REPORT TO THE 28TH LEGISLATURE
STATE OF HAWAIʻI
2015

The State Affordable Care Act Innovation Waiver Task Force

Pursuant to Act 158, Session Laws of Hawaiʻi (SLH) 2014
and
Act 184, SLH 2015

Respectfully Submitted by
The Office of the Governor
December 2015

Contents

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Executive Summary. The federal Patient Protection and Affordable Care Act ("ACA"), P.L. 111-148, makes sweeping changes in health care delivery, coverage, and payment systems. Of prominent interest is the Act's required or permitted health insurance reforms, including the expansion of eligibility for Medicaid, development of state and federal health insurance "marketplaces," benefit design, tax credits and cost-sharing reductions, and individual and employer mandates for coverage. The ACA allows states to waive certain parts of the Act but specifically prohibits waivers from being effective before January 1, 2017.

Hawai'i, with its successful history of health coverage innovation, is interested in the waiver opportunities provided, in large part, because our long-standing Prepaid Health Care Act ("Prepaid") provides a more advanced employer mandate than does the ACA. In 2014, the Legislature created by Act 158 a State Innovation Waiver Task Force with the purpose of developing "a health care reform plan that meets requirements for obtaining a state innovation waiver." Act 158 was amended by Act 184 in 2015 reducing the scope of task force responsibilities. This second task force report outlines the waiver possibilities allowed by the ACA, and recommends which provisions should be waived and which provisions should be retained. Finally, the report summarizes the timeline and work necessary to complete a waiver that can be implemented by January 2017.

The task force recommends three actions, noted below, that support both State and ACA goals:

- ***To come as close as possible to meaningful, universal health insurance coverage***
- ***To ensure that Prepaid remains the standard for employer-sponsored care in Hawai'i***
- ***To reduce unnecessary costs and complexity in the insurance marketplace***

The task force also asks that the 2016 Legislature pass legislation that authorizes submission of an ACA Waiver proposal.

ACA State Innovation Waiver Task Force Recommendations

1. **Maintain access to affordable health insurance coverage for individuals via the State-Based Exchange utilizing the Federal Platform ("SBE-FP").**
2. **Align the ACA with Prepaid Health Care Act requirements for private employers to the extent allowable.**
3. **Waive the ACA Small Business Health Options Program ("SHOP") and its requirements for the small business marketplace, including the employee choice provision**.

Hawai‘i’s ACA Task Force, Process, and Next Steps

The ACA provides for State Innovation Waivers to allow states to adapt and improve on certain sections of the Act. As described in §1332, waivers are available for certain, but by no means all, parts of the ACA and must ensure affordability, access to coverage, and benefits that are at least as good as required under the Act. The section allows for coordinating aspects of Medicare and Medicaid with the ACA via waivers, and would accommodate different strategies for individual coverage. Waivers are optional vehicles that may not be implemented before January 1, 2017; however, states may propose any number of waivers to support innovation after that date, provided they fit the parameters of §1332.

Hawai‘i’s State Legislature, recognizing the possibilities in an ACA waiver, passed legislation in 2014 creating a task force to explore and develop a Hawai‘i-specific proposal. The State Innovation Waiver Task Force, with members as prescribed in Act 158, has met regularly since September 2014. The agencies and individuals who served on the task force in 2015 were:

Beth Giesting, Chair, Governor’s Office
Pono Chong, Chamber of Commerce of Hawai‘i
Joan Danieley, Senate Appointee, Kaiser-Permanente/ Health Care Consultant
Jennifer Diesman, Senate Appointee, HMSA
Bryan FitzGerald, Office for Information Management and Technology
Robert Hirokawa, Hawai‘i Primary Care Association
David Hong, House Appointee, Island Plastic Bags
Daniel Jacob, Office of the Attorney General
Lorrin Kim, Department of Health
Jeff Kissel, Hawai‘i Health Connector
Royden Koito, Department of Labor and Industrial Relations
Derek Mizuno, Employer-Union Health Benefits Trust Fund
Carole Richelieu, Insurance Division
Christine Sakuda, Hawai‘i Health Information Exchange
Leslie Tawata, MedQUEST Administration
Paula Yoshioka, House Appointee, The Queen’s Health System
Paul Young, Healthcare Association of Hawai‘i

All meetings were conducted in accordance with state open meeting requirements, and all materials are posted on the Governor’s website at http://governor.hawaii.gov/healthcareinnovation/healthcare-transformation/.

The task force carefully considered all sections of the ACA that can be waived. It identified those that improve coverage and consumer protections and those that contradict, confuse, or weaken employer-coverage mandates in Prepaid. The task force deliberated over the implications of its recommendations for any changes in benefits and processes related to insurance coverage, regulation, purchase, and cost. While the task force was not itself involved in the urgent work over the past year related to changes in the Hawai‘i Health Connector and federal marketplace responsibilities, it endeavored to ensure that its waiver recommendations are consistent with foreseeable new processes.

Appendix 2 includes the text of §1332 and links to regulations and guidance for developing State Innovation Waivers, as posted in the Federal Register Vol. 77, No. 38, Monday, February 27, 2012, and Vol. 80, No. 241, Wednesday, December 16, 2015.

Among the procedural requirements for an ACA waiver are

- Completion of public hearings. These hearings took place in seven venues on six islands in September and October 2015, in conformance with federal requirements included in the Feb. 27, 2012 guidance. A summary of the hearings is included in Appendix 4.
- Providing public information and promoting input. Additional public information and comment requirements are specified in the Dec. 16, 2015 guidance, which will be met as soon as possible.
- Legislative authority. The state legislature must authorize any proposed waiver. A copy of draft legislation is attached in Appendix 1.

Next steps and timeline. The task force expects to engage in consultation with federal agencies to ensure that our application meets the 2012 and 2015 guidance on §1332 waiver, including fulfilling actuarial and economic analysis requirements and meeting national standards for postings to assure access for individuals with disabilities. Other steps to complete include:

Authorizing legislation. Section 1332(a)(1)(C) requires that a proposed waiver be authorized by enacted state legislation. In order to implement a waiver in 2017, the 2016 Hawai‘i State Legislature would have to approve such legislation (see Appendix 1).

Approval by HHS Secretary. Per ACA §1332(b) (1)(A), the Secretary must determine that the planned waiver provides:

- Coverage that is at least as comprehensive as described in §1302(b), which identifies the Essential Health Benefits (“EHBs”)
- Cost sharing protections that make coverage at least as affordable as the provisions in Title 1 of the ACA
- Coverage to a comparable number of people as the provisions in Title 1 of the ACA
- Budget neutrality so that the waiver plan does not contribute to the federal deficit

Timeline. A preliminary review of any waiver application by the Secretaries of HHS and the Treasury to determine whether it is complete may require 45 days. Once it is determined to be complete, the federal agencies have up to 180 days to carry out the review and public notice process.

The task force proposes a waiver timeline as follows:

Date	Key Event
August 2015	Task force completes recommendations First draft of waiver completed
September-October 2015	Public information provided, public hearings conducted, feedback solicited and compiled
November – December 2015	Waiver recommendations updated Legislative report and draft legislation developed
December 2015	Second report to the Legislature submitted

May 2016	Waiver legislation enacted Application sent to HHS Secretary
July 2016	Application determined to be complete
December 2016	Notification received that proposal is approved Final report to Legislature submitted
January 2017	Waiver implemented
June 2017	First report to HHS Secretary on waiver implementation submitted ACA Waiver task force is dissolved

The ACA's Waiver Opportunities

The ACA includes many advances for health insurance and health care delivery and payment systems. Among them are opportunities for individuals to obtain health insurance made affordable by federal premium subsidies and cost-share reductions. Unfortunately, the ACA also imposes benefit, coverage, and payment rules and mechanisms that are misaligned with Hawai'i's long-standing Prepaid Health Care Act, which, when coupled with public Medicaid, Medicare, and federal and military insurance programs, has resulted in one of the lowest percentages and smallest uninsured populations in the nation.

The ACA calls for the development of state-based insurance exchanges, or "marketplaces," and Hawai'i was the first state to declare its intent to create one. This decision was largely motivated by concern that any other course could jeopardize Prepaid, whose provisions are superior to the ACA in requiring that private employers purchase robust insurance coverage for all but part-time or temporarily employed workers. Subsequent experience demonstrated that the demands for developing and maintaining the technical infrastructure for a state-based exchange were unsustainable for a state with a small population, a limited number of uninsured residents,[1] and a long-established mandate for business-sponsored employee coverage.

The ACA's waiver provisions appear to allow Hawai'i to adjust marketplace requirements to reflect the state's long history with Prepaid and more recent challenges with an on-line marketplace. Waiver parameters are described in §1332 and amplified in the Federal Register, Vol. 77, Number 38 and Vol. 80, Number 241. The following summarizes the requirements for waiver proposals:

[1] Before ACA marketplace coverage was available, the estimated number of uninsured people in Hawai'i was 100,000, approximately half of whom were expected to qualify for expanded Medicaid coverage.

Waiver Proposal and Process Requirements and Options

A complete waiver proposal for the federal Department of Health and Human Services ("HHS") and the Department of the Treasury, if applicable, must include the following:

- Evidence that the State complied with public notice and public hearing requirements per §33.112 (31 CFR 33), including a description of issues raised during the public notice and comment period
- A comprehensive description of the program to implement a waiver
- A copy of enacted state legislation that provides the State with the authority to implement the proposed waiver
- Identification of all ACA provisions that the state seeks to waive and the reasons they should be waived
- Data and analyses, actuarial certifications, assumptions, and targets sufficient to assure the Secretary that coverage, cost-sharing, and availability are at least as good under the waiver as under the ACA
- Economic analysis demonstrating budget neutrality for the federal government, including a 10-year waiver budget projection
- Analysis of the impact of the waiver on health insurance coverage in the state
- Data and assumptions that include information about
    - The age, income, health expenses, and current health status of the affected population
    - The number of employers offering insurance and the number of employees affected
    - Whether or not the waiver increases or decreases administrative burden for individuals, employers, or insurers, how, and why
    - How the waiver will or will not affect implementation of parts of the ACA that are not being waived
    - How the waiver affects the ability of residents to obtain care out of state
- An explanation of how the State will assure compliance and reduce waste, fraud, and abuse related to coverage under the waiver
- A description of the implementation process and timeline
- Targets and a plan for reporting on waiver implementation and impact

Public review and reporting requirements. Within six months of a waiver being implemented and annually thereafter, the State must hold public hearings and document any complaints. States must submit quarterly reports to the HHS Secretary that include any on-going operational challenges and plans to address them. In addition, annual reports will be required that document progress of the waiver, data on compliance, summary descriptions of public hearings, and other information that may be required, including that described in the terms and conditions issued upon waiver approval.

Coordination with other federally-funded health care programs. §1332(a)(5) provides for opportunities to coordinate ACA waivers for Medicaid and Medicare.

Sections of the Affordable Care Act that may be waived. The sections of the ACA that may be waived are outlined below. The task force methodically reviewed each and its section-by-section recommendations are included in Appendix 3.

Provisions of the Affordable Care Act that May be Waived under §1332

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

§1301: Definition of **QHPs**

§1302: **EHB** requirements, including

- Identifying EHBs
- Annual limitations on cost-sharing
- Annual limitations on deductibles for employer-sponsored plans
- Levels of coverage as currently defined by metal levels (platinum, gold, silver, bronze)
- Catastrophic plans
- Child-only plans

§1303: **Special rules** related to abortion services

§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

§1311: Affordable health plan choices via **establishing exchanges**

§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

§1313: **Financial integrity** expectations that exchanges will keep accurate accounts of receipts and expenditures

Premium tax credits and reduced cost-sharing

§1402: **Cost-sharing reductions** via enrollment in QHPs

§36B of the IRS Code: **Refundable credits/premium assistance** for coverage in a QHP

Individual and employer responsibility requirements

§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

§5000A of the IRS Code: Requirement to **maintain minimum coverage (§1501)**

- Penalties
- Exemptions
- Definition of minimum essential coverage

Task Force Recommendations

Ensuring the continuation of Prepaid was the major theme of the task force's work. Early in the process, the task force unanimously endorsed the continuation of Hawai'i's unique private employer mandate, which for more than 40 years, has met or exceeded the goals of the ACA for employer sponsored health coverage.

The task force's general approach and recommendations are:

- Individual and SHOP marketplaces should be treated separately when considering waiver options.
- To the extent allowable, employer sponsored benefits should be consistent with Prepaid for both small and large businesses. Prepaid is the single standard for large businesses, while Hawai'i's small businesses are also subject to two key ACA provisions, namely providing the EHBs, noted below, and the method for premium calculation. The latter difference is important because the ACA requires that premiums for small businesses be priced by community rating adjusted by age and tobacco use but, for large businesses, premiums continue to be rated by experience. The ACA-mandated change has been of concern in Hawai'i, but this provision is not one that may be waived.
- Changes proposed in a waiver should result in better consumer service, reduced duplication and costs, and enhanced security, efficiency, and sustainability. Such improved functionality applies to:
    - Eligibility determination;
    - Outreach, marketing, and application assistance; and
    - Insurance enrollment, billing, and reporting.

Consistent with this approach, the ACA Innovation Waiver Task Force endorses the three following actions for Hawai'i's insurance marketplace:

1. **Maintain access to affordable health insurance coverage for individuals via the SBE-FP**. This benefits individuals and supports Hawai'i's goals for universal coverage at a sustainable cost corresponding with the dimensions of Hawai'i's uninsured population.

2. **Align the ACA with Prepaid requirements, to the extent allowable.** The task force recommends waiving:
    a. The requirement that employer sponsored plans include at least a "silver" level option
    b. Allowing multi-state and co-op plans to serve the employer-sponsored market
    c. Requiring employee choice
    d. Defining eligible employees as those working 30 or more hours per week

3. **Waive the ACA Small Business Health Options Program (SHOP) and its requirements for the**

small business marketplace, including the employee-choice provision. Waiving SHOP means that Hawai'i will not maintain a state-based technology platform that performs eligibility, plan selection, and enrollment functions. Instead, the task force recommends that Hawai'i support a Prepaid Employee Coverage Marketplace ("Prepaid Marketplace"). In the Prepaid Marketplace, Hawai'i's State Department of Labor & Industrial Relations and the Insurance Division of the Department of Commerce & Consumer Affairs will continue to ensure employer compliance and regulate, certify, and ensure rate transparency for qualified health plans. Plan choice and enrollment will continue to be transacted directly between employers and health insurance plans or with the assistance of agents or brokers. Furthermore, Hawai'i will not use the federal technology platform for small business services since healthcare.gov does not accommodate the Hawai'i-specific requirements for coverage that ensure compliance with Prepaid.

The specific sections for which a waiver is recommended and the reason for each are below:

ACA Section	Reason Waiver is Sought
§1301 (a)(1)(C)(ii) Qualified health insurance issuer must offer at least one qualified health plan in the silver level	While the task force recommends support for this provision in the individual marketplace, requiring a qualified health plan to provide at least a silver level plan is not consistent with the Prepaid Marketplace and therefore not consistent with our recommendation to waive SHOP.
§1301 (a)(2) Inclusion of co-op and multi-state qualified health plans.	The task force recommends waiving this section as it is doubtful that co-op and multi-state plans can conform to the requirements of Prepaid. In addition, such plans would be harder to regulate and monitor for compliance than state-based plans.
§1304 (b)(4)(D)(i) and (ii) Continuation of participation for growing small employers	Consistent with Hawai'i's proposal to waive SHOP, the task force recommends waiving this provision, which allows a "growing small employer" to continue to enroll employees through the exchange.
§1311 (b)(1)(B) The establishment of a Small Business Health Options Program (SHOP Exchange)	The task force recommends waiving SHOP in favor of direct enrollment for small businesses for three important reasons: 1. In order to make clear to all small employers in the state the necessity to continue to meet Prepaid rather than ACA requirements. 2. To eliminate the expensive, unnecessary infrastructure required by the ACA for SHOP functions. Maintaining these state-based SHOP functions is not economically feasible, fails to add value to the Hawai'i marketplace, and, in fact, imperils the success of Hawai'i's cost-effective system. 3. To relieve small employers of the added premium costs related to purchasing ACA plans on the SHOP. 4. While Hawai'i values the opportunity to partner with the federal exchange to ensure individual coverage, the unique requirements of Prepaid are not supported by the federal exchange infrastructure.
§1311 (f)(3)(B)	The task force recommends waiving these sections to permit flexibility among state agencies to carry out responsibilities for the individual exchange.

Eligible entity authorized to carry out exchange responsibilities	
§1312 (a)(2) Employer may specify level and employee may choose plans within a level	While acknowledging the attractiveness of employees having the ability to choose their health plans, the task force recommends waiving the consumer choice provision defined in this section in conjunction with waiving SHOP. Supporting reasons are: 1. Assuring such choice for employees of small businesses requires an on-going investment in technical infrastructure disproportionate to the benefits for Hawai'i's small market. 2. The cost to comply with the technical infrastructure necessary to offer consumer choice for insurers offering coverage to businesses would result in the smaller insurers departing the market and the unintended consequence of reduced competition and choice. In fact, during the second year of Hawai'i Health Connector's SHOP exchange, only Kaiser Permanente participated, rendering "consumer choice" meaningless. 3. In Hawai'i's Prepaid environment, consumer choice is relatively insignificant because employers are required to purchase employee coverage with uniformly comprehensive benefits with little of the cost passed on to employees. 4. Offsetting any consumer disadvantages is the fact that employee coverage, benefits, and cost-sharing are significantly better under Prepaid than under ACA provisions.
§1312 (f)(2)(A) Definition of "qualified employer"	The task force recommends waiving this section since, consistent with its recommendation to waive SHOP, there will be no "qualified employers" that may elect to make employees eligible to purchase insurance coverage through the exchange.
§1513/IRC §4980H Definition of eligible employee as one who works 30/more hours/week	The task force recommends waiving the ACA definitions for "full-time" and eligible employees in favor of Prepaid definitions. The ACA defines such employers as those working at least 30 hours per week while Prepaid covers those regularly working 20 or more hours per week.

<u>Notes</u>: The task force endorses maintaining the requirement that small businesses purchase ACA Qualified Health Plans ("QHP") that include all ten of the ACA-prescribed EHBs. While Prepaid coverage has included most of the EHBs, two of the ten benefits, identified below, have not heretofore been required. These two benefits were strongly supported by participants during public hearings.

- *<u>Prescription Drug Coverage</u>. This benefit is provided by the majority of employers, but is not a mandate for Prepaid or addressed by the Hawai'i insurance code. Since the implementation of the EHB provisions in the ACA in 2013, QHPs have included prescription drug benefits.*
- *<u>Children's Vision and Dental Benefits</u>. As with prescription drug coverage noted above, these benefits have been included in ACA QHPs since 2013.*

Appendix 1

Draft Legislation Authorizing Waiver

___.B. NO. __

A BILL FOR AN ACT

RELATING TO THE AFFORDABLE CARE ACT SECTION 1332 WAIVER.

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

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

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

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

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

__.B. NO.

INTRODUCED BY: _____

Report title:
Affordable Care Act Waiver; Authorization

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

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

Appendix 2

ACA Section 1332 and
Links to Federal Register Addressing Waiver Rules

SEC. 1332. WAIVER FOR STATE INNOVATION

(a) APPLICATION.—

(1) IN GENERAL.—A State may apply to the Secretary for the waiver of all or any requirements described in paragraph (2) with respect to health insurance coverage within that State for plan years beginning on or after January 1, 2017. Such application shall—

(A) be filed at such time and in such manner as the Secretary may require;

(B) contain such information as the Secretary may require, including—

(i) a comprehensive description of the State legislation and program to implement a plan meeting the requirements for a waiver under this section; and

(ii) a 10-year budget plan for such plan that is budget neutral for the Federal Government; and

(C) provide an assurance that the State has enacted the law described in subsection (b)(2).

(2) REQUIREMENTS.—The requirements described in this paragraph with respect to health insurance coverage within the State for plan years beginning on or after January 1, 2014, are as follows:

(A) Part I of subtitle D.

(B) Part II of subtitle D.

(C) Section 1402.

(D) Sections 36B, 4980H, and 5000A of the Internal Revenue Code of 1986.

(3) PASS THROUGH OF FUNDING.—With respect to a State waiver under paragraph (1), under which, due to the structure of the State plan, individuals and small employers in the State would not qualify for the premium tax credits, cost-sharing reductions, or small business credits under sections 36B of the Internal Revenue Code of 1986 or under part I of subtitle E for which they would otherwise be eligible, the Secretary shall provide for an alternative means by which the aggregate amount of such credits or reductions that would have been paid on behalf of participants in the Exchanges established under this title had the State not received such waiver, shall be paid to the State for purposes of implementing the State plan under the waiver. Such amount shall be determined annually by the Secretary, taking into consideration the experience of other States with respect to participation in an Exchange and credits and reductions provided under such provisions to residents of the other States.

(4) WAIVER CONSIDERATION AND TRANSPARENCY.—

(A) IN GENERAL.—An application for a waiver under this section shall be considered by the Secretary in accordance with the regulations described in subparagraph (B).

(B) REGULATIONS.—Not later than 180 days after the date of enactment of this Act, the Secretary shall promulgate regulations relating to waivers under this section that provide—

(i) a process for public notice and comment at the State level, including public hearings, sufficient to ensure a meaningful level of public input;

(ii) a process for the submission of an application that ensures the disclosure of—

(I) the provisions of law that the State involved seeks to waive; and

(II) the specific plans of the State to ensure that the waiver will be in compliance with subsection (b);

(iii) a process for providing public notice and comment after the application is received by the Secretary, that is sufficient to ensure a meaningful level of public input and that does not impose requirements that are in addition to, or duplicative of, requirements imposed under the Administrative Procedures Act, or requirements that are unreasonable or unnecessarily burdensome with respect to State compliance;

(iv) a process for the submission to the Secretary of periodic reports by the State concerning the implementation of the program under the waiver; and

(v) a process for the periodic evaluation by the Secretary of the program under the waiver.

(C) REPORT.—The Secretary shall annually report to Congress concerning actions taken by the Secretary with respect to applications for waivers under this section.

(5) COORDINATED WAIVER PROCESS.—The Secretary shall develop a process for coordinating and consolidating the State waiver processes applicable under the provisions of this section, and the existing waiver processes applicable under titles XVIII, XIX, and XXI of the Social Security Act, and any other Federal law relating to the provision of health care items or services. Such process shall permit a State to submit a single application for a waiver under any or all of such provisions.

(6) DEFINITION.—In this section, the term ‘‘Secretary’’ means—

(A) the Secretary of Health and Human Services with respect to waivers relating to the provisions described in subparagraph (A) through (C) of paragraph (2); and

(B) the Secretary of the Treasury with respect to waivers relating to the provisions described in paragraph (2)(D).

(b) GRANTING OF WAIVERS.—

(1) IN GENERAL.—The Secretary may grant a request for a waiver under subsection (a)(1) only if the Secretary determines that the State plan—

(A) will provide coverage that is at least as comprehensive as the coverage defined in section 1302(b) and offered through Exchanges established under this title as certified by Office of the Actuary of the Centers for Medicare & Medicaid Services based on sufficient data from the State and from comparable States about their experience with programs created by this Act and the provisions of this Act that would be waived;

(B) will provide coverage and cost sharing protections against excessive out-of-pocket spending that are at least as affordable as the provisions of this title would provide;

(C) will provide coverage to at least a comparable number of its residents as the provisions of this title would provide; and

(D) will not increase the Federal deficit.

(2) REQUIREMENT TO ENACT A LAW.—

(A) IN GENERAL.—A law described in this paragraph is a State law that provides for State actions under a waiver under this section, including the implementation of the State plan under subsection (a)(1)(B).

(B) TERMINATION OF OPT OUT.—A State may repeal a law described in subparagraph (A) and terminate the authority provided under the waiver with respect to the State.

(c) SCOPE OF WAIVER.—

(1) IN GENERAL.—The Secretary shall determine the scope of a waiver of a requirement described in subsection (a)(2) granted to a State under subsection (a)(1).

(2) LIMITATION.—The Secretary may not waive under this section any Federal law or requirement that is not within the authority of the Secretary.

(d) DETERMINATIONS BY SECRETARY.—

(1) TIME FOR DETERMINATION.—The Secretary shall make a determination under subsection (a)(1) not later than 180 days after the receipt of an application from a State under such subsection.

(2) EFFECT OF DETERMINATION.—

(A) GRANTING OF WAIVERS.—If the Secretary determines to grant a waiver under subsection (a)(1), the Secretary shall notify the State involved of such determination and the terms and effectiveness of such waiver.

(B) DENIAL OF WAIVER.—If the Secretary determines a waiver should not be granted under subsection (a)(1), the Secretary shall notify the State involved, and the appropriate committees of Congress of such determination and the reasons therefore.

(e) TERM OF WAIVER.—No waiver under this section may extend over a period of longer than 5 years unless the State requests continuation of such waiver, and such request shall be deemed granted unless the Secretary, within 90 days after the date of its submission to the Secretary, either denies such request in writing or informs the State in writing with respect to any additional information which is needed in order to make a final determination with respect to the request.

Rules for §1332 were published in the Federal Register on February 27, 2012, Volume 22, Number 38: https://www.gpo.gov/fdsys/pkg/FR-2012-02-27/pdf/2012-4395.pdf

Guidance was subsequently issued in the Federal Register on December 16, 2015, Volume 80, Number 241: https://www.gpo.gov/fdsys/pkg/FR-2015-12-16/pdf/2015-31563.pdf

Appendix 3

Section-by-Section
Analysis and Recommendations

Section-by-Section Discussion

The matrix below summarizes the task force's discussion of the ACA provisions that may be waived and recommendations for retaining or waiving them.

PART I – ESTABLISHMENT OF QUALIFIED HEALTH PLANS

Section 1301: Definition of Qualified Health Plans

§1332 Provisions	Task Force Recommendations
§1301(a)(1)(C)(ii) The definition of "Qualified Health Plan" including providing EHBs, and offering plans conforming to metal levels (bronze, silver, gold, and platinum).	The task force recommends that the Hawai'i Department of Labor and Industrial Relations ("DLIR") serve as the certifying authority for qualified health plans while the Insurance Division ensures that such plans meet health insurance qualifications. **For the Individual Market**. The task force recommends retaining the general terms specified for "qualified health plan" **For the Small Business Market**. The task force recommends: • Maintaining the EHBs. • Waiving SHOP and the metal-level requirement for QHPs offering plans to small businesses. Specifically, the task force recommends waiving the requirement that each QHP offer at least a silver-level plan, since such plans are not consistent with Prepaid. Instead, Hawai'i will maintain requirements under Prepaid that all eligible employers purchase 7(a) and 7(b) plans, as defined in Prepaid and certified by the DLIR.[1]
§1301(a)(2) Inclusion of Co-Op and Multi-State Plans.	The task force recommends waiving these provisions as it is doubtful that such plans can conform to the requirements of

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

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

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

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

§1332 Provisions	Task Force Recommendations
	Prepaid. In addition, these plans would be harder to regulate and monitor for compliance than state-based plans.
§1301(a)(3) Treatment of Qualified Direct Primary Care Medical Home Plans.	The task force recommends retaining these provisions if they meet all the requirements of Prepaid.
§1301(a)(4) Variation of premiums based on rating area.	The task force finds that no waiver is necessary since this is a state option already.
§1301(b)(B) Exceptions for Self-Insured Plans and MEWAS (multiple employer welfare arrangements).	The task force recommends retaining these provisions.

Section 1302: EHB Requirements

§1332 Provisions	Task Force Recommendations
§1302(b) Defines Essential Health Benefits (EHB).	The task force recommends that the EHBs be retained.
§1302(c) Annual limitations on cost-sharing and deductibles for employer-sponsored plans.	The task force recommends retaining these provisions. Currently, *de facto* deductibles in Prepaid plans are more advantageous to employees but, should that change, the ACA limits would serve as a ceiling.
§1302(d) Definition of metal levels by actuarial value.	**For the Individual Market**. The task force recommends retaining the levels of coverage and actuarial values described for bronze, silver, gold, and platinum plans. **For the Small Business Market**. The task force recommends waiving the metal-level requirements for small businesses. Instead, Hawai‘i will maintain Prepaid requirements under which all eligible employers purchase 7(a) and 7(b) plans.
§1302(e) Availability of catastrophic plans.	The task force recommends retaining these provisions.
§1302(f) Availability of child-only plans.	The task force recommends retaining these provisions.

Section 1303: Special Rules Related to Abortion Services

§1332 Provisions	Task Force Recommendations
§1303 Details special rules related to abortion services.	The task force recommends retaining these provisions.

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

§1332 Provisions	Task Force Recommendations
§1304(a) and (b) Defines and details rules for group, individual, and large and small group markets. Specifies rules for aggregation of	The task force recommends retaining these definitions and rules, noting that the PACE Act repealed §1304 definitions for small and large group markets. Hawai‘i law is consistent with the provisions of the PACE Act, which defines a “large

employers, employers not in existence in preceding year, and predecessor employers.	employer" as one with an average of at least 51 employees, and a "small employer" as one with no more than 50 employees.
§1304(b)(D) Defines when a "growing" small employer that purchased employee coverage through SHOP may continue to do so.	The task force recommends waiving this section to be consistent with its recommendation to waive SHOP.

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

Section 1311: Providing Consumers a Health Insurance Exchange

§1332 Provisions	Task Force Recommendations
§1311(b) Requires establishment of an American Health Benefit Exchange, and details responsibilities of the exchange.	The task force recommends retaining the individual exchange via a State-Based Exchange utilizing the Federal Platform (SBE-FP).
§1311(b) Provides for the establishment a SHOP Exchange.	The task force recommends waiving the SHOP requirement and, instead, supporting the "Prepaid Employee Coverage Marketplace." As noted above, Prepaid better meets the goals of the ACA in ensuring small business employee coverage than SHOP.
§1311(f) Specifies which entities are eligible to carry out responsibilities of the Exchange.	The task force recommends waiving or amending this section to allow state agencies, in addition to the state Medicaid agency, to carry out certain Exchange responsibilities.

Section 1312: Consumer Choice

§1332 Provisions	Task Force Recommendations
§1312(a) Provides for choice among QHPs for eligible individuals.	The task force recommends retaining this provision for individuals.
§1312(b) Provides for choice among QHPs for employees using an exchange.	While acknowledging the attractiveness of employees having the ability to choose their health plans, the task force recommends waiving the consumer choice provision defined in this section in conjunction with waiving SHOP. Some of the reasons for this recommendation are as follows: • Assuring such choice for employees of small businesses requires an on-going investment in technical infrastructure disproportionate to the benefits for Hawai'i's small market. • The cost to comply with the technical infrastructure necessary to offer consumer choice for insurers offering coverage to businesses would result in the smaller insurers departing the market and so achieve the unintended consequence of reduced competition and choice. In fact,

§1332 Provisions	Task Force Recommendations
	during the second year of Hawai'i Health Connector's SHOP exchange, only Kaiser Permanente participated, rendering "consumer choice" meaningless. • In Hawai'i's Prepaid environment, consumer choice is relatively insignificant because employers are required to purchase employee coverage with uniformly comprehensive benefits with little of the cost passed on to employees. • Offsetting any consumer disadvantages is the fact that employee coverage, benefits, and cost-sharing are significantly better under Prepaid than under ACA provisions.
§1312(c)(1) Establishes that all enrollees in the individual market are in a single risk pool.	The task force recommends retaining these provisions.
§1312(c)(2) Establishes that all enrollees in the small group market are in a single risk pool.	The task force recommends retaining these provisions.
§1312(c)(3) Allows states to merge individual and small group insurance in a single risk pool if the state deems it appropriate.	The task force recommends retaining these provisions.
§1312(c)(4) Prevents state law from requiring grandfathered plans to be in the individual or small group risk pool.	The task force recommends retaining these provisions.
§1312(d)(1) Allows health issuers to offer coverage outside an exchange, and allows individuals and qualified employers to purchase coverage outside an exchange.	The task force recommends retaining these provisions.
§1312(d)(2) Maintains state control of plans outside of the exchange.	The task force recommends retaining these provisions.
§1312(d)(3) Provides choice to qualified individuals as to whether or not to enroll via an exchange and which plan to choose.	The task force recommends retaining these provisions.
§1312(d)(3)(D) Describes health plan choices for members of Congress and Congressional staff.	The task force recommends retaining these provisions.
§1312(d)(4) Ensures that individuals who cancel enrollment on the exchange in favor of employer coverage won't be penalized.	The task force recommends retaining these provisions.

§1332 Provisions	Task Force Recommendations
§1312(e) Allows enrollment through agents and brokers.	The task force recommends retaining these provisions.
§1312(f) Limits enrollment through an exchange to citizens and lawful residents, and excludes incarcerated individuals.	The task force recommends retaining these provisions.
§1312(f)(2) Allows coverage via the exchange for "qualified employers" and for the large group market.	The task force recommends waiving this section to be consistent with its recommendation to waive SHOP.
§1312(f)(3) Provides that access to coverage through an exchange may be denied to those who are not lawful residents for the entire enrollment period.	The task force recommends retaining these provisions.

Section 1313: Financial Integrity

§1332 Provisions	Task Force Recommendations
§1313(a) Details financial management and protections against fraud and abuse for an exchange.	The task force recommends retaining these provisions.

PREMIUM TAX CREDITS AND REDUCED COST-SHARING

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

Key ACA Provisions	Task Force Recommendations
§1402 Details provisions and eligibility for reductions in cost-sharing and out-of-pocket costs for individuals who enroll in a QHP.	The task force recommends retaining these provisions.

INDIVIDUAL AND EMPLOYER RESPONSIBILITY REQUIREMENTS

Section 1501 and Section 1513: Individual and Employer Responsibility

§1332 Provisions	Task Force Recommendations
§1501/IRC Sec. 5000A Defines the requirement to maintain minimum essential coverage.	The task force recommends retaining these provisions, which impose IRS penalties for individuals who fail to obtain adequate health insurance coverage.
§1513/IRC Sec. 4980H Defines shared responsibility for employers regarding health coverage.	The task force recommends retaining these provisions, which impose IRS penalties for large businesses that fail to provide adequate health insurance coverage to employees. If

	necessary, the task force would amend the section to align employer responsibility with Prepaid.
§1513/IRC Sec. 4980H(c)(2)(B)(ii) Provides that "seasonal worker" is defined by the Secretary of Labor.	The task force recommends replacing this definition with that found in Prepaid HRS 398-3(8).
§1513/IRC Sec. 4980H Defines a "full-time employee" as one working on average at least 30 hours per week.	The task force recommends replacing this definition with that found in Prepaid HRS 398-3(8).

Appendix 4

Report on Public Hearings

Public Hearings

As required by the ACA in §1332(a)(4)(B)(i), when the task force had agreed upon the substance for a draft proposal, public hearings were held in accordance with CFR §33.112 and §155.1312, which address state public notice requirements. Public hearing notices and the written draft proposal were duly posted on the Governor's website and information was distributed to the media and interested parties at least two weeks before hearings commenced. Task force chair, Beth Giesting, was interviewed on-air by Hawai'i Public Radio about the public hearings in advance of the hearing in Honolulu.

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

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

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

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

The Governor's Office hosted the public hearings with Deputy Chief of Staff, Laurel Johnston, serving as convener. Task force chair and Health Innovation Director, Beth Giesting, presented the ACA Waiver Proposal. SIM Project Director, Joy Soares, presented strategies and priorities for SIM. No Wrong Door Project Lead, Debbie Shimizu, presented the project's three-year plan. In the public hearings where break-out groups were indicated, each presenter facilitated discussion of her respective program.

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

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

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