

Overview of Hawaii's Prepaid Health Care Act

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HAWAII PREPAID HEALTH CARE ACT Chapter 393 HRS

Effective date of Law: September 2, 1974

Implementation of Law: January 1, 1975

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OBJECTIVES OF PREPAID HEALTH CARE ACT

- I. Provide health coverage to all employees who.....
 - ✓ Work at least 20 hours per week for four (4) consecutive weeks
 - ✓ Earn 86.67 x Hawaii minimum hourly wage (2005 - \$542) §12-12-1 Definitions
- II. Establish a plan or plans of health coverage to be provided to employees and dependents by the employer.



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OBJECTIVES OF PREPAID HEALTH CARE ACT (con't)

- III. Establish the maximum contribution the employer may require the employee to pay.
 - ✓ Not more than 1.5% of the employee's monthly wage, *but in no event*, more than one-half (1/2) of the monthly premium cost.
- IV. Certify the prevalent contractor plans in the community. §12-12-1 Definitions
- V. Establish the minimum health benefit coverage to be provided by the employer.



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ADMINISTRATION OF THE ACT

The Act is administered through the Department of Labor

Director of Labor approves qualified plans upon the advice from the Health Advisory Council.



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ADMINISTRATION OF THE ACT (con't)

Health Advisory Council §393-7(d)

- ✓ Appointed by the Director of Labor
- ✓ No more than 7 members
- ✓ Representatives of:
 - the medical and public health profession
 - consumer interests
 - persons experienced in prepaid health care protection.

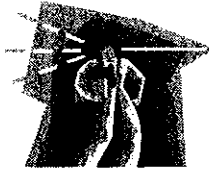


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APPROVED MEDICAL PLAN §393-7

§393-7(a) is the most prevalent medical plan on a fee for service (indemnity) or qualified HMO plan, or



§393-7(b) Meets the requirements of the law as approved by the Director of Labor upon advice of the Advisory Council.

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PREVALENT PLANS 7(a)

- I. HMSA Preferred Provider Plan (PPP)
 - A. In-Network:

Physician	90%
Hospital	90%
DXL	80%
 - B. Out-of-Network: \$100 / \$300 deductible
70% of Eligible Charge
 - C. Out-of-pocket Maximum: \$2,500 / \$7,500
including deductible; 100% thereafter
 - D. Lifetime Maximum: \$1,000,000
with annual renewal of \$10,000




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PREVALENT PLANS 7(a)

II. Kaiser Plan B (HMO)




- A. \$12 registration fee for Physician Services
- B. No charge for Hospital Services
- C. 10% for DXL In & Out-Patient
- D. Out-of-pocket Maximum: \$1,500 / \$4,500

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OTHER PLANS

- I. Employer sponsored plan: Approved contractor plan, a modified contractor plan, or a self-funded plan.
- II. Contractor plans: Plans filed by insurers who desire to market their plans in the State of Hawaii for a 7(a) designation are compared to the prevalent plans:
 - A. Fee-for-Service – HMSA Preferred Provider Plan (PPP)
 - B. HMO – Kaiser Health Plan B




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OTHER PLANS

III. Contractor plans for a 7(a) designation other than the prevalent plans.

A. Comprehensive Medical Plan




- 1. Front end deductible: \$50
Benefit: 80 / 20
\$1,500 stop loss limit including deductible
Lifetime Maximum: \$1,000,000
- 2. Front end deductible: \$100
Benefit: 80 / 20
\$1,000 stop loss limit including deductible
Lifetime Maximum: \$1,000,000

NOTE: No preexisting clause for a contractor 7(a) plan.

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OTHER PLANS

IV. Contractor plans for a 7(b) designation.



- A. Comprehensive Medical Plan
 - 1. Front end deductible: \$300
Benefit: 80 / 20
\$2,500 stop loss limit including deductible
Lifetime Maximum: \$1,000,000

NOTE: If there is a separate hospital deductible, the combined deductible for up-front and hospital shall not exceed \$300.
- B. HMO Plan
 - 1. Physician Services: \$15 copayment
 - Hospital: 90%
 - DXL In- & Out-Patient: 50%
 - Out-of-Pocket Maximum: \$1,500 / \$4,500

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HEALTH CARE CONTRACTOR

- ✓ Self-insurer
- ✓ Nonprofit
- ✓ Insurance Carrier



Approved health care contractor may not refuse to insure except for non-payment of premiums.

§12-12-29 Refusal to insure and
§12-12-30 Qualification for Benefits



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PRINCIPAL & SECONDARY EMPLOYER

§393-6

Employees with two or more employers, the principal employer is:

- ✓ Employer who pays the individual the most wages **OR**
 - ✓ The employees choice **IF** the employee works at least 35 hours per week regularly
- Designated principal employers shall remain as such for one year or until there is a change of employment, whichever is earlier*

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BENEFIT PLAN RULES

Employers may...

- ✓ Offer more than one approved plan from the same or different health care contractor, and shall not be liable for more than the cost of the least expensive plan.
§12-12-12 More than one plan
- ✓ Provide different plans for different classes of employees, subject to the withholding requirements of section 393-13, HRS.
§12-12-13 Classes of employees
- ✓ Out-of-state employer-sponsored plans shall be submitted to the department by the authorized health care contractor
§12-12-14 Out-of-state employer-sponsored plans

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EMPLOYER'S OBLIGATIONS

§12-12-17

- ✓ Provide eligible employees:

- Health care contractor's name
- Plan and group number
- Effective date of coverage
- Employee's cost
- 30 days notice for change in plan or health care contractor



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EMPLOYER'S OBLIGATIONS

(con't) §12-12-17

✓ If premium payments are withheld, provide covered employees who are incapacitated due to illness or injury the following in writing:

1. Within two weeks of the disability, the copayment the employee is required to pay to continue coverage for up to 90 days
2. At least two weeks prior to the date the employer has fulfilled their obligation, the ENTIRE premium cost the employee is required to pay to the employer to continue coverage

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SUPPLEMENTAL COVERAGE TO REQUIRED HEALTH CARE BENEFITS

§12-12-18

(a) When a health care contractor whose health care plan has been approved pursuant to section 393-7, HRS, subsequently provides supplemental benefits such as vision, drug, and dental coverage, these supplemental benefits shall then become a part of the employer's health care plan whether or not initiated by employer or employees.

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SUPPLEMENTAL COVERAGE TO REQUIRED HEALTH CARE BENEFITS

§12-12-18

(a)(con't)

When current or future employees must subscribe to such health care plan without having the option of excluding the supplemental benefits and its applicable cost, the cost of the required health care and supplemental benefits shall become the basis for allocation of premium specified in section 393-13, HRS.



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SUPPLEMENTAL COVERAGE TO REQUIRED HEALTH CARE BENEFITS

§12-12-18

(b) If an employee can choose not to accept the supplemental benefits, the employer may require an employee who elects the coverage to pay for the cost of the supplemental benefits. [Eff: 5/7/81]



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PREMIUM SUPPLEMENTATION

§393-45, 46, 47 & 48 - Rule §12-12-70, 71 & 72

Employers that.....

- ✓ Have less than eight (8) employees
- ✓ Meet requirements of the gross profits less deduction of certain expenses

May file a claim for payment within two (2) years with the burden of proof for entitlement on the employer.

EXCLUDED FROM THE ACT



- I. U.S. Federal employees health plan
- II. State & County employees health plan
- III. Collectively Bargained Plans. *

*Not part of the original act. A result of Federal judicial decision.

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ERISA EXEMPTION

- ✓ Preempted October 5, 1981 by judicial review based on ERISA.
- ✓ Congress exempted Hawaii Prepaid Act from ERISA and signed into law on January 14, 1983. (Public Law 97-473).
- ✓ ERISA exemption froze Hawaii's law as passed in 1974 from changes or amendments.



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LEGAL BACKGROUND

- ✓ 1984 Council of Hawaii Hotels filed complaint in federal Court that collective bargaining agreements are exempt from the Hawaii Prepaid Act under ERISA and the NLRA.



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MANDATED BENEFITS

- ✓ State legislature has mandated benefits through Hawaii's Insurance Law.

- ✓ In Vitro Fertilization
- ✓ Well Baby Care
- ✓ Substance Abuse
- ✓ Mental Health
- ✓ Mammography
- ✓ Immunization
- ✓ Contraceptive Drugs
- ✓ Diabetes self management



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Voluntary Coverage §12-12-3

An employer may voluntarily cover a person excluded from coverage, with a health plan. The voluntarily covered person shall NOT be entitled to the protection of the statute or chapter.



Questions and Answers

