United States General Accounting Office

GAO

Report to the Chairman, Subcommittee on Oversight and Investigations, Committee on Energy and Commerce, House of Representatives

February 1994

HEALTH CARE IN HAWAII

Implications for National Reform

GAO/HEHS-94-68

GAO

United States
General Accounting Office
Washington, D.C. 20548

Health, Education, and
Human Services Division

B-256320

February 11, 1994

The Honorable John D. Dingell
Chairman, Subcommittee on
Oversight and Investigations
Committee on Energy and Commerce
House of Representatives

Dear Mr. Chairman:

Health care reform has risen to the top of the national domestic policy agenda and many observers have cited Hawaii's health insurance system as a possible model for the nation. For almost 20 years Hawaii has been a leader in the effort to achieve universal access to health insurance. It is the only state that requires employers to provide health insurance for their employees, and it has public programs to provide coverage to residents not insured through the employer mandate.

You asked us to provide information about Hawaii's experience on topics central to the current debate on national health care reform. In response to your request, this report describes Hawaii's experience with providing access to health insurance and health services, its experience with health care costs, and the effects of Hawaii's system on the state's small businesses and health care providers.[1]

Results in Brief

Hawaii has the highest level of insurance coverage of any state in the nation. Estimates of the percentage of Hawaii's residents lacking health insurance in 1991 ranged from 3.75 to 7.0 percent in comparison to the national average of about 14 percent. Nevertheless, Hawaii's employer mandate and government programs do not ensure coverage for everyone in the state. Further, even some residents with insurance encounter problems obtaining access to health services and need community health centers and other safety net programs. For example, private providers are not always willing to serve Medicaid patients.

Hawaii has experienced the same trend of rising costs as the rest of the nation. From 1972 to 1991, Hawaii's annual per capita health care expenditure generally matched the national average. However, health

[1]You also asked us to provide information on the Medicaid disproportionate share hospital (DSH) program in Hawaii. The DSH program was established in 1981 to provide for additional Medicaid payments to hospitals that serve large numbers of Medicaid and other low-income patients. This information is in appendix V.

insurance premiums are lower than in the nation as a whole and in the last decade have risen more slowly in Hawaii than nationally. We identified two factors that contribute to lower premiums in Hawaii: reduced cost shifting and insurance companies' use of modified community rating for small businesses.

Hawaii's requirement that employers provide health insurance has not resulted in large disruptions in Hawaii's small business sector. Business owners, however, have expressed concern about the cost and inflexibility of the employer mandate. Hawaii's successful implementation of employer-based health coverage may have been helped by a set of favorable circumstances, such as the large number of employers already providing health insurance at the time the mandate took effect. Thus, if a national employer mandate is adopted, Hawaii's experience might not be replicated throughout the country.

Background

Requirement for Employer-Sponsored Health Insurance Is Unique to Hawaii

Hawaii is the only state to require employers to provide health insurance to their workers. Its expansion of health insurance coverage through the 1974 Prepaid Health Care Act (PHCA) was built on a tradition of employer-based health benefits. This tradition was due partly to the strong role of labor unions in the work force and partly to Hawaii's history of plantation medicine, when large plantations employed physicians to provide free health care to their workers. Hawaii can require employers, including those that self-insure, to provide a minimum level of health care benefits to employees because it has a limited exemption from the federal Employee Retirement Income Security Act of 1974 (ERISA). ERISA preempts state authority to regulate certain self-insured employer health plans. Hawaii is the only state with this exemption.

Under PHCA, employers and employees share financing of premiums for employee coverage, with the employee contribution limited to the lesser of half the premium cost or 1.5 percent of the employee's gross wages. In 1991, a worker earning the average annual wage of $24,128 would have paid at most $30 per month, roughly one-third of the premium cost for

individual coverage under a small business policy. Employees must elect the insurance unless they have comparable coverage from another source.[2]

PHCA outlines two broad categories of benefit plans that employers may provide. The first is an extensive package of medical, hospital, and laboratory services that meets standards specified in the law.[3] Employers offering such a plan are not required to contribute to the cost of coverage for dependents. Employers have a second option of providing a more limited state-approved benefits package,[4] but employers must then pay at least half the cost of dependent coverage. (See app. I for a reproduction of parts I-V and chapter 12, title 12 of PHCA.)

Government Programs Supplement Employer Mandate

Individuals in Hawaii without employer-sponsored health insurance may be eligible for either Medicaid or a state-subsidized insurance program. Hawaii's Medicaid program generally accepts people with incomes up to 62.5 percent of the federal poverty level, while most states set income eligibility at or below 50 percent of poverty,[5] and the program provides several optional Medicaid benefits.[6] The State Health Insurance Program (SHIP) was established in 1989 to provide health care coverage to the "gap group" of low-income residents who are not covered by employer-sponsored health insurance and are not eligible for Medicaid. SHIP accepts people with incomes up to 300 percent of the federal poverty level. SHIP members with incomes between 100 and 300 percent of poverty pay a share of the monthly premium that is determined using a sliding scale; the state pays the entire premium for members whose income is under 100 percent of poverty. Enrollment in SHIP is voluntary.

[2]Employees may also waive coverage for religious reasons.

[3]The benefit package is defined as being equivalent to the most prevalent plan provided by the major fee-for-service insurance provider in the state, which is Hawaii Medical Service Association (HMSA)—the Blue Cross and Blue Shield Plan of Hawaii—or that provided by the major health maintenance organization, which is Kaiser Foundation Health Plan, a nonprofit health maintenance organization. In December 1992, HMSA and Kaiser provided health insurance for about two-thirds and one-fifth, respectively, of Hawaii's insured employees.

[4]These plans must still provide basic hospital, medical, surgical, and other benefits, but are likely to require higher copayments or deductibles or have preexisting-condition exclusions for a limited period.

[5]Hawaii's poverty level is $16,500 for a family of four; for all other states, except Alaska, it is $14,350.

[6]The options that Hawaii provides include programs for pregnant women and infants whose family income is up to 185 percent of the federal poverty level, and the elderly and disabled whose income is up to 100 percent of the federal poverty level.

Hawaii's average Medicaid-eligible population for fiscal year 1993 was about 101,000, about 9 percent of the population.[7] Because of expanded federal eligibility for pregnant women, children, the elderly, and the disabled, and because SHIP outreach activities identified additional people eligible for Medicaid, about 22,000 enrollees were added to the Hawaii Medicaid program between 1988 and 1992.

In December 1992, SHIP covered about 20,000 residents, roughly 2 percent of the population. For most enrollees, SHIP provides minimal and fairly restrictive health benefits that primarily cover preventive care services such as well baby care. SHIP covers 12 physician office visits per calendar year and in most cases limits hospitalization coverage to 5 days. Vision and dental services and prescription drugs are generally not covered.[8]

In July 1993, Hawaii received a waiver from the U.S. Department of Health and Human Services to conduct a 5-year public health care demonstration project, the Hawaii Health QUEST[9] project, involving a part of the Medicaid population and the entire SHIP population.[10] QUEST, scheduled to begin in April 1994, will combine these populations under a managed care delivery system offering comprehensive benefits similar to Medicaid benefits.[11]

Scope and Methodology

We interviewed officials from four Hawaii government departments—Health, Labor and Industrial Relations, Human Services, and Commerce and Consumer Affairs—and the state's two major health insurers—Hawaii Medical Service Association (HMSA) and Kaiser Foundation Health Plan. We also interviewed health care experts,

[7]Percentage calculated using the July 1992 nonmilitary population.

[8]HMSA and Kaiser both participate in SHIP. Kaiser chose to provide the full range of benefits of a federally qualified health maintenance organization but limits SHIP enrollment to 3,500.

[9]Quality care, ensuring Universal access, encouraging Efficient utilization, Stabilizing costs, and Transforming the way health care is provided to public clients.

[10]QUEST will include the SHIP population and the Medicaid population except those individuals currently in the aged, blind, and disabled-related Supplemental Security Income (SSI) programs; refugee cash and medical assistance programs; and medical payments for pensioners programs. Individuals in these categories will continue to be eligible for and receive Medicaid services under the current rules. Under QUEST, the SHIP program, with the possible exception of a small group, will be eliminated.

[11]According to state officials, participants whose incomes are up to 133 percent of the federal poverty level will not have to pay any part of the monthly premiums. Participants with higher incomes will pay a portion of the premium according to a sliding scale, with exceptions for pregnant women and infants under 1 year. There will be no copayments for children.

representatives of Hawaii's business community,[12] health care providers, and officials from the U.S. Bureau of the Census and the U.S. Department of Labor's Bureau of Labor Statistics. We examined the most recent data available from the state of Hawaii, HMSA, Kaiser, the Bureau of the Census, the Bureau of Labor Statistics, the Health Care Financing Administration (HCFA), and other sources.

Highest Rate of Coverage, but Not Universal Care

Hawaii has the highest rate of health insurance coverage of any state in the nation, but it does not have universal coverage. This widespread coverage is the result of the state's employer mandate, the Medicaid program, and SHIP coverage for the gap group. Estimates of Hawaii's uninsured rate range from 3.75 percent in a 1991 survey by the Hawaii Department of Health, to 7.0 percent in 1991, determined from data from the Current Population Survey (CPS). In contrast, 14.1 percent of the nation's population was uninsured in 1991.

Insurance Coverage Is Not Universal

Hawaii's employer mandate, even when combined with public programs, does not ensure that all residents have health insurance. The employer mandate does not cover several categories of employees, including part-time workers—those working fewer than 20 hours per week—government employees, the self-employed, and low-wage earners.[13] These individuals may choose not to purchase health insurance. In addition, waiting or enrollment periods[14] leave some employed individuals temporarily without health insurance coverage.

Hawaii's health care system also has gaps in insurance coverage for the recently unemployed. These individuals may be eligible to purchase

[12]These included representatives of the Chamber of Commerce of Hawaii, Small Business Hawaii, Hawaii Employers Council, and Hawaii Business Health Council.

[13]Employers are not required to provide health insurance coverage for workers whose monthly earnings are less than 86.67 times the hourly minimum wage; that is, less than $456 per month in 1993. Other excluded categories are seasonal agricultural workers, insurance and real estate salespeople working on commission, individual proprietorship members in small family-run businesses, and beneficiaries of government assistance programs.

[14]The act does not require employer-sponsored insurance for newly hired employees, those employed fewer than 4 consecutive weeks. With certain exceptions, people may enroll in SHIP during only one week each quarter.

insurance through their prior employer under federal statute[15] or through SHIP. However, some unemployed individuals elect not to participate because of the financial burden of paying the premiums or because they expect to be re-employed shortly. Other individuals qualify for but do not take advantage of public programs. These individuals include some recent immigrants and homeless people.

In addition, employed persons' dependents who do not qualify for public programs may not be included in an employer-sponsored health insurance plan.[16] A Deputy Director of the Hawaii Department of Health told us that he would like to see PHCA modified to require dependent coverage, but the limitation in the state's ERISA exemption prevents the state from doing so.[17]

Some Hawaii Residents Have Limited Access to Care

Despite having health insurance, some residents in Hawaii have difficulty obtaining health care services. Reasons for this access problem include a limited number of providers in certain areas of the state and a limited willingness on the part of private providers to serve Medicaid patients.

Although Hawaii has more physicians per capita than the national average,[18] state officials and providers told us that these physicians are not adequately distributed throughout the state,[19] a problem shared with other states with rural populations. This problem is more complicated in Hawaii, however, because some Hawaii residents require expensive air transport

[15]For firms with 20 or more employees, the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA) (P.L. 99-272) requires that employers offering health insurance benefits provide former participants and beneficiaries with an opportunity to elect continued coverage when they would otherwise lose such coverage because of "qualifying events" such as death, divorce, termination of employment, or reduced hours. The continuation period varies from 18 to 36 months, depending on the event. The employee may be required to pay for the premium, which may be no higher than 102 percent of the group rate.

[16]We could not obtain specific figures on the number of dependents without this coverage. Kaiser estimated that roughly two-thirds of its groups pay all or part of dependent coverage for their employees and HMSA told us that almost half of its group plan members, excluding state and federal groups, are dependents. In addition, a 1992 survey of 235 Hawaii businesses by the Hawaii Employers Council reported that about three-fourths of these businesses pay at least some portion of full-time employees' dependents' health insurance premiums. Preliminary results from a Kaiser Family Foundation survey of small businesses indicate that dependents of full-time employees were eligible for insurance coverage at slightly more than half of the small businesses surveyed.

[17]Hawaii's ERISA exemption applies only to PHCA as it was enacted in 1974, thus precluding Hawaii from substantively amending it.

[18]In 1991, Hawaii had 17.9 doctors of medicine and doctors of osteopathy per 10,000 resident population, compared to the U.S. average of 15.7 per 10,000.

[19]The federal government has recognized seven areas on five of the state's six major islands as having a shortage of primary health care professionals.

to another island to receive necessary care.[20] For example, residents of Molokai and Lanai must travel to another island for kidney dialysis. Comprehensive trauma facilities are also unavailable on these islands.

Residents covered by Medicaid face limited access to care in some areas, even though providers are located in the vicinity. Officials from health care provider associations told us that private providers generally limit the number of Medicaid patients they serve because of Medicaid's low reimbursement rates. State officials said that they hope the new Hawaii Health QUEST project will improve this population's access to care by increasing the compensation for providing care and improving the availability of care on all the islands. Under QUEST, the state will contract with managed care health plans to provide a full complement of health care services to QUEST enrollees in all geographic areas.

People who cannot obtain care from private providers may receive care from community health centers.[21] These state and federally supported nonprofit centers are designed to provide direct services to hard-to-reach populations, such as the homeless, and those without the ability to pay. The preliminary results of a state survey of uninsured seeking care from the centers reported that about 20 percent came to the centers because they did not have health insurance and about 24 percent came to the centers because of their low costs. Primary care centers also provide some services, such as language capabilities and outreach to the homeless, that are generally not available from private providers.[22]

Representatives of community health centers are concerned that the new QUEST project could have a negative impact on the centers' ability to provide needed services to their clients. These centers generally serve people living in the community and are run by community-based boards of directors. The representatives are concerned that in the event the community health centers participate as subcontractors of large managed care plans under QUEST[23] the centers will lose some of the local control that allows them to adapt their services to the unique cultural and

[20]In emergency cases, Medicaid will pay for air transportation for Medicaid patients.

[21]State hospitals are also part of this safety net. They are required to accept all patients regardless of their level of insurance coverage.

[22]The state will require managed care plans under the Hawaii Health QUEST project to contract with federally qualified health centers unless the plan can demonstrate that it has both adequate capacity and an appropriate range of services for vulnerable populations.

[23]Center representatives said that they would like to bid directly for QUEST as administrators of one or more managed care plans, but cited financial and geographic coverage requirements as possible barriers to health centers administering primary managed care plans.

demographic characteristics of the communities they serve. In addition, the representatives are concerned about the centers' financial viability under QUEST.

Center representatives believe that some of these problems would be alleviated if an individual or a group of community health centers could successfully bid to become a QUEST managed care plan administrator. However, they believe QUEST performance-bond and geographic-coverage requirements are significant barriers to successful center bids.[24]

Overall Costs Parallel National Trend but Premiums Are Lower

The cost experience in Hawaii is seemingly anomalous because, while per capita health care costs are similar in Hawaii and the nation, insurance premiums are lower in Hawaii. PHCA was intended to expand access to coverage, but it did not include explicit efforts to control health care costs.[25]

Per capita expenditures in Hawaii have been very similar to the national average since 1974, and both have increased more rapidly than the overall rate of inflation. The same factors in the health care economy have influenced this trend in Hawaii and the rest of the nation. At the same time, however, health insurance premiums are generally lower in Hawaii than in the nation as a whole and have risen at a slightly slower rate than nationally.

Hawaii Per Capita Expenditures Track National Average

Hawaii's per capita health care expenditures continue to be similar to national levels. We reported earlier that Hawaii's per capita health care expenditures from 1974 to 1982 tracked the national average at the same time the state widened access to coverage through its employer mandate.[26] Similarly, from 1980 to 1991, Hawaii's per capita expenditures for hospitals, physicians, and prescription drugs tracked the national average

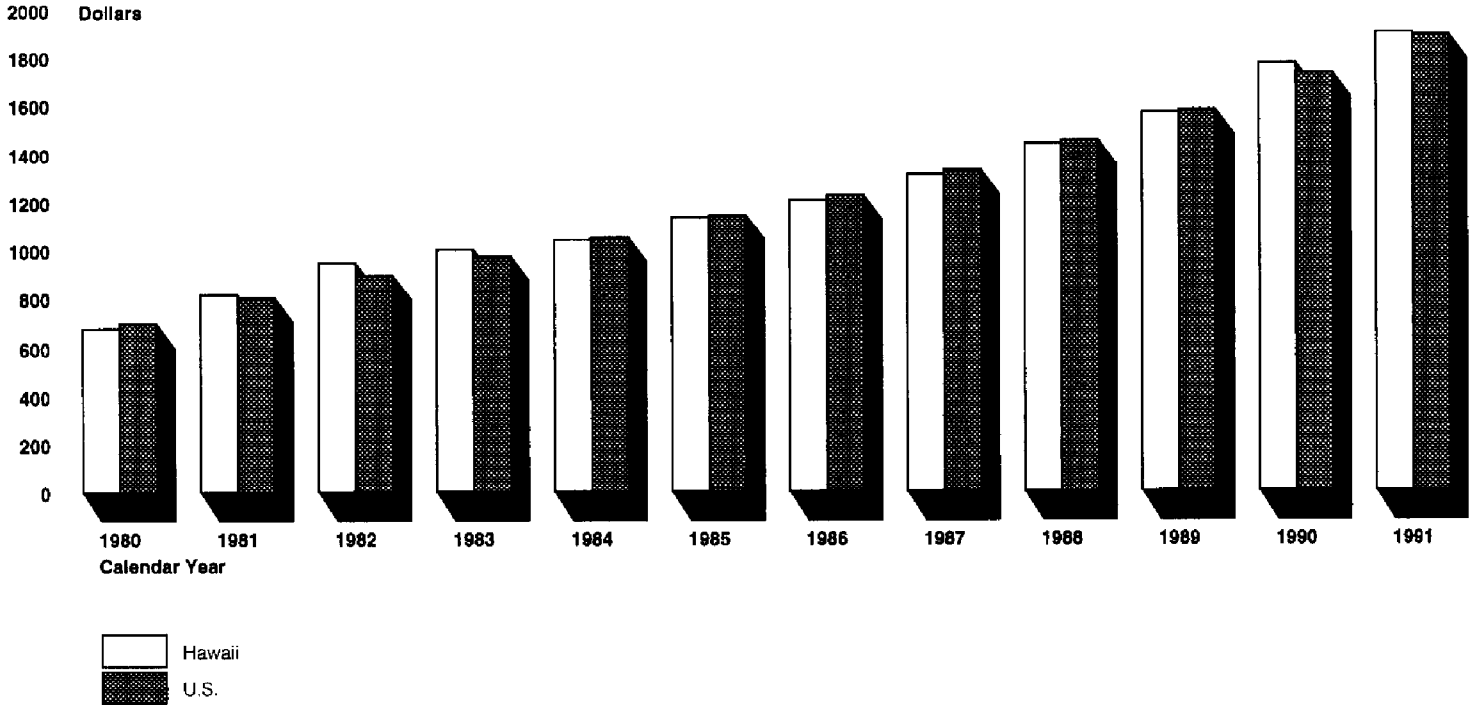
[24]The QUEST request for proposals requires successful bidders to obtain a $1 million performance bond for the state to hold as security against the proper performance of the contract. The bond will be adjusted according to the number of recipients enrolled. After adjustment, the bond must be sufficient to cover approximately 2 months of capitated payments. A center representative estimated that this would require a $2 million to $3 million bond. Regarding geographic coverage, successful bidders must accept recipients from all geographic areas on a particular island, except on the island of Hawaii, which due to its size is divided into two geographic regions.

[25]Hawaii, however, does have certificate-of-need requirements for hospital construction; changes in service; and major capital equipment purchases, such as magnetic resonance imaging machines.

[26]Access to Health Care: States Respond to Growing Crisis (GAO/HRD-92-70, June 16, 1992).

(see fig. 1). Between 1980 and 1991, those expenditures increased at an average annual rate of 9.8 percent in Hawaii and 9.4 percent in the nation.

Figure 1: Hawaii and U.S. Per Capita Expenditures for Hospitals, Physicians, and Prescription Drugs (1980-91)



Source: Health Care Financing Administration.

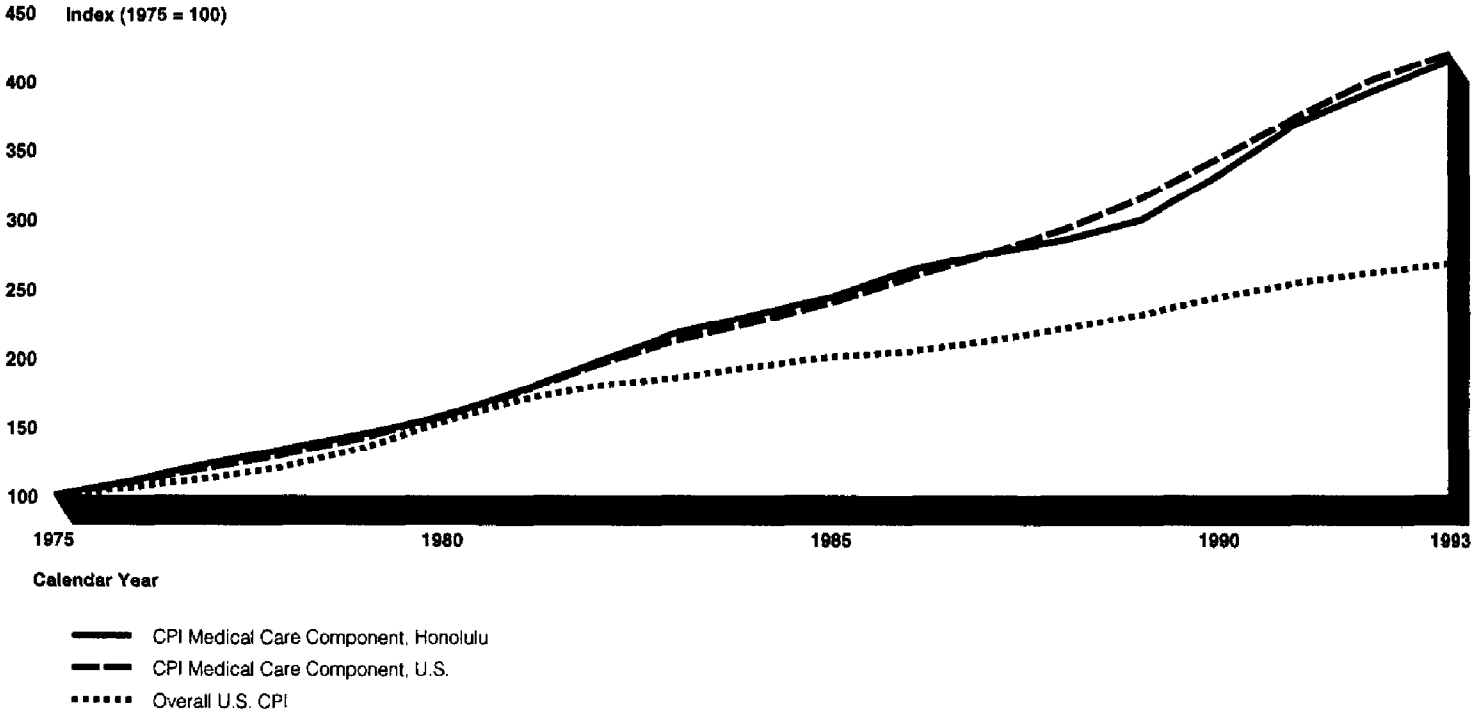
Same Factors Drive Up Health Care Costs in Hawaii and the United States

In both Hawaii and the nation as a whole, health care costs have been rising more rapidly than the average rate of inflation for other goods and services (see fig. 2).[27] State officials, insurers, and health care providers told us that Hawaii is not immune to the factors that have driven up health care costs nationally. These officials said that administrative costs are high and rising; wages for health care professionals, particularly nurses and

[27]Figure 2 uses the rate of inflation for Honolulu because statewide data are not available. The Honolulu data are representative of Hawaii's experience because 75 percent of Hawaii's population resides there.

some technical specialists, have risen significantly in recent years; and medical equipment costs are rising due to advances in technology.[28]

Figure 2: Consumer Price Index (CPI) **Medical Care Component for Honolulu and the United States Compared to Overall CPI** (1975-93)



Note: The 1993 data are based on the first 6 months of the year.
With 75 percent of Hawaii's population, Honolulu is representative of the entire state.

Cost of Medicaid Program Has Escalated

The cost of Hawaii's Medicaid program has increased significantly in the past few years. During this period, Medicaid expenditures nationwide also rose dramatically (see table 1).[29]

[28]We reported on the roles of technological advances and administrative costs in the growth of hospital costs nationwide in Hospital Costs: Adoption of Technologies Drives Cost Growth (GAO/HRD-92-120, Sept. 9, 1992).

[29]Nationwide, Medicaid enrollment increased by 2.7 million beneficiaries from fiscal year 1990 to fiscal year 1991; the largest single-year increase in the program since the mid-1970s.

Table 1: Growth in Hawaii and U.S. Medicaid Expenditures

	Fiscal year		
	1990	1991	1992
Hawaii	17%	10%	32%
U.S.	18%	27%	30%

Source: Hawaii State Department of Human Resources; Health Care Financing Administration (HCFA).

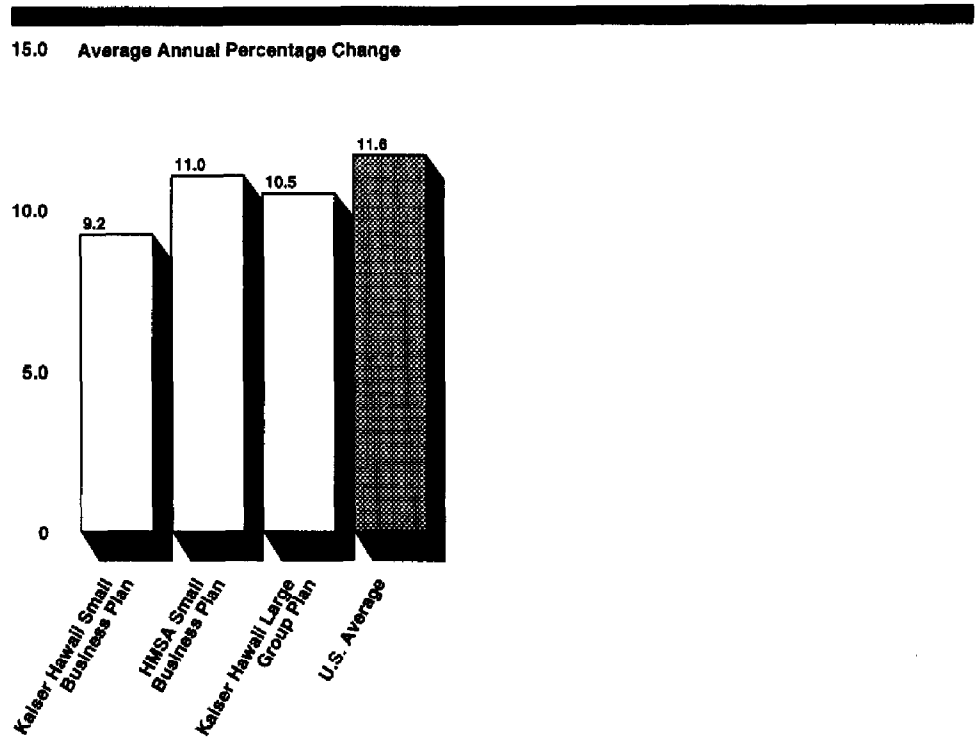
In fiscal year 1992, Hawaii experienced a shortfall in its Medicaid budget, requiring the state legislature to appropriate an additional $64 million to cover costs. Most of the upsurge in Hawaii's Medicaid costs occurred because of increased enrollment prompted by expanded federal program eligibility, Hawaii's recent economic downturn, and the SHIP outreach program, which enrolled additional eligible people in the Medicaid program. The cost per Medicaid beneficiary also increased; from fiscal year 1989 to fiscal year 1991, Hawaii's average cost per recipient rose between 7 and 9 percent each year,[30] primarily due to the escalating cost of health care. (See app. II for additional information on the costs of Hawaii's Medicaid program.)

Health Insurance Premiums Lower in Hawaii

Health insurance premiums are lower and have been rising less rapidly in Hawaii than in the nation as a whole (see fig. 3). In 1991, annual premiums for three of the most prevalent health plans in Hawaii—one large-business plan and two small-business plans—were lower than the U.S. average cost of $1,604 for comparable coverage by $358 to $396 (see fig. 4). Because the figure for the national average includes costs for both large and small companies—and premiums for large companies typically cost less than those for small companies—the lower cost for the two Hawaii small-business plans is especially notable. Moreover, insurance officials in Hawaii told us that premiums for small businesses in Hawaii are not much different from those for large businesses.

[30]From 1988 to 1991, nationwide Medicaid expenditures per capita grew at an average annual rate of 12.3 percent.

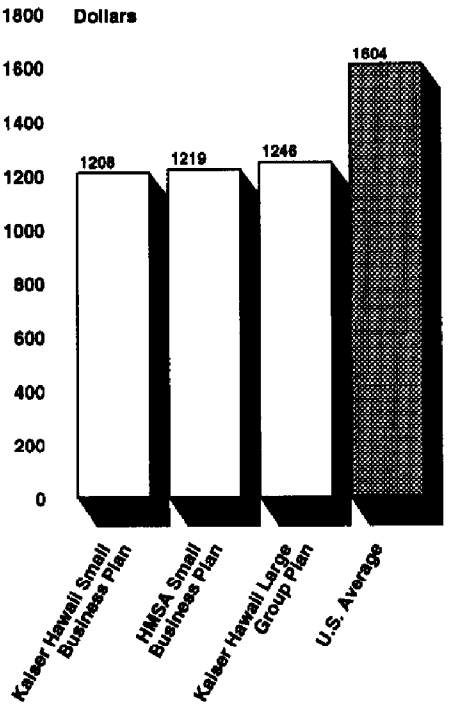
Figure 3: Average Annual Increases in Kaiser Hawaii and HMSA Premiums Compared to the United States (1984-92)



Note: Data for Hawaii are based on annualized changes for single coverage plans for 1984-92.

Sources: Kaiser Foundation of Hawaii, HMSA, and Foster Higgins Health Care Benefits Survey for 1984-92.

Figure 4: Annual Medical Plan Costs for Single Coverage in Hawaii Compared to the United States in 1991



Source: Kaiser Foundation of Hawaii, HMSA, and 1991 Wyatt COMPARE Data Base.

Several factors may contribute to Hawaii's lower premium costs. One is the reduced amount of cost shifting in Hawaii. In general, health care providers pass on the cost of providing uncompensated care to patients with private insurance coverage. Because relatively few Hawaii residents are uninsured, the need for people with insurance to cover such extra costs is minimized. As a result of the state's requirement that all eligible employees accept health insurance, healthy people cannot opt out of the system. Total health care costs, therefore, are spread over wider risk pools that include both healthy and less healthy people. An additional factor that lowers costs for many small businesses is the major insurers' use of

modified community rating for small businesses.[31] (See app. III for detailed information on health insurance premiums in Hawaii.)

Small Businesses Report Little Adverse Impact From Employer Mandate

Most small businesses in Hawaii expressed general satisfaction with the Hawaii health insurance system, but they regard the mandatory provision of insurance as a burden. We found no evidence that the employer mandate resulted in large disruptions in Hawaii's small business sector.[32]

Preliminary results from a Louis Harris and Associates, Inc. survey of small businesses[33] in Hawaii conducted for the Kaiser Family Foundation[34] found that taxes and health insurance are viewed as the top two problems facing small business. Fifty-six percent of small businesses that were surveyed considered the cost of health insurance to be a major problem—more than any other government requirement.[35] However, more small businesses in Hawaii considered the inflation of their health care costs to be under control (54 percent) rather than out of control (41 percent).[36] This is a more favorable view than the view of small businesses in the rest of the country, 62 percent of which characterized the inflation of their health care costs as somewhat or totally out of control.

[31]When insurers use community rating, they base premiums on the anticipated health care utilization of all subscribers in a particular geographic area or other broad grouping. This contrasts with the more common practice of experience rating, in which insurers base premium rates on the medical experience of each insured group. The major fee-for-service insurer in Hawaii uses a system of modified community rating for businesses with fewer than 100 employees. Small businesses are placed in one large risk pool, but their premiums may be adjusted up or down by up to 20 percent, depending on their utilization. For large businesses, however, Hawaii's major insurers determine rates from a company's experience. This results in a wider range of insurance premiums for large companies, with some large businesses paying higher premiums than small ones.

[32]State officials point to the limited use of a State Premium Supplementation Fund as evidence that Hawaii's employer mandate has not overburdened small businesses. PHCA established the fund to subsidize employers with fewer than eight employees, and to pay health care benefits for employees of bankrupt or noncompliant employers. Since July 1975, the state has paid less than $110,000 from this fund. However, business leaders told us that few businesses knew of the existence of the fund until recently, and state officials said that the limitations on the use of the fund are very restrictive. Consequently, the use of the fund may not be a good indicator of the effect of the mandate on small businesses.

[33]These were businesses with 100 or fewer employees; firms of this size employ over half of the state's work force.

[34]Kaiser/Harris Survey of Small Business Owners in Hawaii, 1993 (preliminary findings).

[35]Other requirements include worker's compensation, unemployment compensation, and occupational safety and health requirements.

[36]Forty-six percent of the companies surveyed in Hawaii considered health care cost inflation to be somewhat under control and 8 percent considered these costs to be completely under control.

Businesses Dislike System Inflexibility

Business leaders we interviewed had two complaints related to the inflexibility of the health insurance mandate. First, they were unhappy about the current cap on required employee contributions. Because the level of the cap is 1.5 percent of gross pay, employers pay most of the health insurance premiums. Some employers opt to pay the entire premium. Second, since the passage of the 1974 act, five new mandated benefits have been included in the state insurance code,[37] and businesses are concerned about what they regard as an escalating trend of new mandated benefits.

Business leaders we interviewed disliked the inflexibility of the mandated benefits—they would prefer to tailor health benefits to the needs of their particular employees. For example, employers cannot delete a mandated benefit, such as well-baby care, that may not suit their employees, in order to provide additional benefits, such as dental care.

Insurance Mandate Has Little Effect on Employment Practices

Policymakers and business representatives often express concerns about the effect of an employer mandate on employment practices, including possible reliance on part-time workers, overall employment levels, and effects on salary and other benefits. Because mandatory insurance is required only for employees who work at least 20 hours a week, Hawaii's mandate could cause firms to hire more part-time workers. Three of 10 businesses questioned by the Louis Harris survey reported that in the past 2 years they have hired people for fewer than 20 hours a week primarily to avoid the cost of providing health insurance. However, business leaders told us that hiring part-time workers causes additional administrative burdens and, therefore, has not become a prevalent practice in most industries. The Bureau of Labor Statistics reports that the percentage of part-time workers in Hawaii (which it defines as those working fewer than 35 hours per week) has been lower than or comparable to the average for the rest of the country over the past several years. In 1992, 18.2 percent of Hawaii's work force was employed part-time, compared to 19.2 percent nationwide.[38]

More than three-fourths of small businesses surveyed by Louis Harris reported that the mandate has had little to no effect on employment levels,

[37]These benefits are well-baby care, in vitro fertilization, mammogram screenings, mental health and substance abuse treatment, and newborn adoptee coverage.

[38]Because neither the State of Hawaii nor federal agencies report data on the percentage of workers who are employed fewer than 20 hours per week, data were not readily available to independently determine if a change in the percentage of workers employed fewer than 20 hours a week has occurred since PHCA took effect.

salaries, or other benefits. Nonetheless, about one-fifth of small businesses said that they hired workers who already had insurance through a spouse or another employer, in order to avoid the cost of insuring that worker. Many economists have argued that mandated employer-based benefits do cause a change in wage structures: a higher portion of worker compensation will be in the form of benefits and a smaller portion in the form of take-home wages.[39] Average wages in Hawaii are below the national average, but whether this is attributable to the health care mandate or to other variables is not known. (See app. IV for additional information on economic trends in Hawaii.)

Business leaders we interviewed said that because of Hawaii's low unemployment rate—below 5 percent in July 1993—employers would offer health insurance without the employer mandate to compete for qualified workers. Indeed, when the employer mandate took effect, neither HMSA nor Kaiser experienced unusually large enrollment increases, according to HMSA and Kaiser officials. However, the business leaders acknowledged that the mandate may be preventing some employers from dropping health insurance coverage, particularly during economic downturns.

Providers Generally Satisfied

Health care providers we interviewed were generally satisfied with Hawaii's health care system because the widespread insurance coverage has decreased the amount of uncompensated medical care. However, providers were concerned about the effect of low compensation from public programs, such as Medicaid, which results in their shifting costs to patients with private insurance. The president of one provider association said that he is hopeful that the new Hawaii Health QUEST project will address this problem but was cautious about expecting the problem to be solved.

Implications for Health Care Reform

Hawaii's experience offers three lessons:

- Hawaii's experience indicates that an employer mandate by itself will not necessarily result in universal access to health care. Other publicly sponsored programs are necessary to reach residents who are not able to

[39]Victor R. Fuchs, "National Health Insurance Revisited," National Bureau of Economic Research Working Paper #3884 (1991); Lawrence H. Summers, "What Can Economics Contribute to Social Policy? Some Simple Economics of Mandated Benefits," AEA Papers and Proceedings, Vol. 79, No. 2 (1989), pp. 177-183; and Economic Implications of Rising Health Care Costs, Congressional Budget Office (1992), pp. 34-39.

obtain health insurance at work or who are unemployed. Even if everyone has insurance, special programs may be necessary to assure that all residents have adequate access to health services.

- Hawaii's system of near-universal access has resulted in lower health insurance premiums, particularly for small businesses. However, Hawaii's PHCA did not have explicit cost-control provisions, and Hawaii's health care costs have risen at a rate similar to the national average.
- In Hawaii, the one state with an employer mandate, the mandate has not created large dislocations in the small business sector. However, factors unique to Hawaii may have contributed to this outcome. For example, Hawaii's tradition of employer-provided benefits means that Hawaii may have started with a higher percentage of insured individuals than the United States has now. Additionally, at the time Hawaii introduced its employer mandate, the cost of providing health insurance was significantly lower than it is today.

We discussed the results of this review with officials in the Hawaii Departments of Human Services and Health, as well as officials from the major insurers and representatives of primary care centers. They generally agreed with the information presented. We have incorporated their comments where appropriate. Additionally we sent a draft of this report to the Director of the Hawaii Department of Health for review; however, we did not receive any further comments.

We carried out our work from July to November 1993 in accordance with generally accepted government auditing standards.

As agreed with your office, unless you publicly announce its content earlier, we plan no further distribution of this report until 30 days after its issue date. At that time, we will send copies of this report to the Director, Office of Management and Budget, and interested congressional committees. We will also make copies available to others on request. Please call me on (202) 512-7119 if you or your staff have any questions about this report. Major contributors are listed in appendix VI.

Sincerely yours,

Mark V. Nadel
Associate Director, National
and Public Health Issues

Contents

Tables

Figures

Abbreviations

COBRA	Consolidated Omnibus Budget Reconciliation Act of 1985
CPI	consumer price index
CPS	Current Population Survey
DSH	disproportionate share hospital program
ERISA	Employee Retirement Income Security Act of 1974
HCFA	Health Care Financing Administration
HMSA	Hawaii Medical Service Association
PHCA	Prepaid Health Care Act
SHIP	State Health Insurance Program
QUEST	Quality care, ensuring Universal access, encouraging Efficient utilization, Stabilizing costs, and Transforming the way health care is provided to public clients
SSI	Supplemental Security Income

Hawaii Prepaid Health Care Act

State of Hawaii

Prepaid Health Care Act

(Chapter 393, H.R.S.)

and

Related Administrative Rules
(Chapter 12, Title 12)

Compiled by

Disability Compensation Division

Department of Labor and Industrial Relations

March 1992

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 [L 1974, c 210, pt of §1]

§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. [L 1974, c 210, pt of §1; am L 1978, c 199, pt of §1]

NOTE: The 1978 amendment takes effect on January 1, 1978. L 1978, c 199, §5.

Amendment Note

L 1978 added proviso at end of second paragraph.

§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 his 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 (i) 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 (ii) 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 his 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 his 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 his employer for the tips and gratuities received and is engaged in an occupation in which he customarily and regularly receives more than $20 a month in tips, the combined amount received by him from his employer and tips shall be deemed to be at least equal to the wage required by chapter 387 or a greater sum as determined by regulation of the director.

"Wages" does not include the amount of any payment specified in section 383-11 or 392-22 or chapter 386. [L 1974, c 210, pt of §1; am L 1976, c 78, §1]

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

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

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

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

(B) the individual's base of operation or place from which the service is directed or controlled is not in any state in which some part of the service is performed but the individual's residence is in this State. [L 1974, c 210, pt of §1]

§393-5 Excluded services. "Employment" as defined in section 393-3 does not include 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 cure and cost in connection with such service.

(2) Service performed by an individual in the employ of his spouse, son, or daughter, and service performed by an individual under the age of twenty-one in the employ of his 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 member 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 such service performed by the individual for the employer is performed for remuneration solely 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 such service performed by the individual for the employer is performed for remuneration solely 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 includes 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. [L 1974, c 210, pt of §1; am L 1978, c 110, pt of §6; L 1987, c 339, §4; L 1989, c 217, §2]

§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 him 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 his principal employer. His 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). [L 1974, c 210, pt of §1; am L 1975, c 51, §1]

§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 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. [L 1974, c 210, pt of §1; am L 1976, c 25, §2]

*Not a required benefit. (The President signed Public Law 97-473 on January 14, 1983 which exempted the Hawaii Prepaid Health Care Act from preemption by the Employee Retirement Income Security Act (ERISA), but substance abuse benefits were deleted.)

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. [L 1974, c 210, pt of §1]

§393-12 Choice of plan type and of contractor. (a) Every employer required to provide coverage for his 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.

His 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 he 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 his 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. [L 1974, c 210, pt of §1]

§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 his 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 his wages with respect to pay periods as specified by the director.

If an employee separates from his employment after his 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 percent limitation, from the last salary or wages due the employee, or seek other appropriate means to recover the premium. [L 1974, c 210, pt of §1; am L 1976, c 206, §1]

§393-14 Commencement of coverage. The employer shall provide the coverage required by this chapter for any regular employee, who has been in his 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. [L 1974, c 210, pt of §1]

§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 his 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 his regular wages in such case, whichever is longer. [L 1974, c 210, pt of §1]

§393-16 Liability of secondary employer. An employer who has been notified by an employee, in the form prescribed by the director, that he 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 he is notified by the employee pursuant to section 393-18 that he has become the principal employer. He shall notify the director, in the form prescribed by the director, that he is relieved from the duty of providing coverage or of any change in that status. [L 1974, c 210 pt of §1]

§393-17 Exemption of certain employees. (a) In addition to the exemption specified in section 393-16, an employer shall be relieved of his duty under section 393-11 with respect to any employee who has notified him, 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 him 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. [L 1974, c 210, pt of §1]

§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. [L 1974, c 210, pt of §1]

§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 costs thereof. A collective bargaining agreement may provide that the employer himself 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. [L 1974, c 210, pt of §1; am L 1978, c 199, pt of §2]

§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. [L 1974, c 210, pt of §1]

§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 subsection 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 his wages and to a withholding of such share by the employer for the purpose of providing prepaid health care benefits of his dependents under the plan providing such benefits for himself. [L 1974, c 210, pt of §1; am L 1976, c 81, §1]

§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. [L 1974, c 210, pt of §1]

§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. [L 1974, c 210, pt of §1]

§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. [L 1977, c 91, §1]

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. [L 1974, c 210, pt of §1]

§393-32 Rule making and other powers of the director. The director may adopt, amend, or repeal, pursuant to chapter 91, such rules and regulations as he 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 request by employers for premium supplementation and the period for the payment thereof. [L 1974, c 210, pt of §1]

§393-33 Penalties; injunction. (a) If an employer fails to comply with sections 393-11, 393-12, 393-13, 393-15 he 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 special 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 his principal place of business is located from carrying on his 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. [L 1974, c 210, pt of §1; am L 1977, c 190, §1]

§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 special premium supplementation fund created by section 393-41. [L 1991, c 107, §3]

PART IV. PREMIUM SUPPLEMENTATION

§393-41 Establishment of special premium supplementation fund. There is established in the treasury of the State, separate and apart from all public moneys or funds of the State, a special 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. [L 1974, c 210, pt of §1]

Cross References

For evaluation and review process of fund, see §23-11 (note).

§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 monies 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 monies shall not be commingled with other State funds and shall be maintained in separate accounts on the books of the depositary bank. Such monies 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 his duties under this section as provided in chapter 37. [L 1974, c 210, pt of §1]

§393-43 Disbursements from the fund. Expenditures of monies 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. [L 1974, c 210, pt of §1]

§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 investment 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 [L 1974, c 210, pt of §1]

§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). [L 1974, c 210, pt of §1]

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

(1) Compensation of officers;
(2) Salaries and wages, except wages paid by an individual proprietor to himself;
(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. [L 1974, c 210, pt of §1]

§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 his entitlement. [L 1974, c 210, pt of §1]

§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 the bankruptcy of his employer or because his employer is not in compliance with this chapter. Benefits paid from the premium supplementation fund to such employee may be recovered from his bankrupt or noncomplying employer. The director shall institute administrative and legal actions as provided in section 393-33 to effect recovery of such benefits. [L 1978, c 3, pt of §1]

PART V. TERMINATION OF CHAPTER

§393-51 Termination of chapter. This chapter shall terminate upon the effective date of federal legislation that provides for voluntary prepaid health care for the people of Hawaii in a manner at least as favorable as the health care provided by this chapter, or upon the effective date of federal legislation that provides for mandatory prepaid health care for the people of Hawaii. [L 1974, c 210, pt of §2]

Coverage under this chapter commenced January 1, 1975. [L 1974, c 210, §2]

CHAPTER 12, TITLE 12
PREPAID HEALTH CARE

SUBCHAPTER 1
GENERAL

§12-12-1 Definitions. As used herein:

"Continuation of coverage in case of inability to earn wages" means that allocation of health care premium will be based on an employee's continuing salary, if this be the case, or the salary or wages that the employee received in the last fully completed month prior to the disability. Thus, the employer must continue the coverage by paying for the employer's share of the premium and the employee must contribute towards the premium to the same extent as prior to the disability.

"Covered employee" means an eligible employee who is provided health care coverage by an employer.

"Department" shall be as defined in section 393-3, HRS.

"Director" shall be as defined in section 393-3, HRS.

"Eligible employee" means an employee who has worked for an employer for twenty or more hours a week for four consecutive weeks, and earned 86.67 times the Hawaii minimum hourly wage.

"Employer" shall be as defined in section 393-3, HRS.

"Employment" shall be as defined in section 393-3, HRS, and shall include the period an employee is receiving benefits under chapters 386 or 392, HRS, for a period of not less than that prescribed in section 393-15, HRS.

It shall also include services performed by an individual for wages or under any contract of hire irrespective of whether the common-law relationship of master and servant exists unless and until it is shown to the satisfaction of the director that:

(1) The individual has been and will continue to be free from control or direction over the performance of the service, both under the contract of hire and in fact;

(2) The service is either outside the usual course of the business for which the service is performed or that the service is performed outside of all the places of business of the enterprise for which the service is performed; and

(3) The individual is customarily engaged in an independently established trade, occupation, profession or business of the same nature as that involved in the contract of service.

"Four consecutive weeks" means any consecutive period of four weeks which an employee worked for an employer.

"Health care contract" means the entire approved plan of the health care contractor including its terms and conditions and benefit schedule.

"Premium" shall be as defined in section 393-3, HRS.

"Prepaid health care contractor" shall be as defined in section 393-3, HRS.

"Prepaid health care plan" shall be as defined in section 393-3, HRS.

Prepaid health care plans which have the largest number of subscribers in the State shall be the "HMSA Plan 4" and "Kaiser Plan B" which are located at the end of this chapter.

"Regular employee" shall be as defined in section 393-3, HRS, but does not include dependents of an employee who are covered by a health care plan as an employee of the same employer.

"Regular wages" include an employee's disability income insurance provided for and paid entirely by the employer in excess of that required by any law.

"Seasonal employment" means employment by an employer defined in the second sentence of section 393-3(8), HRS, during its seasonal period or seasonal periods.

"Seasonal period" or "seasonal periods" means the period or periods of seasonal activity of less than an aggregate of twenty-six calendar weeks in twelve consecutive calendar months in which the volume of employment by the employer in the pursuit, measured in terms of average weekly man hours per week, is at least fifty percent more than the average weekly man hours of employment by the employer in the twelve consecutive weeks in such twelve consecutive calendar months when the volume of employment by the employer is the lowest in such pursuit; provided that employment by an employer in seasonal pursuit engaged in the cultivating, harvesting, and

processing of coffee and macadamia nuts and other crops or products constitutes seasonal employment during the employer's seasonal period or seasonal periods, provided further that employment during the seasonal period or seasonal periods by an employer engaged in the cultivating, harvesting, processing, canning, and warehousing of pineapples constitutes seasonal employment.

"Self-insurer" means an employer as defined in section 393-3, HRS, who undertakes to provide the prescribed coverage and benefits directly to the employees without the intervention of a plan provided by a health care contractor or insurer subject to the insurance laws of the State.

"Statute" means chapter 393, HRS, entitled "Prepaid Health Care Act."

"Wages" shall be defined in section 393-3, HRS.

"Week" means a period of seven consecutive days based on the established work week of each employer. [Eff: May 7, 1981; am September 16, 1985] (Auth: HRS §393-32) (Imp: HRS §§393-1, 393-3, 393-4, 393-5, 393-7, 393-11, 393-15)

§12-12-2 Determination of seasonal pursuit and seasonal period. (a) Employers believing themselves to be engaged in seasonal pursuits shall file a request for such determination with the director. The request shall contain data and information necessary to qualify the employer within the provisions as set forth in section 12-12-1 of this chapter and also as set forth in section 393-3(8), HRS, for the twelve months immediately preceding the date of the request for seasonal pursuit determination. The request shall also include similar data and information anticipated to be experienced in the current twelve month period. The request shall be signed by an authorized representative of the employer.

(b) The department shall review the request and information submitted and make determinations of seasonal pursuit and seasonal period or seasonal periods conforming to section 12-12-1. The decision of the department shall be certified in writing to the requesting employer and will remain in effect for the period specified in the decision.

(c) In order to establish the seasonal period or periods for each subsequent twelve month period following initial determination by the department, the employer shall resubmit data and information specified in subsections (a) and (b) not later than one calendar month after the expiration date of the department's decision. [Eff: May 7, 1981] (Auth: HRS §393-32) (Imp: HRS §393-3)

§12-12-3 Voluntary coverage. An employer may voluntarily cover a person excluded under section 393-5, HRS, with a plan which will afford the person health care protection. Such voluntarily covered person shall not be entitled to the protection afforded by the statute or this chapter. [Eff: May 7, 1981] (Auth: HRS §393-32) (Imp: HRS §§393-2, 393-5)

§12-12-4 Monthly pay of regular employee. The monthly wages for the purposes of section 393-11, HRS, shall be 86.67 times the State's minimum wage rounded off to the next higher dollar. [Eff: May 7, 1981] (Auth: HRS §393-32) (Imp: HRS §393-11)

§12-12-5 Employee responsibility. An employee exempt under the statute shall immediately file with the employer on a form provided by the department the reason for such exemption. [Eff: May 7, 1981] (Auth: HRS §393-32) (Imp: HRS §§393-15, 393-16, 393-17, 393-18, 393-21)

§12-12-6 Employee already disabled. Should an employer elect to change the health care plan or contractor while an employee is disabled, the employer shall provide a reasonable extension of benefits, which may be provided by the previous or succeeding health care contractor. [Eff: May 7, 1981; am June 19, 1986] (Auth: HRS §§393-12, 393-15)

§12-12-7 Health care advisory council. The council shall have discretion in determining which plans qualify under section 393-7, HRS. [Eff: May 7, 1981] (Auth: HRS §393-32) (Imp: HRS §393-7)

§12-12-8 Director's rights and duties. The director's rights and duties shall be that prescribed by chapters 371 and 393, HRS. [Eff: May 7, 1981] (Auth: HRS §393-32) (Imp: HRS §§393-31, 393-32)

§§12-12-9 to 12-12-10 (Reserved)

SUBCHAPTER 2
PLANS

§12-12-11 Coverage. An employer may provide an approved individual or a group plan. [Eff: May 7, 1981] (Auth: HRS §393-32) (Imp: HRS §§393-7, 393-11, 393-12, 393-13, 393-14, 393-15)

§12-12-12 More than one plan. An employer may elect to provide more than one approved plan from the same or different health care contractor. The employer shall not be liable for more than the cost of the least expensive plan should there be more than one plan. [Eff: May 7, 1981] (Auth: HRS §393-32) (Imp: HRS §393-12)

§12-12-13 Classes of employees. An employer may provide different plans for different classes of employees. The employer shall not, however, exceed the withholding requirements of section 393-13, HRS, should classes of employees be provided different plans. [Eff: May 7, 1981] (Auth: HRS §393-32) (Imp: HRS §§393-12, 393-13)

§12-12-14 Out-of-state employer-sponsored plans. Any employer-sponsored plan shall be submitted to the department by the authorized health care contractor in accordance with section 12-12-16. [Eff: May 7, 1981] (Auth: HRS §393-32) (Imp: HRS §§393-7, 393-20)

§12-12-15 Collective bargaining agreement. Any prepaid health care plan included in a collective bargaining agreement:

(1) Is presumed to meet the requirements of the statute if the agreement is dated prior to June 3, 1978.

(2) Shall meet the requirements of the statute if the agreement is dated on or after June 3, 1978.

(3) Shall be filed by the employer with the department immediately upon approval of the parties whenever effected, modified, renegotiated, or extended. [Eff: May 7, 1981] (Auth: HRS §393-32) (Imp: HRS §§393-7, 393-19)

§12-12-16 Submission of plans by health care contractors. (a) After the approval of a health plan by the Hawaii State Insurance Commissioner or a signed statement that the plan does not require approval, the health care contractor shall submit eight copies of the plan to the department for review. Each plan shall have attached thereto the evidence of the insurance commissioner's approval or the statement that the plan does not require approval. Any plan submitted under section 393-7(b), HRS, which provides aggregate benefits that are more limited than those provided by plans qualifying under section 393-7(a), HRS, shall include certification that the employer has agreed to contribute at least one-half of the cost of the coverage of dependents under such plan.

(b) After written advice from the prepaid health care advisory council, the director shall notify the health care contractor of the proposed approval or disapproval of the plan. Any proposal to disapprove shall contain the reasons therefor.

(c) The health care contractor may apply for reconsideration in writing within fifteen days after receipt of the proposed disapproval. The request for reconsideration shall include a memorandum of the facts on the basis of which the contractor contends that the plan meets the requirements of section 393-7, HRS.

(d) The director shall notify the health care contractor of the final decision to approve or disapprove the plan. [Eff: May 7, 1981] (Auth: HRS §393-32) (Imp: HRS §§393-7, 393-32)

§12-12-17 Employer's obligation. (a) Each employer shall inform an eligible employee of the entitlement afforded by this statute by providing the health care contractor's name, plan number, group number, effective date of coverage, and employee's cost.

(b) The employer shall give each covered employee thirty days' notice should the employer elect to change the employer's plan or health care contractor.

(c) Any employer who withholds premium payments shall provide a covered employee who is incapacitated due to illness or injury, the following information in writing:

(1) Within two weeks of the disability date, the amount the employee is required to pay directly to the employer for forwarding to the health care contractor in order to continue coverage under section 393-15, HRS.
(2) At least two weeks prior to the date an employer will have completed the employer's obligation under section 393-15, HRS, the entire premium cost the employee is required to pay directly to the employer for forwarding to the health care contractor in order to continue coverage. [Eff: May 7, 1981] (Auth: HRS §393-32) (Imp: HRS §§393-11, 393-12, 393-13, 393-14, 393-15)

§12-12-18 Supplemental coverage to required health care benefits. (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. 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.

(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: May 7, 1981] (Auth: HRS §393-32)(Imp: HRS §§393-7, 393-12, 393-13, 393-15)

§§12-12-19 to 12-12-23 (Reserved)

SUBCHAPTER 3
HEALTH CARE CONTRACTOR REQUIREMENTS

§12-12-24 Self-insurer. Any self-insurer may qualify as a health care contractor upon furnishing satisfactory proof to the director of its solvency and financial ability to defray or reimburse in whole or in part the expenses of health care under an approved health care plan. [Eff: May 7, 1981] (Auth: HRS §393-32) (Imp: HRS §§393-7, 393-12)

§12-12-25 Health care contractor. Every health care contractor required to be licensed by the Hawaii State Insurance Commissioner shall be so licensed before submission of plans to the department. [Eff: May 7, 1981] (Auth: HRS §393-32) (Imp: HRS §§393-3, 393-7, 393-12)

§12-12-26 The health care insurance contract. (a) Every health care contract of insurers subject to the insurance laws of the State, including any amendment, endorsement, or rider to a contract, which provides for benefits under section 393-7, HRS, shall be approved by the Hawaii State Insurance Commissioner prior to submission to the director under section 12-12-16.

(b) Nothing in the statute or this chapter is intended to amend, modify, or change any policy form approval requirements prescribed in the State insurance laws. [Eff: May 7, 1981] (Auth: HRS §393-32) (Imp: HRS §§393-7, 393-12)

§12-12-27 The health care certificate. (a) Every covered employee shall be given written evidence of health care coverage by the employer, which has been provided by the health care contractor.

(b) The health care contractor shall permit continuation of coverage without any diminution of benefits or standards from the plan with which an employee was covered prior to disability during the period specified in section 393-15, HRS. [Eff: May 7, 1981] (Auth: HRS §393-32) (Imp: HRS §§393-7, 393-12, 393-14, 393-15)

§12-12-28 Cancellation of contract. (a) No health care contractor shall cancel a contract providing in whole or in part for health care benefits required by the statute prior to the expiration date of the contract unless written notice of intention to cancel on a specified date and reason therefor has been filed with and served on the employer and the director at least ten days prior to the specified cancellation date.

(b) The ten days' advance notice requirement in subsection (a) need not be complied with when a new contractor is simultaneously substituted. In the event of substitution, the previous contractor shall immediately file with and serve on the employer and the director, notice that the contract was cancelled, the specific date and the reason for cancellation.

(c) If a plan provides by its terms for an expiration date, acceptance of the plan by the director is notice thereof.

(d) The employer shall notify its covered employees of the cancellation of coverage for nonpayment of premium. The employees shall be given an option of individual coverage if premium payment is made within ten days directly to the contractor. [Eff: May 7, 1981] (Auth: HRS §393-32) (Imp: HRS §§393-7, 393-12, 393-13)

§12-12-29 Refusal to insure. No health care contractor other than a self-insurer shall refuse to cover any employer-applicant except for the non-payment of premiums. The health care contractor shall notify the director of all refusals to insure. [Eff: May 7, 1981] (Auth: HRS §393-32) (Imp: HRS §§393-3, 393-7, 393-12, 393-13)

§12-12-30 Disqualification for benefits. Subject to the terms of the health care contract, a covered employee shall not be disqualified for benefits by a health care contractor except for the nonpayment of premium. [Eff: May 7, 1981] (Auth: HRS §393-32) (Imp: HRS §§393-7, 393-11, 393-13)

§12-12-31 Agent. Each health care contractor shall provide the department with the name of an employee or officer of the contractor who is in direct charge of health care matters to whom all correspondence should be addressed. The person should be one who can be reasonably expected to expedite matters relating to the statute. [Eff: May 7, 1981] (Auth: HRS §393-32) (Imp: HRS §§393-3, 393-32)

§12-12-32 Contractors of union plans. Except as to section 12-12-16, all health care contractors, including self-insurers, providing benefits in accordance with a collective bargaining agreement shall comply with all the requirements of the statute and this chapter. [Eff: May 7, 1981] (Auth: HRS §393-32) (Imp: HRS §§393-2, 393-11, 393-12, 393-14, 393-15)

§§12-12-33 to 12-12-40 (Reserved)

SUBCHAPTER 4
BENEFITS AND CLAIMS PROCEDURE

§12-12-41 Withholding by employers. (a) An employer electing to withhold from covered employees may withhold the proportionate cost of the premium each pay period beginning in the month the employees' coverage becomes effective. In no event shall the employer withhold premiums less often than once monthly. An employer shall not withhold more than 1.5 percent of such employee's regular wages or one-half the cost of premium, whichever is less, during each calendar month.

(b) Withholdings by an employer shall be promptly paid to the health care contractor in accordance with the billing requirements of the contractor.

(c) Any employer fails to transmit payments to the health care contractor in accordance with the billing requirements of the contractor shall be penalized as provided under section 393-33, HRS.

(d) In the event an employer withholds but fails to obtain coverage from a health care contractor, the employer shall:

(1) Be liable for all health care expenses incurred by the employee.

(2) Refund the withheld premium to all employees.

(3) Be subject to penalties prescribed by section 393-33, HRS.

[Eff: May 7, 1981] (Auth: HRS §393-32) (Imp: HRS §§393-13, 393-15, 393-24)

§12-12-42 Deductions greater than authorized. (a) In the event an employer withholds more than authorized by section 393-13, HRS, the employer shall:

(1) Refund such excess withholdings to the employee.

(2) Be subject to penalties prescribed by section 393-33, HRS.

(b) If an employee is no longer employed by the employer and cannot be located, the employer shall deposit such sum in the premium supplementation fund. The employer shall provide the director with the employee's full name, social security account number, last known address, the amount due, and any other information requested by the director. The director shall endeavor to locate such employee to return such deductions. If the employee cannot be located for a period of two years from the date of deposit, the director shall cause such moneys to become a part of the premium supplementation fund. [Eff: May 7, 1981] (Auth: HRS §393-32) (Imp: HRS §§393-13, 393-41)

§12-12-43 Notice and proof of claim. (a) Any covered employee claiming benefits or someone acting in behalf of the employee shall furnish a written claim to the health care contractor pursuant to the health care contract.

(b) The claim shall include documents required by the health care contract. [Eff: May 7, 1981] (Auth: HRS §393-32) (Imp: HRS §393-7)

§12-12-44 Denial of claim. (a) If an employee's claim is denied by a health care contractor in whole or in part because of nonpayment of premium, notice of denial in a form prescribed by the director shall be mailed promptly to the employee.

(b) If an employee desires a review of the denied claim, the employee shall file the prescribed notice of denial and a statement giving specific reasons for the request with the director. The request for review shall be filed within twenty days after the date of denial at the office of the department in the county in which the claimant resides or to any office of the department. The director shall forthwith notify the health care contractor of the claimant's request for review, enclosing a copy of the claimant's reasons therefor.

(c) The director, or an officer or employee designated by the director for that purpose, shall investigate the request and render a decision. The decision is final with right of appeal in accord with section 91-14, HRS. [Eff: May 7, 1981] (Auth: HRS §393-32) (Imp: HRS §§393-7, 393-32)

§12-12-45 Controverted workers' compensation claims. In the event of a controverted workers' compensation claim, the health care contractor shall pay or provide for the medical services in accordance with the health care contract and notify the department of such action. If workers' compensation liability is established, the health care contractor shall be reimbursed by the workers' compensation carrier such amounts authorized by chapter 386, HRS, and chapter 10 of title 12, administrative rules. [Eff: May 7, 1981] (Auth: HRS §393-32) (Imp: HRS §§393-7, 393-32)

§12-12-46 Experience rating. If, after the end of a policy year, the employer receives an experience rating credit or a dividend from the health care contractor, the employee's share of the experience rating credit or dividend shall be refunded by the employer or applied to future premium payments of covered employees. "Employee's share" means the mathematical ratio of employer-employee contributions of the experience rating credit or dividend proportionately divided among all covered employees by months of service for the period of credit. [Eff: May 7, 1981] (Auth: HRS §393-32) (Imp: HRS §§393-7, 393-13)

§§12-12-47 to 12-12-59 (Reserved)

SUBCHAPTER 5
REPORTS

§12-12-60 Health care contractors. (a) Health care contractors shall submit a monthly report, in a form designated by the department, showing the following information:

(1) Name of newly enrolled or terminated employer;
(2) State department of labor and industrial relations account number as assigned by the unemployment insurance division;
(3) Plan number;
(4) Group number;
(5) Effective date of coverage; and
(6) Effective date and reason for cancellation.

(b) On April 15 of each year, health care contractors shall file an annual report for each employer and for each plan covering the most recently completed calendar year. This report shall be on a form prescribed by the director and shall contain the following information:

(1) Number of covered employees employed on the twelfth day of the month for each month of the year;
(2) Number of covered employees providing coverage for their dependents for each month of the year; and
(3) Amount returned to the employer due to experience rating credit or dividend during the year.

(c) On April 15 of each year, the following consolidated information shall be furnished by health care contractors for all employers covered by such contractor:

(1) Number of claims filed by covered employees;
(2) Number of claims paid to covered employees; and
(3) Amount of claims paid to covered employees.

(d) If coverage is provided through an association of employers or to employers through a collectively bargained health and welfare type trust fund or similar arrangement, and it is not feasible to obtain information for each employer in the association or trust fund, the health care contractor may file a consolidated report in a form prescribed by the director. [Eff: May 7, 1981] (Auth: HRS §393-32) (Imp: HRS §393-32)

§12-12-61 Employers. (a) On April 15 of each year, all employers providing coverage through a health care contractor shall file an annual report for each plan covering the most recently completed calendar year. This report shall be on a form prescribed by the director and shall provide the following information:

(1) Amount of total wages paid to covered employee;
(2) Amount of employer contributions paid in the year; and
(3) Amount of covered employee contributions paid in the year, if applicable.

(b) On April 15 of each year, employers who provide health care benefits directly to their employees shall file an annual report for each plan covering the most recently completed calendar year. This report shall be on a form prescribed by the director and shall provide the following information:

(1) Number of covered employees employed on the twelfth day of each month;
(2) Amount of total wages paid to covered employees;
(3) Amount of employer contributions paid in the year;
(4) Amount of covered employee contributions paid in the year, if applicable; and
(5) Amount returned to the employer due to experience rating credit or dividends, if applicable. [Eff: May 7, 1981] (Auth: HRS §393-32) (Imp: HRS §393-32)

§12-12-62 Principal and secondary employer. (a) Any principal employer who is informed by an employee to be the secondary employer shall immediately notify the department of such change on the form provided by the department.

(b) Any secondary employer who is subsequently informed by an employee to be the principal employer shall immediately notify the department of such change on the form provided by the department. [Eff: May 7, 1981] (Auth: HRS §393-32) (Imp: HRS §§393-6, 393-16)

§12-12-63 Other employer reports. (a) Status report. Every employer for whom services are performed in employment shall file a report on a form prescribed by the director to determine liability for coverage within ten days after the status report form is mailed by the department. This report shall provide information such as: name of health care contractor, plan number, group number, effective date of plan, number of employees who claim exemption and reason thereof, and employer-employee premium cost for individual and dependents coverage. The employer's health care plan shall accompany this report, if the plan has not been approved by the director.

(b) Employer shall give the department thirty days written notice prior to change in health care plan or health care contractor.

(c) Employee notification to employer.

(1) Any employer whose employee claims exemption from the statute shall file a statement signed by the employee on a form provided by the department. The form shall be filed within ten days of employment or change in status.

(2) On December 31 of each year, each employer shall refile a statement signed by all employees who claim exemption from the statute on a form prescribed by the department. [Eff: May 7, 1981] (Auth: HRS §393-32) (Imp: HRS §§393-17, 393-21)

§12-12-64 Posting of notice of coverage. Each employer shall post and maintain in a conspicuous place or places in and about the place of business typewritten or printed notices stating that the employer has obtained health care coverage required by law, in the form as may be prescribed by the director. [Eff: May 7, 1981] (Auth: HRS §393-32) (Imp: HRS §§393-7, 393-32)

§§12-12-65 to 12-12-69 (Reserved)

SUBCHAPTER 6
PREMIUM SUPPLEMENTATION

§12-12-70 Entitlement to premium supplementation. (a) "Less than eight employees" shall mean the total number of employees who are entitled to and covered as of the twelfth day of each calendar month. An employer who provides coverage to eight or more employees entitled to coverage in a month shall not qualify for premium supplementation for that month.

(b) An employer must be in business for profit to qualify for premium supplementation.

(c) Premium supplementation for the employer's taxable year shall be awarded for those months in that taxable year in which the employer satisfies the requirements of section 393-45, HRS. [Eff: May 7, 1981] (Auth: HRS §393-32) (Imp: HRS §393-45)

§12-12-71 Claim for premium supplementation. (a) A claim for premium supplementation for an employer's taxable year shall be filed with the department within two years after the end of such year. Any claim filed after two years shall not be honored.

(b) The premium supplementation claim shall be filed on a form designated by the department. The claim shall be accompanied by the employer's federal and state tax returns for the years claimed and all books of accounts as may be requested by the department.

(c) Premium supplementation shall be paid rounded off to the nearest dollar. A claim for less than $1 shall not be processed or paid. [Eff: May 7, 1981] (Auth: HRS §393-32) (Imp: HRS §393-47)

§12-12-72 Reduction of premium supplementation. (a) The amount of premium supplementation due shall be reduced by the experience rating credit or dividend received by the employer from a health care contractor.

(b) If an experience rating credit or dividend is received after the premium supplementation is paid to the employer, the department shall reduce any premium supplementation awarded within the next two years by the employer's share of the amount of such experience rating credit or dividend. [Eff: May 7, 1981] (Auth: HRS §393-32) (Imp: HRS §393-45)

§12-12-73 Coverage by the fund. (a) Notwithstanding section 12-12-41(d), the premium supplementation fund shall provide benefits to an eligible employee whose employer has failed to provide coverage in the following manner:

(1) The eligible employee shall be deemed to have selected the most prevalent reimbursement plan if the services were obtained from a health care provider normally paid by such plan.

(2) The eligible employee shall be deemed to have selected the most prevalent fee for service plan if services were obtained from a fee for services health care provider.

(b) The premium supplementation fund shall reimburse the eligible employee for payment of fees based on subsection (a)(1) or (2) less the premium the employee would have paid for such coverage. A claim for reimbursment shall be filed on a form provided by the director within two years after such services are provided, and shall contain a certification by the eligible employee that the employer has refused a written request to provide the required benefits to the eligible employee. An employer shall be deemed to have refused to provide such benefits where the employer fails to contact such eligible employee within thirty calendar days after such eligible employee makes a written request to the employer for such benefits at the employer's place of business.

(c) Any employee who is eligible for or received benefits under other laws shall not be entitled to benefits under this section.

(d) The health care contractor with the most prevailing plan selected in the category of subsection (a)(1) or (2) shall assist the department, upon request, in arriving at the proper reimbursement to the eligible employee. [Eff: May 7, 1981] (Auth: HRS §393-32) (Imp: HRS §393-48)

§§12-12-74 to 12-12-75 (Reserved)

SUBCHAPTER 7
PENALTIES

§12-12-76 Penalties. Penalties under section 393-33, HRS, shall be assessed by the director, or a designated representative, after hearings held in accordance with chapter 91, HRS. [Eff: May 7, 1981] (Auth: HRS §393-32) (Imp: HRS §393-33)

Effective: May 7, 1981

Hawaii's Medicaid Program

Hawaii established its Medicaid program in 1966 under title XIX of the Social Security Act. Initially, the state used government salaried physicians, hospital outpatient clinics at nonprofit hospitals, and state-owned facilities to serve Medicaid recipients. Later in the 1960s, the program moved from exclusively using government health care providers to giving recipients a choice of public and private providers. The State Department of Human Services oversees Hawaii's Medicaid program and the Hawaii Medical Services Association serves as the program's fiscal agent—the agency that administers the program's claims processing functions.

The greatest number of Medicaid recipients live on the island of Oahu; however, the islands of Molokai and Hawaii have the highest percentage of Medicaid recipients when compared to their total populations. In fiscal year 1992, nearly 24 percent of Molokai's residents were covered by Medicaid and approximately 14 percent of the island of Hawaii's residents were on Medicaid.[1] The island of Lanai has both the lowest number of Medicaid recipients and the lowest percentage of recipients (4 percent).

Hawaii's Medicaid-Eligible Population Is Rising

Hawaii's Medicaid-eligible population grew significantly over the past few years. Hawaii's average monthly Medicaid-eligible population rose from 72,070 in fiscal year 1989 to about 101,000 in fiscal year 1993. The expansion in eligibility, combined with outreach activities for the State Health Insurance Program, contributed significantly to the increase in the number of residents identified as eligible for Medicaid.[2] Table II.1 shows the average monthly Medicaid-eligible population for fiscal years 1989 through 1993.

Table II.1: Hawaii Average Monthly Medicaid-Eligible Population (Fiscal Years 1989-93)

	Fiscal year				
	1989	1990	1991	1992	1993
Average monthly eligible population	72,070	73,364	74,573	88,260	101,000[a]

[a]State of Hawaii Department of Human Services estimate.

Source: State of Hawaii Department of Human Services and annual Medicaid Report for the State of Hawaii.

[1]The fiscal year 1992 figures were the most recent figures available from the state and HMSA.

[2]In 1989, Hawaii expanded its Medicaid eligibility to include such optional groups as pregnant women and infants with family incomes less than or equal to 185 percent of poverty, and the elderly and disabled whose income is less than or equal to 100 percent of poverty.

With the rise in the number of Hawaii residents eligible for Medicaid came an increase in Medicaid expenditures and the total amount of Medicaid benefits paid to providers. While providers consider Medicaid reimbursement rates to be low in Hawaii, the rates are slightly higher in the state than they are nationally. Table II.2 compares the fees paid to providers by Medicaid in Hawaii to the average fees paid by Medicaid in the nation as a whole.

Table II.2: Ratio of Medicaid Maximum Fees to Private Fee Levels, 1990

	Hawaii	United States
Primary care	0.58	0.62
Hospital visits	0.57	0.49
Surgery	0.61	0.49
OB-Gyn	0.63	0.57
Laboratory	0.66	0.52
Imaging	1.02	0.58
All services	0.63	0.59

Source: The Urban Institute, State-Level Data Book on Health Care Access and Financing (1993).

Hawaii experienced increases in expenditures for all types of services for Medicaid recipients from fiscal year 1990 to fiscal year 1992. The largest increase in actual cash payments occurred for hospital outpatient services—a 54.7 percent increase from fiscal year 1991 to fiscal year 1992. HMSA attributed this increase to the greater number of recipients using these services. See table II.3 for a summary of total Medicaid expenditures and table II.4 for information about the growth in Medicaid enrollment and expenditures in Hawaii and the United States.

Table II.3: State and Federal Medicaid Expenditures for Hawaii (Fiscal Years 1989-92)

Dollars in Millions

	Fiscal year			
	1989	1990	1991	1992
Hawaii	$109.2	$128.9	$141.6	$183.5
Federal	98.0	113.1	125.1	169.6
Total	**207.2**	**242.0**	**266.7**	**353.1**

Source: State of Hawaii Department of Human Services.

Table II.4: Average Annual Growth in Medicaid Enrollment and Expenditures (Fiscal Years 1988-90)

	Hawaii	United States
Enrollment	1.82%	5.20%
Expenditures	13.67	15.84
Expenditures per enrollee	11.64	10.11

Source: Health Care Financing Administration.

Premium History of Prevalent Insurance Plans in Hawaii (1984-93)

	Kaiser[a] Small Business Plan B		HMSA[b] Small Business Plan 4		Kaiser[a] Large Group Plan B	
	Monthly premium	Percent change	Monthly premium	Percent change	Monthly premium	Percent change
1984	$52.92		$47.52		$52.92	
1985	67.92	28.34%	47.52	0.00%	67.92	28.34%
1986	61.62	-9.28	55.72	17.26	61.62	-9.28
1987	63.88	3.67	64.70	16.12	63.88	3.67
1988	66.24	3.69	73.12	13.01	66.24	3.69
1989	72.68	9.72	87.58	19.78	72.68	9.72
1990	90.36	24.33	94.62	8.04	90.36	24.33
1991	100.70	11.44	101.58	7.36	103.80	14.87
1992	107.20	6.45	109.72	8.01	117.65	13.34
1993	115.49	7.73	128.38	17.01	130.49	10.91

Note: All premiums are for individual coverage.

[a]Kaiser Foundation Health Plan.

[b]Hawaii Medical Service Association.

Source: Kaiser Foundation Health Plan and Hawaii Medical Service Association.

General Employment and Business Data: Hawaii Compared to the United States

Data that would permit a definitive evaluation of the Prepaid Health Care Act's effect on Hawaii's businesses have not been developed. However, some key employment indicators show that Hawaii has done as well or better than the United States as a whole. This appendix contains data on these economic indicators. Table IV.1 shows that from 1976 to 1992, Hawaii's part-time employment rate has remained close to the U.S. average, and table IV.2 demonstrates that since 1980 Hawaii's unemployment rate has been markedly lower than the U.S. average. Indexed growth rates from 1970 to the present for total private employment and employment in retail and wholesale trades show that Hawaii outstrips the U.S. average (figures IV.1 and IV.2).

Table IV.1: Part-Time Employment Rates in the United States and Hawaii, 1976-1992 Annual Averages

	Part-time employment as percent of total employment	
	United States	Hawaii
1976	18.4	18.6
1977	18.3	17.9
1978	18.0	18.0
1979	17.9	17.4
1980	18.7	19.0
1981	19.0	18.6
1982	20.5	19.2
1983	20.3	18.1
1984	19.2	20.0
1985	19.0	20.3
1986	19.0	19.2
1987	18.8	20.0
1988	18.7	19.0
1989	18.5	16.8
1990	18.5	16.0
1991	19.2	16.1
1992	19.2	18.1

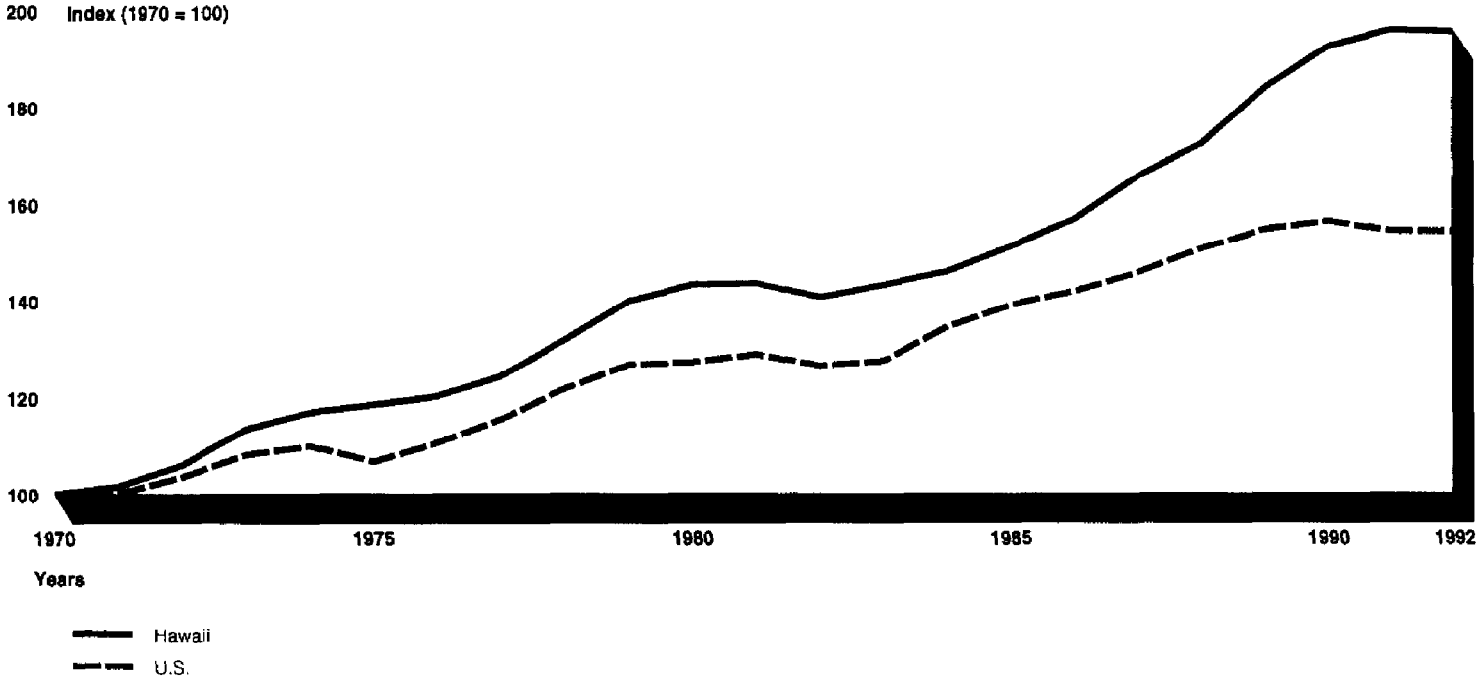
Source: U.S. Department of Labor, Bureau of Labor Statistics.

Table IV.2: Unemployment Rates in the United States and Hawaii, 1976-1992; Annual Averages and First 6 Months of 1993, Seasonally Adjusted

	United States	Hawaii
1976	7.7	9.8
1977	7.1	7.3
1978	6.1	7.7
1979	5.8	6.3
1980	7.1	4.9
1981	7.6	5.4
1982	9.7	6.7
1983	9.6	6.5
1984	7.5	5.6
1985	7.2	5.6
1986	7.0	4.8
1987	6.2	3.8
1988	5.5	3.2
1989	5.3	2.6
1990	5.5	2.8
1991	6.7	2.8
1992	7.4	4.5
1993	7.0	4.7

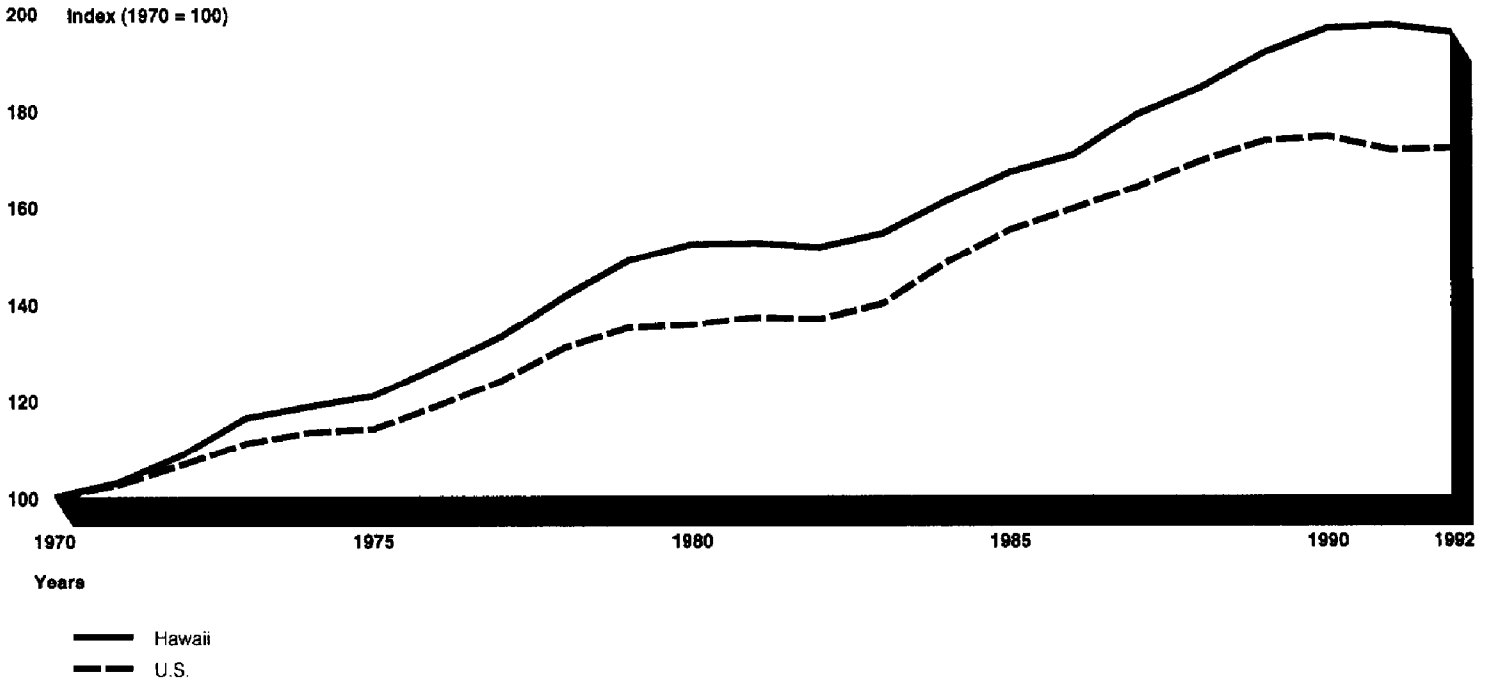
Source: U.S. Department of Labor, Bureau of Labor Statistics.

Figure IV.1: Total Private Employment, Hawaii and the United States (1970-92)



Source: U.S. Department of Labor, Bureau of Labor Statistics.

Figure IV.2: Retail and Wholesale Trade Employment, Hawaii and the United States (1970-92)



Source: U.S. Department of Labor, Bureau of Labor Statistics.

Medicaid Disproportionate Share Hospital Program in Hawaii

Hospitals that serve large numbers of Medicaid patients can face significant financial burdens because Medicaid generally reimburses providers at a lower rate than other insurers. To reduce the burden, the Congress established the Medicaid disproportionate share hospital program (DSH) in 1981.[1] The program allows states to designate hospitals treating large numbers of low-income patients as "disproportionate share hospitals" and to give these hospitals additional Medicaid reimbursement.

Federal legislation gives states minimum criteria and formulas for identifying hospitals that qualify for disproportionate share status. This legislation requires states to consider the amount of charity care provided by the hospitals when deciding if they qualify as disproportionate share hospitals and in calculating their reimbursements. Each state chooses the formulas that are used to qualify hospitals for disproportionate share status and to determine the amount of funds these hospitals receive.[2] In Hawaii, 23 of the 28 acute care facilities in the state received disproportionate share payments in fiscal year 1992. (See table V.1 for data on hospitals' Medicaid utilization, revenues, and income in fiscal year 1992.)

In recent years, disproportionate share payments have climbed rapidly in Hawaii. State officials attribute this increase to Hawaii's decision to designate as disproportionate share hospitals those facilities that derived more than $100,000 of annual revenue from public funds for the care of low-income patients. Total disproportionate share payments in Hawaii rose from almost $8 million in fiscal year 1991 to over $40 million in fiscal year 1992 (see table V.2).

[1]Omnibus Budget Reconciliation Act of 1981, Public Law 97-35.

[2]Criteria established by State of Hawaii to qualify hospitals as disproportionate share facilities read as follows:
A. Either—
(1) Has at least two obstetricians with staff privileges at the facility who have agreed to provide obstetric services to individuals who are eligible for assistance under the Medicaid program; or
(2) Did not offer non-emergency obstetric services as of December 22, 1987; and
B. Either—
(1) Has indigent inpatient days equal to or greater than 15 percent of total acute inpatient days; or
(2) Has a Medicaid inpatient utilization rate equal to or greater than one standard deviation above the statewide mean Medicaid inpatient utilization rate; or
(3) Has a low income utilization rate equal to or greater than 25 percent; or
(4) Is a hospital that derives more than $100,000 of revenue from public funds paid for care of low-income patients (including state general assistance and state cash subsidies but excluding Medicare and Title XIX, Medicaid funds).

Table V.1: Medicaid Utilization, Revenues, and Income (Fiscal Year 1992)

Hospital location and name	Medicaid utilization rate (percent)	Net patient revenues	Net income (loss)
Island of Hawaii			
Hilo Hospital[a]	13.64	$48,834,080	4,995,302
Honokaa Hospital[a]	1.91	1,958,418	328,212
Kau Hospital[a]	16.00	880,418	205,468
Kohala Hospital[a]	0.89	586,054	(1,704,457)
Kona Hospital[a]	17.93	19,901,043	955,017
Island of Kauai			
Kauai Veterans Memorial Hospital[a]	10.71	1,589,644	(6,185,936)
Samuel Mahelona Memorial Hospital[a]	0	3,754,345	(298,725)
Wilcox Memorial Hospital[b]	12.28	32,982,587	(173,593)
Island of Lanai			
Lanai Community Hospital[a]	34.02	513,311	(166,872)
Island of Maui			
Maui Memorial Hospital[a]	9.47	38,767,598	1,147,543
Island of Molokai			
Molokai General Hospital[b]	[e]	2,152,068	(1,398,039)
Island of Oahu			
Castle Medical Center[c]	25.85	43,422,026	2,218,411
Kahuku Hospital[b]	29.72	3,461,775	169,581
Kaiser Foundation Hospital-Hawaii[b]	1.03	[e]	[e]
Kapiolani Medical Center for Women and Children[b]	34.64	113,234,952	16,491,907
Kuakini Medical Center[b]	4.69	88,902,881	(470,757)
Pali Momi Medical Center[b]	10.52	30,403,935	(6,601,193)
The Queens Medical Center[b]	17.58	222,629,488	14,482,044
Rehabilitation Hospital of the Pacific[b]	11.14	19,582,072	908,242
St. Francis Medical Center[c]	11.29	[e]	[e]
St. Francis Medical Center-West[c]	24.67	24,121,083	(3,355,212)
Straub Clinic and Hospital[d]	6.28	153,466,573	(5,495,748)
Wahiawa General Hospital[b]	13.88	23,903,723	(961,100)

[a]State hospital.

[b]Nonprofit hospital.

[c]Church hospital.

[d]Proprietary hospital.

[e]Not available.

Table V.2: DSH Payments (Fiscal Years 1991 and 1992)

Hospital location and name	1991 DSH	1992 DSH	Percent change
Island of Hawaii			
Hilo Hospital[a]	$371,654	$3,544,535	854
Honokaa Hospital[a]	152,233	527,270	246
Kau Hospital[a]	68,845	420,949	511
Kohala Hospital[a]	145,649	757,654	420
Kona Hospital[a]	1,180,328	4,934,850	318
Island of Kauai			
Kauai Veterans Memorial Hospital[a]	768,176	3,440,496	348
Samuel Mahelona Memorial Hospital[a]	255,733	1,438,853	463
Wilcox Memorial Hospital[b]	138,575	386,021	179
Island of Lanai			
Lanai Community Hospital[a]	61,897	334,264	440
Island of Maui			
Maui Memorial Hospital[a]	422,153	7,105,387	1,583
Island of Molokai			
Molokai General Hospital[b]	1,275	9,500	645
Island of Oahu			
Castle Medical Center[c]	473,462	1,832,887	287
Kahuku Hospital[b]	498,406	515,604	3
Kaiser Foundation Hospital-Hawaii[b]	20,849	276,420	1,226
Kapiolani Medical Center for Women and Children[b]	106,003	1,293,745	1,120
Kuakini Medical Center[b]	162,955	585,584	259
Pali Momi Medical Center[b]	104,182	509,901	389
The Queens Medical Center[b]	2,238,280	8,676,643	288
Rehabilitation Hospital of the Pacific[b]	119,999	883,493	636
St. Francis Medical Center[c]	301,193	1,336,270	344
St. Francis Medical Center-West[c]	272,182	575,471	111
Straub Clinic and Hospital[d]	105,404	668,346	534
Wahiawa General Hospital[b]	28,064	299,991	969

[a]State hospital.

[b]Nonprofit hospital.

[c]Church hospital.

[d]Proprietary hospital.

Major Contributors to This Report

Health, Education, and Human Services Division, Washington, D.C.

Sarah F. Jaggar, Director, Health Financing and Policy Issues, (202) 512-7119
Bruce D. Layton, Assistant Director
Helene F. Toiv, Assignment Manager
Frederick K. Caison, Senior Evaluator
Michael F. Gutowski, Adviser

Far East Office

Patricia K. Yamane, Evaluator-in-Charge
Mark D. Ulanowicz, Evaluator

Related GAO Products

Health Care: Rochester's Community Approach Yields Better Access, Lower Costs (GAO/HRD-93-44, Jan. 29, 1993).

Employer-Based Health Insurance: High Costs, Wide Variation Threaten System (GAO/HRD-92-125, Sept. 22, 1992).

State Health Care Reform: Federal Requirements Influence State Reforms (GAO/T-HRD-92-55, Sept. 9, 1992).

Access to Health Care: States Respond to Growing Crisis (GAO/HRD-92-70, June 16, 1992).

Access to Health Care: State Efforts to Assist Small Businesses (GAO/HRD-92-90, May 14, 1992).

Health Care: Problems and Potential Lessons for Reform (GAO/T-HRD-92-23, Mar. 27, 1992).

Health Care Spending: Nonpolicy Factors Account for Most State Differences (GAO/HRD-92-36, Feb. 13, 1992).

Ordering Information

The first copy of each GAO report and testimony is free. Additional copies are $2 each. Orders should be sent to the following address, accompanied by a check or money order made out to the Superintendent of Documents, when necessary. Orders for 100 or more copies to be mailed to a single address are discounted 25 percent.

Orders by mail:

U.S. General Accounting Office
P.O. Box 6015
Gaithersburg, MD 20884-6015

or visit:

Room 1000
700 4th St. NW (corner of 4th and G Sts. NW)
U.S. General Accounting Office
Washington, DC

Orders may also be placed by calling (202) 512-6000 or by using fax number (301) 258-4066.

PRINTED ON RECYCLED PAPER

United States
General Accounting Office
Washington, D.C. 20548-0001

Bulk Mail
Postage & Fees Paid
GAO
Permit No. G100

Official Business
Penalty for Private Use $300

Address Correction Requested