium per Enrolled Employee for Employer-Based Health Insurance," Kaiser Family Foundation, www.kff.org/other/state-indicator/family-coverage/.

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

proposed waiver. Conversely, if small employers used the federal SHOP exchange, Hawai'i could expect the number of small employers providing employee coverage to decline.

Impact on Insurance Coverage in the State

Hawai'i's proposed waiver of the SHOP exchange will not affect coverage in the marketplace, quite simply, because the SHOP exchange brings no added value to the marketplace and employers did not choose to use it. A year and a half after "go-live," the Hawai'i SHOP exchange provided coverage to less than 1% of eligible employers and employees (246 employers and 1,139 employees). This is especially telling in the only state in which small employers are obligated to purchase employee coverage.

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

Hawai'i's proposal to waive the SHOP exchange will not adversely affect competition in the state. For the first year of operations, only two carriers participated in the SHOP exchange and, in the second, only one did. Employers that wished to purchase from the SHOP, therefore, had none of the benefits of competition. In contrast, the marketplace outside the SHOP exchange continued to thrive as smaller carriers offered plans through direct enrollment. This is yet another demonstration of employer groups' preference to purchase coverage directly from issuers.

Increase/Decrease in Administrative Burden

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

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

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

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

The work and cost related to building a SHOP exchange far exceeded the federal dollars expended by the Hawai'i Health Connector - the issuers that decided to participate also spent millions of dollars to try to

accommodate SHOP requirements. In addition, because of largely inoperable Connector technology, the plans had to develop work-arounds and augment assistance center staff to help confused consumers and correct inaccurate application and enrollment information. The additional burden for 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.

It is also a savings of cost and effort to insurers to be relieved of the requirement to devise a silver level plan for employers who cannot purchase it if they comply with Prepaid.

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

For state agencies. The net effect of the proposed waiver will reduce work for state agencies, namely DLIR and the Insurance Division.

DLIR will continue to enforce compliance through the Prepaid Marketplace by ensuring that both plans and employers meet all requirements. DLIR is identified as the agency that will provide required reports to HHS. **We strongly advocate for streamlined reporting appropriate to Hawai‘i’s intent to preserve a simple, straight-forward system that does not add administrative burdens to the state**. DLIR’s enforcement work would substantially increase if the waiver is not granted and Hawai‘i was forced to use the federal SHOP that misinforms Hawai‘i’s small employers about their responsibilities and options under Prepaid.

The State Department of Commerce and Consumer Affairs’ Insurance Division would not be required to add to its administrative responsibilities as a result of the proposed waiver. Without the waiver it would have to review silver level employer plans that cannot be purchased.

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 add Hawai‘i and its plans to a federally-facilitated SHOP exchange for plan selection, enrollment, and premium aggregation
- No additional tax credits, Medicaid expenditures, or other federal subsidies associated with shifting coverage to public programs due to potential non-compliant small businesses who get information from the federal SHOP

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

The State can identify no section of the ACA that would be adversely affected by the proposed waiver. If anything, Hawai‘i’s ability to retain Prepaid in full force and without ambiguity via a waiver will serve to ensure that almost all Hawai‘i employees continue to enjoy robust, affordable health insurance coverage.

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

See *Attachments 2 and 3* that provide detailed data and analysis for Hawai'i's proposed waivers. The actuary and economist find that, compared to a baseline without a waiver, the scenario with a waiver will have no impact on

- Coverage comparability
- Affordability
- Comprehensiveness
- Federal deficit neutrality
- Effect on federal operational considerations

Scope and Comprehensiveness of coverage. All plans sold for employees of small businesses include the ten EHB as well as state-mandated benefits. None of these benefits will change under the waiver. State-mandated benefits are noted below and at https://www.cms.gov/CCIIO/Resources/Data-Resources/Downloads/hawaii-ehb-benchmark-plan.pdf:

ACA EHB Category	Hawai'i EHB Benefit
1. Ambulatory patient services	• Vasectomy • Surgery: operating room, recovery and treatment rooms • Anesthesia • Pathology • Chemotherapy • Radiation therapy • Diagnostic colonoscopy • Dialysis and home dialysis services, supplies, and equipment • Blood and plasma • Medical and surgical supplies • Oxygen • Nuclear medicine • Infertility services • Genetic screening and testing • Genetic counseling • Outpatient surgery • Urgent care visits • Physician office visits • Diagnostic imaging • Home health visits • Skilled nursing facility care • HIV/AIDS treatment • Certain treatment of diabetes • Diagnosis of TMJ dysfunction • Home hospice care • Coverage for certain clinical trials • Medical foods
2. Emergency services	• Emergency room services • Ambulance services
3. Hospitalization	• Room and board • Nursing • Complications of pregnancy • Pathology services • Radiology services • Anesthesia • Medical supplies • Prosthetics • Drugs • Blood

ACA EHB Category	Hawai'i EHB Benefit
	• Transplants • Reconstructive breast surgery following a mastectomy • Surgery to correct congenital anomalies • Other reconstructive surgery • Bariatric surgery • Tubal ligation • Inpatient hospice • Vision procedures • Inpatient visits • Inpatient surgery
4. Maternity and newborn care	• Coverage for newborns and foster children • Minimum inpatient stays following delivery of a baby • Treatment of maternity as any other illness when maternity is provided • Prenatal care • Nurse midwife services
5. Mental health and substance abuse disorder services, including behavioral health treatment	• Treatment for mental illnesses • Treatment for alcoholism and drug abuse
6. Prescription drugs	• Injectable drugs • Retail and mail-order prescription drugs • Prescription contraceptives • Smoking and tobacco cessation prescription drugs
7. Rehabilitative and habilitative services	• Durable medical equipment • Inpatient rehab services • Cardiac rehab • Pulmonary rehab • Physical therapy • Occupational therapy • Speech therapy • IV/infusion therapy • Hyperbaric oxygen therapy • Hearing aids • Speech generating devices • Diagnosis and treatment of autism • Orthodontic treatment of orofacial anomalies resulting from birth defects
8. Laboratory services	• Laboratory services
9. Preventive and wellness services and chronic disease management	• Adult routine physical exams • Well-baby and well-child exams • Immunizations • Routine mammography screening • HPV and cervical cancer screening • Newborn hearing screening • Newborn screening – other • Pediatric hearing screening • Prostate cancer screening • Colorectal cancer screening • Depression screening • Diagnostic bone mass measurement/density screening • Colonoscopy screening • Allergy testing • Diabetes screening • Screening for sexually-transmitted infections – HIV • Screening for sexually-transmitted infections – other • Anemia screening for pregnant women • BRCA screening and counseling about genetic testing • Folic acid supplements for women who may become pregnant

ACA EHB Category	Hawai'i EHB Benefit
	• Hepatitis B screening for newly pregnant women • Rh incompatibility screening for all pregnant women and follow-up testing for women at higher risk • Allergy injections • Smoking and tobacco cessation counseling • Diabetes education • Diabetes monitoring • Breastfeeding and lactation counseling • Nutritional counseling • HPV vaccine • Flu vaccines
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 • Pediatric vision screening • Pediatric eyeglasses and contact lenses • Pediatric dental • Routine hearing exams

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

Benefit	Name of Required Benefit	Market Applicability	Statutory Authority
Hospice Services	Hospice care	Individual, small group, large group, HMO	431:10A-119; 432:1-608; 432D-23
Infertility Treatment	In-vitro fertilization	Individual, small group, large group, HMO	431:10A-116.5 432:1-604 432D-23
Delivery and All Inpatient Services for Maternity Care	Newborn children	Individual, small group, large group, HMO	431:10A-115 432:1-602 432D-23
Mental/Behavioral Health Outpatient Services	Mental illness, alcohol, and drug dependence	Individual, small group, large group, HMO	431M-4 432D-23
Substance Abuse Disorder Outpatient Services	Mental illness, alcohol, and drug dependence	Individual, small group, large group, HMO	431M-4 432D-23
Substance Abuse Disorder Inpatient Services	Mental illness, alcohol, and drug dependence	Individual, small group, large group, HMO	431M-4 432D-23
Specialty Drugs	Chemotherapy services	Individual, small group, large group, HMO	432:1-616
Preventive Care/ Screening/ Immunization	Mammography	Individual, small group, large group, HMO	43110A-116 432:1-605 432D-23
Preventive Care/ Screening/ Immunization	Contraceptive services	Individual, small group, large group, HMO	431:10A-116.6 431:10A-116.7 432:1-604.5 432D-23

Preventive Care/ Screening/ Immunization	Child health supervision service	Individual, small group, large group, HMO	431:10A-115.5 432:1-602.5 432D-23
Preventive Care/ Screening/ Immunization	Colorectal screening	Individual, small group, large group, HMO	431:10A-122
Diabetes Care Management	Diabetes	Individual, small group, large group, HMO	431:10A-121 432:1-612 432D-23
Inherited Metabolic Disorder – PKU	Medical foods and low protein modified food products	Individual, small group, large group, HMO	431:10A-120 432:1-609 432D-23
Prescription Drugs Other	Chemotherapy services	Individual, small group, large group, HMO	432:1-616
Autism spectrum disorders	Applied behavioral analysis services	Individual, small group, large group, HMO	431:10 432:1 432D-23
Orofacial anomalies	Orthodontic treatment for orofacial anomalies resulting from birth defects	Individual, small group, large group, HMO	431:10 432:1 432D-23

Plans available for purchase by small employers are defined under Prepaid as 7(a) and 7(b) plans (see *Appendix 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 as well as paying for most of the employee's premium. 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 $2,000/individual and $6,000/family in a 7(a) plan and $3,000/individual and $9,000/family in 7(b).

10-Year Waiver Budget Projection – Budget Neutrality

Hawai'i is proposing to maintain direct enrollment through the Prepaid Marketplace, a process that has been in operation for more than forty years. **There has been and will be no negative cost or revenue implications for the federal government related to this waiver proposal**. The infrastructure to support Hawai'i's proposed waiver and the Prepaid Marketplace is already fully in place. See *Attachments 2 and 3* that describe the actuarial and economic analysis and conclusions related to this proposal.

Assuring Compliance, Reducing Waste and Fraud

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

- Wields the authority to levy penalties and injunctions for failure to comply with Prepaid[18]

[18] Hawai'i's Prepaid Health Care Act (Chapter 393, Hawaii Revised Statutes) allows the director to assess penalties and enjoin employers from carrying on their business if the employer fails to comply with Prepaid coverage

- Monitors employer compliance through its Disability Compensation Information System that tracks employers' health care coverage for their employees
- Conducts random compliance checks of employers by the Disability Compensation Division's Audit and Investigation section
- Goes on-site to investigate employers who have been 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 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. Hawai'i has an effective rate review program in which it scrutinizes premium rate filings of managed care plans.

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 every year. In addition, the Branch assists consumers, healthcare providers, and health insurance professionals with informal inquiries, and conducts independent external reviews of managed care plan coverage decisions that are appealed by plan members that has likewise resulted in consumer savings of thousands of dollars per year.

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

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

Implementation Timeline and Process

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

requirements (§393-33 and 393-34, HRS). Furthermore, employers that do not provide health care insurance to their eligible employees are liable to pay for their employees' medical expenses.

Reporting Responsibilities

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

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

In its reports, the State proposes to include:

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

Hawai'i proposes to report actual experience vs. projections on the following annual targets:

Number of Small Businesses (50/fewer)	2015 (Baseline)	2017	2018	2019	2020	2021
Projected	29,419	29,700	31,200	32,800	34,400	36,100
Actual	29,419					
Number of Employees of Small Bus. (50/fewer)	**2015 (Baseline)**	**2017**	**2018**	**2019**	**2020**	**2021**
Projected	169,273	172,700	174,400	176,100	177,900	179,700
Actual	169,273					
Small Group Plan Enrollment	**2015 (Baseline)**	**2017**	**2018**	**2019**	**2020**	**2021**
Projected	127,000	129,500	130,800	132,100	133,400	134,800
Actual	127,000					

Individual Plan Enrollment	2015 (Baseline)	2017	2018	2019	2020	2021
Projected	45,431	50,837	54,599	58,203	58,261	58,319
Actual	45,431					

Medicaid Enrollment	2015 (Baseline)	2017	2018	2019	2020	2021
Projected	257,689	261,480	263,696	266,731	269,645	272,244
Actual	257,689					

Medicare Enrollment	2015 (Baseline)	2017	2018	2019	2020	2021
Projected	218,319	236,058	234,396	244,504	254,665	260,901
Actual	218,319					

Small Group Premiums	2016 (Baseline)	2017	2018	2019	2020	2021
Projected	$5,106	$5,462	$5,807	$6,074	$6,365	$6,675
Actual	$5,106					
Maximum out of pocket	**2016 (Baseline)**	**2017**	**2018**	**2019**	**2020**	**2021**
Projected	$3,111	$3,168	$3,224	$3,281	$3,337	$3,309
Actual	$3,111					

Prepaid Premium Supplementation Program	2015 (Baseline)	2017	2018	2019	2020	2021
Projected # Businesses TBD*						
Actual						
Projected Assistance ($$) TBD*						
Actual						

**Depends on negotiated small business tax credit pass-through.*

Waiver Development Process

Hawai'i Waiver Task Force. Hawai'i's State legislature recognized the potential for a Section 1332 waiver in 2014 and, in Act 158 (HB 2581 HD3, SD2, CD1), Regular Session 2014, created a task force "to develop a health care reform plan that meets requirements for obtaining a state innovation waiver." Act 158 was modified somewhat by Act 184 (HB 576 HD1 SD 1 CD1), Regular Session 2015.

The task force was convened regularly after its initial meeting in September 2014 and, during its meetings, considered every aspect of the ACA subject to potential waiver and agreed on the provisions specified in this proposal. Per legislation, the task force will be dissolved on June 30, 2017. Subject to Hawai'i's open meeting laws, all meetings were publicly posted at least one week in advance and members of the public were invited to both attend and comment at every meeting. The task force also submitted an annual report to the legislature summarizing its actions and recommendations. All task force meeting agendas, minutes, presentations, and reports are posted on the Governor's website at http://governor.hawaii.gov/healthcareinnovation/healthcare-transformation/.

Public Hearings. As required in §1332(a)(4)(B)(i), when the task force had agreed upon provisions recommended for waiver, public hearings were held in accordance with CFR §33.112 and §155.1312, which address state public notice requirements. Public hearing notices and the written draft proposal were duly posted on the Governor's website on August 31, 2015, and information was distributed to the media and interested parties at least two weeks before hearings commenced. The public comment period

remained open until October 31, 2015. Task force chair, Beth Giesting, was interviewed on-air by Hawai'i Public Radio about the waiver and scheduled public hearings.

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

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

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

1. The proposed Hawai'i ACA Waiver.
2. The strategies being developed as part of a State Innovation Models (SIM) Planning grant supported by the Centers for Medicare and Medicaid Innovation.
3. A "No Wrong Door" three-year plan supported by the federal Agency for Community Living intended to enhance access to services for the elderly, people with disabilities, and veterans.

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

The Governor's Office hosted the public hearings with Deputy Chief of Staff Laurel Johnston serving as convener, and task force chair, Beth Giesting, presenting the ACA Waiver Proposal. Attendance for all seven public hearings totaled 163 with considerable variation by island, as follows:

Kauaʻi	15	Hilo	10
Maui	40	Lanaʻi	25
Kona	9	Molokaʻi	9
Oʻahu	55	**TOTAL**	**163**

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

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

Legislation. As required under §1332(a)(1)(B)(i), the 2016 State legislature passed legislation that authorizes submission and implementation of the proposed waiver. Senate Bill 2775 was signed into law as Act 13 by Governor David Ige on April 25, 2016. A copy of the Act can be found in *Attachment 1*.

Attachment 1: Enacted Legislation

THE SENATE
TWENTY-EIGHTH LEGISLATURE, 2016
STATE OF HAWAII

S.B. NO. 2775

JAN 27 2016

A BILL FOR AN ACT

RELATING TO THE AFFORDABLE CARE ACT SECTION 1332 STATE INNOVATION WAIVER.

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

SECTION 1. The legislature finds that the State of Hawaii has a bold history as an innovator in ensuring that its residents have access to health care. The Hawaii Prepaid Health Care Act has ensured the availability of employer-sponsored health insurance for workers and their families for more than forty years, meeting or exceeding the goals of the federal Patient Protection and Affordable Care Act of 2010 (Affordable Care Act) for employer sponsored health coverage.

The legislature further finds that the State of Hawaii has taken all necessary steps to comply with the implementation of the health insurance exchange and other insurance reforms required by the Affordable Care Act, but that there remain concerns that portions of the Affordable Care Act could undermine certain gains made by the Hawaii Prepaid Health Care Act.

Under section 1332 of the Affordable Care Act, a state can apply for a state innovation waiver, allowing the State to implement innovative ways to provide access to quality health care. Act 158, Session Laws of Hawaii 2014, established a state innovation waiver task force to develop a health care reform plan that would meet the requirements for obtaining a state innovation waiver in compliance with the Affordable Care Act. Act 184, Session Laws of Hawaii 2015, amended the scope of the task force's responsibilities to facilitate the development of a state innovation waiver application in a timely manner.

The state innovation waiver task force has met regularly since September 2014, holding meetings in accordance with state open meeting requirements, and posting all materials on the Governor's website, satisfying the procedural requirement of the Affordable Care Act. In those meetings, the task force carefully considered all sections of the Affordable Care Act for potential waiver, identifying those provisions that improve coverage and consumer protections and those that contradict, confuse, or weaken employer-coverage mandates in the Hawaii Prepaid Health Care Act.

Once the task force agreed upon the substance of its draft proposal, the task force held a series of seven public hearings on six islands, as required by federal law. These public hearings conformed to state and federal public notice requirements and were attended by a total of one hundred sixty-three community participants. The draft plan and additional information were made publicly available prior to and at the public hearings.

The results of the task force's efforts are contained in its report to the legislature, submitted in December of 2015, recommending three actions for Hawaii's insurance marketplace:

(1) Maintain access to affordable health insurance coverage for individuals via the state-based exchange utilizing the federal platform;

(2) Align the Affordable Care Act with the Hawaii Prepaid Health Care Act's requirements for private employers to the extent allowable; and

(3) Waive the Affordable Care Act Small Business Health Options Program and its requirements for the small business marketplace, including the employee choice provision.

Accordingly, in order to facilitate the development of innovative approaches to insuring the people of Hawaii, the purpose of this Act is to authorize the State to submit a state innovation waiver proposal and to implement such waiver upon approval by the federal government.

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

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

INTRODUCED BY: Ron J. H. Baker
By Request

S.B. NO. 2775

Report Title:
State Innovation Waiver, Affordable Care Act

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

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

SB HMS 2016-1291

Attachment 2: Actuarial Analysis

OLIVER WYMAN

HAWAI'I 1332 WAIVER APPLICATION

ACTUARIAL ANALYSES AND CERTIFICATION

June 14, 2016

Tammy Tomczyk, FSA, FCA, MAAA

Peter Kaczmarek, FSA, MAAA

This product was prepared with support from the Robert Wood Johnson Foundation through its State Health Reform Assistance Network program.

MARSH & McLENNAN COMPANIES

CONTENTS

1

Executive Summary

The State of Hawai'i is applying for a State Innovation Waiver under Section 1332 of the Patient Protection and Affordable Care Act (ACA). In particular, the State of Hawai'i is seeking to waive the following provisions of the ACA:

- §1301(a)(1)(C)(ii) & 1301(a)(2) – Requirement to offer a Silver plan and multistate options in the Small Group Marketplace
- §1304(b)(4)(D)(i)&(ii) – Continuation of Participation in Small Business Health Options Program (SHOP)
- §1311(b)(1)(B) – Establishment of a SHOP Exchange
- §1312(a)(2) – Employee Choice

If approved, the 1332 Waiver will be effective January 1, 2017 for an initial period of five years with an option to renew for an additional five years. As part of the Waiver application, the Centers for Medicare and Medicaid Services (CMS) regulations require the State of Hawai'i to provide actuarial analyses and an actuarial certification to support the State's estimates that the 1332 Waiver application will comply with the following three requirements.[1]

- **Scope of Coverage Requirement** – The 1332 Waiver will provide coverage to at least a comparable number of the State's residents as would be provided absent the 1332 Waiver.
- **Affordability Requirement** - The 1332 Waiver will provide coverage and cost-sharing protections against excessive out-of-pocket spending that results in coverage which is at least as affordable for the State's residents as would be provided absent the 1332 Waiver.
- **Comprehensiveness of Coverage Requirement** – The 1332 Waiver will provide coverage that is at least as comprehensive for the State's residents as would be provided absent the 1332 Waiver.

Our work did not include analyses or certification for the fourth 1332 Waiver requirement, that being a demonstration of deficit neutrality.

The purpose of this report is to outline the assumptions and methodology used in generating the actuarial projections that support the actuarial certification of compliance with the three 1332 Waiver requirements outlined above. However, this report may be utilized as the basis for

[1] Waiver for State Innovation Guidance 45 CFR Part 155

economic or other analyses to support meeting the Deficit Neutrality requirement. Other uses of this report may be inappropriate.

The actuarial analyses in this report are based on the following two underlying scenarios.

- **Baseline Scenario** – The Baseline Scenario represents the current and future state of the health care market in the State of Hawai'i, absent the 1332 Waiver where stakeholders in the Hawai'i health market place must comply with all provisions of the ACA and the Hawai'i Prepaid Health Care Act (Prepaid), as applicable to them.
- **Waiver Scenario** – The Waiver Scenario is a revision from the Baseline Scenario where Hawai'i's 1332 Waiver application is assumed to be approved by CMS and all waived provisions are no longer in effect starting in 2017.

In the "Baseline and Waiver Scenarios" section of the report, we outline the assumptions and details underlying these scenarios. The "Actuarial Analyses and Projections" section of the report, along with Appendix A, provide supporting information and projections under the two scenarios to support our findings related to the three 1332 Waiver requirements noted above.

The results of our analyses allow us to conclude that the Baseline and Waiver scenarios will generate the same actuarial projections for membership, premium and claims for each market segment. Therefore, we are able to certify that Hawai'i's 1332 Waiver application meets the scope of coverage, affordability and comprehensiveness of coverage requirements under the regulation.

2

Baseline and Waiver Scenarios

In order to conduct the actuarial analyses as presented in this report, we developed two scenarios. The first scenario can be described as the Baseline Scenario, where the Waiver application is not in effect and stakeholders in the Hawai'i health market place must comply with all provisions of the ACA and the Hawai'i Prepaid Health Care Act (Prepaid), as applicable to them. The second scenario, or the Waiver Scenario, is a revision from the Baseline Scenario where Hawai'i's 1332 Waiver application is assumed to be approved by CMS and all waived provisions are no longer in effect, starting in 2017. **As an overall outcome of the analyses, we are concluding that the Baseline and Waiver Scenarios will generate the same actuarial projections, and therefore meet the scope of coverage, affordability and comprehensiveness of coverage requirements.** In the remainder of this section, we outline the underlying assumptions and details of these two scenarios.

Baseline Scenario

The Baseline Scenario below outlines the current and future state of the health care market in the State of Hawai'i, absent a 1332 Waiver. Oliver Wyman has conducted a series of discussions with various members of Hawai'i State agencies to develop credible assumptions for the Baseline Scenario. In addition, we reviewed Federal and Hawai'i specific health insurance market regulations, surveyed the primary health insurance carriers offering commercial health insurance coverage in Hawai'i, and gathered and reviewed various sources of publicly available information. Oliver Wyman previously created a series of research reports on the Hawai'i health insurance market which provided significant background information for this report. This prior comprehensive review, augmented by updated and additional information, allowed us to develop a credible and realistic Baseline Scenario.

The Baseline Scenario assumes that in the absence of a 1332 Waiver, the future state of the health insurance market in Hawai'i can be characterized as follows:

- **ACA and Prepaid Health Care Act**
  All provisions of the ACA and Prepaid are assumed to be in effect. Small Group employers[2] that are subject to Prepaid and health insurance carriers offering Small Group plans are required to comply with all components of both the ACA and Prepaid regulations. Prepaid-exempt Small Group employers, if any, need to comply with all requirements of ACA regulations.

[2] In Hawai'i, a Small Group Employer is defined as a group with up to 50 employees.

- **Direct Enrollment SHOP**
  Hawai'i currently has a state-based SHOP that utilizes direct enrollment. CMS has issued an extended transitional policy[3] which allows for the direct enrollment of groups through SHOP Qualified Health Plan (QHP) issuers and/or agents and brokers through plan years that begin in 2018. Hereafter we refer to this option as the "Direct Enrollment SHOP." We anticipate that the majority of Small Group employers in Hawai'i will continue to purchase plans directly from carriers in 2017-2018, outside of the Direct Enrollment SHOP.

- **Federally Facilitated SHOP and Available Plans**
  For plan years beginning in 2019, a Federally Facilitated SHOP (FF-SHOP) will be available to Small Group employers under the Baseline Scenario, offering plans that comply with both the ACA and Prepaid and have actuarial values of 90% (ACA Platinum metal level and Prepaid-approved 7A Plans) or 80% (ACA Gold metal level and Prepaid-approved 7B Plans). In addition, plans with actuarial values of 70% (ACA Silver metal level which are not Prepaid-compliant) will also be offered through the FF-SHOP, as required by the ACA, but will only be sold to Prepaid-exempt Small Employer groups, if any.

- **Federally Facilitated SHOP and Prepaid Compliance**
  It is assumed that the FF-SHOP will not be able to accommodate the administration of Prepaid regulations and therefore cannot ensure compliance. Therefore, there will be no direct checks and balances to ensure Small Group employers that are subject to Prepaid can only select from Prepaid compliant plans. The Hawai'i Department of Labor and Industry Relations (DLIR) will therefore enforce compliance with Prepaid, for groups both inside and outside the FF- SHOP.

- **Federally Facilitated SHOP Competition and Employer Choice**
  In 2015 and 2016, only one insurance carrier offered QHPs through the Direct Enrollment SHOP in Hawai'i.[4] There are four insurance carriers offering ACA compliant plans directly to Small Group employers in 2016.[5] Participating in the SHOP requires carriers to invest in IT interface. Based on discussions with representatives of the State of Hawai'i who have engaged with carriers, the State does not anticipate that additional carriers will make these investments in the future. Therefore, under the Baseline Scenario we assume that at most one carrier, Kaiser, will offer QHPs on the SHOP exchange in the future. Employers will have the choice to select plans through the FF-SHOP from at most a single carrier.

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[3] https://www.cms.gov/CCIIO/Resources/Regulations-and-Guidance/Downloads/1332-and-SHOP-Guidance-508-FINAL.PDF

[4] http://labor.hawaii.gov/aca-smallbiz/

[5] http://cca.hawaii.gov/ins/files/2015/10/Q1-off-exchange-2016-Small-Group-Premiums.pdf

- **Federally Facilitated SHOP and Employee Choice**
  Under §1312(a)(2) of the ACA, an employer may select a reference plan at any metal level of coverage to be made available to employees through the SHOP, and each employee may then choose to enroll in any health plan offered at that metal level. This is commonly referred to as "employee choice." Under the Baseline Scenario this choice is assumed to be made available to employees both via the Direct Enrollment SHOP through 2018, and through the FF-SHOP starting in 2019.

- **Small Business Employer Tax Credits**
  Qualified Small Group employers can obtain tax credits for up to two years when purchasing QHPs available through a SHOP. This option will continue to be offered through direct enrollment with QHP issuers through 2018 and additionally when QHPs are purchased through the FF-SHOP in 2019 and beyond. Due to current low enrollment in QHPs purchased through the SHOP we expect the Small Business Employer Tax Credit amounts to be minimal in the Baseline Scenario in 2017 and later.

- **Federally Facilitated SHOP Fees**
  Starting in 2019, carriers offering coverage through the FF-SHOP will be required to pay user fees, which will likely be passed along to employers through higher premiums. The amount of the user fees have not yet been established for years after 2017. However, we believe aggregate SHOP fees collected in 2019 and beyond will have minimal impact on Small Group Employer premium rates and affordability for employees due to assumed low enrollment in the FF-SHOP.

- **Prepaid-Exempt Small Group Employers**
  Small Group employers who are exempt from Prepaid regulations will continue to make decisions as to whether to offer employer sponsored health coverage at their own discretion under the ACA regulations. Prepaid-exempt Small Group employers could potentially select plans which are not Prepaid-compliant but are ACA compliant, for example by selecting plans with a metal level of 70% - Silver plans. Based on a survey of Small Group insurance carriers in Hawai'i, no significant enrollment in plans other than the 7A or 7B plans has been identified, indicating that any potential Prepaid-exempt Small Group employers are currently not selecting plans which are not Prepaid-complaint.

Waiver Scenario

The Waiver Scenario below outlines changes to the future state of the health care market in the State of Hawai'i if the 1332 Waiver application were approved and in effect starting in 2017. This scenario is a revision from the Baseline Scenario with the following alternate assumptions:

- **ACA and Prepaid Health Care Act**
  The provisions of the ACA for which a Waiver is being requested are assumed to no longer be in effect in 2017 and later. All Prepaid provisions will remain in effect. Small Group employers subject to Prepaid and health insurance carriers offering Small Group plans need to continue to comply with all non-waived ACA and Prepaid regulations. Prepaid-exempt Small Group employers need to continue to comply with all non-waived ACA regulations.

- **Direct Enrollment SHOP**
  The CMS transitional policy of direct enrollment through SHOP Qualified Health Plan (QHP) issuers and/or agents and brokers will be in place through plan years beginning in 2018, as in the Baseline Scenario. With no FF-SHOP in place starting in 2019 under the Waiver scenario, all groups will continue to purchase QHPs through the Direct Enrollment SHOP in 2019 and beyond. For the limited number of Small Group employers currently purchasing QHP plans through the current Direct Enrollment SHOP, we anticipate that they will be able to select equivalent plans via the continued Direct Enrollment SHOP.

- **Federally Facilitated SHOP and Available Plans**
  The FF-SHOP will not be in place in 2019 or beyond under the Waiver Scenario. Small Group employers can continue to purchase plans directly from health insurance carriers through the continuation of the Direct Enrollment SHOP option. Prepaid-compliant plans with actuarial values of 90% (ACA Platinum metal level and Prepaid-approved 7A Plans) or 80% (ACA Gold metal level and Prepaid-approved 7B Plans) will continue to be made available. Availability of plans with actuarial values of 70% (ACA Silver metal level which are not Prepaid-compliant) are no longer required in the Waiver Scenario; however, these plans may be made available to Prepaid-exempt Small Group employers only, at the carriers' discretion.

- **Federally Facilitated SHOP and Prepaid Compliance**
  With no FF-SHOP in place under the Waiver Scenario, the FF-SHOP's inability to enforce compliance with Prepaid is no longer an issue. The potential for a non-compliant plan being issued to a Small Group employer that is subject to Prepaid is largely eliminated given that carriers offering coverage in the Small Group market have years of experience with Prepaid and its requirements. Compliance with Prepaid will be enforced by DLIR.

- **Federally Facilitated SHOP Competition and Employer Choice**
  As described in the Baseline Scenario, the SHOP offering in the future was assumed to be limited to one carrier based on current SHOP participation levels (i.e., only Kaiser is currently participating in the Direct Enrollment SHOP). Therefore, in the Waiver Scenario, employer choice will not be limited or altered due to elimination of the SHOP. Small Group employers can continue to purchase QHP equivalent, Prepaid-compliant

plans with actuarial values that meet Platinum or Gold Metal AV requirements via the Direct Enrollment SHOP.

- **Federally Facilitated SHOP and Employee Choice**
  The requirement that an employer may select a reference plan at any metal level of coverage to be made available to employees through the SHOP, and each employee may then choose to enroll in any health plan offered at that metal level will be waived in the Waiver Scenario. This is not expected to limit an employee's choice of plan options because it is expected that carriers that would be willing to offer coverage through the FF-SHOP in 2019 and later under the Baseline Scenario, which includes employee choice, will also be willing to allow Small Group employers to select multiple plan options in the Direct Enrollment SHOP.

- **Small Business Employer Tax Credits**
  The 1332 Waiver application states that Small Group employers purchasing QHP equivalent coverage directly from carriers participating in the Direct Enrollment SHOP will be able to apply for Small Business Employer Tax Credits under the Waiver Scenario in the same manner as under the Baseline Scenario. We concluded that based on this underlying assumption there will be no change in the amount of qualified Small Business Employer Tax Credits being available between the Baseline and Waiver scenarios.

- **SHOP Fees**
  SHOP fees will not be collected in 2019 and beyond.

- **Prepaid-Exempt Small Group Employers**
  Small Group Employers that are exempt from Prepaid regulations can continue to make the decision whether to offer employer-sponsored health coverage at their discretion, and may select any ACA compliant plan made available by carriers. As described in the Baseline Scenario, current enrollment in plans other than 7A or 7B Prepaid-compliant plans is minimal. We expect no impact for Prepaid-exempt Small Group employers as a result of the Waiver requirements.

- **Other Health Coverages**
  We assume there will be no direct impact on the scope of coverage, affordability, and comprehensiveness of coverage requirements for Hawai'i residents with health coverage obtained through channels other than the Small Group market. All current and future regulations in these other health insurance markets would remain unchanged, including:

    - Insurance purchased by individuals directly from health insurance carriers or via the Federally-Facilitated Marketplace (FFM) (Direct Purchase or Individual Market).
    - Health coverage obtained via Large Group employers including State and Federal employees and self-insured employer groups.

  - Health coverage directly sponsored by State and/or Federal government including Medicare, Medicaid, CHIP, Military and Veteran Services.

- **Uninsured**
  We assume the 1332 Waiver provisions will have no direct impact on Hawai'i residents who are currently uninsured, nor will they lead to an increase in the number of uninsured residents. Prepaid regulation ensures that eligible employees of Small Group employers must continue to be offered health coverage in the Waiver Scenario. Small Group employees that do not meet eligibility requirements for coverage under Prepaid will continue to obtain coverage through the same channels they do today, either through their employers who offer them coverage despite the fact that they are not required to do so under Prepaid, or through other channels such as Direct Purchase or one of the Government sponsored programs, such as Medicaid or Medicare.

3

Actuarial Analyses and Projections

This section describes in detail the data sources, assumptions, methodology and results of the actuarial analyses and projections performed by Oliver Wyman. Appendix A contains a series of detailed tables that present the results of the actuarial projections for the Baseline and Waiver Scenarios. These results demonstrate the 1332 Waiver application meets the Scope of Coverage, Affordability and Comprehensiveness of Coverage requirements.

Scope of Coverage Requirement

The 1332 Waiver guidance[6] provides the following key components under the Scope of Coverage requirement:

- A comparable number of state residents must be forecast to have coverage under the waiver as would have coverage absent the waiver,
- Coverage refers to minimum essential coverage,
- Comparable means that in each year the waiver would be in effect the forecast of the number of covered individuals with the Waiver in place is no less than the forecast of the number of covered individuals absent the Waiver,
- The impact on all state residents is considered, in particular vulnerable residents,
- Supporting data includes information on the number of individuals covered by income, health status and age groups, and
- A description of the model used to produce these estimates including data sources and quality, key assumptions, and parameters must be provided.

Enrollment by Market Segment – Market Segment Definitions

In order to meet the above guidelines for the scope of coverage requirement, Oliver Wyman analyzed enrollment information by market segment for all residents in Hawai'i. The market segments analyzed can be described as follows.

- **Individual Market – Direct Purchase**
  Major medical health insurance coverage purchased by individuals directly from health insurance carriers or via the Federally-Facilitated Marketplace. Major medical health insurance includes all plans which in 2015 and in future will comply with the federal minimum essential coverage requirement.

[6] Waivers for of State Innovation Guidance 45 CFR Part 155

- **Small Group Employer Market**
  Major medical health coverage purchased by Small Group employers, including Prepaid-exempt and Prepaid-compliant Small Group employers.

- **Large Group Employer Market**
  Major medical health coverage purchased by Large Group employers including State and Federal employees and self-insured groups.

- **Government Coverage**
  Health coverage sponsored by State and/or the Federal government including Medicare (both fee-for-service and Medicare Advantage), Medicaid, the Children's Health Insurance Program (CHIP), and Military coverages via Tricare and Veteran Services.

- **Uninsured**
  Residents who are not covered by any of the health coverage types described above, or with health coverage that does not comply with the federal minimum essential coverage requirement.

Enrollment by Market Segment – Data Sources

We choose 2015 as our baseline year as it represents the most recent year of complete enrollment data available. To develop the baseline enrollment we gathered membership information from various sources, using what we considered to be the most credible source for each market segment. Our goal was to collect annual enrollment in as much detail as possible in order to account for residents who change market segments during the year and could therefore be accounted for in more than one data source. We gathered this same information for 2013 and 2014 and compared it with our 2015 results to ensure they were reasonably consistent across years, and shifts between types of health coverage during this period were consistent with expectations (e.g., membership in the Individual Market increased while the number of uninsured individuals decreased). We adjusted the enrollment counts from these various sources so that our total 2015 membership across all types of coverage matched the most recent 2015 Hawai'i population estimate provided by the US Census Bureau.[7]

Based on the 2015 data we first developed projections of future enrollment in 2016 through 2026. Future annual changes in enrollment by type of coverage and for the uninsured population were projected based upon National Health Expenditure Data[8] (NHED) for 2016-2024 with assumed growth for periods 2025-2026 based on the 2024 growth rate. The overall projected population growth was compared against information in the report titled "Population and

[7] http://factfinder.census.gov/faces/tableservices/jsf/pages/productview.xhtml?pid=PEP_2015_PEPANNRES&src=pt

[8] NHE Projections 2014-2024 – Table 17. https://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/NationalHealthExpendData/NationalHealthAccountsProjected.html

Economic Projections for the State of Hawai'i to 2040"[9] for consistency. The projected ten-year time frame from 2017 through 2026 represents the period during which the 1332 Waiver would be in effect for the first five years with an assumed renewal for another five year period. The enrollment projections were developed both for the Baseline and Waiver scenarios described in the previous section of this report. Enrollment projections also include breakdowns by income to poverty ratio, age and health status for each type of health coverage.

The data sources and any adjustments to the raw data for each type of health coverage, income to poverty ratio, age and health status are as follows.

- **Individual Market – Direct Purchase**
  The data source for this market segment was the Supplemental Health Care Exhibit (SHCE) which is submitted by health insurance carriers as part of their annual Statutory Financial Reporting to the National Association of Insurance Commissioners (NAIC). The SHCE is reported for each jurisdiction in which the carrier has written comprehensive major medical health business during the year. Allocation of data by jurisdiction in the SHCE should be based upon the situs of the contract. We compiled information on 2015 member months for Comprehensive Health Coverage in the Individual Market from Part 1, Line 4, Column 1 and for the Student Health Plans from Part 1, Line 4, Column 9 of SHCE for all carriers that reported this information for the State of Hawai'i. The sum of the member months metric divided by 12 represents an approximation of the average number of residents with major medical health insurance coverage in the Individual Market in the State of Hawai'i. We acknowledge that the SHCE membership metric could potentially include individuals who are not considered long term residents of Hawai'i but maintain health contracts issued in Hawai'i; however, we consider this a rare exception given the geographic location of Hawai'i.

- **Small Group Employer Market**
  We utilized SHCE member month information from Part 1, Line 4, Column 2 as representing Comprehensive Health Coverage for Small Group employers as reported by entities in the State of Hawai'i. We again acknowledge that the SHCE membership for Small Group employer plans is based on the state in which the contract was issued and not necessarily the state of residency of the enrolled employees and their dependents, but we consider the SHCE metric to be a close approximation of the number of Hawai'i residents with Small Group employer coverage.

- **Large Group Employer Market**
  We utilized a combination of the following two data sources to develop our estimate of enrollment in the Large Group employer market.

[9] Table 1-1 Hawai'i State growth rates 2015-2030. http://files.hawaii.gov/dbedt/economic/data_reports/2040-long-range-forecast/2040-long-range-forecast.pdf

- SHCE member month information from Part 1, Line 4, Column 3 (Comprehensive Health Coverage for Large Group Employers including Federal Employees Health Benefit Plan and State employees fully insured programs), and,

- Information from the Accident and Health Policy Experience Exhibit (AHPEE), which is part of the required Statutory Financial Reporting with the NAIC for Hawai'i domiciled entities, Column 7 Member Months for Administrative Services Only (ASO) and Stop Loss/Excess Loss types of health coverages.

Final estimates for Large Group enrollment were adjusted proportionally so that our total 2015 membership across all types of health coverage matched the 2015 Hawai'i population estimate provided by the US Census Bureau.

- **Government Coverage**
  Data sources for enrollment in various Government sponsored health plans are as follows.

  - **Medicare**
    Monthly enrollment reports provided by CMS[10] for enrollment in Original Medicare and Medicare Advantage in the state of Hawai'i.

  - **Medicaid and CHIP**
    Monthly enrollment reports for Medicaid managed care programs for Children, CHIP, Current Foster Care, Pregnant Women and Low Income Adults provided by Hawai'i MedQUEST.[11] Enrollment for other programs reported by MedQUEST (e.g., enrollment for members who are aged, blind or disabled) was excluded in order to avoid double counting, due to likelihood that these members are dually enrolled in both Medicaid and Medicare.

  - **Military coverages - Tricare and Veterans Health Administration (VA)**
    American Community Survey (ACS) 2014 1-Year PUMS Files.[12] We selected Hawai'i specific micro data and estimated the enrollment in Military coverages based on positive responses to the Health Insurance Coverage question exclusively for TRICARE or VA Health Care. We assumed the same percentage of Military coverage to total Hawai'i population in 2014 as for 2015.

[10] https://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/CMSProgramStatistics/Downloads/Enrollment_Dashboard_Data_File.zip

[11] http://www.med-quest.us/ManagedCare/MQDquestenroll.html

[12] https://www.census.gov/programs-surveys/acs/data/pums.html

Final estimates for enrollment in government coverage were adjusted proportionally so that our total 2015 membership across all types of health coverage matched the 2015 Hawai'i total population estimate provided by the US Census Bureau.

- **Uninsured**
  We utilized 2014 ACS data to estimate the percentage of uninsured residents in the State of Hawai'i. Individuals who responded by selecting "No" for all available types of health coverage included in the ACS Health Insurance Coverage questions were determined to be Uninsured in 2014. We assumed that substantial changes in the uninsured population took place between 2014 and 2015. Given ACS data for 2015 is not yet available, we took the estimated total count of uninsured residents in 2014 from the ACS results and decreased it by the increase in enrollment in the Individual Market between 2014 and 2015 to derive an estimate of Uninsured residents in 2015. Final estimates for the number of Uninsured individuals was adjusted proportionally so that our total 2015 membership across all types of health coverage matched the 2015 Hawai'i total population estimate provided by the US Census Bureau.

- **Enrollment by Income to Poverty Ratio and Age**
  A breakdown by income to poverty ratio and age was developed from 2014 ACS data, utilizing State of Hawai'i statistics for each market segment and the uninsured group. We applied these distributions to the 2015 enrollment estimates to estimate 2015 membership by income to poverty ratio and age for each market segment. We are projecting the same distributions by income to poverty ratio and age for our projection years 2017-2026 as we have not performed any micro simulation modeling of future changes in income levels or age based on the assumption that there will be no difference in enrollment by income or age in each market segment between the Baseline and Waiver scenarios.

- **Enrollment by Health Status**
  We utilized the 2015 Annual Social and Economic Supplement (ASEC) of the Current Population Survey (CPS)[13] to develop a breakdown of health status by six available categories for each type of health care coverage and the uninsured group for the State of Hawai'i. We applied the distributions by health status to our projected 2015 enrollment estimates by type of coverage. We are projecting the same distribution for projection years 2017-2026 as we have not performed any micro simulation modeling of future changes in health status based on the assumption that there will be no impact on enrollment between the Baseline and Waiver scenarios for all health status ranges.

[13] https://www.census.gov/did/www/saipe/data/model/info/cpsasec.html

Projections Supporting the Scope of Coverage Requirement

The supporting enrollment projections for the scope of coverage requirement in the Baseline and Waiver scenarios, along with changes between scenarios, can be found in Tables 1-15 of Appendix A. As outlined in the section "Baseline and Waiver Scenarios," given the nature of the provisions of the ACA that would be waived under the 1332 Waiver application and the expectation that premiums would not increase with the Waiver in place, we are projecting that the Baseline and Waiver scenarios will generate the same actuarial enrollment projections for all residents in the State of Hawai'i in 2017-2026. We are also projecting that the Waiver Scenario will not impact the coverage of vulnerable residents and are projecting the same enrollment for each income to poverty, age and health status for the period 2017-2026.

Affordability Requirement

The 1332 Waiver guidance provides for the following key components under the Affordability requirement.

- Health care coverage under the Waiver must be forecast to be as affordable overall for the State's residents as coverage absent the Waiver.
- Affordability refers to State residents' ability to pay for health care.
- Affordability may be measured by comparing residents' net out-of-pocket spending for health coverage and services to their incomes.
- Out-of-pocket expenses include both premium contributions and any cost sharing associated with the coverage.
- The impact on all state residents is considered, in particular individuals with large health care spending and vulnerable residents.

Out-of-Pocket Spending Projections Supporting the Affordability Requirement

In order to meet the above guidelines under the affordability requirement, Oliver Wyman gathered and analyzed information on current out-of-pocket spending for State of Hawai'i residents with Individual, Small Group and Large Group types of health coverage. We projected the spending for these subgroups for the period 2016-2026 which includes the Waiver period of 2017-2026. These projections were developed for both the Baseline and Waiver scenarios. As outlined in the section "Baseline and Waiver Scenarios" we are projecting that the Baseline and Waiver scenarios will generate the same actuarial out-of-pocket spending projections for residents with Individual, Small Group and Large Group types of health coverage in the State of Hawai'i in 2017-2026.

Projections for other types of coverage including Government Sponsored coverages and the Uninsured were not performed as we assumed that the 1332 Waiver application would not directly impact affordability for residents with Government Sponsored coverage or for Uninsured individuals. We have not provided projections by income, age or health status as the nature of the waived provisions would not impact the relative difference in premium rates within any of the

income, age or health status groups, including vulnerable residents and individuals with large health care spending. The out-of-pocket spending projections were estimated as the sum of residents' contributions to health coverage premiums and out-of-pocket spending for health expenditures. The supporting projections for the Affordability requirement in the Baseline and Waiver scenarios, along with changes between the two scenarios, can be found in Tables 16-24 of Appendix A.

Premium Contribution - Methodology and Data Sources

Similar to our enrollment projections we utilized information from the SHCE to make these projections. We estimated the current overall cost of health coverage premium using Health Premiums Earned from the 2015 SHCE, Part 1, Line 1.1 for the Individual Market (Columns 1 and 9), Small Group Market (Column 2) and Large Group Market (Column 3) for all carriers that filled out SHCE data for the State of Hawai'i. We calculated 2015 total premium per member per month (PMPM) using the total premiums and enrollment from SHCE and utilized it to project total premium PMPMs for future years 2016-2026 for Individual, Small Group and Large Group coverage. The growth in total premium PMPM is based on available premium rate filing information of health carriers in Hawai'i, and projected rate changes for years 2016-2018. These projections take into account differences in premium rate growth between ACA-compliant, transitional and grandfathered plans. The growth in Total Premium PMPM for periods 2019-2026 is based on the NHED forecast for spending per enrollee for Private Health Insurance and Employer-sponsored Private Health Insurance.[14]

Next we estimated the portion of the total premium PMPM paid by the insured, either as a direct premium payment for the Individual market or as a premium contribution for the Small Group and Large Group markets. For the Individual market, we accounted for the share of Advance Premium Tax Credits (APTCs) provided by the Federal Government and projected growth in the subsidized member premium PMPM component of premium using historical average growth in CPI-U[15] for 2017-2026. In the 2017-2026 projections we assumed that the share of APTC eligible member will remain constant from the 2016 estimation.

For estimating employee premium contributions in the Small Group and Large Group employer markets we utilized an approach similar to that taken in the Individual market. We estimated the employee premium contributions PMPM based on data from the Medical Expenditure Panel Survey (MEPS)[16] for the state of Hawai'i. We projected the future growth in employee premium

[14] NHE Projections 2014-2024 – Table 17. https://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/NationalHealthExpendData/NationalHealthAccountsProjected.html

[15] Table 24, CPI Detailed Report, http://www.bls.gov/cpi/cpid1603.pdf

[16] Hawaii 2011-2014 Premium and employee contributions for ESI by SHADAC, http://www.shadac.org/publications/meps-ic-tables-employer-coverage-estimates-firm-size

contributions PMPM using Hawai'i Wage Growth Statistics[17] on the assumption that under Prepaid regulations the employee contribution is limited to 1.5% of the employee's wages, and therefore employee premium contributions will grow at a rate consistent with wages. The remainder of projected premium PMPM (total premium PMPM minus employee premium contributions PMPM) provides us with future employer contribution PMPM. We have not accounted for any Small Group Employer Tax Credits provided by the Federal Government due to limitations on availability of this information for Hawai'i. However, given the limited enrollment in qualified SHOP plans as described in the Baseline and Waiver Scenario section, we expect the level of these tax credits to be *de minimis*.

Allowable Claims and Member Cost Sharing - Methodology and Data Sources

The methodology used to estimate insured out-of-pocket cost for health care expenditures can be summarized in the following steps.

- Estimate the health plan carriers' projected share of total benefit expenditures, (i.e. incurred claims),
- In the Individual market, adjust incurred claims to account for Cost Sharing Reduction (CSR) subsidies provided by the Federal Government,
- Estimate the total benefit expenditure (i.e., allowable claims) based on incurred claims divided by the average Actuarial Values (AVs) of health plans, and
- Estimate member out-of- pocket cost for health care expenditures as the difference between allowable claims and incurred claims (including CSRs).

Similar to the projections of premium contributions, we limited our analyses to the Individual, Small Group and Large Group markets. For estimating the health plan carriers' share of total benefit expenditures we utilized data from the 2015 SHCE, Part 1, Line 5.0 Total Incurred Claims for the Individual Market (Columns 1 and 9), Small Group Market (Column 2) and Large Group Market (Column 3) for all carriers that reported SHCE data for the State of Hawai'i. Incurred claims were divided by total member months resulting in incurred claims PMPM. Incurred claims PMPM were projected to the future period 2016-2018 based on total projected premium PMPM and target loss ratio assumptions. For periods 2019-2026 we utilized the same NHED growth rates that were used for total premium PMPM projections.

To estimate total benefit expenditures we surveyed the four commercial health plans with the majority of the enrollment in the Individual and Small Group markets in the State of Hawai'i. We requested information on AV levels and corresponding membership in their major medical plans in 2015. The results of the survey were used to estimate current and future AV levels in the two markets, aggregated across the two years, to develop an average AV for each market.

[17] Internal statistical report from Hawai'i DLIR

Allowable claims PMPM were then estimated based on projected incurred claims PMPM for each market, divided by the expected average AV level for the respective market. For the Large Group market we assumed the same average AV level as in the Small Group market since the same Prepaid regulations on health coverage are in place for Small and Large Group employers.

For the Individual market, we utilized the membership information in CSR plans from the AV survey, previously calculated allowable claims PMPM for ACA compliant Silver plans, and an assumption for the percent of members that are CSR eligible based on the 2016 ASPE report to estimate the CSR claims PMPM. To project future allowable and CSR claims PMPMs in 2016-2026 we assumed similar ratios between CSR claims, incurred claims and insured out-of-pocket costs will be in effect due to Prepaid and ACA requirements on AV levels for plans in the Individual and Small Group markets.

Comprehensiveness of Coverage Requirement

The 1332 Waiver guidance provides the following key components on the Comprehensiveness of Coverage requirement.

- Health care coverage under the Waiver must be forecast to be at least as comprehensive overall for residents of the state as coverage absent the Waiver.
- Comprehensiveness refers to coverage requirements for ACA essential health benefits (EHBs) and as appropriate, Medicaid and CHIP standards.
- The impact on all state residents is considered.

Support for Meeting the Comprehensiveness of Coverage Requirement

We have not performed additional actuarial analyses or projections to support the Comprehensiveness of Coverage requirement of the 1332 Waiver. We refer to enrollment projections in Table 1-16 of Appendix A which were developed for the Scope of Coverage requirement, showing no changes in enrollment between the Baseline and Waiver scenarios for all types of major medical health plans. Further, all plans in the Individual and Small Group markets which are not grandfathered or transitional plans will continue to be required to provide coverage for all EHBs, and nothing in Hawai'i's 1332 Waiver application impacts the scope of services covered by the Medicaid or CHIP programs.

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Actuarial Certification

I, Tammy Tomczyk, am a Fellow in the Society of Actuaries, and a member of the American Academy of Actuaries, and am qualified to provide the following certification.

This actuarial certification applies to the State of Hawai'i's application for a State Innovation Waiver under Section 1332 of the Patient Protection and Affordable Care Act requesting a waiver from the following provisions of the ACA in the State of Hawai'i, effective 1/1/2017 for a period of ten years:

- §1301(a)(1)(C)(ii) & 1301(a)(2) – Requirement to offer a Silver plan and multistate options in the Small Group Marketplace
- §1304(b)(4)(D)(i)&(ii) – Continuation of Participation in Small Business Health Options Program (SHOP)
- §1311(b)(1)(B) – Establishment of a SHOP Exchange
- §1312(a)(2) – Employee Choice

Reliance
In performing the analyses outlined in this report and arriving at my opinion, I used and relied on information provided by the State of Hawai'i, including their draft Waiver Application titled "Hawai'i's Proposal to Waive Certain Provisions of the Patient Protection & Affordable Care Act," and information obtained from carriers currently offering coverage in the Individual and Small Group markets in Hawai'i.

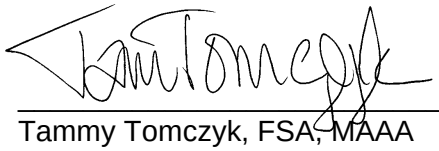
I used and relied on this information without independent investigation or verification. If this information is inaccurate, incomplete, or out of date, my findings and conclusions may need to be revised. While I have relied on the data provided without independent investigation or verification, I have reviewed the data for consistency and reasonableness. Where I found the data inconsistent or unreasonable, I requested clarification.

Actuarial Certification
In my opinion, the State of Hawai'i 1332 Waiver application complies with the following requirements.

- **Scope of Coverage Requirement** – The 1332 Waiver will provide coverage to at least a comparable number of the State's residents as would be provided absent the 1332 Waiver.

- **Affordability Requirement** - The 1332 Waiver will provide coverage and cost-sharing protections against excessive out-of-pocket spending that results in coverage which is at least as affordable for the State's residents as would be provided absent the 1332 Waiver.
- **Comprehensiveness of Coverage Requirement** – The 1332 Waiver will provide coverage that is at least as comprehensive for the State's residents as would be provided absent the 1332 Waiver.

This certification conforms to the applicable Actuarial Standards of Practice promulgated by the Actuarial Standards Board.



Tammy Tomczyk, FSA, MAAA

06/13/16

Date

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Disclaimer and Limitations

The Trustees of Princeton University, with support from the Robert Wood Johnson Foundation (RWJF) through its State Health Reform Assistance Network program, engaged Oliver Wyman Actuarial Consulting, Inc. (Oliver Wyman) to assist the State of Hawai'i (the State) in performing actuarial analyses as part of their State Innovation Waiver application under Section 1332 of the Patient Protection and Affordable Care Act (ACA), also known as a 1332 Waiver. The actuarial services we provided consisted of analyses and forecasting in support of our actuarial certification of compliance with the 1332 Waiver requirements related to scope of coverage, affordability and comprehensiveness of coverage.

This report was prepared for the sole use of the State. All decisions in connection with the implementation or use of advice or recommendations contained in this report are the sole responsibility of the State. This report is not intended for general circulation or publication, nor is it to be used or distributed to others for any purpose other than those that may be set forth herein or in the definitive documentation pursuant to which this report has been issued. The estimates included within are based on regulations issued by the United States Department of Health and Human Services (HHS) and the applicable laws and regulations of the State of Hawai'i. Our work may not be used or relied upon by any other party or for any purpose other than for which they were issued by Oliver Wyman. Oliver Wyman is not responsible for the consequences of any unauthorized use.

For our analyses, we relied on a wide range of data and information and other sources of data as described throughout this report. This includes information received from commercial carriers currently offering coverage in the State. Though we have reviewed the data for reasonableness and consistency, we have not independently audited or otherwise verified this data. Our review of data may not reveal errors or imperfections. We have assumed that the data provided is both accurate and complete. The results of our analyses are dependent on this assumption. If this data or information are inaccurate or incomplete, our findings and conclusions may need to be revised.

All projections are based on information and data available as of June 3, 2016, and the projections are not a guarantee of results which might be achieved. In addition, the projections we show in this report are dependent upon a number of assumptions regarding the future economic environment, medical trend rates, carrier behavior, the behavior of individuals and employers in light of incentives and penalties, and a number of other factors. These assumptions are disclosed within the report and have been discussed with State of Hawai'i representatives, RWJF and other consultants assisting the State. While these analyses comply

with applicable Actuarial Standards of Practice, users of these analyses should recognize that our projections involve estimates of future events, and are subject to economic, statistical and other unforeseen variations from projected values. To the extent that future conditions are at variance with the assumptions we have made in developing these projections, actual results will vary from our projections, and the variance may be substantial.

Oliver Wyman is not engaged in the practice of law and this report, which may include commentary on legal issues and regulations, does not constitute, nor is it a substitute for, legal advice. Accordingly, Oliver Wyman recommends that the State secures the advice of competent legal counsel with respect to any legal matters related to this report or otherwise.

This report is intended to be read and used as a whole and not in parts. Separation or alteration of any section or page from the main body of this report is expressly forbidden and invalidates this report.

There are no third party beneficiaries with respect to this report, and Oliver Wyman does not accept any liability to any third party. In particular, Oliver Wyman shall not have any liability to any third party in respect to the contents of this report or any actions taken or decisions made as a consequence of the results, advice, or recommendations set forth herein.

The information contained in this document and in any of the attachments is not intended by Oliver Wyman to be used, nor can it be used, for the purpose of avoiding penalties under the Internal Revenue Code or imposed by any legislative body on the taxpayer or plan sponsor.

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Appendix A

1. Actuarial Projections supporting the Coverage Requirement
    a. Tables 1 – 3: Hawai'i Health Coverage By Category 2015-2026 for Baseline, Waiver and Change Baseline to Waiver.
    b. Tables 4 – 6: Hawai'i Health Coverage Distribution By Category 2015-2026 for Baseline, Waiver and Change Baseline to Waiver.
    c. Tables 7 – 9: Hawai'i Health Coverage Distribution By Category and Income to Poverty Ratio 2015-2026 for Baseline, Waiver and Change Baseline to Waiver.
    d. Tables 10 – 12: Hawai'i Health Coverage Distribution By Category and Age 2015-2026 for Baseline, Waiver and Change Baseline to Waiver.
    e. Tables 13 – 15: Hawai'i Health Coverage Distribution By Category and Health Status for Baseline, Waiver and Change Baseline to Waiver.
    f. Tables 16 – 18: Hawai'i Premium Contribution By Coverage and Source 2015-2026 for Baseline, Waiver and Change Baseline to Waiver.
    g. Tables 19 – 21: Hawai'i Health Expenditure By Coverage and Source of Funds 2015-2026 for Baseline, Waiver and Change Baseline to Waiver.
    h. Tables 22 – 24: Hawai'i Total Net Out-Of-Pocket Spending By Coverage 2015-2026 for Baseline, Waiver and Change Baseline to Waiver.

Table 1 - Hawai'i Coverage By Category - Baseline Scenario

	Baseline Year		Waiver Period									
Source of Health Insurance Coverage	**2015**	**2016**	**2017**	**2018**	**2019**	**2020**	**2021**	**2022**	**2023**	**2024**	**2025**	**2026**
Individual Market - Direct Purchase	45,431	50,837	54,599	58,203	58,261	58,319	58,203	58,144	58,144	58,028	57,912	57,796
Total Direct Purchase	**45,431**	**50,837**	**54,599**	**58,203**	**58,261**	**58,319**	**58,203**	**58,144**	**58,144**	**58,028**	**57,912**	**57,796**
Small Group Employer Market	130,606	129,953	129,303	129,045	130,077	130,988	131,774	132,432	132,830	133,228	133,628	134,029
Large Group Employer Market	621,695	618,586	615,493	614,262	619,176	623,511	627,252	630,388	632,279	634,176	636,079	637,987
Total Employer Based	**752,301**	**748,539**	**744,797**	**743,307**	**749,253**	**754,498**	**759,025**	**762,820**	**765,109**	**767,404**	**769,706**	**772,015**
Total Government Coverage	**575,365**	**586,542**	**599,142**	**609,392**	**619,764**	**630,266**	**639,966**	**650,469**	**660,395**	**669,975**	**679,760**	**689,754**
Uninsured	**58,506**	**55,347**	**54,129**	**54,075**	**54,562**	**54,944**	**55,273**	**55,605**	**55,994**	**55,938**	**55,882**	**55,826**
Total HI	**1,431,603**	**1,441,265**	**1,452,667**	**1,464,977**	**1,481,840**	**1,498,027**	**1,512,467**	**1,527,039**	**1,539,642**	**1,551,346**	**1,563,261**	**1,575,392**

Table 2 - Hawai'i Coverage By Category - Waiver Scenario

	Baseline Year		Waiver Period									
Source of Health Insurance Coverage	**2015**	**2016**	**2017**	**2018**	**2019**	**2020**	**2021**	**2022**	**2023**	**2024**	**2025**	**2026**
Individual Market - Direct Purchase	45,431	50,837	54,599	58,203	58,261	58,319	58,203	58,144	58,144	58,028	57,912	57,796
Total Direct Purchase	**45,431**	**50,837**	**54,599**	**58,203**	**58,261**	**58,319**	**58,203**	**58,144**	**58,144**	**58,028**	**57,912**	**57,796**
Small Group Employer Market	130,606	129,953	129,303	129,045	130,077	130,988	131,774	132,432	132,830	133,228	133,628	134,029
Large Group Employer Market	621,695	618,586	615,493	614,262	619,176	623,511	627,252	630,388	632,279	634,176	636,079	637,987
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Total Government Coverage	**575,365**	**586,542**	**599,142**	**609,392**	**619,764**	**630,266**	**639,966**	**650,469**	**660,395**	**669,975**	**679,760**	**689,754**
Uninsured	**58,506**	**55,347**	**54,129**	**54,075**	**54,562**	**54,944**	**55,273**	**55,605**	**55,994**	**55,938**	**55,882**	**55,826**
Total HI	**1,431,603**	**1,441,265**	**1,452,667**	**1,464,977**	**1,481,840**	**1,498,027**	**1,512,467**	**1,527,039**	**1,539,642**	**1,551,346**	**1,563,261**	**1,575,392**

Table 3 - Hawai'i Coverage By Category - Change Baseline to Waiver

	Baseline Year		Waiver Period									
Source of Health Insurance Coverage	**2015**	**2016**	**2017**	**2018**	**2019**	**2020**	**2021**	**2022**	**2023**	**2024**	**2025**	**2026**
Individual Market - Direct Purchase	-	-	-	-	-	-	-	-	-	-	-	-
Total Direct Purchase	**-**	**-**	**-**	**-**	**-**	**-**	**-**	**-**	**-**	**-**	**-**	**-**
Small Group Employer Market	-	-	-	-	-	-	-	-	-	-	-	-
Large Group Employer Market	-	-	-	-	-	-	-	-	-	-	-	-
Total Employer Based	**-**	**-**	**-**	**-**	**-**	**-**	**-**	**-**	**-**	**-**	**-**	**-**
Total Government Coverage	**-**	**-**	**-**	**-**	**-**	**-**	**-**	**-**	**-**	**-**	**-**	**-**
Uninsured	**-**	**-**	**-**	**-**	**-**	**-**	**-**	**-**	**-**	**-**	**-**	**-**
Total HI	**-**	**-**	**-**	**-**	**-**	**-**	**-**	**-**	**-**	**-**	**-**	**-**

Table 4 - Hawai'i Coverage Distribution By Category - Baseline Scenario

	Baseline Year		Waiver Period									
Source of Health Insurance Coverage	**2015**	**2016**	**2017**	**2018**	**2019**	**2020**	**2021**	**2022**	**2023**	**2024**	**2025**	**2026**
Individual Market - Direct Purchase	3.2%	3.5%	3.8%	4.0%	3.9%	3.9%	3.8%	3.8%	3.8%	3.7%	3.7%	3.7%
Total Direct Purchase	**3.2%**	**3.5%**	**3.8%**	**4.0%**	**3.9%**	**3.9%**	**3.8%**	**3.8%**	**3.8%**	**3.7%**	**3.7%**	**3.7%**
Small Group Employer Market	9.1%	9.0%	8.9%	8.8%	8.8%	8.7%	8.7%	8.7%	8.6%	8.6%	8.5%	8.5%
Large Group Employer Market	43.4%	42.9%	42.4%	41.9%	41.8%	41.6%	41.5%	41.3%	41.1%	40.9%	40.7%	40.5%
Total Employer Based	**52.5%**	**51.9%**	**51.3%**	**50.7%**	**50.6%**	**50.4%**	**50.2%**	**50.0%**	**49.7%**	**49.5%**	**49.2%**	**49.0%**
Total Government Coverage	**40.2%**	**40.7%**	**41.2%**	**41.6%**	**41.8%**	**42.1%**	**42.3%**	**42.6%**	**42.9%**	**43.2%**	**43.5%**	**43.8%**
Uninsured	**4.1%**	**3.8%**	**3.7%**	**3.7%**	**3.7%**	**3.7%**	**3.7%**	**3.6%**	**3.6%**	**3.6%**	**3.6%**	**3.5%**
Total HI	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**

Table 5 - Hawai'i Coverage Distribution By Category - Waiver Scenario

	Baseline Year		Waiver Period									
Source of Health Insurance Coverage	**2015**	**2016**	**2017**	**2018**	**2019**	**2020**	**2021**	**2022**	**2023**	**2024**	**2025**	**2026**
Individual Market - Direct Purchase	3.2%	3.5%	3.8%	4.0%	3.9%	3.9%	3.8%	3.8%	3.8%	3.7%	3.7%	3.7%
Total Direct Purchase	**3.2%**	**3.5%**	**3.8%**	**4.0%**	**3.9%**	**3.9%**	**3.8%**	**3.8%**	**3.8%**	**3.7%**	**3.7%**	**3.7%**
Small Group Employer Market	9.1%	9.0%	8.9%	8.8%	8.8%	8.7%	8.7%	8.7%	8.6%	8.6%	8.5%	8.5%
Large Group Employer Market	43.4%	42.9%	42.4%	41.9%	41.8%	41.6%	41.5%	41.3%	41.1%	40.9%	40.7%	40.5%
Total Employer Based	**52.5%**	**51.9%**	**51.3%**	**50.7%**	**50.6%**	**50.4%**	**50.2%**	**50.0%**	**49.7%**	**49.5%**	**49.2%**	**49.0%**
Total Government Coverage	**40.2%**	**40.7%**	**41.2%**	**41.6%**	**41.8%**	**42.1%**	**42.3%**	**42.6%**	**42.9%**	**43.2%**	**43.5%**	**43.8%**
Uninsured	**4.1%**	**3.8%**	**3.7%**	**3.7%**	**3.7%**	**3.7%**	**3.7%**	**3.6%**	**3.6%**	**3.6%**	**3.6%**	**3.5%**
Total HI	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**

Table 6 - Hawai'i Coverage Distribution By Category - Change Baseline to Waiver

	Baseline Year		Waiver Period									
Source of Health Insurance Coverage	**2015**	**2016**	**2017**	**2018**	**2019**	**2020**	**2021**	**2022**	**2023**	**2024**	**2025**	**2026**
Individual Market - Direct Purchase	-	-	-	-	-	-	-	-	-	-	-	-
Total Direct Purchase	**-**	**-**	**-**	**-**	**-**	**-**	**-**	**-**	**-**	**-**	**-**	**-**
Small Group Employer Market	-	-	-	-	-	-	-	-	-	-	-	-
Large Group Employer Market	-	-	-	-	-	-	-	-	-	-	-	-
Total Employer Based	**-**	**-**	**-**	**-**	**-**	**-**	**-**	**-**	**-**	**-**	**-**	**-**
Total Government Coverage	**-**	**-**	**-**	**-**	**-**	**-**	**-**	**-**	**-**	**-**	**-**	**-**
Uninsured	**-**	**-**	**-**	**-**	**-**	**-**	**-**	**-**	**-**	**-**	**-**	**-**
Total HI	**-**	**-**	**-**	**-**	**-**	**-**	**-**	**-**	**-**	**-**	**-**	**-**

Table 7 - Hawai'i Coverage Distribution By Category and Income to Poverty Ratio - Baseline Scenario

	Baseline Year		Waiver Period									
Source of Health Insurance Coverage	**2015**	**2016**	**2017**	**2018**	**2019**	**2020**	**2021**	**2022**	**2023**	**2024**	**2025**	**2026**
0 to 138%	-	-	-	-	-	-	-	-	-	-	-	-
139% to 150%	942	1,054	1,132	1,207	1,208	1,209	1,207	1,206	1,206	1,203	1,201	1,199
151% to 200%	3,635	4,067	4,368	4,657	4,661	4,666	4,657	4,652	4,652	4,643	4,633	4,624
201% to 250%	2,723	3,047	3,272	3,488	3,492	3,495	3,488	3,485	3,485	3,478	3,471	3,464
251% to 300%	2,740	3,067	3,293	3,511	3,514	3,518	3,511	3,507	3,507	3,500	3,493	3,486
301% to 400%	8,445	9,450	10,150	10,820	10,830	10,841	10,820	10,809	10,809	10,787	10,766	10,744
401% +	26,945	30,152	32,383	34,520	34,555	34,589	34,520	34,485	34,485	34,416	34,348	34,279
Total Direct Purchase	**45,431**	**50,837**	**54,599**	**58,203**	**58,261**	**58,319**	**58,203**	**58,144**	**58,144**	**58,028**	**57,912**	**57,796**
0 to 138%	57,970	57,680	57,392	57,277	57,735	58,139	58,488	58,781	58,957	59,134	59,311	59,489
139% to 150%	5,011	4,986	4,961	4,951	4,991	5,026	5,056	5,081	5,097	5,112	5,127	5,143
151% to 200%	41,363	41,156	40,950	40,868	41,195	41,483	41,732	41,941	42,067	42,193	42,320	42,447
201% to 250%	64,626	64,303	63,981	63,853	64,364	64,815	65,204	65,530	65,726	65,923	66,121	66,319
251% to 300%	56,039	55,759	55,480	55,369	55,812	56,203	56,540	56,823	56,994	57,164	57,336	57,508
301% to 400%	145,620	144,891	144,167	143,879	145,030	146,045	146,921	147,656	148,099	148,543	148,989	149,436
401% +	381,672	379,764	377,865	377,109	380,126	382,787	385,083	387,009	388,170	389,334	390,502	391,674
Total Employer Based	**752,301**	**748,539**	**744,797**	**743,307**	**749,253**	**754,498**	**759,025**	**762,820**	**765,109**	**767,404**	**769,706**	**772,015**
0 to 138%	187,725	191,372	195,483	198,827	202,211	205,638	208,803	212,230	215,468	218,594	221,786	225,047
139% to 150%	12,822	13,071	13,352	13,581	13,812	14,046	14,262	14,496	14,717	14,931	15,149	15,372
151% to 200%	49,327	50,286	51,366	52,245	53,134	54,034	54,866	55,766	56,617	57,439	58,277	59,134
201% to 250%	43,615	44,462	45,417	46,194	46,981	47,777	48,512	49,308	50,060	50,787	51,528	52,286
251% to 300%	35,888	36,586	37,371	38,011	38,658	39,313	39,918	40,573	41,192	41,790	42,400	43,023
301% to 400%	72,828	74,243	75,838	77,135	78,448	79,778	81,005	82,335	83,591	84,804	86,043	87,308
401% +	173,158	176,522	180,314	183,399	186,521	189,681	192,600	195,761	198,748	201,632	204,577	207,584
Total Government Coverage	**575,365**	**586,542**	**599,142**	**609,392**	**619,764**	**630,266**	**639,966**	**650,469**	**660,395**	**669,975**	**679,760**	**689,754**
0 to 138%	22,473	21,259	20,792	20,771	20,958	21,105	21,231	21,359	21,508	21,487	21,465	21,444
139% to 150%	1,634	1,546	1,512	1,510	1,524	1,535	1,544	1,553	1,564	1,562	1,561	1,559
151% to 200%	4,831	4,570	4,469	4,465	4,505	4,536	4,564	4,591	4,623	4,619	4,614	4,609
201% to 250%	4,882	4,618	4,517	4,512	4,553	4,585	4,612	4,640	4,672	4,668	4,663	4,658
251% to 300%	4,475	4,233	4,140	4,136	4,173	4,202	4,228	4,253	4,283	4,278	4,274	4,270
301% to 400%	9,503	8,990	8,792	8,783	8,862	8,924	8,978	9,032	9,095	9,086	9,077	9,068
401% +	10,709	10,131	9,908	9,898	9,987	10,057	10,117	10,178	10,249	10,239	10,229	10,218
Total Uninsured	**58,506**	**55,347**	**54,129**	**54,075**	**54,562**	**54,944**	**55,273**	**55,605**	**55,994**	**55,938**	**55,882**	**55,826**
Total HI	**1,431,603**	**1,441,265**	**1,452,667**	**1,464,977**	**1,481,840**	**1,498,027**	**1,512,467**	**1,527,039**	**1,539,642**	**1,551,346**	**1,563,261**	**1,575,392**

Sources: 2014 American Community Survey for HI.

Table 8 - Hawai'i Coverage Distribution By Category and Income to Poverty Ratio - Waiver Scenario

	Baseline Year		Waiver Period									
Source of Health Insurance Coverage	**2015**	**2016**	**2017**	**2018**	**2019**	**2020**	**2021**	**2022**	**2023**	**2024**	**2025**	**2026**
0 to 138%	-	-	-	-	-	-	-	-	-	-	-	-
139% to 150%	942	1,054	1,132	1,207	1,208	1,209	1,207	1,206	1,206	1,203	1,201	1,199
151% to 200%	3,635	4,067	4,368	4,657	4,661	4,666	4,657	4,652	4,652	4,643	4,633	4,624
201% to 250%	2,723	3,047	3,272	3,488	3,492	3,495	3,488	3,485	3,485	3,478	3,471	3,464
251% to 300%	2,740	3,067	3,293	3,511	3,514	3,518	3,511	3,507	3,507	3,500	3,493	3,486
301% to 400%	8,445	9,450	10,150	10,820	10,830	10,841	10,820	10,809	10,809	10,787	10,766	10,744
401% +	26,945	30,152	32,383	34,520	34,555	34,589	34,520	34,485	34,485	34,416	34,348	34,279
Total Direct Purchase	**45,431**	**50,837**	**54,599**	**58,203**	**58,261**	**58,319**	**58,203**	**58,144**	**58,144**	**58,028**	**57,912**	**57,796**
0 to 138%	57,970	57,680	57,392	57,277	57,735	58,139	58,488	58,781	58,957	59,134	59,311	59,489
139% to 150%	5,011	4,986	4,961	4,951	4,991	5,026	5,056	5,081	5,097	5,112	5,127	5,143
151% to 200%	41,363	41,156	40,950	40,868	41,195	41,483	41,732	41,941	42,067	42,193	42,320	42,447
201% to 250%	64,626	64,303	63,981	63,853	64,364	64,815	65,204	65,530	65,726	65,923	66,121	66,319
251% to 300%	56,039	55,759	55,480	55,369	55,812	56,203	56,540	56,823	56,994	57,164	57,336	57,508
301% to 400%	145,620	144,891	144,167	143,879	145,030	146,045	146,921	147,656	148,099	148,543	148,989	149,436
401% +	381,672	379,764	377,865	377,109	380,126	382,787	385,083	387,009	388,170	389,334	390,502	391,674
Total Employer Based	**752,301**	**748,539**	**744,797**	**743,307**	**749,253**	**754,498**	**759,025**	**762,820**	**765,109**	**767,404**	**769,706**	**772,015**
0 to 138%	187,725	191,372	195,483	198,827	202,211	205,638	208,803	212,230	215,468	218,594	221,786	225,047
139% to 150%	12,822	13,071	13,352	13,581	13,812	14,046	14,262	14,496	14,717	14,931	15,149	15,372
151% to 200%	49,327	50,286	51,366	52,245	53,134	54,034	54,866	55,766	56,617	57,439	58,277	59,134
201% to 250%	43,615	44,462	45,417	46,194	46,981	47,777	48,512	49,308	50,060	50,787	51,528	52,286
251% to 300%	35,888	36,586	37,371	38,011	38,658	39,313	39,918	40,573	41,192	41,790	42,400	43,023
301% to 400%	72,828	74,243	75,838	77,135	78,448	79,778	81,005	82,335	83,591	84,804	86,043	87,308
401% +	173,158	176,522	180,314	183,399	186,521	189,681	192,600	195,761	198,748	201,632	204,577	207,584
Total Government Coverage	**575,365**	**586,542**	**599,142**	**609,392**	**619,764**	**630,266**	**639,966**	**650,469**	**660,395**	**669,975**	**679,760**	**689,754**
0 to 138%	22,473	21,259	20,792	20,771	20,958	21,105	21,231	21,359	21,508	21,487	21,465	21,444
139% to 150%	1,634	1,546	1,512	1,510	1,524	1,535	1,544	1,553	1,564	1,562	1,561	1,559
151% to 200%	4,831	4,570	4,469	4,465	4,505	4,536	4,564	4,591	4,623	4,619	4,614	4,609
201% to 250%	4,882	4,618	4,517	4,512	4,553	4,585	4,612	4,640	4,672	4,668	4,663	4,658
251% to 300%	4,475	4,233	4,140	4,136	4,173	4,202	4,228	4,253	4,283	4,278	4,274	4,270
301% to 400%	9,503	8,990	8,792	8,783	8,862	8,924	8,978	9,032	9,095	9,086	9,077	9,068
401% +	10,709	10,131	9,908	9,898	9,987	10,057	10,117	10,178	10,249	10,239	10,229	10,218
Total Uninsured	**58,506**	**55,347**	**54,129**	**54,075**	**54,562**	**54,944**	**55,273**	**55,605**	**55,994**	**55,938**	**55,882**	**55,826**
Total HI	**1,431,603**	**1,441,265**	**1,452,667**	**1,464,977**	**1,481,840**	**1,498,027**	**1,512,467**	**1,527,039**	**1,539,642**	**1,551,346**	**1,563,261**	**1,575,392**

Sources: 2014 American Community Survey for HI.

Table 9 - Hawai'i Coverage Distribution By Category and Income to Poverty Ratio - Change Baseline to Waiver

	Baseline Year		Waiver Period									
Source of Health Insurance Coverage	**2015**	**2016**	**2017**	**2018**	**2019**	**2020**	**2021**	**2022**	**2023**	**2024**	**2025**	**2026**
0 to 138%	-	-	-	-	-	-	-	-	-	-	-	-
139% to 150%	-	-	-	-	-	-	-	-	-	-	-	-
151% to 200%	-	-	-	-	-	-	-	-	-	-	-	-
201% to 250%	-	-	-	-	-	-	-	-	-	-	-	-
251% to 300%	-	-	-	-	-	-	-	-	-	-	-	-
301% to 400%	-	-	-	-	-	-	-	-	-	-	-	-
401% +	-	-	-	-	-	-	-	-	-	-	-	-
Total Direct Purchase	**-**	**-**	**-**	**-**	**-**	**-**	**-**	**-**	**-**	**-**	**-**	**-**
0 to 138%	-	-	-	-	-	-	-	-	-	-	-	-
139% to 150%	-	-	-	-	-	-	-	-	-	-	-	-
151% to 200%	-	-	-	-	-	-	-	-	-	-	-	-
201% to 250%	-	-	-	-	-	-	-	-	-	-	-	-
251% to 300%	-	-	-	-	-	-	-	-	-	-	-	-
301% to 400%	-	-	-	-	-	-	-	-	-	-	-	-
401% +	-	-	-	-	-	-	-	-	-	-	-	-
Total Employer Based	**-**	**-**	**-**	**-**	**-**	**-**	**-**	**-**	**-**	**-**	**-**	**-**
0 to 138%	-	-	-	-	-	-	-	-	-	-	-	-
139% to 150%	-	-	-	-	-	-	-	-	-	-	-	-
151% to 200%	-	-	-	-	-	-	-	-	-	-	-	-
201% to 250%	-	-	-	-	-	-	-	-	-	-	-	-
251% to 300%	-	-	-	-	-	-	-	-	-	-	-	-
301% to 400%	-	-	-	-	-	-	-	-	-	-	-	-
401% +	-	-	-	-	-	-	-	-	-	-	-	-
Total Government Coverage	**-**	**-**	**-**	**-**	**-**	**-**	**-**	**-**	**-**	**-**	**-**	**-**
0 to 138%	-	-	-	-	-	-	-	-	-	-	-	-
139% to 150%	-	-	-	-	-	-	-	-	-	-	-	-
151% to 200%	-	-	-	-	-	-	-	-	-	-	-	-
201% to 250%	-	-	-	-	-	-	-	-	-	-	-	-
251% to 300%	-	-	-	-	-	-	-	-	-	-	-	-
301% to 400%	-	-	-	-	-	-	-	-	-	-	-	-
401% +	-	-	-	-	-	-	-	-	-	-	-	-
Total Uninsured	**-**	**-**	**-**	**-**	**-**	**-**	**-**	**-**	**-**	**-**	**-**	**-**
Total HI	**-**	**-**	**-**	**-**	**-**	**-**	**-**	**-**	**-**	**-**	**-**	**-**

Sources: 2014 American Community Survey for HI.

Table 10 - Hawai'i Coverage Distribution By Category and Age - Baseline Scenario

	Baseline Year		Waiver Period									
Source of Health Insurance Coverage	**2015**	**2016**	**2017**	**2018**	**2019**	**2020**	**2021**	**2022**	**2023**	**2024**	**2025**	**2026**
0 to 17	6,493	7,265	7,803	8,318	8,326	8,335	8,318	8,310	8,310	8,293	8,276	8,260
18 to 24	1,401	1,568	1,684	1,795	1,797	1,798	1,795	1,793	1,793	1,789	1,786	1,782
25 to 29	3,147	3,521	3,782	4,032	4,036	4,040	4,032	4,028	4,028	4,020	4,012	4,004
30 to 34	3,564	3,988	4,283	4,566	4,571	4,575	4,566	4,561	4,561	4,552	4,543	4,534
35 to 39	2,951	3,302	3,546	3,780	3,784	3,788	3,780	3,776	3,776	3,769	3,761	3,754
40 to 44	4,342	4,859	5,219	5,563	5,569	5,574	5,563	5,558	5,558	5,546	5,535	5,524
45 to 49	4,806	5,378	5,776	6,157	6,163	6,169	6,157	6,151	6,151	6,138	6,126	6,114
50 to 54	4,145	4,638	4,981	5,310	5,315	5,321	5,310	5,305	5,305	5,294	5,284	5,273
55 to 59	5,047	5,648	6,066	6,466	6,473	6,479	6,466	6,460	6,460	6,447	6,434	6,421
60 to 64	8,896	9,955	10,691	11,397	11,408	11,420	11,397	11,386	11,386	11,363	11,340	11,317
65+	639	715	768	819	819	820	819	818	818	816	814	813
Total Direct Purchase	**45,431**	**50,837**	**54,599**	**58,203**	**58,261**	**58,319**	**58,203**	**58,144**	**58,144**	**58,028**	**57,912**	**57,796**
0 to 17	161,407	160,600	159,797	159,477	160,753	161,878	162,850	163,664	164,155	164,647	165,141	165,637
18 to 24	75,059	74,684	74,310	74,162	74,755	75,278	75,730	76,109	76,337	76,566	76,796	77,026
25 to 29	60,824	60,520	60,217	60,097	60,578	61,002	61,368	61,675	61,860	62,045	62,231	62,418
30 to 34	63,094	62,778	62,464	62,339	62,838	63,278	63,658	63,976	64,168	64,360	64,553	64,747
35 to 39	56,097	55,817	55,538	55,426	55,870	56,261	56,599	56,881	57,052	57,223	57,395	57,567
40 to 44	69,380	69,033	68,688	68,551	69,099	69,583	70,000	70,350	70,561	70,773	70,985	71,198
45 to 49	63,536	63,218	62,902	62,776	63,278	63,721	64,104	64,424	64,617	64,811	65,006	65,201
50 to 54	66,860	66,526	66,193	66,061	66,589	67,055	67,458	67,795	67,998	68,202	68,407	68,612
55 to 59	64,564	64,241	63,920	63,792	64,303	64,753	65,141	65,467	65,663	65,860	66,058	66,256
60 to 64	60,101	59,801	59,502	59,383	59,858	60,277	60,638	60,941	61,124	61,308	61,492	61,676
65+	11,379	11,322	11,265	11,243	11,333	11,412	11,481	11,538	11,573	11,607	11,642	11,677
Total Employer Based	**752,301**	**748,539**	**744,797**	**743,307**	**749,253**	**754,498**	**759,025**	**762,820**	**765,109**	**767,404**	**769,706**	**772,015**
0 to 17	137,882	140,560	143,580	146,036	148,521	151,038	153,363	155,880	158,258	160,554	162,899	165,294
18 to 24	49,817	50,785	51,876	52,763	53,661	54,571	55,411	56,320	57,179	58,009	58,856	59,721
25 to 29	36,133	36,835	37,626	38,270	38,921	39,581	40,190	40,849	41,473	42,074	42,689	43,316
30 to 34	29,136	29,702	30,340	30,860	31,385	31,917	32,408	32,940	33,442	33,927	34,423	34,929
35 to 39	22,124	22,554	23,038	23,432	23,831	24,235	24,608	25,012	25,393	25,762	26,138	26,522
40 to 44	15,262	15,559	15,893	16,165	16,440	16,719	16,976	17,255	17,518	17,772	18,032	18,297
45 to 49	14,812	15,100	15,424	15,688	15,955	16,225	16,475	16,746	17,001	17,248	17,500	17,757
50 to 54	16,457	16,777	17,137	17,430	17,727	18,027	18,305	18,605	18,889	19,163	19,443	19,729
55 to 59	17,554	17,895	18,280	18,592	18,909	19,229	19,525	19,846	20,148	20,441	20,739	21,044
60 to 64	17,679	18,022	18,410	18,725	19,043	19,366	19,664	19,987	20,292	20,586	20,887	21,194
65+	218,508	222,753	227,538	231,431	235,370	239,358	243,042	247,031	250,800	254,439	258,155	261,951
Total Government Coverage	**575,365**	**586,542**	**599,142**	**609,392**	**619,764**	**630,266**	**639,966**	**650,469**	**660,395**	**669,975**	**679,760**	**689,754**
0 to 17	5,278	4,993	4,883	4,878	4,922	4,956	4,986	5,016	5,051	5,046	5,041	5,036
18 to 24	11,338	10,726	10,490	10,480	10,574	10,648	10,712	10,776	10,851	10,841	10,830	10,819
25 to 29	7,718	7,301	7,140	7,133	7,197	7,248	7,291	7,335	7,386	7,379	7,372	7,364
30 to 34	5,937	5,617	5,493	5,488	5,537	5,576	5,609	5,643	5,682	5,677	5,671	5,665
35 to 39	5,315	5,028	4,917	4,912	4,956	4,991	5,021	5,051	5,086	5,081	5,076	5,071
40 to 44	3,041	2,877	2,813	2,811	2,836	2,856	2,873	2,890	2,910	2,907	2,905	2,902
45 to 49	3,710	3,510	3,433	3,429	3,460	3,484	3,505	3,526	3,551	3,547	3,544	3,540
50 to 54	6,335	5,993	5,861	5,856	5,908	5,950	5,985	6,021	6,063	6,057	6,051	6,045
55 to 59	3,758	3,555	3,477	3,474	3,505	3,529	3,551	3,572	3,597	3,593	3,590	3,586
60 to 64	4,406	4,168	4,076	4,072	4,109	4,137	4,162	4,187	4,216	4,212	4,208	4,204
65+	1,670	1,580	1,545	1,544	1,558	1,569	1,578	1,588	1,599	1,597	1,596	1,594
Total Uninsured	**58,506**	**55,347**	**54,129**	**54,075**	**54,562**	**54,944**	**55,273**	**55,605**	**55,994**	**55,938**	**55,882**	**55,826**
Total HI	**1,431,603**	**1,441,265**	**1,452,667**	**1,464,977**	**1,481,840**	**1,498,027**	**1,512,467**	**1,527,039**	**1,539,642**	**1,551,346**	**1,563,261**	**1,575,392**

Sources: 2014 American Community Survey for HI.

Table 11 - Hawai'i Coverage Distribution By Category and Age - Waiver Scenario

	Baseline Year		Waiver Period									
Source of Health Insurance Coverage	**2015**	**2016**	**2017**	**2018**	**2019**	**2020**	**2021**	**2022**	**2023**	**2024**	**2025**	**2026**
0 to 17	6,493	7,265	7,803	8,318	8,326	8,335	8,318	8,310	8,310	8,293	8,276	8,260
18 to 24	1,401	1,568	1,684	1,795	1,797	1,798	1,795	1,793	1,793	1,789	1,786	1,782
25 to 29	3,147	3,521	3,782	4,032	4,036	4,040	4,032	4,028	4,028	4,020	4,012	4,004
30 to 34	3,564	3,988	4,283	4,566	4,571	4,575	4,566	4,561	4,561	4,552	4,543	4,534
35 to 39	2,951	3,302	3,546	3,780	3,784	3,788	3,780	3,776	3,776	3,769	3,761	3,754
40 to 44	4,342	4,859	5,219	5,563	5,569	5,574	5,563	5,558	5,558	5,546	5,535	5,524
45 to 49	4,806	5,378	5,776	6,157	6,163	6,169	6,157	6,151	6,151	6,138	6,126	6,114
50 to 54	4,145	4,638	4,981	5,310	5,315	5,321	5,310	5,305	5,305	5,294	5,284	5,273
55 to 59	5,047	5,648	6,066	6,466	6,473	6,479	6,466	6,460	6,460	6,447	6,434	6,421
60 to 64	8,896	9,955	10,691	11,397	11,408	11,420	11,397	11,386	11,386	11,363	11,340	11,317
65+	639	715	768	819	819	820	819	818	818	816	814	813
Total Direct Purchase	**45,431**	**50,837**	**54,599**	**58,203**	**58,261**	**58,319**	**58,203**	**58,144**	**58,144**	**58,028**	**57,912**	**57,796**
0 to 17	161,407	160,600	159,797	159,477	160,753	161,878	162,850	163,664	164,155	164,647	165,141	165,637
18 to 24	75,059	74,684	74,310	74,162	74,755	75,278	75,730	76,109	76,337	76,566	76,796	77,026
25 to 29	60,824	60,520	60,217	60,097	60,578	61,002	61,368	61,675	61,860	62,045	62,231	62,418
30 to 34	63,094	62,778	62,464	62,339	62,838	63,278	63,658	63,976	64,168	64,360	64,553	64,747
35 to 39	56,097	55,817	55,538	55,426	55,870	56,261	56,599	56,881	57,052	57,223	57,395	57,567
40 to 44	69,380	69,033	68,688	68,551	69,099	69,583	70,000	70,350	70,561	70,773	70,985	71,198
45 to 49	63,536	63,218	62,902	62,776	63,278	63,721	64,104	64,424	64,617	64,811	65,006	65,201
50 to 54	66,860	66,526	66,193	66,061	66,589	67,055	67,458	67,795	67,998	68,202	68,407	68,612
55 to 59	64,564	64,241	63,920	63,792	64,303	64,753	65,141	65,467	65,663	65,860	66,058	66,256
60 to 64	60,101	59,801	59,502	59,383	59,858	60,277	60,638	60,941	61,124	61,308	61,492	61,676
65+	11,379	11,322	11,265	11,243	11,333	11,412	11,481	11,538	11,573	11,607	11,642	11,677
Total Employer Based	**752,301**	**748,539**	**744,797**	**743,307**	**749,253**	**754,498**	**759,025**	**762,820**	**765,109**	**767,404**	**769,706**	**772,015**
0 to 17	137,882	140,560	143,580	146,036	148,521	151,038	153,363	155,880	158,258	160,554	162,899	165,294
18 to 24	49,817	50,785	51,876	52,763	53,661	54,571	55,411	56,320	57,179	58,009	58,856	59,721
25 to 29	36,133	36,835	37,626	38,270	38,921	39,581	40,190	40,849	41,473	42,074	42,689	43,316
30 to 34	29,136	29,702	30,340	30,860	31,385	31,917	32,408	32,940	33,442	33,927	34,423	34,929
35 to 39	22,124	22,554	23,038	23,432	23,831	24,235	24,608	25,012	25,393	25,762	26,138	26,522
40 to 44	15,262	15,559	15,893	16,165	16,440	16,719	16,976	17,255	17,518	17,772	18,032	18,297
45 to 49	14,812	15,100	15,424	15,688	15,955	16,225	16,475	16,746	17,001	17,248	17,500	17,757
50 to 54	16,457	16,777	17,137	17,430	17,727	18,027	18,305	18,605	18,889	19,163	19,443	19,729
55 to 59	17,554	17,895	18,280	18,592	18,909	19,229	19,525	19,846	20,148	20,441	20,739	21,044
60 to 64	17,679	18,022	18,410	18,725	19,043	19,366	19,664	19,987	20,292	20,586	20,887	21,194
65+	218,508	222,753	227,538	231,431	235,370	239,358	243,042	247,031	250,800	254,439	258,155	261,951
Total Government Coverage	**575,365**	**586,542**	**599,142**	**609,392**	**619,764**	**630,266**	**639,966**	**650,469**	**660,395**	**669,975**	**679,760**	**689,754**
0 to 17	5,278	4,993	4,883	4,878	4,922	4,956	4,986	5,016	5,051	5,046	5,041	5,036
18 to 24	11,338	10,726	10,490	10,480	10,574	10,648	10,712	10,776	10,851	10,841	10,830	10,819
25 to 29	7,718	7,301	7,140	7,133	7,197	7,248	7,291	7,335	7,386	7,379	7,372	7,364
30 to 34	5,937	5,617	5,493	5,488	5,537	5,576	5,609	5,643	5,682	5,677	5,671	5,665
35 to 39	5,315	5,028	4,917	4,912	4,956	4,991	5,021	5,051	5,086	5,081	5,076	5,071
40 to 44	3,041	2,877	2,813	2,811	2,836	2,856	2,873	2,890	2,910	2,907	2,905	2,902
45 to 49	3,710	3,510	3,433	3,429	3,460	3,484	3,505	3,526	3,551	3,547	3,544	3,540
50 to 54	6,335	5,993	5,861	5,856	5,908	5,950	5,985	6,021	6,063	6,057	6,051	6,045
55 to 59	3,758	3,555	3,477	3,474	3,505	3,529	3,551	3,572	3,597	3,593	3,590	3,586
60 to 64	4,406	4,168	4,076	4,072	4,109	4,137	4,162	4,187	4,216	4,212	4,208	4,204
65+	1,670	1,580	1,545	1,544	1,558	1,569	1,578	1,588	1,599	1,597	1,596	1,594
Total Uninsured	**58,506**	**55,347**	**54,129**	**54,075**	**54,562**	**54,944**	**55,273**	**55,605**	**55,994**	**55,938**	**55,882**	**55,826**
Total HI	**1,431,603**	**1,441,265**	**1,452,667**	**1,464,977**	**1,481,840**	**1,498,027**	**1,512,467**	**1,527,039**	**1,539,642**	**1,551,346**	**1,563,261**	**1,575,392**

Sources: 2014 American Community Survey for HI.

Table 12 - Hawai'i Coverage Distribution By Category and Age - Change Baseline to Waiver

	Baseline Year		Waiver Period									
Source of Health Insurance Coverage	**2015**	**2016**	**2017**	**2018**	**2019**	**2020**	**2021**	**2022**	**2023**	**2024**	**2025**	**2026**
0 to 17	-	-	-	-	-	-	-	-	-	-	-	-
18 to 24	-	-	-	-	-	-	-	-	-	-	-	-
25 to 29	-	-	-	-	-	-	-	-	-	-	-	-
30 to 34	-	-	-	-	-	-	-	-	-	-	-	-
35 to 39	-	-	-	-	-	-	-	-	-	-	-	-
40 to 44	-	-	-	-	-	-	-	-	-	-	-	-
45 to 49	-	-	-	-	-	-	-	-	-	-	-	-
50 to 54	-	-	-	-	-	-	-	-	-	-	-	-
55 to 59	-	-	-	-	-	-	-	-	-	-	-	-
60 to 64	-	-	-	-	-	-	-	-	-	-	-	-
65+	-	-	-	-	-	-	-	-	-	-	-	-
Total Direct Purchase	**-**	**-**	**-**	**-**	**-**	**-**	**-**	**-**	**-**	**-**	**-**	**-**
0 to 17	-	-	-	-	-	-	-	-	-	-	-	-
18 to 24	-	-	-	-	-	-	-	-	-	-	-	-
25 to 29	-	-	-	-	-	-	-	-	-	-	-	-
30 to 34	-	-	-	-	-	-	-	-	-	-	-	-
35 to 39	-	-	-	-	-	-	-	-	-	-	-	-
40 to 44	-	-	-	-	-	-	-	-	-	-	-	-
45 to 49	-	-	-	-	-	-	-	-	-	-	-	-
50 to 54	-	-	-	-	-	-	-	-	-	-	-	-
55 to 59	-	-	-	-	-	-	-	-	-	-	-	-
60 to 64	-	-	-	-	-	-	-	-	-	-	-	-
65+	-	-	-	-	-	-	-	-	-	-	-	-
Total Employer Based	**-**	**-**	**-**	**-**	**-**	**-**	**-**	**-**	**-**	**-**	**-**	**-**
0 to 17	-	-	-	-	-	-	-	-	-	-	-	-
18 to 24	-	-	-	-	-	-	-	-	-	-	-	-
25 to 29	-	-	-	-	-	-	-	-	-	-	-	-
30 to 34	-	-	-	-	-	-	-	-	-	-	-	-
35 to 39	-	-	-	-	-	-	-	-	-	-	-	-
40 to 44	-	-	-	-	-	-	-	-	-	-	-	-
45 to 49	-	-	-	-	-	-	-	-	-	-	-	-
50 to 54	-	-	-	-	-	-	-	-	-	-	-	-
55 to 59	-	-	-	-	-	-	-	-	-	-	-	-
60 to 64	-	-	-	-	-	-	-	-	-	-	-	-
65+	-	-	-	-	-	-	-	-	-	-	-	-
Total Government Coverage	**-**	**-**	**-**	**-**	**-**	**-**	**-**	**-**	**-**	**-**	**-**	**-**
0 to 17	-	-	-	-	-	-	-	-	-	-	-	-
18 to 24	-	-	-	-	-	-	-	-	-	-	-	-
25 to 29	-	-	-	-	-	-	-	-	-	-	-	-
30 to 34	-	-	-	-	-	-	-	-	-	-	-	-
35 to 39	-	-	-	-	-	-	-	-	-	-	-	-
40 to 44	-	-	-	-	-	-	-	-	-	-	-	-
45 to 49	-	-	-	-	-	-	-	-	-	-	-	-
50 to 54	-	-	-	-	-	-	-	-	-	-	-	-
55 to 59	-	-	-	-	-	-	-	-	-	-	-	-
60 to 64	-	-	-	-	-	-	-	-	-	-	-	-
65+	-	-	-	-	-	-	-	-	-	-	-	-
Total Uninsured	**-**	**-**	**-**	**-**	**-**	**-**	**-**	**-**	**-**	**-**	**-**	**-**
Total HI	**-**	**-**	**-**	**-**	**-**	**-**	**-**	**-**	**-**	**-**	**-**	**-**

Sources: 2014 American Community Survey for HI.

Table 13 - Hawai'i Coverage Distribution By Category and Health Status - Baseline Scenario

	Baseline Year		Waiver Period									
Source of Health Insurance Coverage	**2015**	**2016**	**2017**	**2018**	**2019**	**2020**	**2021**	**2022**	**2023**	**2024**	**2025**	**2026**
Excellent	14,423	16,140	17,334	18,478	18,496	18,515	18,478	18,459	18,459	18,423	18,386	18,349
Very Good	10,383	11,619	12,478	13,302	13,315	13,328	13,302	13,289	13,289	13,262	13,235	13,209
Good	16,539	18,507	19,877	21,189	21,210	21,231	21,188	21,167	21,167	21,125	21,083	21,041
Fair	3,674	4,111	4,415	4,707	4,711	4,716	4,707	4,702	4,702	4,692	4,683	4,674
Poor	412	461	495	528	528	529	528	527	527	526	525	524
Total Direct Purchase	**45,431**	**50,837**	**54,599**	**58,203**	**58,261**	**58,319**	**58,203**	**58,144**	**58,144**	**58,028**	**57,912**	**57,796**
Excellent	202,272	201,260	200,254	199,853	201,452	202,862	204,080	205,100	205,715	206,332	206,951	207,572
Very Good	280,943	279,539	278,141	277,585	279,805	281,764	283,455	284,872	285,727	286,584	287,444	288,306
Good	236,747	235,564	234,386	233,917	235,788	237,439	238,864	240,058	240,778	241,500	242,225	242,952
Fair	28,096	27,956	27,816	27,760	27,982	28,178	28,347	28,489	28,574	28,660	28,746	28,832
Poor	4,242	4,221	4,200	4,192	4,225	4,255	4,280	4,302	4,315	4,328	4,341	4,354
Total Employer Based	**752,301**	**748,539**	**744,797**	**743,307**	**749,253**	**754,498**	**759,025**	**762,820**	**765,109**	**767,404**	**769,706**	**772,015**
Excellent	135,428	138,059	141,025	143,437	145,879	148,351	150,634	153,106	155,442	157,697	160,000	162,353
Very Good	146,892	149,745	152,962	155,579	158,227	160,908	163,385	166,066	168,600	171,046	173,544	176,096
Good	195,064	198,854	203,125	206,600	210,117	213,677	216,966	220,527	223,892	227,140	230,457	233,845
Fair	76,143	77,623	79,290	80,646	82,019	83,409	84,693	86,083	87,396	88,664	89,959	91,282
Poor	21,837	22,261	22,740	23,129	23,522	23,921	24,289	24,688	25,064	25,428	25,799	26,179
Total Government Coverage	**575,365**	**586,542**	**599,142**	**609,392**	**619,764**	**630,266**	**639,966**	**650,469**	**660,395**	**669,975**	**679,760**	**689,754**
Excellent	12,632	11,950	11,687	11,676	11,781	11,863	11,934	12,006	12,090	12,078	12,066	12,054
Very Good	17,178	16,250	15,893	15,877	16,020	16,132	16,229	16,326	16,440	16,424	16,407	16,391
Good	22,838	21,605	21,129	21,108	21,298	21,447	21,576	21,705	21,857	21,835	21,814	21,792
Fair	4,098	3,877	3,792	3,788	3,822	3,849	3,872	3,895	3,922	3,918	3,914	3,910
Poor	1,760	1,665	1,629	1,627	1,642	1,653	1,663	1,673	1,685	1,683	1,681	1,680
Total Uninsured	**58,506**	**55,347**	**54,129**	**54,075**	**54,562**	**54,944**	**55,273**	**55,605**	**55,994**	**55,938**	**55,882**	**55,826**
Total HI	**1,431,603**	**1,441,265**	**1,452,667**	**1,464,977**	**1,481,840**	**1,498,027**	**1,512,467**	**1,527,039**	**1,539,642**	**1,551,346**	**1,563,261**	**1,575,392**

Table 15 - Hawai'i Coverage Distribution By Category and Health Status - Change from Baseline to Waiver Scenario

	Baseline Year		Waiver Period									
Source of Health Insurance Coverage	**2015**	**2016**	**2017**	**2018**	**2019**	**2020**	**2021**	**2022**	**2023**	**2024**	**2025**	**2026**
Excellent	-	-	-	-	-	-	-	-	-	-	-	-
Very Good	-	-	-	-	-	-	-	-	-	-	-	-
Good	-	-	-	-	-	-	-	-	-	-	-	-
Fair	-	-	-	-	-	-	-	-	-	-	-	-
Poor	-	-	-	-	-	-	-	-	-	-	-	-
Total Direct Purchase	**-**	**-**	**-**	**-**	**-**	**-**	**-**	**-**	**-**	**-**	**-**	**-**
Excellent	-	-	-	-	-	-	-	-	-	-	-	-
Very Good	-	-	-	-	-	-	-	-	-	-	-	-
Good	-	-	-	-	-	-	-	-	-	-	-	-
Fair	-	-	-	-	-	-	-	-	-	-	-	-
Poor	-	-	-	-	-	-	-	-	-	-	-	-
Total Employer Based	**-**	**-**	**-**	**-**	**-**	**-**	**-**	**-**	**-**	**-**	**-**	**-**
Excellent	-	-	-	-	-	-	-	-	-	-	-	-
Very Good	-	-	-	-	-	-	-	-	-	-	-	-
Good	-	-	-	-	-	-	-	-	-	-	-	-
Fair	-	-	-	-	-	-	-	-	-	-	-	-
Poor	-	-	-	-	-	-	-	-	-	-	-	-
Total Government Coverage	**-**	**-**	**-**	**-**	**-**	**-**	**-**	**-**	**-**	**-**	**-**	**-**
Excellent	-	-	-	-	-	-	-	-	-	-	-	-
Very Good	-	-	-	-	-	-	-	-	-	-	-	-
Good	-	-	-	-	-	-	-	-	-	-	-	-
Fair	-	-	-	-	-	-	-	-	-	-	-	-
Poor	-	-	-	-	-	-	-	-	-	-	-	-
Total Uninsured	**-**	**-**	**-**	**-**	**-**	**-**	**-**	**-**	**-**	**-**	**-**	**-**
Total HI	**-**	**-**	**-**	**-**	**-**	**-**	**-**	**-**	**-**	**-**	**-**	**-**

Sources: Current Population Survey, 2015 Annual Social and Economic (ASEC) Supplement.

Table 16 - Hawai'i Premium Contribution - Baseline Scenario

		Baseline Year		Waiver Period									
Source of Health Insurance Coverage	**Premium Contribution Source**	**2015**	**2016**	**2017**	**2018**	**2019**	**2020**	**2021**	**2022**	**2023**	**2024**	**2025**	**2026**
Individual Market - Direct Purchase	Other (APTC)	22,456,521	38,221,762	56,656,173	71,988,975	79,214,806	83,894,637	88,872,581	93,770,973	99,359,791	104,558,564	110,006,545	115,715,348
Individual Market - Direct Purchase	Insured Contribution	124,640,446	168,394,164	225,209,810	273,454,499	294,874,505	309,291,934	324,324,827	339,239,663	356,167,399	371,879,146	388,301,561	405,467,094
Total Direct Purchase		**147,096,967**	**206,615,926**	**281,865,983**	**345,443,475**	**374,089,311**	**393,186,570**	**413,197,408**	**433,010,636**	**455,527,190**	**476,437,710**	**498,308,106**	**521,182,442**
Small Group Employer Market	Employer + Other	538,872,064	580,903,115	625,974,670	676,335,653	716,469,129	760,601,338	808,288,600	857,124,638	906,069,247	957,733,256	1,012,265,806	1,069,824,165
Small Group Employer Market	Employee	78,417,860	79,912,053	81,434,717	83,236,604	85,930,850	88,624,296	91,311,400	93,986,459	96,547,369	99,178,057	101,880,426	104,656,428
Small Group Employer Market	Total	617,289,924	660,815,168	707,409,387	759,572,257	802,399,979	849,225,635	899,600,001	951,111,097	1,002,616,616	1,056,911,314	1,114,146,232	1,174,480,593
Large Group Employer Market	Employer + Other	1,963,755,268	2,061,677,943	2,164,103,212	2,278,080,347	2,418,334,894	2,573,021,857	2,740,556,222	2,912,298,395	3,084,690,877	3,266,788,411	3,459,125,853	3,662,267,256
Large Group Employer Market	Employee	428,648,402	435,930,073	443,335,442	452,226,006	465,917,053	479,546,380	493,084,259	506,500,339	519,246,065	532,312,528	545,707,799	559,440,153
Large Group Employer Market	Total	2,392,403,670	2,497,608,017	2,607,438,654	2,730,306,353	2,884,251,947	3,052,568,237	3,233,640,480	3,418,798,734	3,603,936,942	3,799,100,939	4,004,833,652	4,221,707,409
Total Employer Based	**Employer + Other**	**2,502,627,332**	**2,642,581,059**	**2,790,077,882**	**2,954,416,000**	**3,134,804,023**	**3,333,623,195**	**3,548,844,822**	**3,769,423,033**	**3,990,760,124**	**4,224,521,668**	**4,471,391,659**	**4,732,091,421**
Total Employer Based	**Employee**	**507,066,262**	**515,842,126**	**524,770,159**	**535,462,610**	**551,847,903**	**568,170,677**	**584,395,659**	**600,486,798**	**615,793,433**	**631,490,585**	**647,588,225**	**664,096,581**
Total Employer Based	**Total**	**3,009,693,594**	**3,158,423,185**	**3,314,848,041**	**3,489,878,610**	**3,686,651,926**	**3,901,793,872**	**4,133,240,481**	**4,369,909,831**	**4,606,553,558**	**4,856,012,253**	**5,118,979,884**	**5,396,188,002**

Table 17 - Hawai'i Premium Contribution - Waiver Scenario

		Baseline Year		Waiver Period									
Source of Health Insurance Coverage	**Premium Contribution Source**	**2015**	**2016**	**2017**	**2018**	**2019**	**2020**	**2021**	**2022**	**2023**	**2024**	**2025**	**2026**
Individual Market - Direct Purchase	Other (APTC)	22,456,521	38,221,762	56,656,173	71,988,975	79,214,806	83,894,637	88,872,581	93,770,973	99,359,791	104,558,564	110,006,545	115,715,348
Individual Market - Direct Purchase	Insured Contribution	124,640,446	168,394,164	225,209,810	273,454,499	294,874,505	309,291,934	324,324,827	339,239,663	356,167,399	371,879,146	388,301,561	405,467,094
Total Direct Purchase		**147,096,967**	**206,615,926**	**281,865,983**	**345,443,475**	**374,089,311**	**393,186,570**	**413,197,408**	**433,010,636**	**455,527,190**	**476,437,710**	**498,308,106**	**521,182,442**
Small Group Employer Market	Employer + Other	538,872,064	580,903,115	625,974,670	676,335,653	716,469,129	760,601,338	808,288,600	857,124,638	906,069,247	957,733,256	1,012,265,806	1,069,824,165
Small Group Employer Market	Employee	78,417,860	79,912,053	81,434,717	83,236,604	85,930,850	88,624,296	91,311,400	93,986,459	96,547,369	99,178,057	101,880,426	104,656,428
Small Group Employer Market	Total	617,289,924	660,815,168	707,409,387	759,572,257	802,399,979	849,225,635	899,600,001	951,111,097	1,002,616,616	1,056,911,314	1,114,146,232	1,174,480,593
Large Group Employer Market	Employer + Other	1,963,755,268	2,061,677,943	2,164,103,212	2,278,080,347	2,418,334,894	2,573,021,857	2,740,556,222	2,912,298,395	3,084,690,877	3,266,788,411	3,459,125,853	3,662,267,256
Large Group Employer Market	Employee	428,648,402	435,930,073	443,335,442	452,226,006	465,917,053	479,546,380	493,084,259	506,500,339	519,246,065	532,312,528	545,707,799	559,440,153
Large Group Employer Market	Total	2,392,403,670	2,497,608,017	2,607,438,654	2,730,306,353	2,884,251,947	3,052,568,237	3,233,640,480	3,418,798,734	3,603,936,942	3,799,100,939	4,004,833,652	4,221,707,409
Total Employer Based	**Employer + Other**	**2,502,627,332**	**2,642,581,059**	**2,790,077,882**	**2,954,416,000**	**3,134,804,023**	**3,333,623,195**	**3,548,844,822**	**3,769,423,033**	**3,990,760,124**	**4,224,521,668**	**4,471,391,659**	**4,732,091,421**
Total Employer Based	**Employee**	**507,066,262**	**515,842,126**	**524,770,159**	**535,462,610**	**551,847,903**	**568,170,677**	**584,395,659**	**600,486,798**	**615,793,433**	**631,490,585**	**647,588,225**	**664,096,581**
Total Employer Based	**Total**	**3,009,693,594**	**3,158,423,185**	**3,314,848,041**	**3,489,878,610**	**3,686,651,926**	**3,901,793,872**	**4,133,240,481**	**4,369,909,831**	**4,606,553,558**	**4,856,012,253**	**5,118,979,884**	**5,396,188,002**

Table 18 - Hawai'i Premium Contribution - Change from Baseline to Waiver Scenario

		Baseline Year		Waiver Period									
Source of Health Insurance Coverage	**Premium Contribution Source**	**2015**	**2016**	**2017**	**2018**	**2019**	**2020**	**2021**	**2022**	**2023**	**2024**	**2025**	**2026**
Individual Market - Direct Purchase	Other (APTC)	-	-	-	-	-	-	-	-	-	-	-	-
Individual Market - Direct Purchase	Insured Contribution	-	-	-	-	-	-	-	-	-	-	-	-
Total Direct Purchase		**-**	**-**	**-**	**-**	**-**	**-**	**-**	**-**	**-**	**-**	**-**	**-**
Small Group Employer Market	Employer + Other	-	-	-	-	-	-	-	-	-	-	-	-
Small Group Employer Market	Employee	-	-	-	-	-	-	-	-	-	-	-	-
Small Group Employer Market	Total	-	-	-	-	-	-	-	-	-	-	-	-
Large Group Employer Market	Employer + Other	-	-	-	-	-	-	-	-	-	-	-	-
Large Group Employer Market	Employee	-	-	-	-	-	-	-	-	-	-	-	-
Large Group Employer Market	Total	-	-	-	-	-	-	-	-	-	-	-	-
Total Employer Based	**Employer + Other**	**-**	**-**	**-**	**-**	**-**	**-**	**-**	**-**	**-**	**-**	**-**	**-**
Total Employer Based	**Employee**	**-**	**-**	**-**	**-**	**-**	**-**	**-**	**-**	**-**	**-**	**-**	**-**
Total Employer Based	**Total**	**-**	**-**	**-**	**-**	**-**	**-**	**-**	**-**	**-**	**-**	**-**	**-**

Table 19 - Hawai'i Health Expenditure Source of Funds - Baseline Scenario

		Baseline Year		Waiver Period									
Source of Health Insurance Coverage	**Source of Funds**	**2015**	**2016**	**2017**	**2018**	**2019**	**2020**	**2021**	**2022**	**2023**	**2024**	**2025**	**2026**
Individual Market - Direct Purchase	Insurer & Other	194,721,917	234,127,779	262,329,413	292,886,523	307,252,021	322,937,236	339,372,804	355,646,069	374,139,665	391,314,172	409,277,058	428,064,512
Individual Market - Direct Purchase	Insured Out Of Pocket	53,604,246	69,934,272	78,358,136	87,485,585	91,776,578	96,461,772	101,371,097	106,231,943	111,756,004	116,886,051	122,251,589	127,863,426
Total Direct Purchase		**248,326,163**	**304,062,051**	**340,687,549**	**380,372,107**	**399,028,598**	**419,399,008**	**440,743,901**	**461,878,012**	**485,895,669**	**508,200,224**	**531,528,647**	**555,927,938**
Small Group Employer Market	Insurer	514,922,203	528,652,135	565,927,509	607,657,806	641,919,983	679,380,508	719,680,001	760,888,878	802,093,293	845,529,051	891,316,986	939,584,474
Small Group Employer Market	Employee Out Of Pocket	55,280,119	58,739,126	62,880,834	67,517,534	71,324,443	75,486,723	79,964,445	84,543,209	89,121,477	93,947,672	99,035,221	104,398,275
Small Group Employer Market	Total	570,202,322	587,391,261	628,808,344	675,175,339	713,244,426	754,867,231	799,644,445	845,432,086	891,214,770	939,476,723	990,352,206	1,043,982,749
Large Group Employer Market	Insurer	2,131,563,873	2,247,847,215	2,346,694,788	2,457,275,718	2,595,826,752	2,747,311,414	2,910,276,432	3,076,918,861	3,243,543,248	3,419,190,845	3,604,350,287	3,799,536,668
Large Group Employer Market	Employee Out Of Pocket	236,840,430	249,760,802	260,743,865	273,030,635	288,425,195	305,256,824	323,364,048	341,879,873	360,393,694	379,910,094	400,483,365	422,170,741
Large Group Employer Market	Total	2,368,404,303	2,497,608,017	2,607,438,654	2,730,306,353	2,884,251,947	3,052,568,237	3,233,640,480	3,418,798,734	3,603,936,942	3,799,100,939	4,004,833,652	4,221,707,409
Total Employer Based	**Insurer**	**2,646,486,076**	**2,776,499,350**	**2,912,622,298**	**3,064,933,523**	**3,237,746,735**	**3,426,691,921**	**3,629,956,433**	**3,837,807,738**	**4,045,636,541**	**4,264,719,896**	**4,495,667,273**	**4,739,121,142**
Total Employer Based	**Employee Out Of Pocket**	**292,120,549**	**308,499,928**	**323,624,700**	**340,548,169**	**359,749,637**	**380,743,547**	**403,328,493**	**426,423,082**	**449,515,171**	**473,857,766**	**499,518,586**	**526,569,016**
Total Employer Based	**Total**	**2,938,606,625**	**3,084,999,277**	**3,236,246,998**	**3,405,481,693**	**3,597,496,372**	**3,807,435,468**	**4,033,284,925**	**4,264,230,820**	**4,495,151,712**	**4,738,577,662**	**4,995,185,858**	**5,265,690,158**

Table 20 - Hawai'i Health Expenditure Source of Funds - Waiver Scenario

		Baseline Year		Waiver Period									
Source of Health Insurance Coverage	**Source of Funds**	**2015**	**2016**	**2017**	**2018**	**2019**	**2020**	**2021**	**2022**	**2023**	**2024**	**2025**	**2026**
Individual Market - Direct Purchase	Insurer	194,721,917	234,127,779	262,329,413	292,886,523	307,252,021	322,937,236	339,372,804	355,646,069	374,139,665	391,314,172	409,277,058	428,064,512
Individual Market - Direct Purchase	Insured Out Of Pocket	53,604,246	69,934,272	78,358,136	87,485,585	91,776,578	96,461,772	101,371,097	106,231,943	111,756,004	116,886,051	122,251,589	127,863,426
Total Direct Purchase		**248,326,163**	**304,062,051**	**340,687,549**	**380,372,107**	**399,028,598**	**419,399,008**	**440,743,901**	**461,878,012**	**485,895,669**	**508,200,224**	**531,528,647**	**555,927,938**
Small Group Employer Market	Insurer	514,922,203	528,652,135	565,927,509	607,657,806	641,919,983	679,380,508	719,680,001	760,888,878	802,093,293	845,529,051	891,316,986	939,584,474
Small Group Employer Market	Employee Out Of Pocket	55,280,119	58,739,126	62,880,834	67,517,534	71,324,443	75,486,723	79,964,445	84,543,209	89,121,477	93,947,672	99,035,221	104,398,275
Small Group Employer Market	Total	570,202,322	587,391,261	628,808,344	675,175,339	713,244,426	754,867,231	799,644,445	845,432,086	891,214,770	939,476,723	990,352,206	1,043,982,749
Large Group Employer Market	Insurer	2,131,563,873	2,247,847,215	2,346,694,788	2,457,275,718	2,595,826,752	2,747,311,414	2,910,276,432	3,076,918,861	3,243,543,248	3,419,190,845	3,604,350,287	3,799,536,668
Large Group Employer Market	Employee Out Of Pocket	236,840,430	249,760,802	260,743,865	273,030,635	288,425,195	305,256,824	323,364,048	341,879,873	360,393,694	379,910,094	400,483,365	422,170,741
Large Group Employer Market	Total	2,368,404,303	2,497,608,017	2,607,438,654	2,730,306,353	2,884,251,947	3,052,568,237	3,233,640,480	3,418,798,734	3,603,936,942	3,799,100,939	4,004,833,652	4,221,707,409
Total Employer Based	**Insurer**	**2,646,486,076**	**2,776,499,350**	**2,912,622,298**	**3,064,933,523**	**3,237,746,735**	**3,426,691,921**	**3,629,956,433**	**3,837,807,738**	**4,045,636,541**	**4,264,719,896**	**4,495,667,273**	**4,739,121,142**
Total Employer Based	**Employee Out Of Pocket**	**292,120,549**	**308,499,928**	**323,624,700**	**340,548,169**	**359,749,637**	**380,743,547**	**403,328,493**	**426,423,082**	**449,515,171**	**473,857,766**	**499,518,586**	**526,569,016**
Total Employer Based	**Total**	**2,938,606,625**	**3,084,999,277**	**3,236,246,998**	**3,405,481,693**	**3,597,496,372**	**3,807,435,468**	**4,033,284,925**	**4,264,230,820**	**4,495,151,712**	**4,738,577,662**	**4,995,185,858**	**5,265,690,158**

Table 21 - Hawai'i Health Expenditure Source of Funds - Change from Baseline to Waiver Scenario

		Baseline Year		Waiver Period									
Source of Health Insurance Coverage	**Source of Funds**	**2015**	**2016**	**2017**	**2018**	**2019**	**2020**	**2021**	**2022**	**2023**	**2024**	**2025**	**2026**
Individual Market - Direct Purchase	Insurer	-	-	-	-	-	-	-	-	-	-	-	-
Individual Market - Direct Purchase	Insured Out Of Pocket	-	-	-	-	-	-	-	-	-	-	-	-
Total Direct Purchase		**-**	**-**	**-**	**-**	**-**	**-**	**-**	**-**	**-**	**-**	**-**	**-**
Small Group Employer Market	Insurer	-	-	-	-	-	-	-	-	-	-	-	-
Small Group Employer Market	Employee Out Of Pocket	-	-	-	-	-	-	-	-	-	-	-	-
Small Group Employer Market	Total	-	-	-	-	-	-	-	-	-	-	-	-
Large Group Employer Market	Insurer	-	-	-	-	-	-	-	-	-	-	-	-
Large Group Employer Market	Employee Out Of Pocket	-	-	-	-	-	-	-	-	-	-	-	-
Large Group Employer Market	Total	-	-	-	-	-	-	-	-	-	-	-	-
Total Employer Based	**Insurer**	**-**	**-**	**-**	**-**	**-**	**-**	**-**	**-**	**-**	**-**	**-**	**-**
Total Employer Based	**Employee Out Of Pocket**	**-**	**-**	**-**	**-**	**-**	**-**	**-**	**-**	**-**	**-**	**-**	**-**
Total Employer Based	**Total**	**-**	**-**	**-**	**-**	**-**	**-**	**-**	**-**	**-**	**-**	**-**	**-**

Table 22 - Hawai'i Total Net Out-Of-Pocket Spending - Baseline Scenario

		Baseline Year		Waiver Period									
Source of Health Insurance Coverage	**Item**	**2015**	**2016**	**2017**	**2018**	**2019**	**2020**	**2021**	**2022**	**2023**	**2024**	**2025**	**2026**
Individual Market - Direct Purchase	Insured Premium Contribution	124,640,446	168,394,164	225,209,810	273,454,499	294,874,505	309,291,934	324,324,827	339,239,663	356,167,399	371,879,146	388,301,561	405,467,094
Individual Market - Direct Purchase	Insured Out Of Pocket	53,604,246	69,934,272	78,358,136	87,485,585	91,776,578	96,461,772	101,371,097	106,231,943	111,756,004	116,886,051	122,251,589	127,863,426
Total Direct Purchase	**Total Insured**	**178,244,692**	**238,328,436**	**303,567,946**	**360,940,084**	**386,651,083**	**405,753,706**	**425,695,924**	**445,471,606**	**467,923,402**	**488,765,197**	**510,553,150**	**533,330,519**
Small Group Employer Market	Employee Premium Contribution	78,417,860	79,912,053	81,434,717	83,236,604	85,930,850	88,624,296	91,311,400	93,986,459	96,547,369	99,178,057	101,880,426	104,656,428
Small Group Employer Market	Employee Out Of Pocket	55,280,119	58,739,126	62,880,834	67,517,534	71,324,443	75,486,723	79,964,445	84,543,209	89,121,477	93,947,672	99,035,221	104,398,275
Small Group Employer Market	Total Employee	133,697,979	138,651,179	144,315,551	150,754,138	157,255,293	164,111,020	171,275,845	178,529,668	185,668,846	193,125,730	200,915,647	209,054,703
Large Group Employer Market	Employee Premium Contribution	428,648,402	435,930,073	443,335,442	452,226,006	465,917,053	479,546,380	493,084,259	506,500,339	519,246,065	532,312,528	545,707,799	559,440,153
Large Group Employer Market	Employee Out Of Pocket	236,840,430	249,760,802	260,743,865	273,030,635	288,425,195	305,256,824	323,364,048	341,879,873	360,393,694	379,910,094	400,483,365	422,170,741
Large Group Employer Market	Total Employee	665,488,833	685,690,875	704,079,307	725,256,641	754,342,247	784,803,204	816,448,307	848,380,212	879,639,759	912,222,622	946,191,164	981,610,894
Total Employer Based	**Employee Premium Contribution**	**507,066,262**	**515,842,126**	**524,770,159**	**535,462,610**	**551,847,903**	**568,170,677**	**584,395,659**	**600,486,798**	**615,793,433**	**631,490,585**	**647,588,225**	**664,096,581**
Total Employer Based	**Employee Out Of Pocket**	**292,120,549**	**308,499,928**	**323,624,700**	**340,548,169**	**359,749,637**	**380,743,547**	**403,328,493**	**426,423,082**	**449,515,171**	**473,857,766**	**499,518,586**	**526,569,016**
Total Employer Based	**Total Employee**	**799,186,811**	**824,342,054**	**848,394,859**	**876,010,779**	**911,597,540**	**948,914,223**	**987,724,152**	**1,026,909,880**	**1,065,308,605**	**1,105,348,351**	**1,147,106,811**	**1,190,665,597**

Table 23 - Hawai'i Total Net Out-Of-Pocket Spending - Waiver Scenario

		Baseline Year		Waiver Period									
Source of Health Insurance Coverage	**Item**	**2015**	**2016**	**2017**	**2018**	**2019**	**2020**	**2021**	**2022**	**2023**	**2024**	**2025**	**2026**
Individual Market - Direct Purchase	Insured Premium Contribution	124,640,446	168,394,164	225,209,810	273,454,499	294,874,505	309,291,934	324,324,827	339,239,663	356,167,399	371,879,146	388,301,561	405,467,094
Individual Market - Direct Purchase	Insured Out Of Pocket	53,604,246	69,934,272	78,358,136	87,485,585	91,776,578	96,461,772	101,371,097	106,231,943	111,756,004	116,886,051	122,251,589	127,863,426
Total Direct Purchase	**Total Insured**	**178,244,692**	**238,328,436**	**303,567,946**	**360,940,084**	**386,651,083**	**405,753,706**	**425,695,924**	**445,471,606**	**467,923,402**	**488,765,197**	**510,553,150**	**533,330,519**
Small Group Employer Market	Employee Premium Contribution	78,417,860	79,912,053	81,434,717	83,236,604	85,930,850	88,624,296	91,311,400	93,986,459	96,547,369	99,178,057	101,880,426	104,656,428
Small Group Employer Market	Employee Out Of Pocket	55,280,119	58,739,126	62,880,834	67,517,534	71,324,443	75,486,723	79,964,445	84,543,209	89,121,477	93,947,672	99,035,221	104,398,275
Small Group Employer Market	Total Employee	133,697,979	138,651,179	144,315,551	150,754,138	157,255,293	164,111,020	171,275,845	178,529,668	185,668,846	193,125,730	200,915,647	209,054,703
Large Group Employer Market	Employee Premium Contribution	428,648,402	435,930,073	443,335,442	452,226,006	465,917,053	479,546,380	493,084,259	506,500,339	519,246,065	532,312,528	545,707,799	559,440,153
Large Group Employer Market	Employee Out Of Pocket	236,840,430	249,760,802	260,743,865	273,030,635	288,425,195	305,256,824	323,364,048	341,879,873	360,393,694	379,910,094	400,483,365	422,170,741
Large Group Employer Market	Total Employee	665,488,833	685,690,875	704,079,307	725,256,641	754,342,247	784,803,204	816,448,307	848,380,212	879,639,759	912,222,622	946,191,164	981,610,894
Total Employer Based	**Employee Premium Contribution**	**507,066,262**	**515,842,126**	**524,770,159**	**535,462,610**	**551,847,903**	**568,170,677**	**584,395,659**	**600,486,798**	**615,793,433**	**631,490,585**	**647,588,225**	**664,096,581**
Total Employer Based	**Employee Out Of Pocket**	**292,120,549**	**308,499,928**	**323,624,700**	**340,548,169**	**359,749,637**	**380,743,547**	**403,328,493**	**426,423,082**	**449,515,171**	**473,857,766**	**499,518,586**	**526,569,016**
Total Employer Based	**Total Employee**	**799,186,811**	**824,342,054**	**848,394,859**	**876,010,779**	**911,597,540**	**948,914,223**	**987,724,152**	**1,026,909,880**	**1,065,308,605**	**1,105,348,351**	**1,147,106,811**	**1,190,665,597**

Table 24 - Hawai'i Total Net Out-Of-Pocket Spending - Change from Baseline to Waiver Scenario

		Baseline Year		Waiver Period									
Source of Health Insurance Coverage	**Item**	**2015**	**2016**	**2017**	**2018**	**2019**	**2020**	**2021**	**2022**	**2023**	**2024**	**2025**	**2026**
Individual Market - Direct Purchase	Insured Premium Contribution	-	-	-	-	-	-	-	-	-	-	-	-
Individual Market - Direct Purchase	Insured Out Of Pocket	-	-	-	-	-	-	-	-	-	-	-	-
Total Direct Purchase	**Total Insured**	**-**	**-**	**-**	**-**	**-**	**-**	**-**	**-**	**-**	**-**	**-**	**-**
Small Group Employer Market	Employee Premium Contribution	-	-	-	-	-	-	-	-	-	-	-	-
Small Group Employer Market	Employee Out Of Pocket	-	-	-	-	-	-	-	-	-	-	-	-
Small Group Employer Market	Total Employee	-	-	-	-	-	-	-	-	-	-	-	-
Large Group Employer Market	Employee Premium Contribution	-	-	-	-	-	-	-	-	-	-	-	-
Large Group Employer Market	Employee Out Of Pocket	-	-	-	-	-	-	-	-	-	-	-	-
Large Group Employer Market	Total Employee	-	-	-	-	-	-	-	-	-	-	-	-
Total Employer Based	**Employee Premium Contribution**	**-**	**-**	**-**	**-**	**-**	**-**	**-**	**-**	**-**	**-**	**-**	**-**
Total Employer Based	**Employee Out Of Pocket**	**-**	**-**	**-**	**-**	**-**	**-**	**-**	**-**	**-**	**-**	**-**	**-**
Total Employer Based	**Total Employee**	**-**	**-**	**-**	**-**	**-**	**-**	**-**	**-**	**-**	**-**	**-**	**-**

Oliver Wyman
411 East Wisconsin Avenue
Suite 1300
Milwaukee, WI 53202-4419
414 223 7989

Attachment 3: Economic Analysis

DEPARTMENT OF BUSINESS, ECONOMIC DEVELOPMENT AND TOURISM

RESEARCH AND ECONOMIC ANALYSIS DIVISION

DAVID Y. IGE
GOVERNOR

LUIS P. SALAVERIA
DIRECTOR

DR. EUGENE TIAN
CHIEF STATE ECONOMIST

June 6, 2016

Ms. Sylvia Matthews Burwell
U.S. Department of Health and Human Services
200 Independence Avenue, S.W.
Washington, DC 20201

Re: Hawaii Section 1332 Waiver Proposal

Dear Secretary Burwell:

We contend that there is very little chance that Hawaii is proposed waiver of certain aspects of the Affordable Care Act will have negative economic consequences to either the Federal Government or the State of Hawaii. The waiver's explicit intent is to maintain the system of health insurance mandates put in place by the Prepaid Health Care Act more than forty years ago. As outlined in the document entitled "Projected Economic Effects of Hawaii Proposed Section 1332 Waiver", we conclude that the waiver will have no impact on:

1. Coverage Comparability
2. Affordability of Coverage
3. Comprehensiveness of Benefits
4. Deficit Neutrality for the Federal Government

According to the U.S. Census Bureau's American Community Survey, Hawaii has been ranked in the top three states with health insurance coverage. Data from the U.S. Bureau of Economic Analysis indicated that the health care industry in Hawaii was the second largest contributor to job growth during the past decade. This progress may be, at least in part, attributed to the Prepaid Health Care Act of Hawaii. I believe that the proposed waiver will help Hawaii continue to achieve its high ranking.

If you have any questions, please contact me at 808-586-2474 or via email at eugene.x.tian@hawaii.gov

Sincerely,

Eugene Tian, Ph.D.
Economic Research Administrator
and Hawaii State Economist

Hawai‘i: Projected Economic Effects of Proposed Section 1332 Waiver

Coverage Comparability

Standard (December 2015 Guidance):

> "To meet the coverage requirement, a comparable number of state residents must be forecast to have coverage under the waiver as would have coverage absent the waiver."
>
> "Assessment of whether the proposal covers a comparable number of individuals also takes into account the effects across different groups of state residents, and, in particular, vulnerable residents, including low-income individuals, elderly individuals, and those with serious health issues or who have a greater risk of developing serious health issues."

Response: The proposed waiver is focused primarily on allowing Hawai‘i to forego the creation and maintenance of a state-only on-line SHOP exchange or participating in the federal SHOP. There are no changes contemplated in employer-sponsored coverage required of small employers under Hawai‘i's Prepaid Health Care Act. Therefore, there is no basis to expect any differences in coverage comparability with or without a waiver.

Hawai‘i Forecast and Assessment: Coverage Comparability

Hawai‘i's current and projected coverage trends are shown below. There is no difference in the projection without a waiver (the "baseline") compared with the proposed waiver being granted ("with waiver"). Hawai‘i's coverage compares favorably to national averages. Contrast is especially notable between the high rate of small insurers who offer coverage in Hawai‘i's Prepaid marketplace (82%) and the U.S. average (32%).

Table 1. Insurance Coverage Comparisons: Hawai‘i Waiver Projections (2015) and U.S. (2014)

Overall Health Coverage by Type[1]			
	Hawai‘i Baseline	**Hawai‘i With Waiver**	**U.S.**
Employer-based	52.5%	52.5%	54.2%
Direct-purchased	3.2%	3.2%	12.8%
Government coverage	40.2%	40.2%	38.0%
Uninsured	4.1%	4.1%	11.7%

[1]Oliver Wyman Actuarial Analysis and Certification for Hawai‘i 1332 Waiver Proposal, 2016.

Employer-Sponsored Insurance[2]			
	Hawai'i Baseline	Hawai'i With Waiver	U.S.
Employers offering insurance – all firms	86%	86%	48%
Employee uptake of insurance – all firms	84%	84%	77%
Small employers offering coverage (<50 workers)	82%	82%	32%
Employee uptake of insurance - small firms	88%	88%	73%

a) As shown in Table 2 below, whether with a waiver or without one, there is little variation expected in the types of insurance coverage people have during the period 2017-2021. The category with the largest change is projected to be "government coverage," which includes Medicaid and CHIP, Medicare, and military coverage. This category is forecast to increase due to a 2% per year increase in the number of residents aged 65 and older during the period.

Table 2. Projections of Population and Coverage by Category for Hawai'i

	2015 Reference Yr	2017	2018	2019	2020	2021
State population[3]	1,418,300	1,443,944	1,456,940	1,470,052	1,483,283	1,495,149
Civilian employment[4]	607,042	612,500	616,200	619,900	623,600	627,400
Unemployment[5]	3.2%	3.2%	3.2%	3.2%	3.2%	3.2%
Insurance Distribution: Hawai'i Baseline[6]						
% Employer-based	52.5%	51.3%	50.7%	50.6%	50.4%	50.2%
# Employer-based	752,301	744,797	743,307	749,253	754,498	759,025
% Direct-purchased	3.2%	3.8%	4.0%	3.9%	3.9%	3.8%
# Direct-purchased	45,431	54,599	58,203	58,261	58,319	58,203
% Government coverage	40.2%	41.2%	41.6%	41.8%	42.1%	42.3%
# Government coverage	575,365	599,142	609,392	619,764	630,266	639,966
% Uninsured	4.1%	3.7%	3.7%	3.7%	3.7%	3.7%
# Uninsured	58,506	54,129	54,075	54,562	54,944	55,273

[2] "ESI Availability and Enrollment," November 2015 (for 2014), State Health Access Data Assistance Center, http://www.shadac.org/sites/default/files/publications/MEPS-IC_Offer_Tables_2014.pdf#overlay-context=publications/meps-ic-tables-employer-coverage-estimates-firm-size.

[3] "Population and Economic Projections for the State of Hawai'i to 2040," DBEDT 2040 Series, Hawai'i Dept. of Business and Economic Development, March 2012, http://files.hawaii.gov/dbedt/economic/data_reports/2040-long-range-forecast/2040-long-range-forecast.pdf, Table 1-1, page 2. Report forecasts state population growth as .9% per year 2015-20 and .8% per year 2020-25.

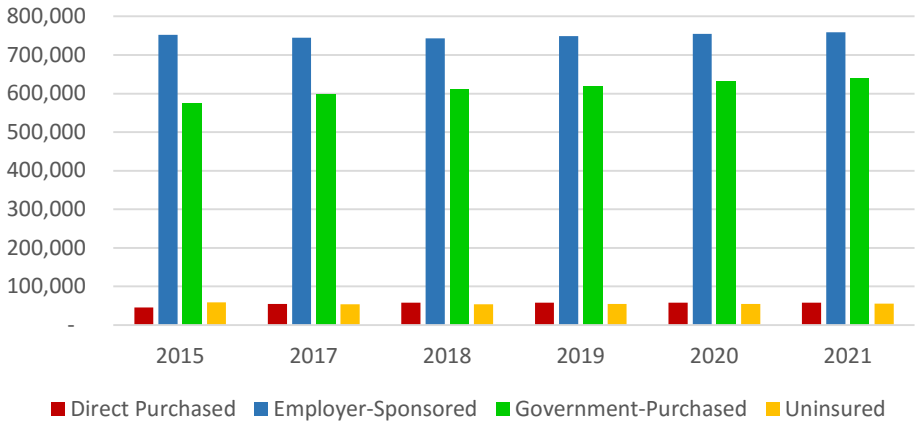
[4] Ibid. Page 8. Projected growth of civilian employment is .6% per year.

[5] "Hawai'i Economy at a Glance," U.S. Bureau of Labor Statistics, www.bls.gov/eag/eag.hi.htm. BLS reports HI unemployment rate of 3.2% for 12/2015. "Outlook for the Economy," 4th Quarter 2015, DBEDT, http://dbedt.hawaii.gov/economic/qser/outlook-economy/ cites projected unemployment decrease of .2% for 2018 and .1% for 2018.

[6] Oliver Wyman Actuarial Analysis and Certification for Hawai'i 1332 Waiver Proposal, 2016.

	2015 Reference Yr [7]	2017	2018	2019	2020	2021
Insurance Distribution: Hawai'i With Waiver						
% Employer-based	52.5%	51.3%	50.7%	50.6%	50.4%	50.2%
# Employer-based	752,301	744,797	743,307	749,253	754,498	759,025
% Direct-purchased	3.2%	3.8%	4.0%	3.9%	3.9%	3.8%
# Direct-purchased	45,431	54,599	58,203	58,261	58,319	58,203
% Government coverage	40.2%	41.2%	41.6%	41.8%	42.1%	42.3%
# Government coverage	575,365	599,142	609,392	619,764	630,266	639,966
% Uninsured	4.1%	3.7%	3.7%	3.7%	3.7%	3.7%
# Uninsured	58,506	54,129	54,075	54,562	54,944	55,273

Figure 1. Hawai'i Coverage Trends
Baseline and With Waiver



b) Hawai'i's proposal to forego the use of a SHOP exchange would result in no change forecast in coverage for employees of small businesses. The Prepaid Health Insurance Act mandates coverage for employers of all sizes.

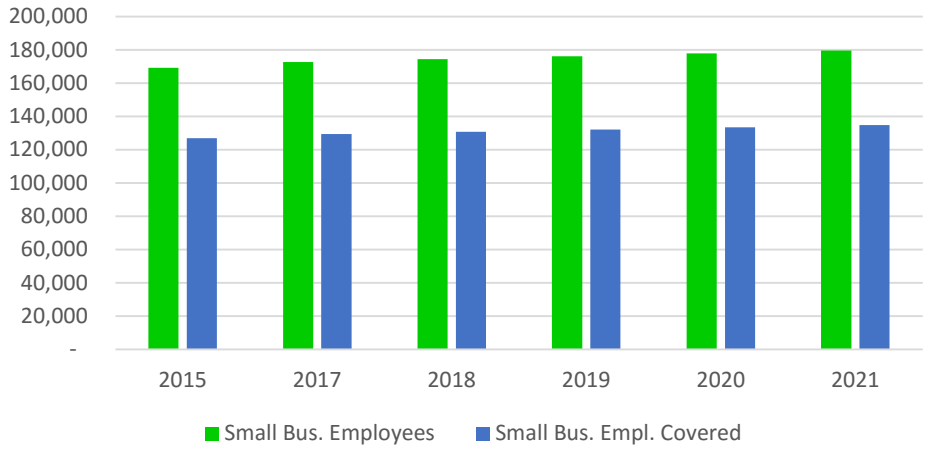
Table 3. Hawai'i Small Business Growth and Insurance Coverage Forecast

Hawai'i: Baseline	2015 Reference Yr	2017	2018	2019	2020	2021
Total small businesses employees[8]	169,273	172,675	174,402	176,146	177,908	179,687
Small firm plan enrollment/up-take[9]	75%	75%	75%	75%	75%	75%
Small business employees covered[10]	127,000	129,500	130,800	132,100	133,400	134,800

[7] Ibid.
[8] Hawai'i Dept. of Labor & Industrial Relations (DLIR) reported 169,273 employees for businesses with 50/fewer workers, quarter ending March 2015. Forecast growth based on annual 1% increases, slightly higher than DBEDT projection of .6% growth for all businesses, and projected in "Population and Economic Projections, DBEDT 2040 Series," page 8.
[9] "Employer Coverage Estimates by Firm Size," SHADAC, November 2015, http://www.shadac.org/publications/meps-ic-tables-employer-coverage-estimates-firm-size. If 82% of Hawai'i small firms offer insurance with 88% uptake, then enrollment for small business employees would be approximately 75%.
[10] Number of small business employees multiplied by up-take estimate.

Hawai'i: With Waiver	2015 Reference Yr	2017	2018	2019	2020	2021
Total small businesses employees[11]	169,273	172,675	174,402	176,146	177,908	179,687
Small firm plan enrollment/up-take[12]	75%	75%	75%	75%	75%	75%
Small business employees covered[13]	127,000	129,500	130,800	132,100	133,400	134,800

Figure 2. Hawai'i Small Business Coverage Trends, Baseline and With Waiver



c) Hawai'i is the country's most racially/ethnically diverse state and its health insurance coverage reflects this diversity. Insurance coverage by race is projected to be the same with or without a waiver for every year of the waiver period.

Table 4. Hawai'i Health Insurance Coverage by Race and Ethnicity, 2013[14]

Racial/Ethnic Distribution of Coverage in Hawai'i: Baseline						
Race/Ethnicity	Population	Employer/ Military	Individual	Medicare	Medicaid	Uninsured
Hispanic	136,450	68.0%	2.1%	6.0%	18.2%	5.7%
White	320,519	61.3%	6.9%	18.7%	5.6%	7.6%
African Am./Black	27,523	87.1%	2.5%	2.5%	3.9%	4.0%
Asian	515,567	59.5%	4.7%	23.4%	6.3%	6.1%
Native Hawaiian	74,579	55.3%	2.9%	13.8%	20.9%	7.1%
Pacific Islander	46,781	39.3%	1.2%	7.3%	41.1%	11.1%
Other/Multiple	271,146	61.3%	3.6%	9.4%	18.1%	7.6%
TOTAL	1,392,565	60.7%	4.5%	16.4%	11.5%	6.9%

[11] Hawai'i Dept. of Labor & Industrial Relations (DLIR) reported 169,273 employees for businesses with 50/fewer workers, quarter ending March 2015. Forecast growth based on annual 1% increases, slightly higher than DBEDT projection of .6% growth for all businesses, and projected in "Population and Economic Projections, DBEDT 2040 Series," page 8.

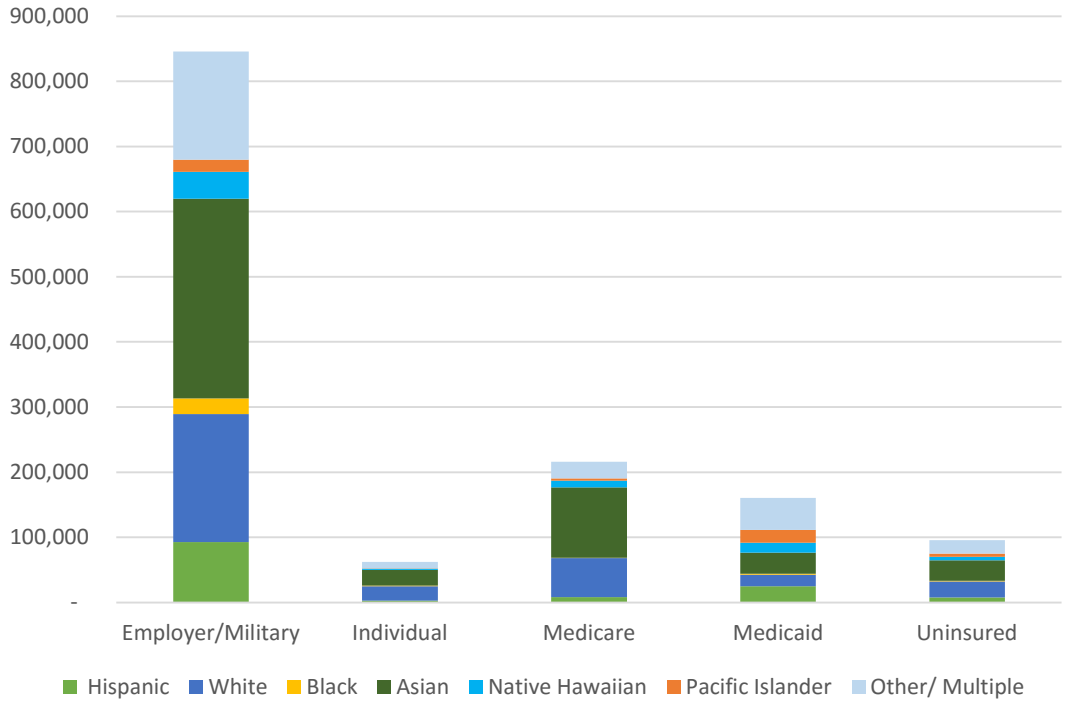
[12] "Employer Coverage Estimates by Firm Size," SHADAC, November 2015, http://www.shadac.org/publications/meps-ic-tables-employer-coverage-estimates-firm-size. If 82% of Hawai'i small firms offer insurance with 88% uptake, then approximately 75% of small business employees would be covered.

[13] Number of small business employees multiplied by up-take estimate.

[14] SHADAC analysis of 2013 American Community Survey (ACS), non-institutionalized population.

Racial/Ethnic Distribution of Coverage in Hawai‘i: With Waiver						
Race/Ethnicity	Population	Employer/ Military	Individual	Medicare	Medicaid	Uninsured
Hispanic	136,450	68.0%	2.1%	6.0%	18.2%	5.7%
White	320,519	61.3%	6.9%	18.7%	5.6%	7.6%
African Am./Black	27,523	87.1%	2.5%	2.5%	3.9%	4.0%
Asian	515,567	59.5%	4.7%	23.4%	6.3%	6.1%
Native Hawaiian	74,579	55.3%	2.9%	13.8%	20.9%	7.1%
Pacific Islander	46,781	39.3%	1.2%	7.3%	41.1%	11.1%
Other/Multiple	271,146	61.3%	3.6%	9.4%	18.1%	7.6%
TOTAL	1,392,565	60.7%	4.5%	16.4%	11.5%	6.9%

Figure 3. Hawai'i Insurance Coverage by Race/Ethnicity



d) Hawai‘i’s proposed waiver effects small employers and employees exclusively; accordingly, there are no differences projected between the baseline and waiver scenarios on coverage and protections for vulnerable populations. Employers are required by Prepaid to offer the same insurance coverage to all employees, regardless of income, age, or health status. Actuarial analysis estimates that between 23,000 and 24,000 individuals covered by employer-sponsored insurance will report poor health status, but the numbers do not change between the baseline and the waiver scenarios. Medicare and Medicaid, which disproportionately cover people who are low-income, elderly, or in poor health, do not change in baseline projections compared with a waiver and, as noted in Table 2 above, enrollment in those programs is not forecast to decline.

Affordability of Coverage

Standard (December 2015 Guidance):

> "To meet the affordability requirement, health care coverage under the waiver must be forecast to be as affordable overall for state residents as coverage absent the waiver."
>
> "Affordability refers to state residents' ability to pay for health care and may generally be measured by comparing residents' net out-of-pocket spending for health coverage and services to their incomes. Out-of-pocket expenses include both premium contributions (or equivalent costs for enrolling in coverage), and any cost sharing, such as deductibles, co-pays, and co-insurance associated with coverage….The impact on all state residents is considered, regardless of the type of coverage they would have absent the waiver. This condition generally must be forecast to be met in each year that the waiver would be in effect."

Response: The proposed waiver is focused on the small business health options program (SHOP), specifically requesting relief from the creation and maintenance of a state-only on-line SHOP exchange or the participation in a federal SHOP exchange. There are no changes contemplated in the affordability of employer-sponsored coverage as a result of a waiver.

Hawai'i Forecast and Assessment: Affordability

While cost trends are expected to continue to rise in parallel with federal projections (CMS's projection is 6.0% during the period 2015-23), there is no difference in the forecast affordability of insurance coverage for any state residents between the baseline and the waiver.

Hawai'i's current premium affordability compares favorably to national averages as shown below.

Table 5. Affordability of Employer-Sponsored Coverage: Hawai'i vs. US

	Hawai'i	US
Employer-Based Insurance Premiums[15]	$5,316	$5,832
Employer contribution[16]	$4,856	$4,598
Employee contribution[17]	$460	$1,234
Deductibles (small firms)	$200[18]	$1,836[19]

[15] "Average Single Premium per Enrolled Employee for Employer-Based Health Insurance (2014)," Kaiser Family Foundation, www.kff.org/other/state-indicator/single-coverage/

[16] Ibid.

[17] Ibid.

[18] Information gathered from websites for Hawai'i-based insurers offering Prepaid 7A plans: HMAA (http://www.hmaa.com/healthplans/smallbusinesses/), HMSA (https://hmsa.com/health-plans/employers/small-business-plans/), Kaiser Permanente (https://businesshealth.kaiserpermanente.org/wp-content/uploads/2015/12/KP-Hawaii-Small-Business-Plan-Grid-2016.pdf), UHA (https://uhahealth.com/benefits?active=medical)

[19] "Employer Health Benefits: 2015 Summary of Findings," Sept. 2015, Kaiser Family Foundation, http://kff.org/health-costs/report/2015-employer-health-benefits-survey/

a) Hawai'i's proposed waiver addresses coverage by small businesses exclusively. The following shows Hawai'i employer-sponsored insurance premium projections for baseline and with the waiver.

Table 6. Hawai'i Employer-Sponsored Insurance Premium Cost Projections[20]

Hawai'i: Baseline	2016 Reference Yr	2017	2018	2019	2020	2021
7A Platinum[21]						
Average premium/year	$5,822	$6,333	$6,656	$7,029	$7,437	$7,875
7A Gold[22]						
Average premium/year	$4,681	$5,092	$5,352	$5,651	$5,979	$6,332
Hawai'i: With Waiver	**2016 Reference Yr**	**2017**	**2018**	**2019**	**2020**	**2021**
7A Platinum[23]						
Average premium/year	$5,822	$6,119	$6,431	$6,791	$7,185	$7,609
7A Gold[24]						
Average premium/year	$4,681	$4,920	$5,171	$5,460	$5,777	$6,118

b) Affordability trends show that the cost burden for employees will be little changed over the waiver period. Because Prepaid caps employee premium contributions at 1.5% of wages, increases in premiums will be passed on to employees only in proportion to any increased wages. The employer-employee premium share trend is projected as follows:

Table 7. Cost Trends for Employees and Employers

Hawai'i: Baseline	2016 Reference Yr	2017	2018	2019	2020	2021
Average cost/year[25]	$5,106	$5,462	$5,807	$6,074	$6,365	$6,675
Employee Share[26]	$611	$618	$624	$631	$637	$643
Employer Share	$4,495	$4,844	$5,183	$5,443	$5,728	$6,032
Hawai'i: With Waiver	**2016 Reference Yr**	**2017**	**2018**	**2019**	**2020**	**2021**
Average cost/year[27]	$5,106	$5,462	$5,807	$6,074	$6,365	$6,675
Employee Share[28]	$611	$618	$624	$631	$637	$643
Employer Share	$4,495	$4,844	$5,183	$5,443	$5,728	$6,032

[20] National Health Expenditure Projections, 2014-24," CMS, Table 3. Forecast increases for private insurance are 5.1% for 2017 and 2018, 5.6% for 2019, 5.8% for 2020, and 5.9% for 2021, https://www.cms.gov/research-statistics-data-and-systems/statistics-trends-and-reports/nationalhealthexpenddata/nationalhealthaccountsprojected.html

[21] Prepaid-compliant plans for 7A (employee-only) coverage have a value corresponding to platinum or gold. Premiums are publicly posted on Insurance Division website (http://cca.hawaii.gov/ins/files/2015/10/Q1-off-exchange-2016-Small-Group-Premiums.pdf)

[22] Ibid.

[23] Prepaid-compliant plans for 7A (employee-only) coverage have a value corresponding to platinum or gold. Premiums are publicly posted on Insurance Division website (http://cca.hawaii.gov/ins/files/2015/10/Q1-off-exchange-2016-Small-Group-Premiums.pdf)

[24] Ibid.

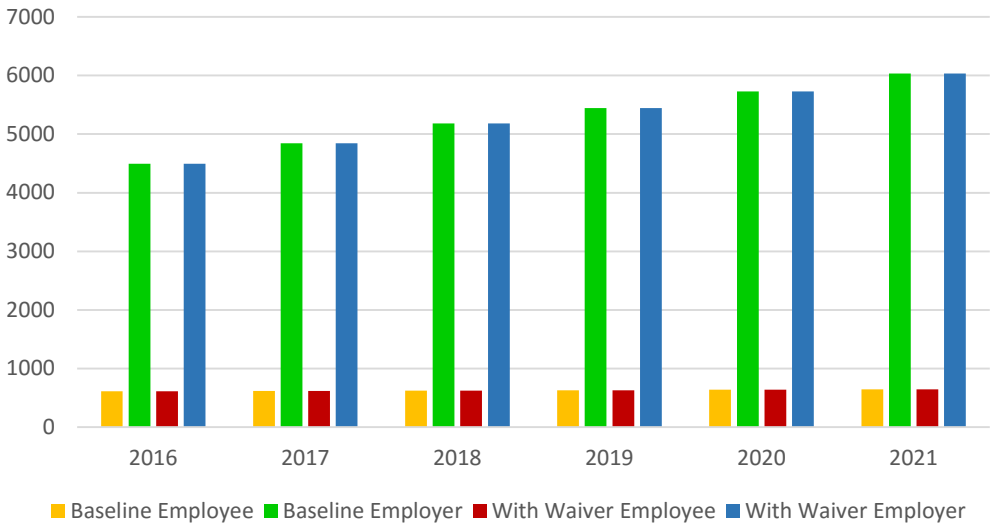
[25] Oliver Wyman Actuarial Analysis and Certification for Hawai'i 1332 Waiver Proposal, 2016.

[26] Prepaid caps employee premium contributions at 1.5% of wages, Chapter 393, Hawai'i Revised Statutes, http://www.capitol.hawaii.gov/hrscurrent/Vol07_Ch0346-0398/HRS0393/HRS_0393-.htm

[27] Oliver Wyman Actuarial Analysis and Certification for Hawai'i 1332 Waiver Proposal, 2016.

[28] Prepaid caps employee premium contributions at 1.5% of wages, Chapter 393, Hawai'i Revised Statutes, http://www.capitol.hawaii.gov/hrscurrent/Vol07_Ch0346-0398/HRS0393/HRS_0393-.htm

Figure 4. Premium and Cost Share Projections



Besides the amount that employees of small businesses may contribute to premiums, the maximum deductible for 7A plans is $200 and out-of-pocket maximums currently range from $2,200 to $2,500 per year.

Table 8. Calculation of Maximum Employee Cost

Hawai'i: Baseline	2016 Reference Yr	2017	2018	2019	2020	2021
Ave. small business annual wages[29]	$40,763	$41,171	$41,624	$42,040	$42,461	$42,885
Est. maximum small business employee premium contribution[30]	$611	$618	$624	$631	$637	$643
7A Max. deductible[31]	$200	$200	$200	$200	$200	$200
7A Max. out-of-pocket (non prem.)[32]	$2,500	$2,550	$2,600	$2,650	$2,700	$2,750
Est. max. insurance cost for employees of small businesses (prem. contribution plus OOP)	$3,111	$3,168	$3,224	$3,281	$3,337	$3,393

[29] Baseline small business average wage reported by DLIR. Five-year trend based on DBEDT wage increase projections of 1%/year ("Outlook for the Economy, 4th Quarter 2015," http://dbedt.hawaii.gov/economic/qser/outlook-economy. Figures are provided as basis to calculate average small employee premium contribution.

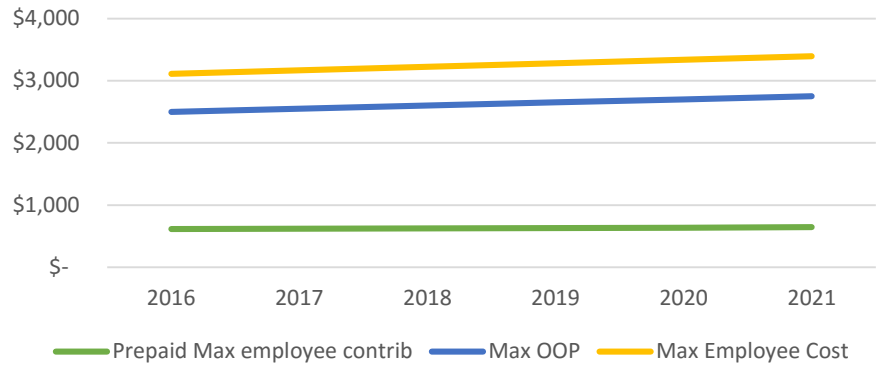
[30] Employee maximum contribution to premium is capped at 1.5% of wages.

[31] Maximum deductible listed on eligible insurer websites ranged from $0 to $200. In addition, co-insurance ranged from 10 – 30% and visit co-pays from $10 – 20.

[32] Maximum OOP is listed on eligible insurer websites. Inflation factor used is approximately 2%/year.

Hawai'i: With Waiver	2016 Reference Yr	2017	2018	2019	2020	2021
Ave. small business annual wages[33]	$40,763	$41,171	$41,624	$42,040	$42,461	$42,885
Est. maximum small business employee premium contribution[34]	$611	$618	$624	$631	$637	$643
7A Max. deductible[35]	$200	$200	$200	$200	$200	$200
7A Max. out-of-pocket (non prem.)[36]	$2,500	$2,550	$2,600	$2,650	$2,700	$2,750
Total est. max. insurance cost for employees of small businesses (prem. contribution plus OOP)	$3,111	$3,168	$3,224	$3,281	$3,337	$3,393

Figure 5. Hawai'i Employee Maximum Insurance Costs



c) Hawai'i's proposed waiver effects small employers and employees exclusively; accordingly, it would have no effect on vulnerable populations. Such coverage will be subject to Prepaid, which limits employee contributions regardless of income, age, or health status. While premium contributions for older or sicker workers will be the same as for any other workers (i.e., capped according to wages), they may pay more for co-pays if they receive more care. Such co-pays, of course, are capped. Actuarial analysis estimates that between 23,000 and 24,000 individuals covered by employer-sponsored insurance will report poor health status, but the numbers do not change between the baseline and the waiver scenarios. Medicare and Medicaid, which disproportionately cover people who are low-income, elderly, or in poor health, will not be changed by Hawai'i's waiver and, as noted in Table 2 above, enrollment in those programs is projected to hold steady.

[33] Baseline small business average wage reported by DLIR. Five-year trend based on DBEDT wage increase projections of 1%/year ("Outlook for the Economy, 4th Quarter 2015," http://dbedt.hawaii.gov/economic/qser/outlook-economy. Figures are provided as basis to calculate average small employee premium contribution.

[34] Employee maximum contribution to premium is capped at 1.5% of wages.

[35] Maximum deductible listed on eligible insurer websites ranged from $0 to $200. In addition, co-insurance ranged from 10 – 30% and visit co-pays from $10 – 20.

[36] Maximum OOP is listed on eligible insurer websites. Inflation factor used is approximately 2%/year.

d) Since Hawai‘i’s waiver would ensure the continuation of Prepaid requirements and, since Prepaid-eligible plans have an actuarial value of at least 80% AV (gold level), the proposed waiver will not result in residents having coverage of less than 60% AV.

Comprehensiveness

Standard (December 2015 Guidance):

> “To meet the comprehensiveness requirement, health care coverage under the waiver must be forecast to be as comprehensive overall for state residents as coverage absent the waiver.”
>
> “Comprehensiveness refers to the scope of benefits provided by the coverage as measured by the extent to which coverage meets the requirements for essential health benefits (EHBs)….The impact on all state residents is considered, regardless of the type of coverage they would have absent the waiver. Comprehensiveness is evaluated by comparing coverage under the waiver to the state’s EHB benchmark….”

Response: Hawai‘i is not proposing to waive or amend any aspects of the ACA that pertain to comprehensiveness of benefits; accordingly, there is no difference with or without a waiver. As described in Hawai‘i’s proposal, the waiver program would:

- Provide a scope of benefits that includes all ten Essential Health Benefits
- Maintain the benchmark plan selected by the State
- Have no effect on coverage or benefits for any residents, including vulnerable populations

Hawai‘i Forecast and Assessment: Comprehensiveness

There is no difference in comprehensiveness between the baseline and waiver. The proposal enumerates the benefits required under Prepaid and the State Insurance Code and their relationship to the EHB and benchmark plan. Hawai‘i’s waiver would have no effect on Medicaid or CHIP enrollment or benefits.

Deficit Neutrality

Standard (December 2015 Guidance):

> “Under the deficit neutrality requirement, the projected Federal spending net of Federal revenues under the State Innovation Waiver must be equal to or lower than projected Federal spending net of Federal revenues in the absence of the waiver”

Response: Hawai'i's proposed waiver has no foreseeable budgetary consequences to the federal government.

Hawai'i Forecast and Assessment: Deficit Neutrality

There are no differences in budgetary effect for the federal government between the baseline and the waiver. Supporting points are:

- **10-year effect on federal revenues**. Hawai'i's waiver would preserve an employer-mandate in effect since 1974. Accordingly, it will not reduce federal revenues related to payroll or excise taxes or user fees.
- **10-year effect on federal spending**. Hawai'i's proposed waiver will not increase federal spending. In fact, Hawai'i's Prepaid Health Care Act logically saves federal expenditures because low-wage workers, who might otherwise get federal benefits, are covered by employer-sponsored insurance.
- **10-year effect on operational costs**. Hawai'i is not requesting any state-specific operational considerations related to its waiver proposal.

Effects on Deficit Neutrality										
Baseline	2017	2018	2019	2020	2021	2022	2023	2024	2025	2026
APCT/CSR (millions)	$56.6	$72.0	$79.1	$83.9	$88.9	$93.8	$99.4	$104.6	$110.0	$115.7
Employer contrib. earning tax deductions (millions)	$626	$676	$716	$761	$808	$857	$906	$958	$1012	$1070
SHOP operational costs offset by SHOP premium fees @ 3.5% (0.5% of employers estimated to use federal SHOP) (millions)	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
Small employer tax credits (millions)	$9	$9	$9	$9	$9	$9	$9	$9	$9	$9
Effects on Deficit Neutrality										
With Waiver	2017	2018	2019	2020	2021	2022	2023	2024	2025	2026
APCT/CSR (millions)	$56.6	$72.0	$79.1	$83.9	$88.9	$93.8	$99.4	$104.6	$110.0	$115.7
Employer contrib. earning tax deductions (millions)	$626	$676	$716	$761	$808	$857	$906	$958	$1012	$1070
SHOP fees not applicable	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
Small employer tax credits (millions)	$9	$9	$9	$9	$9	$9	$9	$9	$9	$9
Effects on Deficit Neutrality										
Net Change	2017	2018	2019	2020	2021	2022	2023	2024	2025	2026
APCT/CSR (millions)	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
Employer contrib. earning tax deductions (millions)	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
SHOP fees	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
Small employer tax credits (millions)	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0

Impact on Other Programs

Standard (December 2015 Guidance):

> "The assessment of whether a State Innovation Waiver proposal satisfies the statutory criteria set forth in Section 1332 takes into consideration the impact of changes to ACA provisions made pursuant to the State Innovation Waiver. The assessment also considers related changes to the state's health care system that, under state law, are contingent only on the approval of the State Innovation Waiver."
>
> "The assessment does not consider the impact of …changes contingent on other Federal determinations, including approval of Federal waivers [such as Section 1115 Medicaid waivers] pursuant to statutory provision other than Section 1332."

Response: Under its proposed waiver, Hawai'i does not foresee any effect on aspects of the ACA for which a waiver is not requested. The proposed waiver is not associated with any coordinated Medicaid or Medicare waiver proposals so it will have no effect on eligibility, enrollment, or benefits related to Medicaid, Medicare, CHIP, or any other public insurance program.

Hawai'i Forecast and Assessment: Impact on Other Programs

Hawai'i's proposed waiver is very important to the continued strength and sustainability of health care delivery across the state. Providers of all kinds rely on a balance of payments that includes employer-sponsored commercial insurance to help off-set less robust payments from Medicare and Medicaid. Should failure to secure the proposed waiver result in erosion of employer-sponsored coverage, more individuals would purchase coverage, most likely at a lower actuarial value with higher co-pays and deductibles. Predictably, such a scenario would result in an increase in unpaid medical bills and stress on the health care sector as well as on individuals with medical debt that is currently almost unknown in Hawai'i.

Appendices

Appendix 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 EHB
  - 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

Appendix 2: Section by Section Consideration of Waivable Provisions

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

- **The goal of universal health insurance coverage**. To that end, the State will continue to participate in a federally-facilitated marketplace for individuals and families, and strongly advocates choice and affordability for those seeking coverage there.
- **Retaining the benefits of Prepaid**. Eliminating the SHOP exchange makes it clear to Hawai'i employers that Prepaid is the single mandate for employer coverage and keeps them from being exposed to contradictory information on the federal SHOP.
- **Ensuring sustainability and eliminating infrastructure and costs that do not add value**. A state-based SHOP exchange for Hawai'i is not economically viable and the unique requirements of Prepaid make sharing the federal marketplace for SHOP untenable. Any premium fee added to SHOP-based QHPs would also add cost but no value for Hawai'i's employers.

ESTABLISHMENT OF QUALIFIED HEALTH PLANS

Section 1301: Definition of Qualified Health Plans

Key ACA Provisions	Hawai'i Proposal
The definition of "Qualified Health Plan" including providing EHB, and offering plans conforming to metal levels with the inclusion of at least silver and gold	Hawai'i proposes that DLIR serve as the certifying authority for qualified health plans. All plans will continue to be ACA QHPs as determined by the Insurance Commissioner. **For the Individual Market**. Hawai'i proposes to retain the general terms specified for "qualified health plan." **For the Small Employer Market**. Hawai'i proposes to: • Maintain the EHB • Waive the minimum requirement of at least one silver plan for the small business market since Prepaid compliant plans currently have an average value of gold or platinum. Silver plans cannot be purchased by employers for Prepaid-eligible employees.
Inclusion of Co-Op and Multi-State Plans	Hawai'i proposes to waive this section since multi-state plans are less likely to conform to the requirements of Prepaid and would be harder to regulate and monitor for compliance than state-based plans.
Treatment of Qualified Direct Primary Care Medical Home Plans	Hawai'i proposes to retain these provisions.
Exceptions for Self-Insured Plans and MEWAS (multiple employer welfare arrangements)	Hawai'i proposes to retain these provisions.

Section 1302: EHB Requirements

Key ACA Provisions	Hawai'i Proposal
Defines EHB	Hawai'i proposes to retain the EHB.
Annual limitations on cost-sharing	Hawai'i proposes to retain these provisions. Currently, cost-sharing in Prepaid plans is more advantageous to employees but, should that change, the ACA limits would serve as a ceiling.
Annual limitations on deductibles for employer-sponsored plans	Hawai'i proposes to retain these provisions. Currently, deductibles in Prepaid plans are more advantageous to employees but, should that change, the ACA limits would serve as a ceiling.
Definition of metal levels by actuarial value	**For the Individual Market**. Hawai'i proposes to retain the levels of coverage and actuarial values described for bronze, silver, gold, and platinum plans. **For the Small Business Market**. Hawai'i proposes to waive the minimum requirement of at least one silver plan for the small business market since Prepaid compliant plans currently have an average value of gold or platinum. Silver plans cannot be purchased by employers for Prepaid-eligible employees.
Availability of catastrophic plans	Hawai'i proposes to retain these provisions.
Availability of child-only plans	Hawai'i proposes to retain these provisions.
Defines payment to federally-qualified health centers	Hawai'i proposes to retain these provisions.

Section 1303: Special Rules Related to Abortion Services

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

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

Key ACA Provisions	Hawai'i Proposal
Specifies rules for aggregation treatment of employers, employers not in existence in preceding year, and predecessor employers	Hawai'i proposes to retain these provisions.
Defines when a "growing" small employer that purchased employee coverage through SHOP may continue to do	Hawai'i proposes to waive the SHOP exchange so this provision, which would allow a "growing small employer" to continue to enroll employees through SHOP, would no longer be applicable.

CONSUMER CHOICES AND INSURANCE COMPETITION THROUGH HEALTH BENEFIT EXCHANGES

Section 1311: Providing Consumers a Health Insurance Exchange

Key ACA Provisions	Hawai'i Proposal
Requires establishment of an American Health Benefit Exchange, and details responsibilities of the exchange	Hawai'i proposes to retain the individual exchange via the Federally-Facilitated Marketplace.
Provides for the establishment of a SHOP exchange	Hawai'i proposes to waive the SHOP exchange for three important reasons: 1. To eliminate the burden of an expensive, unnecessary infrastructure for SHOP functions. Maintaining state-based SHOP functions is not economically feasible, fails to add value to the Prepaid Marketplace, and, in fact, imperils the success of Hawai'i's cost-effective system. 2. To relieve small employers of the added premium costs related to purchasing ACA plans on the SHOP. To avoid participating in the Federal SHOP, which provides misleading information to any Hawai'i small employers as to its responsibilities to provide employee coverage.
Specifies which entities are eligible to carry out responsibilities of the Exchange	Hawai'i proposes to waive this section to permit flexibility as to which state agencies, in addition to the Medicaid agency, can carry out responsibilities for the exchange.

Section 1312: Consumer Choice

Key ACA Provisions	Hawai'i Proposal
Details provisions for consumer choice among QHPs through an exchange	Currently, small employers in Hawai'i may select and pay for coverage at the level of a reference plan, giving employees a choice of specific options. This would continue as an option under Hawai'i's proposed waiver. Waiving *mandated* employee choice is necessary because: • Assuring such choice for employees of small businesses may require an on-going investment in technical infrastructure disproportionate to the benefits for Hawai'i's small market. • Only one Hawai'i plan participated in Hawai'i's SHOP exchange, rendering "consumer choice" meaningless. It is highly unlikely that any of the three other commercial insurers in Hawai'i will compete on SHOP in the future. • In Hawai'i's Prepaid environment, consumer choice is less significant because employers are required to purchase employee coverage with uniformly comprehensive benefits and can pass very little of the cost on to employees.

Key ACA Provisions	Hawai‘i Proposal
	• Employee coverage, benefits, and cost-sharing are significantly better under Prepaid than under ACA provisions.
Establishes that all enrollees in the individual market are in a single risk pool	Hawai‘i proposes to retain these provisions.
Establishes that all enrollees in the small group market are in a single risk pool	Hawai‘i 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	Hawai‘i proposes to retain these provisions.
Prevents state law from requiring grandfathered plans to be in the individual or small group risk pool	Hawai‘i proposes to retain these provisions.
Allows health issuers to offer coverage outside an exchange, and allows individuals and qualified employers to purchase coverage outside an exchange	Hawai‘i proposes to retain these provisions.
Maintains state control of plans outside of the exchange	Hawai‘i 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	Hawai‘i proposes to retain these provisions.
Describes health plan choices for members of Congress and Congressional staff	Hawai‘i proposes to retain these provisions.
Ensures that individuals who cancel enrollment on the exchange in favor of employer coverage will not be penalized	Hawai‘i proposes to retain these provisions.
Allows enrollment through agents and brokers	Hawai‘i proposes to retain these provisions.
Limits enrollment through an exchange to citizens and lawful residents	Hawai‘i proposes to retain these provisions.
Excludes incarcerated individuals	Hawai‘i proposes to retain these provisions.

Key ACA Provisions	Hawai‘i Proposal
Allows coverage via the exchange for the large group market	Hawai‘i proposes to waive this section to be consistent with its recommendation to waive the SHOP exchange.
Provides that access to coverage through an exchange may be denied to those who are not lawful residents for the entire enrollment period	Hawai‘i proposes to retain these provisions.

Section 1313: Financial Integrity

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

PREMIUM TAX CREDITS AND REDUCED COST-SHARING

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

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

INDIVIDUAL AND EMPLOYER RESPONSIBILITY REQUIREMENTS

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

Key ACA Provisions	Hawai‘i Proposal
Defines and details requirements for offering health insurance coverage by large employers and responsibilities of employees for enrolling	Hawai‘i proposes to retain these provisions.

Appendix 3: Q & A about the Hawai‘i Prepaid Health Care Act

History and Overview. The Hawai‘i Prepaid Health Care Act (“Prepaid”) was the first in the nation to set minimum standards for

health care benefits for workers. Employers, excluding Federal, State and City government and several others specifically excluded by the law, are required to provide Hawai‘i employees, who suffer a disability due to non-work related illness or injury, with adequate medical coverage, protecting them from the high cost of medical and hospital care. Detailed in Chapter 393, Hawai‘i Revised Statutes, Prepaid became law and was exempted from the federal Employee Retirement Income Security Act (“ERISA”) by Congress[1] in 1983. Because Prepaid is sanctioned by a Congressional ERISA exemption, any substantive change in the Act’s provisions would void the entire law.

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

Prepaid	ACA
• Employers with even a single permanent employee must provide coverage.	• Only large employers must offer employee coverage.
• All employees who work 20 or more hours per week for 4 consecutive weeks are eligible for coverage.	• Permanent employees are eligible for coverage if they work 30 hours or more per week.
• The actuarial value of Prepaid plans averages 80-90%.	• 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 W-2 earnings.

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

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

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

Answer 1. Employers must provide health care coverage to employees who work at least 20 hours per week and earn 86.67 times the current Hawai‘i minimum wage per month, which, as of January 1, 2016, equaled $736.70 ($8.50 x 86.67). Coverage commences after four (4) consecutive weeks of employment or the earliest time thereafter at which coverage can be provided by the health care plan contractor, which is usually the first of the month.[2]

[1] P.L. No. 97-473, §301 (29 U.S. C. §1144(b)(5))
[2] http://labor.hawaii.gov/dcd/about-phc/

"Employer," for purposes of Prepaid, does ***not*** include the United States Government, the State of Hawai'i or any of its political sub-divisions, any other state, or any foreign government.[3]

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

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

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

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

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

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

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

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

a) Already enrolled in another health insurance or Prepaid health care plan
b) Covered as a dependent under a Prepaid health care plan
c) A recipient of public insurance such as Medicaid or Medicare or some other public health care assistance plan
d) A spouse, child, or parent employed by the employer
e) A seasonal (agricultural) worker
f) An insurance agent or real estate broker working on commission
g) A domestic worker who provides attendant and day care services in the employ of a recipient of social service payments.[4]

In the event that the circumstances supporting an exemption end, the employer must enroll the employee in a Prepaid plan as provided in the Act, usually the first of the month following the reported change.[5] Self-employed individuals without employees are not eligible for Prepaid coverage.

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[3] §393-3 (3)
[4] §393-5
[5] §393-17

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

Answer 5. Except as negotiated under collective bargaining agreements, the employer must pay at least half of the cost of the premium but, "in no case shall the employee contribute more than 1.5% of the employee's wages…."[6] In effect, employers are currently paying an estimated 85% of the cost of employee premiums.

Question 6. Who chooses the insurer and plan type?

Answer 6. The employer chooses one or more insurer and plan type on behalf of employees.

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

Answer 7. The benefits identified in Prepaid[7] include:

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

Also covered by Prepaid but not codified in the statute are all additional benefits mandated in the insurance code as changed from time to time by State legislation. A list of such benefits is attached below.

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

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

Upon approval, plans are designated as 7(a) or 7(b) plans. Plans designated as 7(a) are equal to or better than the benefits offered by the plan with the largest number of subscribers (also known as the "prevalent plan") in the State of Hawai'i. Plans designated as 7(b) provide for sound basic hospital, surgical, medical, and other health care benefits; however, the plan's benefits, such as the deductible, out of pocket limit, benefit level and copayments, may be more limited than the benefits provided by plans qualifying as 7(a). Employers that choose more robust – and more expensive - 7(a) plans must provide coverage to employees only. If a 7(b) plan is chosen, the employer must pay one-half of the cost for dependents' coverage in addition to covering the employee with no more than a 1.5% of wages contribution.[8]

[6] §393-13
[7] §393-7 (c)
[8] http://labor.hawaii.gov/dcd/about-phc/

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

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

a) Purchase an approved plan (the DLIR website provides a link to the list of already approved plans). In Hawai'i, insurance companies, mutual benefit societies and health maintenance organizations can sell health care plans to Hawai'i employers directly. These plans must be reviewed by the Prepaid Health Care Advisory Council and approved by the Director of the DLIR before they can be marketed to employers.

b) Purchase an insured plan of the employer's choice. Some employers with corporate offices located outside of Hawai'i purchase a health care plan and offer it to their employees on a nationwide basis. Employers that choose this option must submit their plan to DLIR for review by the Prepaid Health Care Advisory Council and approval by the Director to ensure the benefits are comparable to plans sold in Hawai'i.

c) Provide a health care plan that is funded by the employer. A self-insured employer must show proof of financial solvency and ability to pay benefits by furnishing DLIR with the latest audited financial statements for review. Following the initial approval, the audited financial statements must be filed annually for continued approval. Employers choosing this option must complete an application for self-insurance as well as submit a copy of their health care plan to DLIR for review by the Prepaid Health Care Advisory Council and approval by the Director to ensure the benefits are comparable to plans sold in Hawai'i.[9]

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

Answer 10. Prepaid's influence on coverage and consumer expectations is the single most significant aspect of health insurance in Hawai'i. Between public and private sector employees and their dependents, there are more than 850,000 Prepaid-covered lives.

Question 11. How is Prepaid enforced with employers?

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

- Levy Prepaid health care penalties and injunctions. Employers that do not provide health care insurance to their eligible employees are liable to pay for their employees' medical expenses[10]
- Monitor employer compliance through its Disability Compensation Information System that tracks employers' health care coverage of their employees

[9] http://labor.hawaii.gov/dcd/about-phc/

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

- Conduct random compliance checks of employers by the Disability Compensation Division's Audit and Investigation sections
- Carry out on-site investigations of employers identified through its Delinquent/Non-Compliant Employer reports
- Maintain a hotline for employees or others to report employers who fail to comply with Prepaid

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

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

The Health Insurance Branch also addresses inquiries and complaints pertaining to federal and state laws governing health insurance resulting in consumer saving in the thousands of dollars per year. In addition, the Branch assists consumers, health care 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.

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:

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

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

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

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

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

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

(1) The service is localized in this State; or

(2) The service is not localized in any state but some of the service is performed in this State and

(A) The individual's base of operation, or, if there is no base of operation, the place from which such service is directed or controlled, is in the State; or

(B) The individual's base of operation or place from which the service is directed or controlled is not in any state in which some part of the service is performed but the individual's residence is in this State.

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

(1) Service performed by an individual in the employ of an employer who, by the laws of the United States, is responsible for care and cost in connection with such service;

(2) Service performed by an individual in the employ of the individual's spouse, son, or daughter, and service performed by an individual under the age of twenty-one in the employ of the individual's father or mother;

(3) Service performed in the employ of a voluntary employee's beneficiary association providing for the payment of life, sick, accident, or other benefits to the members of the association or their dependents or their designated beneficiaries, if:

(A) Admission to membership in the association is limited to individuals who are officers or employees of the United States government; and

(B) No part of the net earnings of the association inures (other than through such payments) to the benefits of any private shareholder or individual;

(4) Service performed by an individual for an employer as an insurance agent or as an insurance solicitor if all service performed by the individual for the employer is performed for remuneration by way of commission;

(5) Service performed by an individual for an employer as a real estate salesperson or as a real estate broker if all service performed by the individual for the employer is performed for remuneration by way of commission;

(6) Service performed by an individual who, pursuant to the federal Economic Opportunity Act of 1964, is not subject to the provisions of law relating to federal employment, including unemployment compensation;

(7) Domestic, which include attendant care, and day care services authorized by the department of human services under the Social Security Act, as amended, performed by an individual in the employ of a recipient of social service payments.

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

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

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

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

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

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

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

(1) Hospital benefits:

(A) In-patient care for a period of at least one hundred twenty days of confinement in each calendar year covering

(i) Room accommodations;
(ii) Regular and special diets;
(iii) General nursing services;
(iv) Use of operating room, surgical supplies, anesthesia services, and supplies;
(v) Drugs, dressings, oxygen, antibiotics, and blood transfusion services.

(B) Out-patient care

(i) Covering use of out-patient hospital;
(ii) Facilities for surgical procedures or medical care of an emergency and urgent nature.

(2) Surgical benefits:

(A) Surgical services performed by a licensed physician, as determined by plans meeting the standards of subsections (a) and (b);
(B) After-care visits for a reasonable period;
(C) Anesthesiologist services.

(3) Medical benefits:

(A) Necessary home, office, and hospital visits by a licensed physician;
(B) Intensive medical care while hospitalized;
(C) Medical or surgical consultations while confined.

(4) Diagnostic laboratory services, x-ray films, and radio- therapeutic services, necessary for diagnosis or treatment of injuries or diseases.

(5) Maternity benefits, at least if the employee has been covered by the prepaid health care plan for nine consecutive months prior to the delivery.

(6) Substance abuse benefits:

(A) Alcoholism and drug addiction are illnesses and shall receive benefits as such. In-patient and out-patient benefits for the diagnosis and treatment of substance abuse, including but not limited to alcoholism and drug addiction, shall be specifically stated and shall not be less than the benefits for any other illness, except as provided in this subsection. Medical treatment of substance abuse shall not be limited or reduced by restricting coverage to the mental health or psychiatric benefits of a plan. However, any psychiatric services received as a result of the treatment of substance abuse may be limited to the psychiatric benefits of the plan.

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

(i) Providing the benefits in its own facility and utilizing its own staff, or
(ii) Contracting for the provision of these benefits, or

(iii) Authorizing the patient to utilize outside services and defraying or reimbursing the expenses at a rate not to exceed that for provision of services utilizing the health contractor's own facilities and staff.

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

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

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

PART II. MANDATORY COVERAGE

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

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

(1) A plan which obligates the prepaid health care plan contractor to furnish the required health care benefits; or

(2) A plan which obligates the prepaid health care plan contractor to defray or reimburse the expenses of health care.

The employer's election is binding for one year.

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

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

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

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

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

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

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

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

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

(1) Protected by health insurance or any prepaid health care plan established under any law of the United States;

(2) Covered as a dependent under a prepaid health care plan, entitling the employee to the health benefits required by this chapter;

(3) A recipient of public assistance or covered by a prepaid health care plan established under the laws of the State governing medical assistance.

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

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

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

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

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

§393-20 Adjustment of employer-sponsored plans. Where employees subject to the coverage of this chapter are included in the coverage provisions of an employer-sponsored prepaid health care plan covering similar employees employed outside the State and the majority of such employees are not subject to this chapter, the benefits

applicable to the employees covered by this chapter shall be adjusted within one year after the effective date of this chapter so as to meet the requirements of this chapter.

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

(1) Requesting the waiver by a writing submitted to the employer; and

(2) Receiving approval of the waiver from the director upon the director determining that the employee has other coverage under a prepaid health care plan which provides benefits that meet the standards prescribed in section 393-7.

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

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

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

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

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

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

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

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

PART III. ADMINISTRATION AND ENFORCEMENT

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

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

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

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

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

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

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

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

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

PART IV. PREMIUM SUPPLEMENTATION

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

§393-42 Management of the fund. The director of finance shall be the treasurer and custodian of the premium supplementation fund and shall administer the fund in accordance with the directions of the director of labor and industrial relations. All moneys in the fund shall be held in trust for the purposes of this part only and shall not be expended, released, or appropriated or otherwise disposed of for any other purpose. Moneys in the fund may be deposited in any 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.

Appendix 4: Healthcare.Gov Excerpts that Conflict with Prepaid

Statements directed to small employers at healthcare.gov explicitly contradict Prepaid obligations.

Hawai'i Law	Healthcare.gov: Information for Small Employers that Conflicts with Hawai'i law
A business with even a single qualified employee who works 20+ hours/week for four consecutive weeks must provide health insurance.	**"If you have fewer than 50 full-time equivalent (FTE) employees, you are not required to provide insurance to your employees. You can choose to offer insurance through the SHOP Marketplace or any other source. But you don't have to, and you don't face a penalty if you don't."** *("More answers: The SHOP Marketplace, Do I have to provide insurance to my employees?" https://www.healthcare.gov/small-businesses/provide-shop-coverage/shop-marketplace-overview/)*
Employers may not recoup more than 1.5% of salary for employee premiums.	**"Think about how much money you're able to spend for group coverage. You'll also need to consider how much your employees can spend for their coverage."** *("About the SHOP Marketplace" https://marketplace.cms.gov/outreach-and-education/about-shop-2016.pdf and "10 Tips to Get SHOP Marketplace Coverage" https://marketplace.cms.gov/outreach-and-education/tips-for-coverage-shop-2016.pdf)* **"As with all health and dental plans, you and your employees have to pay a monthly premium. You decide up front exactly how much you can afford to contribute towards your employees' premiums."** *("Things to Think About When Choosing a Plan for Your Business" https://marketplace.cms.gov/outreach-and-education/things-to-think-about-shop-2016.pdf)* **"You have choice and flexibility. You can:** o **Choose how much you pay toward your employees' premiums, and whether to offer coverage to their dependents"** *https://www.healthcare.gov/small-businesses/provide-shop-coverage/shop-marketplace-overview/*
Employers must offer coverage at the earliest date possible after regular employee has worked four consecutive weeks.	**"Decide how long your employees' initial enrollment period is, and how long new employees must wait before joining the plan"** *https://www.healthcare.gov/small-businesses/provide-shop-coverage/shop-marketplace-overview/* **"You'll need to choose a month to start coverage. Consider what timing would work best for you and your employees."** *("About the SHOP Marketplace" https://marketplace.cms.gov/outreach-and-education/about-shop-2016.pdf and "10 Tips to Get SHOP Marketplace Coverage" https://marketplace.cms.gov/outreach-and-education/tips-for-coverage-shop-2016.pdf)* **"Under the health care law, if you offer health insurance to your employees, you must offer it to all eligible employees within 90 days of their employment start date."** *https://www.healthcare.gov/small-businesses/health-care-law-and-business/how-aca-affects-businesses/*

	"You have choice and flexibility. You can: o **Decide how long your employees' initial enrollment period is, and how long new employees must wait before joining the plan"** https://www.healthcare.gov/small-businesses/provide-shop-coverage/shop-marketplace-overview/
Hawai'i employers must offer coverage to all regular non-exempt employees regardless of up-take rates.	**"In most states, 70% of your eligible employees must enroll in the plan(s) you offer in order for your small business to participate in the Small Business Health Options Program (SHOP) Marketplace at any point during the year. This percentage may be different in your state."** *("SHOP Employee Minimum Participation Rate"* *https://marketplace.cms.gov/outreach-and-education/employee-minimum-participation-shop-2016.pdf*)
Employers must purchase Prepaid-approved plans that are currently at an average actuarial value of gold or platinum.	**"Health plans in the SHOP Marketplace are put into 4 plan categories based on how your employees and the plan can expect to share the costs for health care: Bronze, Silver, Gold, and Platinum."** (*"Things to Think About When Choosing a Plan for Your Business"* *https://marketplace.cms.gov/outreach-and-education/things-to-think-about-shop-2016.pdf*)
Prepaid requires that small employers offer medical insurance.	**"Employers offering SHOP Marketplace coverage can now offer a dental plan to employees without offering a health plan."** *("Things to Think About When Choosing a Plan for Your Business"* *https://marketplace.cms.gov/outreach-and-education/things-to-think-about-shop-2016.pdf*) **"You have choice and flexibility. You can:** o **Offer only health coverage, health and dental coverage, or only dental coverage"** *https://www.healthcare.gov/small-businesses/provide-shop-coverage/shop-marketplace-overview/*
Hawai'i employers should avoid healthcare.gov. Information provided there could jeopardize compliance with Prepaid, which remains in force under the ACA.[11]	**"If your business is in a state that isn't running its own SHOP Marketplace, use HealthCare.gov to enroll. Select APPLY NOW for your state, then follow the steps below."** *("Steps for Employers to Enroll in the SHOP Marketplace"* *https://marketplace.cms.gov/technical-assistance-resources/logo-and-infographics/steps-employers-enroll-shop-2016.pdf*)

[11] Per ACA *§1560(b) RULE OF CONSTRUCTION REGARDING HAWAII'S PREPAID HEALTH CARE ACT.—Nothing in this title (or an amendment made by this title) shall be construed to modify or limit the application of the exemption for Hawaii's Prepaid Health Care Act (Haw. Rev. Stat. §§ 393–1 et seq.) as provided for under section 514(b)(5) of the Employee Retirement Income Security Act of 1974 (29 U.S.C.1144(b)(5)).*

Appendix 5: Letters of Support

Chamber of Commerce HAWAII
The Voice of Business

June 2, 2016

Secretary Sylvia Matthews Burwell
U.S. Department of Health and Human Services
200 Independence Avenue, S.W.
Washington, DC 20201

Re: Hawaii Section 1332 Waiver Proposal

Dear Secretary Burwell:

The Chamber of Commerce Hawaii supports the state's proposed Section 1332 waiver. This proposal is intended to ensure that the Prepaid Health Care Act is not eroded. It also ensures that Hawaii will not have to develop a web-based marketplace for small employers that is unneeded, expected to be unused and can only increase the cost of coverage.

- In Hawaii, employers have shouldered responsibility to health coverage, understanding the importance of contributing to the public good as well as keeping employees healthy and productive.
- Hawaii is also unique in having a cooperative, low-tech, but highly effective enrollment system for small businesses and their employees.
- Since health insurance coverage is a major expense any costs that don't add significant value – such as developing and maintaining an enrollment website – must be avoided.
- Health care consumers in Hawaii have benefited for years from Prepaid and now, because Hawaii adopted other ACA coverage opportunities, our uninsured rate is about as low as it can go.
- Also of note, the Chamber of Commerce Hawaii was among a number of community and public agencies that served on the task force and committees that developed the proposed waiver and we believe the open process carried out over more than a year ensured ample discussion and good decision-making for the people of Hawaii.

Mahalo,

Sherry Menor-McNamara
President and CEO

1132 Bishop Street, Suite 2105 • Honolulu, Hawaii 96813 • Phone: (808) 545-4300 • Facsimile: (808) 545-4369

INTERNATIONAL LONGSHORE & WAREHOUSE UNION
LOCAL OFFICE • 451 ATKINSON DRIVE • HONOLULU, HAWAII 96814 • PHONE 949-4161
HAWAII DIVISION: 100 West Lanikaula Street, Hilo, Hawaii 96720 • OAHU DIVISION: 451 Atkinson Drive, Honolulu, Hawaii 96814
MAUI COUNTY DIVISION: 896 Lower Main Street, Wailuku, Hawaii 96793 • KAUAI DIVISION: 4154 Hardy Street, Lihue, Hawaii 96766
LOCAL 142

June 7, 2016

The Honorable Sylvia Matthews Burwell
Secretary, U.S. Department of Health and Human Services
200 Independence Avenue, S.W.
Washington, D.C. 20201

RE: Hawaii Section 1332 Waiver Proposal

Dear Secretary Burwell:

The ILWU Local 142 supports Hawaii's proposed 1332 waiver to help ensure that Hawaii's workers have equitable health insurance benefits under the Prepaid Health Care Act.

The ILWU is the largest private sector labor union in Hawaii and represents 18,000 members statewide who work in various industries. Our members work on the docks as longshoremen, in hotels as housekeepers, cooks, and landscapers, in agriculture growing pineapple, coffee and macadamia nuts, and as automotive technicians, x-ray technicians, supermarket clerks and warehousemen, and production and sales workers in the state's largest bakery. Our members and their families have health care coverage through their collective bargaining agreements. However, many of their friends and family who do not work for unionized companies must rely on the Prepaid Health Care Act for coverage to help them pay for needed medical care.

The Prepaid Health Care Act not only ensures that all full-time employees have medical coverage but also sets the standard for the coverage that is required. Hawaii has a law like no other in the nation. In fact, we had hoped that the Affordable Care Act would be more like Hawaii's law that imposes a mandate on employers, but we understand that universal coverage virtually necessitates shared responsibility.

Health insurance is a fundamental benefit that all consumers must have. The Prepaid Health Care Act ensures access to health benefits and lower out-of-pocket costs for the vast majority of working people and their families. The proposed waiver will protect Hawaii's Prepaid Health Care Act by allowing Hawaii to continue enrollment without building an expensive web-based system. Instead of SHOP, employers can easily access health insurance through user-friendly insurers without the need for an exchange system that will only add to the cost of insurance.

Hawaii's recent experience with the Hawaii Health Connector has clearly illustrated the huge cost of setting up an IT system to run an exchange in a small marketplace where most of the workforce already has access to health insurance. Use of the federal SHOP exchange would only confuse and frustrate employers and their employees.

The Affordable Care Act provided consumers throughout the nation with new opportunities for health insurance coverage. We are proud that Hawaii early adopted Medicaid expansion to increase the insured population. We support ongoing efforts to enroll individuals and families through the federal exchange for health care coverage. We believe that universal coverage is possible and will assure access to quality health care and reduce costs.

Toward that end, we support the Section 1332 waiver proposed by the State of Hawaii to protect and preserve Hawaii's Prepaid Health Care Act. We respectfully request your favorable consideration of the state's proposal.

Sincerely,

Donna Domingo

Donna Domingo
President

csphowu

HPCA
HAWAI'I PRIMARY CARE ASSOCIATION

June 7, 2016

Secretary Sylvia Matthews Burwell
US Department of Health and Human Services
200 Independence Avenue, S.W.
Washington, DC 20201

Re: Hawai'i Section 1332 Waiver Proposal

Dear Secretary Burwell:

The Hawai'i Primary Care Association (HPCA) represents the providers of care in underserved areas so is aware of health insurance issues and disparities across the state, especially for people with income, racial, geographic, or other barriers to care. We support Hawai'i's proposal to waive provisions of the Affordable Care Act (ACA) that might detract from effectiveness of the Prepaid Health Care Act.

Prepaid has a long history of ensuring that virtually all people who work have employer-sponsored coverage. This means that the proposed waiver will be more, rather than less, likely to ensure that there is equality in coverage for workers. Coverage will remain the same for all employees, including the availability of insurance, the array of benefits, and the out-of-pocket costs. Workers of all ages, income levels, geographic locations, ethnic and racial identification, and pre-existing conditions will all have the same high level of coverage because Prepaid's requirements remain intact for small employers.

I also served as a member of the task force that worked on Hawai'i's waiver proposal and can provide assurances, to the best of my knowledge, the process has been aimed at ensuring that, between the ACA and the Prepaid Health Care Act, a significant majority of the people of Hawai'i have the best, most comprehensive, and affordable health insurance coverage possible.

Very truly yours,

Robert Hirokawa, DrPH
Chief Executive Officer

ADD 1003 BISHOP STREET PAUAHI TOWER SUITE 1810 HONOLULU, HI 96813 TEL 808.536.8442 WEB HAWAIIPCA.NET

Healthcare Association of Hawaii

June 3, 2016

The Honorable Sylvia Matthews Burwell
US Department of Health and Human Services
200 Independence Avenue, S.W.
Washington, DC 20201

Dear Madam Secretary Burwell:

RE: Letter of Support for State of Hawaii's Section 1332 Waiver

The Healthcare Association of Hawaii (HAH), established in 1939, serves as the leading voice of healthcare on behalf of 180 member organizations that represent almost every aspect of the healthcare continuum in Hawaii. Our members include acute care hospitals, skilled nursing facilities, assisted living facilities, home health agencies, hospices and durable medical equipment suppliers. In addition to providing access to appropriate, affordable, high quality care to all of Hawaii's residents, our members contribute greatly to Hawaii's economy by employing over 20,000 people statewide.

We are writing today to express our strong support for the State of Hawaii's Section 1332 waiver before you. We were pleased to serve on the governor's task force that considered and provided recommendations on what we believe to be the best path for health insurance coverage for Hawaii residents.

As you may know, Hawaii has a long and proud history of healthcare innovation. The state's Prepaid Health Care Act (PHCA), which was adopted in 1974, allows Hawaii employees access to health insurance via an employer mandate. The PHCA has worked well for decades, providing certainty to employees and stability to the healthcare system.

By granting this waiver, HHS will preserve this touchstone of our healthcare system and make it clear to all employers in Hawaii that they are expected to continue to provide coverage in accordance with the PHCA. We believe that the continuation of the PHCA will ensure that consumers use their health insurance effectively; that providers continue to receive adequate payments from commercial insurers; and that we can keep our uninsured rate to one of the lowest in the nation.

This waiver represents the efforts of a diverse group of stakeholders and interested parties, and will support the vitality of our health care system in the state. As such, we respectfully request that you approve the State of Hawaii's Section 1332 Waiver as presented.

Sincerely,

George W. Greene, Esq.
President and CEO
Healthcare Association of Hawaii

CC: Laurel A. Johnston, Office of the Governor

Phone: (808) 521-8961 | Fax: (808) 599-2879 | HAH.org | 707 Richards Street, PH2 - Honolulu, HI 96813

HAWAII HEALTH SYSTEMS
CORPORATION
Quality Healthcare For All

June 6, 2016

CEO – 16 – 050

Secretary Sylvia Matthews Burwell
U.S. Department of Health and Human Services
200 Independence Avenue, S.W.
Washington, D.C. 20201

RE: State of Hawaii Section 1332 State Innovation Waiver Proposal

Dear Secretary Burwell:

I am the Chief Executive Officer of the Hawaii Health Systems Corporation ("HHSC") writing in support of the State of Hawaii's Section 1332 State Innovation Waiver Proposal ("Waiver"). HHSC is a state agency operating 14 public hospitals on 5 islands across the state.

The primary factor that distinguishes healthcare and health insurance in our state and provides the basis for the Waiver request is Hawaii's Prepaid Health Care Act ("PHC"). The PHC requirements for employers to provide health insurance have resulted in a high proportion of our population being insured. And the health insurance mandate provides that policies are comprehensive. Our state-selected benchmark plan includes the ten Essential Health Benefits and thus the proposed waiver will not diminish benefits currently provided by employers nor result in decreased affordability of health insurance.

Many of our HHSC facilities are in rural communities with high rates of poverty and require operating subsidies of state funds. The relatively high rate of comprehensive health insurance in our working population brought about by the PHC has greatly helped HHSC facilities to offset losses from those who are uninsured or underinsured. In addition, the adoption of ACA's coverage options to enroll low-income residents in either Medicaid or individual and family plans combined with the PHC has further led to a relatively small number of people who remain uninsured.

Our population in Hawaii enjoys relatively good health and lower health care costs compared to other states. While the PHC is by no means the only reason for this situation, it has certainly contributed by assuring that all working people have the same benefits and protections regardless of income, health status, race, or age. For these reasons I ask that you give your favorable consideration to Hawaii's Waiver application.

Sincerely,

Linda Rosen, M.D., M.P.H.
Chief Executive Officer

3675 KILAUEA AVENUE • HONOLULU, HAWAII 96816 • PHONE: (808) 733-4020 • FAX: (808) 733-4028

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www.hhsc.org <http://www.hhsc.org>