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STATE OF HAWAIʻI
KA MOKUʻĀINA O HAWAIʻI
DEPARTMENT OF LABOR AND INDUSTRIAL RELATIONS
KA ʻOIHANA PONO LIMAHANA

March 24, 2025

To: The Honorable Henry J.C. Aquino, Chair
The Honorable Chris Lee, Vice Chair, and
Members of the Labor and Technology Committee

Date: Monday, March 24, 2025
Time: 3:00 p.m.
Place: Conference Room 224, State Capitol

From: Jade T. Butay, Director
Department of Labor and Industrial Relations (DLIR)

Re: S.C.R. 145 LEGISLATIVE WORKING GROUP PAID FAMILY AND MEDICAL LEAVE

Chair Aquino, Vice Chair Lee, and Members of the Senate Committee on Labor and Technology:

The DLIR has historically supported the intent of Paid Family and Medical Leave (PFML) measures considered by the Legislature because the department's statutory mission includes administering programs designed to enhance the economic security, physical and economic well-being, and productivity of workers, as well as fostering positive labor-management relations. However, as the saying goes, "the devil is in the details." The department has consistently raised concerns about these proposals, particularly because they could jeopardize Hawaii's Prepaid Health Care Law (Prepaid). Additionally, the department has explained that, as the administrator of both Prepaid and the Hawaii Family Leave Law, it lacks the expertise necessary to determine how to avoid jeopardizing the Prepaid Law.

Unlike other states and jurisdictions, Hawaii has a unique situation: it is the only state that requires employers to provide workers with adequate medical coverage for non-work-related illness or injury through the Prepaid Health Care Law (PHC Act). Additionally, Hawaii requires employers to provide Temporary Disability Insurance (TDI) coverage, which offers partial wage replacement for non-work-related injury or sickness, including pregnancy.

The Prepaid and TDI laws were enacted after years of advocacy by organized labor and other stakeholders. Furthermore, the Legislature passed these laws only after comprehensive studies,[1,2] including an actuarial component, were conducted through

an appropriation to the Legislative Reference Bureau (LRB) in 1967. These appropriations were made to procure the expertise necessary for the research and to provide model legislation for enactment. The studies were led by the eminent jurist Stefan Riesenfeld, who conducted an in-depth analysis of both national and local health insurance markets, covering public and private insurance offerings and enrollment. Dr. Riesenfeld's model legislation was largely adapted into HRS Chapter 392 (TDI) in 1969 and HRS Chapter 393 (Prepaid) in 1974 (study attached).

However, in 1974, Congress also enacted the Employee Retirement Income Security Act (ERISA), which is administered by the U.S. Department of Labor. ERISA regulates pension and employee benefit programs, including employment-based health insurance coverage provided by private employers or unions. It was enacted to address fraud and mismanagement in private pension plans by establishing comprehensive federal standards to protect employee pension and benefit programs.

ERISA contains a Preemption Clause (29 U.S. Code § 1144) that essentially preempts any state law that conflicts with ERISA and prohibits states from enacting statutes contrary to ERISA:

> (a) Supersedure; effective date
>
> Except as provided in subsection (b) of this section, the provisions of this subchapter and subchapter III shall supersede any and all State laws insofar as they may now or hereafter relate to any employee benefit plan described in section 1003(a) of this title and not exempt under section 1003(b) of this title. This section shall take effect on January 1, 1975.

ERISA preemption prevents states from requiring employers to offer health coverage or dictating the terms of their health plans, as outlined in the Prepaid Health Care Act, HRS Chapter 393. However, to avoid ERISA's preemption and preserve Hawaii's Prepaid Health Care Law, Hawaii's Congressional Delegation successfully secured an exemption, which was signed into law by President Ronald Reagan in 1982. This gave Hawaii the only waiver to the ERISA preemption as follows:

> (B) Nothing in subparagraph (A) shall be construed to exempt from subsection (a)—
> (i) any State tax law relating to employee benefit plans, or
> (ii) any amendment of the Hawaii Prepaid Health Care Act enacted after September 2, 1974, to the extent it provides for more than the effective administration of such Act as in effect on such date.

PFML proposals have contained a provision for continuing health care benefits throughout the duration of the proposed PFML leave. However, this provision directly conflicts with the Prepaid Health Care Law, HRS 393-15, which limits an employer's obligation to continue coverage once an employee is no longer able to earn wages.

PFML proposals have also frequently included provisions that conflict with or raise issues regarding other laws administered by the DLIR, including TDI, the Hawaii Family Leave Law, and the Employment Security Law (unemployment insurance). Moreover, these proposals often contain contradictory, ambiguous, or erroneous provisions that would hinder the department's ability to administer them (see DLIR testimony on HB755 (2025), HB2757 (2024), and SB360 (2023)).

A key shortcoming of previous Paid Family Leave studies is their failure to adequately address ERISA preemption issues through a thorough legal review. The 2016 study did not discuss ERISA, while the 2019 study stated, "…and avoiding Employee Retirement Income Security Act (ERISA) status is also advised."

Both studies significantly underestimated the staffing required to administer a Paid Family Leave program. One study estimated 22 staff members, and the other estimated 30, while the department has consistently testified that approximately 120 staff would be needed to implement and administer such a program. The department was not consulted in developing these staffing estimates, which were not based on Hawaii-specific data regarding employers, employees, and wages. Similarly, these studies did not adequately address Information Technology (IT) requirements or costs, nor did they consider whether and how the Office of Enterprise Technology Services (ETS) would support the IT program. Furthermore, commercial off-the-shelf solutions for the IT needs of a PFML program do not currently exist.

For all the reasons outlined above, the DLIR recommends conducting a comprehensive study, including an actuarial component, like the Riesenfeld studies that led to the creation of the TDI and Prepaid Laws. Importantly, this study should detail how to implement a PFML law without jeopardizing the Prepaid Law. Such a study would inform all stakeholders, including the Legislature and the DLIR, about how a PFML law could operate without significantly undermining the intent and benefits of existing laws. Additionally, the study should provide an accurate assessment of the costs to employers, employees, and the State associated with establishing and administering a PFML law.

The department believes that neither the Legislature, the DLIR, nor the other stakeholders suggested in SCR 145 have the expertise required to accomplish what is outlined in the previous paragraphs as the only realistic path forward for creating a PFML law in Hawaii.

In addition, the DLIR is nearly 60% reliant on federal funds for operating its programs and uses a portion of that funding to support the central services functions of HR, IT, and fiscal. The department prefers to have flexibility to respond to federal initiatives and potential changes in federal funding levels. The department is currently preparing for potential changes in federal funding as part of the executive-wide effort led by the Department of Budget and Finance. Moreover, the department has recently been assigned responsibility for the Office of the State Fire Marshall as well as the Hawaii Retirement Savings Program.

Lastly, DLIR programs that administer current laws, such as the Disability Compensation Division (TDI, Prepaid, Workers' Compensation) and the Wage Standards Division (Child Labor, Wage & Hour, Payment of Wages, Hawaii Family Leave, Prevailing Wages, Unlawful Termination), have struggled to enforce these laws and have not had their capacity restored to previous levels, including those before the last major Reduction-in-Force in 2009.

1 https://lrb.hawaii.gov/wp-content/uploads/1971_PrepaidHealthCareInHawaii.pdf
2 https://lrb.hawaii.gov/wp-content/uploads/1969_TemporaryDisabilityInsurance.pdf

PREPAID HEALTH CARE IN HAWAII

Stefan A. Riesenfeld
Professor of Law
University of California

Report No. 2, 1971

LEGISLATIVE REFERENCE BUREAU

UNIVERSITY OF HAWAII
Honolulu, Hawaii 96822

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FOREWORD

Prepaid Health Care in Hawaii completes the assignment made to the Legislative Reference Bureau by Act 198, Session Laws of Hawaii 1967. The first portion of that legislative request produced Bureau Report No. 1, 1969, Temporary Disability Insurance, which proved instrumental in the enactment of the Hawaii Temporary Disability Insurance Law (Act 148, Session Laws of Hawaii 1969; Chapter 392, Hawaii Revised Statutes). As in the case of the earlier study and report, the study on Prepaid Health Care in Hawaii was conducted by Professor Stefan A. Riesenfeld, and he is the author of the Report. The Bureau expresses its great appreciation to Professor Riesenfeld, Emanuel S. Heller Professor of Law at the University of California, for carrying out this project. It has been a distinct honor and pleasure again to have the Professor associated with the Legislative Reference Bureau.

Many individuals and agencies have been most helpful and cooperative in supplying data and information necessary for this study and report. The Bureau is especially indebted for the contributions of Robert Schmitt, State Statistician, Department of Planning and Economic Development; Gordon Frazier, Chief Research and Statistics Officer, and Orlando Watanabe, Temporary Disability Insurance Administrator, Department of Labor and Industrial Relations; Jack T. Wakayama, Chief of Research and Statistics, Department of Social Services and Housing; Iola Rhyne, Tax Research and Planning Officer, Department of Taxation; J. R. Veltmann, Executive Vice President, Hawaii Medical Service Association; Irving Hutkins, Vice President and Manager, Hawaii Region, Kaiser Foundation Health Plan, Inc.; and the Health Insurance Association of America.

Carroll Taylor, Douglas Ige, and Patricia K. Putman of the Bureau staff assisted in the study and preparation of this Report.

Henry N. Kitamura
Director

January, 1971

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Part I

THE QUEST FOR COMPULSORY HEALTH INSURANCE IN THE UNITED STATES IN HISTORICAL PERSPECTIVE

The history of the establishment of compulsory health insurance in the United States is a tale of wasted efforts and slow progress.[1] While Germany enacted pioneering legislation establishing compulsory insurance against medical and hospital costs for broad segments of the population as early as 1883[2] and England took a similar step in 1911,[3] efforts toward similar legislation on either the federal level or the state level in the United States have remained unsuccessful. Compulsory health insurance has been achieved only for limited categories of the civilian population, viz. workers suffering from industrial injuries and individuals having attained the age of 65 years. Provisions entitling workmen suffering industrial injuries to medical care or compensation for its costs were included in a number of the early workmen's compensation laws, enacted in 1911 and thereafter.[4] While at first the protection afforded was drastically limited in duration or amount, or both, these restrictions were progressively relaxed and finally eliminated. Today, most workmen's compensation acts provide for unlimited medical benefits. Hawaii removed such restrictions in 1923.[5] Compulsory hospital insurance for the aged (medicare) was the great step taken in 1965[6] which represents the beginning of a new era. Hence it seems appropriate to organize the discussion of the efforts toward compulsory health insurance in the United States into two phases, one covering the era from 1910 to 1965 and the other beginning with medicare.

A. From 1910 to 1965

Encouraged by the adoption of compulsory health insurance legislation abroad, the early advocates of social insurance in the United States included protection against the costs of medical care as an essential part of their program. The American Association for Labor Legislation (organized in 1909) developed in 1914 a set of widely discussed Health Insurance Standards,[7] followed by a Tentative Draft of a Health Insurance Act.[8] Efforts were made in fifteen states to introduce that or a similar type of legislation, resulting in the appointment of study commissions in the majority of these states.[9] Ultimately, however, all these efforts were aborted.

In the early thirties the interest in governmental programs providing protection against the costs of medical care revived, especially after the publication in 1932 of the final report of the Committee on the Costs of Medical Care, appointed on the initiative of

President Hoover in 1927.[10] The Committee, however, cautioned against the introduction of compulsory public health insurance as a general program but favored group pre-payment programs through the use of private insurance or taxation, or a combination of both methods.[11] In 1934 President Roosevelt appointed the celebrated Committee on Economic Security which studied the inclusion of compulsory public health insurance within the framework of the federal social security system which was to be newly created. The Committee decided not to recommend any action with respect to compulsory health insurance at that time in order to avoid the risk of a rejection of the whole program.[12]

After the passage of the Social Security Act in 1935, new efforts were launched to secure health insurance either on the state level or in form of a joint federal-state system. Symptomatic of the former approach was the elaboration in 1935 of a model bill for state compulsory health insurance by the American Association for Social Security, under the leadership of Abraham Epstein.[13] The joint state-federal approach was adopted in Senator Wagner's all-inclusive National Health Bill of 1939 which provided for federal participation in state compulsory health insurance schemes.[14] It should be noted that the Model Bill of the American Association for Social Security, as well as the National Health Bill, contemplated medical cost benefits and wage-loss benefits[15] and that most of the numerous state bills that were introduced between 1936 and 1945 included both types of benefits.[16]

Toward the end of World War II, the drive for compulsory health insurance on the federal level received new vigor, climaxing in the two Wagner-Murray-Dingell bills introduced in Congress in 1943 and 1945[17] and the repeated efforts of President Truman to secure congressional adoption of compulsory health insurance,[18] prompting the proposal of a revised Wagner-Murray-Dingell bill in 1945.[19] Although bills of this type were extensively debated in Congress between 1946 and 1950, the resistance of powerful interest groups led to the defeat of the program. By 1950 the idea of a federal general compulsory health insurance program had been shelved for all practical purposes although bills of this type continued to be introduced by a few Congressmen.[20]

Between 1952 and 1965, the main efforts at the federal level focused on health insurance for the aged, culminating ultimately in the adoption of the medicare program. There persisted, however, efforts toward compulsory health insurance on a broader basis at the state level.

Noteworthy among the efforts at the state level have been the repeated drives in that direction in California and New York. In 1945 Governor Earl Warren of California launched an intensive campaign to secure the adoption of a compulsory health insurance program in his state. The administration bill[21] as well as certain competing bills were the subject of extensive hearings held by the Assembly Interim Committee on Public Health. The Committee reported adversely on any compulsory health insurance scheme,[22] and the bill died in the Committee on Public Health to which it was referred.[23] In 1959 Governor Brown of California appointed a Committee on the Study of Medical Aid and Health under the chairmanship of Dr. Egeberg. In 1960 that Committee submitted its report which was published under the title, "Health Care for California".[24] The report, which ranged over a broad spectrum of problems relating to the health needs of the citizens and the means of meeting them, included a special chapter focusing on the methods of financing the costs of personal health services. The Committee recommended, by way of long-range goals, that "prepayment for health services be extended to cover substantially the entire population of California" and that "necessary financing to assure [the availability of comprehensive health care of high quality to everyone in the State] be provided from individual, private or public sources".[25] Although the Committee discussed various avenues for securing additional funds needed to broaden the prepayment of health services, including employer/employee payroll taxes,[26] it refrained from recommending or endorsing a particular system, but limited itself to calling for a study "aimed particularly at the problem of financing a minimum of prepaid health service for substantially the entire population".[27] The Committee took note of the fact that a limited hospital benefit, provided by the State Unemployment Compensation Disability Law,[28] was already financed by an employee-financed payroll tax and pointed out that a moderate increase of this tax, coupled with an increase of the maximum earning base of such tax, could provide minimum health benefits for the employee himself.[29] It may be mentioned that the California approach differed materially in that respect from the position taken by New York in its Disability Benefits Law of 1949 which permits a credit for medical and hospital benefits up to 40 per cent of the actuarial value of the temporary disability benefits provided by the Act.[30]

In New York, the year 1945 likewise marked the start of renewed efforts toward compulsory health insurance. The New York legislature had established, the year before, a temporary Commission on Medical Care for the purpose of developing programs for medical care for the inhabitants of the state.[31] The Commission submitted its report, entitled "Medical Care for the People of the State of New York", in

1946.[32] The report discussed in great detail various plans for compulsory health insurance and the financing thereof[33] and analyzed in particular two sets of bills for the establishment of compulsory health insurance introduced in 1945: one by Assembly Majority Leader I. M. Ives (A. 2542) and the other by Senator Joseph and Assemblymen Austin and Jack (S. 479 and A. 261 and A. 141).[34] The majority of the Commission rejected any plan for compulsory health insurance in view of its tremendous costs,[35] despite the fact that in an opinion poll conducted by the Commission, 51.9 per cent of the sample had voted for, and only 35.6 per cent against, such a system.[36]

Efforts for the introduction of compulsory health insurance in New York thereafter became more or less dormant until 1958 when Governor Rockefeller decided to revive the idea. As part of his platform he proposed to add major medical expense insurance to the protection afforded by the Temporary Disability Law and appointed a Special Task Force to study the problem.[37] Although this body issued a negative report[38] in view of the limited coverage of the Temporary Disability Law, the existing coverage under voluntary plans, the freezing effects of a mandatory system, and the possible adverse effects on economic expansion and job opportunities, the gubernatorial idea was taken up by the Joint Legislative Committee on Health Insurance Plans even prior to the release of the task force report.[39] The Joint Legislative Committee endorsed the gubernatorial idea in principle but considered mandatory basic hospital and surgical coverage as demanding a higher priority than protection against catastrophic expenses.[40] Bills to that effect were introduced in the Senate primarily for study purposes.[41] The bills evoked little interest until 1962 when organized labor indicated its support of mandatory health insurance. Hearings were held, and the New York Insurance Department submitted a study of the impact of a revised version of the principal bill by Senator Metcalf, introduced in 1960.[42] As a result, in 1963 a modified bill was introduced which afforded somewhat different benefits and coverage but again provided essentially only hospitalization insurance.[43] The changes were made mainly to meet certain objections raised by industry and insurance companies spokesmen on the one hand and organized labor on the other. Although the bill failed to achieve passage, the Committee instructed the chairman to reintroduce the bill in 1964.[44] The year 1965 brought further support for the idea of compulsory hospitalization insurance. Not only did the Joint Legislative Committee on Health Insurance Plans continue its efforts in behalf of the establishment of compulsory hospitalization insurance by the reintroduction of a mandatory hospitalization bill and additional hearings thereon,[45] but the Governor's Committee on Hospital Costs under the chairmanship of

Mr. Marion Folsom likewise strongly advocated the passage of a state hospitalization insurance law including also coverage of home and long-term care.[46] The report referred to both lack and inadequacy of coverage as the chief reasons for mandatory legislation of that type.[47] The Folsom committee report resulted in the adoption of the recommendations relating to the improvement of hospital facilities and services,[48] but the recommendations relating to compulsory health insurance were not implemented on the legislative level. Among other factors, the enactment of the medicare and medicaid provisions in the Social Security Amendments of 1965[49] had substantially changed the picture so as to make a revision of the original ideas, though not an abandonment thereof, necessary.

As a result on the eve of the reform of 1965, compulsory medical care insurance existed only within the framework of workmen's compensation. In addition, there were state programs of public medical care for certain groups of patients and, above all, the medical care programs for veterans on the federal level. Legislation to that effect reached back to the early days of national existence and received major impetus in connection with World War I. In 1930 the Veterans Administration was established and all programs for medical, hospital, and domiciliary care of veterans suffering from service-connected disabilities brought under its responsibility.[50] The pertinent legal provisions are now consolidated in the U.S. Code, Title 38. During 1967 over 750,000 patients were treated in Veterans Administration hospitals, and 6,268,000 medical visits to outpatients were furnished by the program.[51]

B. Period Since the Establishment of Medicare and Medicaid

The establishment of the federal medicare and medicaid programs by the Social Security Amendments of 1965 constituted a major change of the health care scene, since it profoundly modified the status of the two segments of the population in need of the costliest type of medical care: the aged and the indigent. Especially medicare, which adopted the social insurance rather than the social assistance approach, constituted a real departure from the pre-existing pattern.

As was pointed out before, by 1951, the idea of universal comprehensive national health insurance had been shelved for all practical purposes. The advocates of compulsory health insurance came to focus on a more limited goal and, beginning in 1952, the principal efforts in Congress centered around compulsory health care insurance, especially hospital insurance, for social security (OASI) recipients. The pertinent bills proposed hospitalization insurance, including medical care during hospitalization, for persons eligible for benefits under the OASI program, i.e., the aged and their dependents or survivors.[52] After the addition of disability insurance by the Social Security Amendments of 1956, some bills included the disabled in the proposed health insurance scheme,[53] but the majority continued to exclude them. The original bills of this type were introduced by Senator Murray[54] and Representatives Cellar[55] and Dingell[56] in 1952. The Eisenhower Administration, however, did not endorse this approach. Nevertheless, the proposals reached a more active state when Congressman Forrand, an influential member of the Ways and Means Committee, also introduced such a bill,[57] providing hospital benefits of up to 60 days per calendar year, nursing home care following discharge from a hospital, and surgical benefits for OASI (but not disability insurance) eligibles. The various bills became the subject of hearings held in 1958 by the Committee on Ways and Means, in the context of a series of hearings on all titles of the Social Security Act.[58] The Committee, however, did not make any proposals for the extension of the social security system so as to include hospital insurance for the aged or OASI eligibles. Subsequent efforts[59] also suffered defeat.[60]

The picture changed materially in 1961 when President Kennedy included health insurance for the aged through social security in the legislative program of his administration and made it part of a special message to Congress.[61] The administration proposals crystallized in the so-called King-Anderson bill,[62] providing limited hospital care, nursing home services, home-health services, and outpatient hospital-diagnostic services (subject to a deductible) for

persons aged 65 and over.[63] A slightly broader coverage was proposed in the second Kerr-Anderson bill, introduced in 1963.[64] The provisions of this bill were added by the Senate to other proposed Social Security Amendments that had passed the House, but the whole measure died in the Conference Committee at the end of the Eighty-Eighth Congress.[65]

A new Kerr-Anderson bill providing insurance for the aged against hospital and related health care costs was introduced in the next Congress[66] and finally resulted in the adoption of the medicare and medicaid programs. The system of compulsory health insurance for the aged as detailed in the Kerr-Anderson bills was modified after hearings before the House Ways and Means Committee. The new program, as embodied in the Mills bill (H.R. 6675), created two related health insurance programs, i.e., a compulsory basic program covering hospital and related health care costs and a voluntary supplementary program affording protection against the costs of physicians' care and of certain other items of personal health care not covered by the basic program.[67] H.R. 6675 succeeded in being passed by both houses.[68] The two medicare programs formed a new Title XVIII of the Social Security Act. In addition, a greatly expanded system of medical aid to the needy was incorporated in a new Title XIX.

Although medicare brought mandatory health insurance for the aged, the remainder of the population was left, apart from the classical payment for service system, either to voluntary prepayment plans (including those on a collectively bargained basis) or to public provision, primarily under Title XIX. To be sure Title XIX envisages and authorizes prepayment coverage of medical assistance, either in toto or in part,[69] but no extensive resort to this form of coverage has been possible owing to the stringent coverage requirements and practical difficulties caused by the provisions of the Act relating to eligibility determinations. As a result, the quest for legislation requiring mandatory prepayment plan coverage for the population under 65 continued to have vitality.

Noteworthy is the fact that the adoption of the medicare and medicaid provisions by Congress did not halt the efforts in New York toward compulsory health insurance endorsed by the Rockefeller administration. Even in the immediate wake of congressional legislation, the newly established Senate and Assembly Committee on Public Health felt that the need for statewide compulsory health insurance called for further hearings and, as a result thereof, recommended legislation requiring mandatory extension of hospital insurance coverage to the entire work force and its dependents as a condition of employment.[70]

In his January, 1967, annual message, Governor Rockefeller reaffirmed his view that the problem of catastrophic expenses of illness required public action, although he doubted whether such action could be taken on the individual state level without federal intervention.[71] On February 22, 1967, the Governor, the Assembly Speaker, and Majority and Minority Leaders called for the study of "a program which would require basic health service insurance for the great majority of employees" of the State of New York.[72] A draft of a bill entitled "Health Insurance Benefits Law" (to constitute a new chapter of the State Workmen's Compensation Law) was introduced in both houses and assigned for hearings to the Joint Legislative Committee on the Problems of Public Health and Medicare.[73] As a result of the hearings, the committee staff drafted some major substantive amendments, including one providing a state subsidy for low-income families.[74] The Committee, however, felt unable to complete its task and scheduled the bill for further hearings during 1967 and 1968.[75] While such hearings were still being held and ten days prior to the date of the Committee's 1968 report, Governor Rockefeller, on March 20, 1968, sent a message to the legislature urging adoption of a revised system of compulsory health benefits, incorporated in an accompanying bill, entitled "Health Security Act".[76] The bill was introduced by the Committee on Rules on March 21, 1968.[77] It was designed to meet some of the objections raised by various groups, especially labor, against the prior bill. The measure, which was to form a new chapter of the New York Public Health Law, provided specified compulsory health insurance or health plan benefits, not including surgical and medical benefits, for employees and their dependents.[78] Due to the lack of time, the Joint Legislative Committee on the Problems of Public Health, Medicare, Medicaid and Compulsory Health and Hospital Insurance could do no more than to back the principles of the new bill without endorsing any of its specific provisions.[79] No positive legislative action ensued.

In 1969, the measure was reintroduced with certain modifications, mainly designed to conform the benefits provided to those available under medicare Part A and to exempt small employers.[80] While the majority of the Joint Legislative Committee continued to support the legislation, no attempt to secure legislative action was taken.[81]

In 1970, Governor Rockefeller proposed a further revision of his plan for compulsory health insurance, now entitled "Universal Health Insurance Act", which was introduced on April 1, 1970.[82] The new bill, the fate of which is still undetermined, provides mandatory health insurance benefits for all employees and their dependents, as well as noncorporate employers,[83] voluntary coverage for persons without employment after the termination of their coverage as employees

(limited to 180 days),[84] and mandatory coverage of persons receiving public assistance or determined to be eligible for public assistance.[85] The proposed act is to be administered by a newly established public corporation, called state health insurance corporation, vested with vast regulatory and managerial powers.[86] The insurance is provided by the employer through contracts with commercial insurance carriers, nonprofit insurance corporations, or the newly created[87] health service corporation. Employee benefits normally are financed by joint, but not equal, contributions of the employee and the employer. Unless a lesser percentage is stipulated by agreement, employees earning annual wages of $6,000 or more contribute 35 per cent of the cost of their coverage, employees earning at least $5,000 but less than $6,000 contribute 20 per cent, and employees earning less than $5,000 are not liable for contributions.[88] Employers pay at least 65 per cent of the premium costs but need not make aggregate contributions (including wages withheld from the employees) in excess of four per cent of their annual payroll.[89] Any balance is paid, as a subvention, by the state health insurance corporation.[90] In the case of voluntary temporary insurance of persons out of employment, the individual and the state health insurance corporation share the cost on an equal basis.[91]

The newest development in the field of compulsory health insurance is the President's announcement of his Family Health Insurance Plan for poor families with children. The plan envisages health benefits insurance coverage having a premium value of $500. Families having an income between $1,600 and $3,000 would contribute 5 per cent of the cost, families having an income between $3,000 and $4,500 would contribute 10 per cent, and families with incomes from $4,500 to $5,620 would contribute 25 per cent. Legislative proposals are promised for January 1971.[92]

Finally, it should be noted that the general desirability of prepayment plan protection against medical cost was again strongly stressed in the June, 1970, Recommendations of the United States Department of Health, Education and Welfare, Task Force on Medicaid and Related Programs.[93]

Part II

EXAMINATION OF A NEED FOR LEGISLATIVE ACTION IN HAWAII

Although prepayment plans covering the costs of hospital and medical expenses originated in the United States as early as 1880,[1] the spectacular rise of prepayment coverage by commercial insurance carriers, nonprofit insurance corporations, and medical groups occurred only in the three decades since 1940. Between 1940 and 1968, the number of persons with hospital expense protection rose from 12.3 million to 169.5 million, the number of persons with surgical expense protection rose from 5.4 million to 155.7 million, and the number of persons with regular medical expense coverage from 3.0 million to 129.1 million.[2] Hence the need for public action depends on the size of the coverage gap still existing and the adequacy of the coverage provided.

The following inquiry focuses on the situation in the State.

A. Estimated Size of the Coverage Gap

Basic Data

Any estimate of the coverage gap existing in Hawaii is vitally affected by great uncertainty with respect to the three basic sets of figures which determine the result:

a. The size of the resident civilian population;

b. The size and composition of the civilian labor force;

c. The extent of commercial health insurance protection and its overlap with other pre-payment plans.

Unfortunately, the greatest doubts relate to the fundamental reference quantity: the size of the resident civilian population. When original estimates of the coverage gap were made early in 1970 by the Legislative Reference Bureau, the resident civilian population, as of July 1, 1969, was estimated at 736,750 persons.[3] The preliminary census figures for 1970, however, indicate that the 1969 data were overestimated by 44,392 persons and that the resident civilian population as of that date was actually only 692,358 persons.[4] This latter figure, therefore, must be the basic reference for the new estimate.

The figure 692,358 does not include 56,282 members of the armed forces stationed in the Islands but does include both 59,697 dependents of military personnel[5] and an estimated 43,000 people over 65.[6] Since the military dependents are covered by a special federal health insurance program called CHAMPUS and the aged are subject to the medicare program, the potential universe for general coverage programs totals 589,661.

The civilian labor force as of July, 1969, is now estimated to have been 340,750, including 9,650 unemployed.[7] Therefore, the active civilian labor force as of that date was 331,100. This estimate is based both on the returns of employers covered by the Hawaii Employment Security Law and on estimates of employment for those employers excluded from coverage under that law. The figure 331,100, therefore, indicates jobs rather than persons and requires a downward revision to adjust for employees holding more than one job. Unfortunately, there are no local data indicating how many of these jobs are occupied by people holding more than one job. The United States Bureau of Labor Statistics, however, has made available to the Legislative Reference Bureau national data on the percentage of jobs as of May, 1969, in each industry classification which are secondary jobs. By applying these percentages to the total number of jobs in the various industries in Hawaii and by making an upward adjustment to reflect the people holding more than two jobs, it can be estimated that the number of jobs occupied by moonlighters in July, 1969, was 14,758.[8] Hence, the number of persons actively pursuing employment as of the indicated date was 316,342.

Since this report excludes persons entitled to medicare from its purview, a further downward adjustment is required to estimate the size of the active civilian labor force under 65. The number of people over 65 in the labor force is not known, but there are methods of estimating this figure. In 1969, the number of persons over 65 in active civilian employment in the United States totaled 3,233,000,[9] or 16.6 per cent of the total population in that age group (19,463,000).[10] If the national percentage were applicable to Hawaii, the data would indicate that the number of employed persons aged 65 and over in the State would total 7,138. This figure is in agreement with estimates arrived at in a different fashion. The Department of Planning and Economic Development estimated that in 1965 on Oahu, 4,420 individuals of age 65 and over were in the labor force and that in 1967 on the neighbor islands, 1,417 persons in that age group were in active civilian employment.[11] The population of persons aged 65 and over during those periods was estimated at 36,020.[12] This would yield a percentage of 16.2 for the people age 65 and over in active civilian employment. Applying this percentage to the current 65 and

Table 1

EXTENT OF GROSS COVERAGE OF PREPAID HEALTH PLANS
IN THE STATE (1969)

Type Name of Plan	Hospital			Surgical		
	Subscribers	Dependents	Total	Subscribers	Dependents	Total
HMSA (Group)[1]	110,308	202,973	313,281	110,308	202,973	313,281
HMSA (Individual)[1]	18,349	8,336	26,685	18,349	8,336	26,685
Kaiser (Group)[2,3]	19,155	38,366	57,521	19,155	38,366	57,521
Kaiser (Individual)[2]	3,773	3,675	7,448	3,773	3,675	7,448
Commercial Carrier (Group)[4]	37,720	48,482	86,202	37,760	47,888	85,648
Commercial Carrier (Individual)[4]	20,263	16,349	36,612	17,753	11,181	28,934
Independent Sugar Plans	10,126	18,625	28,751	10,126	18,625	28,751
Total	219,694	336,806	556,500	217,224	331,044	548,268

Type Name of Plan	Medical		
	Subscribers	Dependents	Total
HMSA (Group)	110,308	202,973	313,281
HMSA (Individual)[5]	18,349	8,336	26,685
Kaiser (Group)[2,3]	19,155	38,366	57,521
Kaiser (Individual)[2]	3,773	3,675	7,448
Commercial Carrier (Group)[4,6]	33,456	41,804	75,260
Commercial Carrier (Individual)[4,6]	4,575	4,548	9,123
Independent Sugar Plans	10,126	18,625	28,751
Total	199,742	318,327	518,069

1. Data for July, 1969.
2. Data for June, 1969.
3. Excludes sugar plan coverage.
4. 12/31/68 figures.
5. Only in-hospital visits.
6. Data are for nonsurgical medical expenses, but do not cover major medical expenses and, in a number of policies, cover only in-hospital visits.

over population results in an estimate of 6,966 of this age group in employment. In addition, the 1960 census data showed that 16.1 per cent of the 65 and over were employed (or 6,923 based on 1969 population figures).[13] Hence, it is safe to estimate that the number of employed persons aged 65 and over is around 7,000.

As a result, it can be concluded that the active civilian labor force under 65 in July, 1969, consisted of approximately 309,350 individuals.

Responses from the various types of prepaid health plan operators in the State indicating the gross coverage of individuals under 65 as of the summer and fall of 1969 (excluding the 59,697 individuals who have coverage as military dependents under the CHAMPUS program) are tabularized on Table 1.

It should be noted that these data indicate gross coverage and that they need adjustment for duplication and that, in addition, the data for medical coverage require further refinement, since some of this coverage extends only to in-hospital visits of physicians and therefore may cause an exaggerated picture of the scope of protection afforded by this type of coverage.

Adjustments for duplication are particularly crucial in the case of hospital insurance because otherwise the desirable but over-optimistic picture would be created that out of an estimated total resident civilian population of 692,358 individuals, 659,197 were protected by prepayment coverage against hospital expenses (43,000 under medicare, 59,697 as military dependents, and 556,500 under general private plans), leaving a coverage gap of only 33,161 individuals, i.e., only 4.8 per cent. On the basis of a population universe that excludes individuals 65 and over and military dependents (a potential coverage group of 589,661), the coverage gap would be 5.6 per cent. In the case of the other health expenses, the coverage gap widens. Excluding persons 65 and over and the military dependents, the coverage gap in the case of surgical expenses would be 41,393 or 7.0 per cent and, in the case of medical expenses (regardless of actual scope), 71,592 or 12.1 per cent of the relevant population universe.

The Under-Count and Duplication Issues

A fundamental assumption of this report is that the population estimate based on the preliminary 1970 census data is a reliable quantity. Unfortunately, this assumption can only be made with great

hesitation. Early in 1968, the resident population of Hawaii (exclusive of the armed forces) was estimated at 777,462 people.[14] In 1969 the estimate of the 1968 resident civilian population was adjusted downward in order to eliminate a discrepancy between the estimates of the United States Census Bureau and the State of Hawaii Department of Planning and Economic Development. The new preliminary figure was 724,989.[15] Subsequently, it was further adjusted downward to a final figure of 717,640.[16] As a result of the 1970 census data, still further downward adjustment was deemed to be called for. The estimated population for July 1, 1968, is now set at 670,117; for July 1, 1969, at 692,358; and for April 1, 1970, at 706,820.[17] In other words, within two years the estimates for 1968 underwent a downward adjustment by 107,345 people or 13.8 per cent. Certainly it is discomforting to work with reference data of such uncertitude.

In addition, the 1960 census (like other census data before) suffered from a sizeable undercount which--nationwide--is estimated at 3.1 per cent of the true total (5.7 million people).[18] Hence, it reasonably can be surmised that the 1970 census suffered from similar deficiencies and that the true resident civilian population probably exceeds the adjusted estimate. If the 1960 and the 1970 census count missed 3 per cent of the civilian population in Hawaii, the true count for 1969 would be 713,771. Hence, any narrowness of the estimated coverage gap based on the 692,358 mark must be viewed with appropriate reservations.

Similar difficulties exist with respect to ascertaining the extent of duplication of prepayment protection, especially with reference to the hospital insurance data. Table 1 shows that the gross hospital coverage consists of group insurance, covering subscribers and dependents totalling 485,755 or 87.3 per cent, and individual insurance, covering 70,745 or 12.7 per cent. Table 1 shows further that noncommercial carriers cover 433,686 or 77.9 per cent, while commercial carriers cover 122,814 or 22.1 per cent. Undoubtedly, duplication exists both between individual and group coverage and between commercial and noncommercial coverage. There is practically no duplication of coverage within the HMSA or the Kaiser coverage, but duplication may exist between group and individual commercial coverage (inter-industry duplication) and between commercial and noncommercial coverage. The difficulty relates to the quantification of these overlaps.

On a nationwide basis, the Health Insurance Association of America (HIAA) estimated in 1967 that the inter-industry duplication amounted to 6 per cent for group insurance and 18 per cent for individual insurance, and that the duplication with noncommercial

insurance was 13 per cent for group insurance and 10 per cent for individual insurance.[19] On that basis, the gross hospital coverage for Hawaii (556,500) would have to be reduced by 26,629 since the non-duplicative commercial coverage would be reduced to 96,185 from a duplicative total of 122,814, resulting in a net coverage of 529,871. The coverage gap on that basis, assuming no census undercount, would be 59,790 residents.

The Department of Health, Education and Welfare has taken the view that this correction is too conservative because household survey findings, made at various dates between 1953 and 1963, showed a consistently lower coverage than that based on the HIAA estimates.[20] Moreover, the Department found that the nationwide correction figures used by HIAA did not apply uniformly from state to state but required variations according to the ratio of gross enrollment to the population covered.[21] In 1966 when the raw gross coverage of people under 65 in Hawaii was reported as 508,000 the Department made a duplication estimate (hereinafter called estimate no. 1) by applying first an inter-industry correction of 2.7 per cent[22] and after that an overall correction of 5.54 per cent.[23] Applying these factors to present coverage data, the inter-industry duplication would require a deduction of 3,316 persons and the overall correction, an additional deduction of 30,646 individuals or a total deduction of 33,962 persons, resulting in a net coverage of 522,538 or a coverage gap of 67,123.[24] Applying another method, the Department of Health, Education and Welfare arrived at a second estimate (hereinafter called estimate no. 2), reflecting the findings of the household surveys, under which the coverage gap would be even larger, amounting to 105,268.[25] Estimate no. 2 seems to be unrealistic and is based on data which are contradicted by the known realities. Actually, the main sources of duplication are simultaneous protection as "subscriber" and as "dependent" and simultaneous protection by individual and group plans. In Hawaii, the latter is probably the major source of duplication.[26] Hence, a correction lying midway between the figures arrived at by using the industry's nationwide factors (26,629) and by the Department's low estimate (33,962) is probably the fairest assumption, resulting in net hospital coverage of 526,204 and leaving a coverage gap of 63,457 based on the unadjusted preliminary 1970 census data. Allowing for a 3 per cent undercount of both the total population and the 65 and over, and assuming that there was no undercount of military dependents since this figure is not derived from census data, the actual coverage gap for hospital insurance would amount to 83,540 persons.[27]

Similar corrections apply to surgical and medical policies. According to HIAA's correction method, the inter-industry correction factors for surgical policies are again 6 per cent for group policies

and 18 per cent for individual policies, while the factors correcting for duplication between commercial and noncommercial policies are 12 per cent and 10 per cent, respectively.[28] On that basis, the figures for surgical coverage in Table 1 (548,268) must be corrected by subtracting 23,519 (85,648 x .18 + 28,934 x .28). Hence, the estimated net coverage for surgical protection would be 524,729, resulting in a coverage gap of 64,912 persons (on the basis of the unadjusted census figures). Using the HEW correction methods underlying estimate no. 1,[29] the total duplication would amount to 42,800 persons,[30] resulting in a net coverage of 505,468 individuals or in a coverage gap of 84,193. Taking the median of the HIAA correction for duplication and the HEW correction for duplication, the deduction to be applied would total 33,160 persons, resulting in net surgical coverage of 515,108 and leaving a coverage gap of 74,553 on the basis of the unadjusted census. Adjusted for undercount the coverage gap for surgical insurance, therefore, is estimated at 94,636 persons.

The greatest difficulties in the adjustment for duplication are presented by the protection against regular medical expenses, even apart from the fact that the classification "regular medical" includes both policies that cover only in-hospital physicians' visits as well as policies that provide also for home and office visits. Thus, all HMSA individual policies listed in Table 1 provide only for in-hospital visits, and the same is true with respect to four-fifths of the persons covered by group medical expense policies.[31] Obviously, policies of that type provide "some" but not "adequate" coverage against medical expenses. On the other hand, in addition to the regular medical commercial policies listed in Table 1, substantial major medical expense coverage exists,[32] as indicated in Table 2.

Table 2

MAJOR MEDICAL INSURANCE

Type	Primary Insured	Dependents	Total
Commercial Group Policies	22,733	37,388	60,121
Individual Policies	2,381	3,926	6,307
HMSA			
Group	106,513	198,602	305,115
Individual	18,349	8,336	26,685
Total	149,976	248,252	398,228

Source: Citation HIAA letter, figures from HMSA.

For purposes of this report, the coverage gap is estimated on the basis of persons without any medical (other than surgical) coverage, not on the basis of persons lacking adequate medical coverage. An estimate on the latter basis would be quite conjectural, although elimination of the individual HMSA coverage and four-fifths of the commercial group coverage might constitute a reasonable approximation.

The method applied by the HIAA to correct for duplication on a nationwide basis computes the inter-industry factors at 5 per cent for group insurance and 18 per cent for individual insurance and the inter-types factor at 10 per cent for group insurance and 10 per cent for individual insurance.[33] Application of these factors to the medical coverage data set forth in Table 1 yields 11,289 (75,260 x .15) for group insurance and 2,554 (9,123 x .28) for individual insurance or a total reduction of 13,843. Hence, the net coverage on that basis would amount to 504,226 individuals, resulting in a coverage gap of 85,435 persons (on the basis of the unadjusted census figures). Unfortunately, HEW has not published a state-by-state estimate of medical coverage on the basis of the methodology developed by it for hospital and surgical coverage. Using, therefore, the median of the factors used by HEW for the other types of coverage (i.e., 2.4 per cent for inter-industry duplication and 6.5 per cent for overall reduction),[34] the applicable correction would be 35,568 yielding an estimated net coverage of 482,501 individuals. The coverage gap on that basis would be 107,160. Taking again the median of the corrections computed on the basis of the two methods, the duplication would be estimated at a total of 24,706 persons, resulting in a net medical coverage of 493,363 and leaving a coverage gap of 96,298 persons on the basis of the unadjusted census. Adjusted for undercount, the coverage gap for any kind of medical insurance, therefore, is estimated at 116,381.

Hence, the estimated coverage gaps for the various types of health costs, after allowing for a census undercount, are estimated to be at the following magnitudes or within the following limits:

Hospital	83,540	or	13.7%	(79,873 - 87,206)
Surgical	94,636	or	15.5%	(84,995 - 104,276)
Regular Medical	116,381	or	19.1%	(105,518 - 127,243)

According to the most recent adjusted population estimates for Hawaii, as contained in Statistical Report 79 of the Department of Planning and Economic Development, the resident civilian population of the State in 1969 totalled 698,445 persons. Excluding persons over 65 and armed forces dependents but not adjusting for undercount, the relevant universe would be 595,748. On that basis the coverage gaps would be:

Hospital Insurance	69,544	or	11.7%
Surgical Insurance	80,640	or	13.5%
Regular Medical Insurance	102,385	or	17.2%

Coverage in Relation to Employment

One of the crucial problems to be answered is the determination of the number of employees who have no health insurance coverage, whether as "subscriber" or "dependent", and hence what portion of the coverage gap is comprised of employees. Unfortunately, the question is not susceptible of an accurate answer and can be resolved only on the basis of general estimates and assumptions. Since group insurance normally is employment-generated (regardless of whether the employer assumes all or part of the premium required), it is fair to assume that practically all the subscribers covered by group insurance are wage earners. To be sure some of the employers are covered by group plans,[35] but an estimate of how many is difficult to make. It should be noted that omission of an allowance for group coverage of employers and other self-employed results in a slight overestimate of employee's coverage.

As reported above, the active civilian labor force as of July, 1969, after deduction of the employed aged 65 and over and after correction for multiple jobholders, totaled 309,350 individuals under 65. Deducting self-employed under 65, estimated at 27,835[36] from that figure, it is estimated that the number of employed wage earners under 65 totaled 281,515 individuals. The number of individuals covered by group plans as subscribers[37] at that date was:

Hospital Expenses	177,309 or 63.0%
Surgical Expenses	177,349 or 63.0%
Regular Medical	173,045 or 61.5%

In addition to these figures relating to group insurance, a proper portion of the individual nonduplicative policies must be allocated to subscriber wage earners. An estimate of this number must take account of the fact that the self-employed will primarily be covered by the policies of this type and that, in addition, a sizeable percentage of individual policies are duplicative, with group protection. If it is assumed that the self-employed are as likely to have prepayment protection as the population as a whole, then 86.3, 84.5, and 80.9 per cent of the self-employed have individual hospital, surgical, and medical protection, respectively, and that for each category of insurance, 28 per cent[38] of the remaining policies are duplicating policies, then the number of additional wage earner subscribers covered by nonduplicative individual policies would total 13,221,[39] 11,775,[40] and 3,008[41] for hospital, surgical, and medical insurance, respectively.

Hence, the total subscriber coverage of wage earners by health insurance policies is estimated to be as follows:

Hospital Expenses	190,530 or 67.7%
Surgical Expenses	189,124 or 67.2%
Medical Expenses	176,053 or 62.5%

Hence, noncoverage of wage earners as subscribers is estimated at 90,985 for hospital insurance, 92,391 for surgical insurance, and 105,462 for medical insurance.

It is reasonable to conclude that a substantial portion of the wage-earners who are not covered as subscribers are nevertheless covered as dependents, and the principal task therefore is to arrive at a plausible estimate of the extent of the coverage of wage earners as dependents. Dependents coverage may arise either from plans of subscriber-wage earners or from the special plan for military dependents. While the extent of the gross coverage of dependents is known on the basis of the replies of the insurance organizations (see Table 1) and an adjustment for net coverage is possible within acceptable limits, an estimate of the number of wage earners among these dependents must remain somewhat conjectural.

The wage-earners most likely to be covered as dependents are married women and workers under 19. Some employed husbands might be covered as dependents, but it can be assumed the number so covered would be statistically insignificant. Women regardless of marital status constitute approximately 40 per cent of the total labor force (123,740),[42] 63 per cent of whom are estimated to be married with husband present.[43] The task is to determine how many of these married women are wage earners. In 1960, female wage earners comprised 91.6 per cent of all employed women.[44] Assuming this ratio to be the same in 1969, and assuming that married women comprise an aliquot portion of the female wage earners, then 113,346 women were wage earners in 1969, of whom 71,408 were married.

Similarly, 1960 census data indicate that employed single persons under 19 comprised 4.9 per cent of the persons under 65 in active employment.[45] It can be assumed that practically all people in the under 19 class are wage earners and are not self-employed. Applying this percentage to current employment figures produces an estimate of 15,158 employed single wage earners under 19. Under applicable policies, these 15,158 single wage earners under 19 as well as the 71,408 married women with husband present could be covered as dependents. As indicated before, an effort is made to estimate how many of the

single wage earners under 19 and of the married female wage earners under 65 are in fact so covered.

If one were to engage in the extreme assumption that all of the single wage earners under 19 and all of the married female employees under 65 are covered either as dependents of employed male wage-earners or as military dependents and that all other employees under 65 have subscriber coverage to the extent that such coverage is possible under the figures for subscriber coverage indicated above, the number of employees lacking coverage would be insignificant. Since the total number of wage earners under 65 was estimated at 281,515, the elimination of the 71,408 married women employees under 65 and of the unmarried employees under 19 would leave 194,949 employees as the potential universe for subscriber coverage. Hence, the number of employed lacking subscriber coverage would be 4,419 with respect to hospital insurance, 5,825 with respect to surgical insurance, and 18,896 for medical insurance. Of course, as indicated, this is only an extreme assumption. On a rational basis it can hardly be assumed that the total civilian labor force under 65 in active employment is covered either as subscribers or as dependents and that practically the whole population universe coverage gap of 83,540 persons (for the case of hospital insurance) must be allocated to dependents not in the active labor force and the families of the unemployed.

Conversely, it could be assumed that married women under 65 and single persons under 19 constitute a portion of the covered wage earner subscribers proportional to their participation in the labor force. In that case, the number of employed married women under 65 having subscriber coverage would be 23.1 per cent of the total or 44,012 with respect to hospital insurance, 43,688 with respect to surgical insurance, and 40,668 for regular medical insurance. In the case of the single employees under 19, the share in the subscriber coverage would be 4.9 per cent, or 9,336 with respect to hospital insurance, 9,267 for surgical insurance, and 8,627 for medical insurance. If all the remaining married female wage earners under 65 and employed single persons under 19 were covered as dependents, the number so covered would be, accordingly, for the married women, 27,396, 27,720, and 30,740 with respect to the three classes of health insurance and for the employed under 19 years of age, 5,822, 5,891, and 6,531, respectively. Hence, the total dependency coverage of employed individuals who are either married women under 65 or single persons under 19 would total 33,218, 33,611, and 37,271 for hospital, surgical, and regular medical insurance, respectively.

On that basis, the number of wage earners other than married women under 65 and single persons under 19 would be 281,515 - (71,408 + 15,158) = 194,949 persons, including married men whose wives are also in employment. On the basis of the data for subscriber coverage set forth above, the deficiency in subscriber coverage would be 194,949 - (190,530 - (44,012 + 9,336)) = 57,767 for hospital insurance, 194,949 - (189,124 - (43,688 + 9,267)) = 58,780 for surgical insurance, and 194,949 - (176,053 - (40,668 + 8,627)) = 68,191 for regular medical insurance.

The above figures are predicated on the further assumption that none of the husbands of the employed married women under 65 who have subscriber coverage are covered as dependents of such women. If it were assumed that all married women[46] with subscriber coverage have employed husbands covered as their dependents, the number of employees not covered as subscribers or dependents would be 57,767 - 44,012 = 13,755 for hospital insurance, 58,780 - 43,688 = 15,092 for surgical insurance, and 68,191 - 40,668 = 27,523 for regular medical insurance. In other words, on the assumption that married women under 65 and single persons under 19 contribute to the subscriber coverage in proportion to their share in the wage-earner labor force, the number of employees not covered either as subscribers or dependents would lie between 57,767 and 13,755 for hospital insurance, between 58,780 and 15,092 for surgical insurance, and between 68,191 and 27,523 for regular medical insurance.

On the basis of these two extreme assumptions, it may be concluded that the truth lies probably somewhere in the middle between the upper limit of assumption 2 and the figures resulting from assumption 1, i.e., the number of employees lacking coverage either as subscribers or dependent is 31,093 for hospital insurance, 32,303 for surgical insurance, and 43,544 for regular medical insurance.

The previous estimates are supported by a different set of considerations. The total coverage gap in the population of the State was estimated at 83,540 individuals for hospital insurance, 94,636 individuals for surgical insurance, and 116,381 individuals for regular medical insurance. The problem sought to be determined is an estimate of the number of individuals in the active labor force, and in particular wage earners, within these coverage gap groups.

Actually, the population classes without health insurance coverage within the gaps consist primarily of:

(a) Persons in the active labor force without subscriber or dependents coverage and their dependents;

(b) The unemployed, whose coverage has run out, and their dependents;

(c) Dependents of persons in the labor force who have only self-coverage; and

(d) Individuals not in the labor force, other than dependents of persons in the labor force and military dependents, and their dependents.

Unfortunately, it is not possible to estimate the size of some of these groups with sufficient certainty.

The size of the groups listed under (c) and (d) is probably quite small.

The number of unemployed in July, 1969, was estimated at 9,650. This estimate includes persons over 65[47] and persons under 19 who may be covered as dependents.[48] In addition, statistics show that the incidence of unemployment among young wage earners is much higher than in the labor force at large.[49] Hence, it is reasonable to assume that the unemployed have a lower dependents' ratio than the members of the labor force at large. In the light of these considerations, it does not seem unreasonable to conclude that persons in the active labor force and their dependents[50] constitute the largest part of the total coverage gap in hospital insurance and that an estimate that the number of wage earners in that group amounts to a figure of 31,100 is quite plausible,[51] particularly if it can be assumed that a larger percentage of these wage earners consists of single persons and other persons without dependents than among the wage earners with self and dependents coverage.

The same considerations apply to the number of uncovered wage earners in the gaps relating to surgical and regular medical insurance.

Estimating, accordingly, that the number of wage earners without coverage as either subscriber or dependents amounts to 31,100 for hospital insurance, 32,300 for surgical insurance, and 43,600 for regular medical insurance, the number of employees having dependents coverage would be 59,900 (or 65.8 per cent of the employees lacking subscriber coverage) for hospital insurance, 60,100 (or 65.0 per cent)

for surgical insurance, and 61,900 (or 58.7 per cent) for regular medical insurance.

In other words, the total percentage of wage earners without subscriber or dependents coverage is estimated at 11 per cent for hospital insurance, 11.5 per cent for surgical insurance, and 15.5 per cent for regular medical insurance.

The Subscribers and the Non-Subscribers: Who Are They?

In the foregoing section, an attempt was made to arrive at an estimate of the number of employees who are:

(a) Covered as subscribers;

(b) Not covered as subscribers but covered as dependents; and

(c) Not covered either as subscribers or as dependents.

It was estimated on the basis of gross coverage data relating to subscriber coverage that in 1969 190,530 (or 67.7 per cent) of the employees had hospital coverage, 189,124 (or 67.2 per cent) had surgical coverage, and 176,053 (or 62.5 per cent) had regular medical coverage. Correspondingly, it was estimated that the number of employees with dependents or no coverage totaled 90,985 for hospital insurance, 92,391 for surgical insurance, and 105,462 for medical insurance.

On the basis of the figures of married women and young persons under 19 years, it was estimated that dependents coverage was in the neighborhood of 65.0 per cent of the persons without subscriber coverage.

In the following section an attempt is made to study in greater detail the coverage situation with respect to certain categories of employment, differentiating between:

(a) Federal employees,

(b) State and municipal employees, and

(c) Wage earners in private employment.

Federal employees. As of July, 1969, the number of federal civilian employees in the State (including persons 65 and over) was estimated at 35,540 of whom 11,460 were nondefense workers, and 24,080 were defense workers.[52] Assuming that the percentage of employed over 65 among the defense workers is the overall percentage prevailing in the State (2.2 per cent) and that the number of persons over 65 among the federal nondefense employees is practically zero, the number of federal civilian employees under 65 is estimated at 35,000.

Health benefits for federal employees in the form of group coverage are governed by the Federal Employees Health Benefits Act of 1959.[53] The law covers all federal employees (as defined in section 8901 in conjunction with section 2105 as amended in 1968)[54] and empowers the Civil Service Commission to contract for or approve prepayment health benefit coverage under employee organization plans or group or individual practice prepayment plans.[55] In addition, the Civil Service Commission may contract for or approve one government-wide plan offered by a carrier providing for service benefits and one government-wide plan offered by a carrier providing for indemnity benefits.[56]

The coverage may be subscriber only coverage (self-coverage) or subscriber and dependents coverage. The coverage is financed jointly by withholdings from the pay of the subscriber and by government contributions. The bi-weekly contribution of the government is $1.62 for the subscriber only coverage and $3.94 for family coverage, but not more than half of the total subscription costs. In addition, the federal government pays one-half of the administrative expenses.[57] Family includes unmarried children under 22 years of age.[58]

According to the statistics supplied by the local health benefit organizations, the enrollment of federal employees in their plans covers 21,742 subscribers and 53,154 dependents. 5,223 have subscriber only coverage. Accordingly, subscriber coverage, excluding coverage by nonlocal organizations,[59] extends to 62.1 per cent of the total federal labor force.

Hence, the subscriber coverage shows a coverage gap of a ratio which is 9 per cent larger than the statewide figures. It cannot be explained by assuming that all nonsubscribers have dependents coverage under plans covering the spouse, especially since the percentage of married women (who might thought to be covered as dependents rather than subscribers) among the federal employees is considerably less than the

state average,[60] a fact which is explainable by the high percentage of defense workers.

The foregoing data do not account for any nonduplicative coverage which may exist by virtue of individual policies that are secured by federal employees. A proportionate allocation of the total nonduplicative policies allocated above to nonself-employed employees would entail an addition of 1,639 individual hospital insurance policies and 1,460 surgical and 373 medical policies.

State employees. The number of state and local employees under 65 as of July, 1969, was estimated at 36,600.[61] The percentage of women among this class of workers is substantially above the state average and was estimated at 58.6 per cent in 1965 (at a time when the state average was 37.1 per cent).[62] If the ratio of married women in the labor force to all women in the labor force can be assumed to be the general ratio, i.e., 63 per cent, it would follow that 36.9 per cent of state and municipal employees are married women.

Health benefits for state and local employees are provided by the State Public Employees Health Fund Law of 1961[63] which to a large degree is modeled after the federal pattern. The State makes a monthly contribution of $5 for each employee beneficiary and $15 for each employee beneficiary with dependents, with the qualification, however, that the State's total contribution is $15 when both husband and wife are employee beneficiaries.

According to the figures obtained from the state fund, 22,580 state and local employees under 65 in active service were covered by group plans by either HMSA or Kaiser; 7,474 had coverage as subscribers only; and the remaining 15,106 had subscriber and dependents coverage.[64] Accordingly, of the total number of active state employees (under 65), 61.7 per cent had subscriber coverage. This is somewhat lower than the statewide percentage which was estimated to be 63.0 per cent (for hospital insurance). This disparity is explainable by the high percentage of married women in this category which might entail a greater percentage of coverage as dependents. This factor is important because it would lead to the conclusion that the statewide estimate that 21 per cent of all employees have hospital coverage as dependents is the weighted result of a higher percentage of dependents coverage among the state employees and a lower percentage of such coverage among the employees in private employment.

The foregoing data do not account for nonduplicative individual policies that may be held by state employees. Proportionate allocation to this class of employees would result in an additional coverage of 1,719 employees with hospital insurance, 1,531 with surgical coverage, and 391 with regular medical coverage.

Employees in private employment. The number of employees under 65 years of age in private employment (including those employed in the sugar industry) is estimated at 209,915.[65] In view of the fact that (1) the total number of employees under 65 years of age covered as subscriber by either group or individual policies was estimated at 190,530, 189,124, and 176,053, respectively, for hospital, surgical, and regular medical benefits and that (2) the number of federal employees so covered was estimated at 23,381, 23,202, and 22,115 and the number of state employees so covered was estimated at 24,299, 24,111, and 22,971 for the three risk classes;[66] it must be concluded that the total subscriber coverage of private employees is of the following extent:

Hospital insurance	142,850
Surgical insurance	141,811
Regular medical insurance	130,967

Hence, the numbers of employees in private employment not covered as subscribers are estimated at:

Hospital insurance	67,065 or 31.95%
Surgical insurance	68,104 or 32.44%
Regular medical insurance	78,948 or 37.61%

As pointed out before, a high percentage of these wage earners lacking subscriber coverage might be covered as dependents. Taking the unweighted state averages estimated before, i.e., 65.8 per cent, 65.0 per cent, and 58.7 per cent for the health benefit classes, respectively, the number of employees with dependents coverage would be:

Hospital insurance	44,129
Surgical insurance	44,268
Regular medical insurance	46,342

Accordingly, the number of employees in private employment without subscriber or dependents coverage would have the following magnitude:

Hospital coverage	22,936 or 10.93%
Surgical coverage	23,836 or 11.36%
Regular medical coverage	32,606 or 15.53%

It should be noted that these percentages are calculated on the basis of two assumptions which are not wholly supported on a judgment basis and require adjustments in opposite directions: viz. the assumptions:

a. That the percentage of public employees having non-duplicatory individual policies is the same as the percentage of private employees (an assumption which may inflate the number of public employees having subscriber coverage); and

b. That the percentage of employees covered as dependents is the same for state employees as for private employees (an assumption which is too low and may result in a lowering of the percentage of private employees covered as dependents).

Accordingly, as a valid overall estimate, it may be estimated that 11 per cent of private employees lack hospital and surgical coverage and 15 per cent regular medical coverage.

Efforts were made to ascertain further details with respect to group coverage in private employment. For that purpose, two approaches were pursued:

(1) A questionnaire was sent to employers covered by the Hawaii Employment Security Law, soliciting information as to the availability, scope, and nature of group coverage for employees, classes and number of employees so protected, employer's share in the costs, etc.

(2) The unions operating in Hawaii were contacted for information as to the number of union members covered by health benefit plans established pursuant to collective bargaining agreement.

The latter approach resulted in the ascertainment that 57,500 employees in private employment are covered as subscribers under union negotiated health benefit plans.[67] Hence, coverage so provided extends to 27.4 per cent of the estimated number of wage earners in private employment (209,915).

The questionnaire sent to the employers was designed to provide detailed information as to the type of employers (in terms of type of business and size of firm) who provide coverage, the categories of employees who are covered or excluded from existing coverage, the method of financing, type of plan, and other matters. A sample of the questionnaire is included in the Appendix.

The questionnaire was mailed to 14,075 addresses obtained from the Department of Labor and Industrial Relations, after exclusion of the sugar industry which was contacted directly. The addresses included different units of the same firm, former employers who have gone out of business, and some individuals who no longer employed others. Unfortunately, the response was poor. Only 3,842 completed questionnaires were received, including answers from 368 individuals who either had gone out of business or ceased to be employers. Slightly more than 300 replies were erroneously completed or otherwise not susceptible to analysis.

3,020 returned questionnaires were responsive to the questions and analyzed with the aid of SWIS. Of the 3,020 firms replying validly, 1,124 reported some kind of coverage, while 1,896 reported no health benefit coverage of any kind. The firms responding to the 3,020 questionnaires had 62,191 individuals under 65 in their employment. On the basis of the estimate that there were approximately 14,000 active firms in the State with 199,789 employees (not counting the sugar industry), the replies covered 21.6 per cent of the employers and 31.1 per cent of the labor force in private employment. This indicates, of course, that the sample is not representative but biased toward the larger size firms.

The 1,896 firms without coverage had 10,030 employees, while the 1,124 firms affording coverage to all, or certain categories of their employees had 52,161 individuals under 65 in their employ. The number of employees with coverage in this group of 52,161 totaled 47,051, while the remaining 5,110 were excluded from coverage because of the type of their employment (probationary, part-time, temporary, custodial, etc.). The figures show that of the total of 62,191 employees accounted for in the sample, 15,140 had no coverage, while 47,051 had coverage. In other words, 75.7 per cent of all employees

constituting the population of the sample had group coverage as subscribers. This exceeds the estimates of the first part of the report which supported an estimate of subscriber groups coverage in private employment, excluding the sugar industry, of 61.5 per cent for hospital insurance, 61.5 per cent for surgical insurance, and 59.4 per cent for regular medical insurance. The difference, of course, is explainable by the fact that the replies to the questionnaire, as shown on Table 4, were biased toward large size firms, which tend to be firms providing coverage.

An effort was made, by means of the questionnaire, to correlate the coverage or noncoverage pattern to business type and size of firm. The following tables and comments are designed to show the resulting conclusions.

Table 5 shows that 61.8 per cent of the 1,896 employers without coverage had 3 or less employees and that 88.8 per cent had less than 10 employees. Conversely, Table 6 shows that among the firms with coverage, only 16.9 per cent had 3 or less employees and only 45.0 per cent had less than 10. In other words, noncoverage tends to concentrate among the smaller employers. This conclusion is substantiated further by Table 7, which shows that 86.0 per cent of the firms with 3 or less employees and 61.8 per cent of the firms with 4 to 9 employees do not have medical plans for their employees.

Looking at the distribution of coverage and noncoverage by type of business, Table 7 shows that the percentage of noncoverage was highest in the service industries (69.9 per cent) and in the wholesale and retail trades (64.1 per cent), while the highest percentages of coverage existed in construction and moving (61.9 per cent) and transportation, communication, and utility (58.1 per cent).

Noncoverage, therefore, depended both on the type of business and the firm size. Table 7 indicates that the highest percentage of noncoverage was in the small service industries (3 or less: 91.5 per cent; 4 to 9: 60.6 per cent) followed by the small wholesale or retail trades (3 or less: 86.0 per cent; 4 to 9: 69.6 per cent) and the small transportation and communication (3 or less: 82.8 per cent; 4 to 9: 50.0 per cent).

Hence, the impact of any compulsory coverage would primarily benefit employees in the small firms engaged in trade and commerces, especially the single women employed by them.

Table 3

TOTAL NUMBER OF FIRMS ANALYZED (SAMPLE FIRMS)
BY SIZE AND TYPE OF BUSINESS

Type of Business	Size of Business				Total
	3 or less	4-9	10-19	20 or more	
Wholesale or Retail Trade	352	312	174	138	976
Technical or Nontechnical Service	613	325	128	110	1,176
Finance, Insurance, Real Estate	183	68	25	45	321
Construction or Moving	89	76	29	74	268
Manufacturing	32	28	25	33	118
Transportation, Communication, Utility	29	16	15	33	93
Others	64	3	1	--	68
Total	1,362	828	397	433	3,020

Table 4

COMPARISON OF NUMBER OF FIRMS ANALYZED
TO NUMBER OF FIRMS IN THE STATE AS OF MARCH, 1967,
BY SIZE OF BUSINESS

Size of Business	Number of Firms in the State as of March, 1967	Firms Analyzed					
		Total		With Plan		Without Plan	
		Number	Per Cent	Number	Per Cent	Number	Per Cent
3 or less	6,040	1,362	22.5	190	3.1	1,172	19.4
4-9	3,129	828	26.5	316	10.1	512	16.4
10-19	1,469	397	27.0	232	15.8	165	11.2
20 and over	1,496	433	28.9	386	25.8	47	3.1
Total	12,134	3,020	24.9	1,124	9.3	1,896	15.6

Table 5

FIRMS WITHOUT PLAN BY SIZE AND TYPE OF BUSINESS

Type of Business	Size of Business				Total	Per Cent
	3 or less	4-9	10-19	20 and over		
Wholesale or Retail Trade	305	217	84	20	626	33.0
Technical or Nontechnical Services	561	197	50	14	822	43.4
Finance, Insurance, Real Estate	145	37	7	1	190	10.0
Construction or Moving	54	33	8	7	102	5.4
Manufacturing	21	17	9	4	51	2.7
Transportation, Communication, Utility	24	8	6	1	39	2.0
Others	62	3	1	--	66	3.5
Total	1,172	512	165	47	1,896	100.0
Per Cent	61.8	27.0	8.7	2.5	100.0	

Table 6

FIRMS WITH PLAN BY SIZE AND TYPE OF BUSINESS

Type of Business	Size of Business				Total	Per Cent
	3 or less	4-9	10-19	20 and over		
Wholesale or Retail Trade	47	95	90	118	350	31.1
Technical or Nontechnical Services	52	128	78	96	354	31.5
Finance, Insurance, Real Estate	38	31	18	44	131	11.7
Construction or Moving	35	43	21	67	166	14.8
Manufacturing	11	11	16	29	67	5.9
Transportation, Communication, Utility	5	8	9	32	54	4.8
Others	2	--	--	--	2	0.2
Total	190	316	232	386	1,124	100.0
Per Cent	16.9	28.1	20.6	34.4	100.0	

Table 7

FIRMS WITH PLAN AS PERCENTAGE OF
TOTAL SAMPLE FIRMS BY TYPE AND SIZE OF BUSINESS

Type of Business	Size of Business				Total
	3 or less	4-9	10-19	20 or more	
Wholesale or Retail Trade	13.4	30.4	51.7	85.5	35.9
Technical or Nontechnical Services	8.5	39.4	60.9	87.3	30.1
Finance, Insurance, Real Estate	20.8	45.6	72.0	97.8	40.8
Construction or Moving	39.3	56.6	72.4	90.5	61.9
Manufacturing	34.4	39.3	64.0	87.9	56.8
Transportation, Communication, Utility	17.2	50.0	60.0	97.0	58.1
Others	3.1	--	--	--	2.9
Total	14.0	38.2	58.4	89.1	37.2

B. The Coverage Gap and Medicaid

In the foregoing part it was pointed out that the relevant population group for which health care coverage is a matter of concern consists of the resident civilian population under 65 with the exclusion of military dependents.

On that basis (unadjusted for under-count), it was found that the following number of persons in 1969 lacked health care insurance, depending on the kind of care:

hospital insurance:	69,544 or 11.7%
surgical insurance:	80,640 or 13.5%
medical insurance:	102,385 or 17.2%

Relating the coverage gap to persons in private employment not covered either as subscriber or as individual, it was estimated that the number of employees in private employment with respect to the various types of care is:

hospital insurance:	22,936 or 10.93%
surgical insurance:	23,836 or 11.36%
medical insurance:	32,606 or 15.53%

Since voluntary coverage for hospital insurance which is the costliest part of the basic protection is almost 90 per cent, it must be asked where the gap is not already substantially filled by Medicaid. Despite the heavy burden of that program, however, its reaches are severely curtailed.

General Features of Medicaid Coverage

Medicaid was established as a new federal public assistance program as a part of the amendments to the Social Security Act which also provided medicare for the aged.[68] At that time medicaid received only limited public attention, particularly since the responsible congressional committees had grossly underestimated the financial implications of the new Title XIX. Thus the Reports of the Committee on Ways and Means of the House and of the Finance Committee of the Senate gave the following predictions as to the numerical and financial effects of the amendments:[69]

> The expanded medical assistance (Kerr-Mills) program is estimated to provide new or increased medical assistance to about 8 million needy persons during an early year of operation. States could, in the future, provide aid to as many as twice this number who need help with medical costs. . . .
>
> As the accompanying table[70] shows, if all States took full advantage of provisions of the proposed title XIX, the additional Federal participation would amount to $238 million. However, because all States cannot be expected to act immediately to establish programs under the new title and because of provisions of the bill which permit States to receive the additional funds only to the extent that they increase the total expenditures, the Department of Health, Education and Welfare estimates that additional Federal costs in the first year of operation will not exceed $200 million.

Unfortunately it became almost immediately clear that the predictions suffered from three glaring forecasting miscalculations

(a) as to the number of persons affected;

(b) as to the level of aid granted; and

(c) as to the development of the costs of medical care.

Thus soon after the adoption of the law, one of the recognized experts in the field concluded that the total number of persons potentially eligible for medical aid would soon exceed the 35 million mark.[71] Of course, reliable actual estimates were impossible owing to the broad range of discretion left to the states in defining medical indigency and their eligibility standards for medical aid.[72]

In view of the far reaching potential of the coverage provisions of the federal law and their impact on policy choices on the state level, it is important to outline the basic federal requirements and limitations.

Scope of Title XIX

Title XIX aimed at "enabling each State, as far as practicable under the conditions of such State, to furnish medical assistance on behalf of families with dependent children and of aged, blind or permanently and totally disabled individuals, whose income and resources are insufficient to meet the costs of necessary medical services."[73] As originally enacted[74] it specified no ceilings on

financial eligibility of individuals belonging to the enumerated categories which would limit federal financial participation in state plans. Income limitations were solely dependent on the states' ideas on the criteria for the "medically needy". Title XIX focussed on setting floors, proscribing discriminations, and defining the area of federal participation. The amendments of 1967, however, introduced income limitations with respect to the extent of federal participation.

The area of federal participation is not easily described, and the governing provisions of Title XIX[75] are subject to elaborate interpretations[76] and regulations[77] issued by the Department of Health, Education and Welfare.

Federal participation requires a minimum compulsory coverage of certain categories by the State plan,[78] but is available also to optional coverage of specified additional classes of persons.[79] In addition, however, the federal act contains the important mandate to the states to gradually and before July 1, 1977, include all persons meeting the plan's eligibility standards whether or not the aid so provided is entitled to federal sharing.[80]

The federal interpretations differentiate between "categorically needy"[81] and "medically needy".[82] Categorically needy[83] are:[84]

(1) All individuals receiving aid or assistance under the state's approved plans under Titles I, IV, X, and XIV (Old-Age Assistance, Aid to Families with Dependent Children, Aid to the Blind, Aid to the Permanently and Totally Disabled);[85]

(2) All residents of the state who would be eligible under one of the state programs under these titles but for the durational requirements of the particular program;[86]

(3) All persons who would be eligible for aid or assistance under the state plans, except for any other eligibility condition or other requirement in such plan that is expressly prohibited in a medical assistance program under Title XIX;[87]

(4) Persons who meet all the conditions of eligibility, including financial eligibility, of one of the state's approved plans under Titles I, IV, X, and XIV, but have not applied for such assistance;[88]

(5) Persons in a medical facility who but for such confinement would be eligible for financial assistance under one of the state's approved plans under Titles I, IV, X, and XIV;[89]

(6) Persons who would be eligible for financial assistance under another state public assistance plan, except that the relevant state plan imposes eligibility conditions more stringent than, or in addition to, those required by the Social Security Act;[90]

(7) Children under 21 who except for age, would be dependent children under the state's AFDC plan;[91]

(8) Individuals under 21 who qualify on the basis of financial eligibility, but do not qualify as dependent children;[92]

(9) Caretaker relatives who have in their care one or more children under 21, who except for age, would be dependent children under the state's AFDC plan;[93]

(10) Spouses essential to recipients of old age assistance, aid to the blind, or aid to the permanently and totally disabled;[94]

(11) General assistance recipients and persons who would be eligible for general assistance but have not applied therefore.[95]

"Medically needy" are persons who, except for income and resources, belong to the same group of persons as the individuals covered as categorically needy.[96]

The Act differentiates between compulsory and optional coverage. Compulsory coverage is prescribed for those classes of "categorically" needy listed above under number 1, 2, 3, and 7. All other classes listed above may be included as optional coverage.

Federal participation in the cost of medicaid is available for the four classes subject to compulsory coverage listed above and all other classes of categorically needy listed above, except general assistance recipients (supra, number 11). Federal participation is also provided for coverage of medically needy, falling within the classes enumerated (supra, numbers 1 to 10) subject, however, to the income limitations introduced by the 1967 amendments.[97]

The most important groups of optional coverage without federal participation under a state plan are therefore:

(1) The recipients of general assistance,

(2) Self-supporting individuals between 21 and 65 years of age, whose income and resources cover their maintenance needs according to the income and resources level of the medically needy, but not their needs for medical care.

Actually the states have made varying use of the optional coverage possibilities, in particular for individuals who are not categorically but only medically needy. Although quantitative data for various states are not truely comparable, since they are the result of too many variables, it is not without significance that for the various states the per inhabitant costs of medical assistance and maintenance assistance and the relation of both items to one another show wide variations and furnish an indicator of the relative extent of medical assistance.

During the calendar year 1968, for example, in ten states the per inhabitant expenditures for medical assistance exceeded the per inhabitant expenditures for maintenance assistance,[98] the top burden in both categories being borne by the residents of New York. The following table (Table 8) shows the respective data for New York, California, the national average, and Hawaii.

Table 8

EXPENDITURES PER INHABITANT FOR MAINTENANCE AND MEDICAL ASSISTANCE: CALENDAR YEAR 1968

State	Medical Assistance	Maintenance Assistance
New York	$63.95	$56.65
California	34.85	54.60
National Average	20.20	27.95
Hawaii	13.65	22.05

Source: U.S. Department of Health, Education and Welfare Medicaid, Selected Statistics, 1951-1969 (N.C. SS Report B-6), Table II-8.

Hawaii during 1968 ranked 22nd in the nation on the basis of per inhabitant cost of maintenance assistance and 23rd on the basis of medical assistance.

The same picture is obtained by a comparison of the number of recipients who are entitled to both maintenance and medical assistance with the number of recipients of medical assistance only, see Table 9.

Table 9

RECIPIENTS OF MEDICAL VENDOR PAYMENTS BY FORM OF MEDICAL VENDOR PAYMENTS AND MONEY PAYMENT STATUS
August 1969

State	Total	Money and Medical Assistance	Medical Only	4:2
U.S. Total (Title XIX)	4,071,000	2,764,000	1,308,000	32.1
New York	831,000	438,000	393,000	47.3
California	800,000	708,000	91,700	11.5
Massachusetts	248,000	105,000	144,000	58.1
Hawaii	10,300	8,400	1,800	17.5

Source: U.S. Department of Health, Education and Welfare, Medical Assistance Financed Under Public Assistance Titles of the Social Security Act, August 1969 (NCSS Report B-1 (8/69)), Table 7.

In assessing the significance of these data it must be understood that the "medical only" category includes not only the "medically needy" but also persons who are categorically needy but fail to qualify under the governing state law for other than income limitation. Moreover, the relative numbers reflect also the comparative liberality of the state plans under the other titles, especially Titles I and IV. Thus the low ratio of medical assistance only recipients in California reflects also the broad coverage of California's OAA program. In New York only 27.7 per cent of the aged who receive Title XIX assistance also receive money payments while in California the percentage is 79.1.[99]

Medicaid in Hawaii

Medicaid in Hawaii has its statutory basis in section 346-14(1) Hawaii Revised Statutes, which requires the Department of Social Services and Housing to:

> Administer, establish programs and standards, and promulgate rules as deemed necessary for all public assistance, including payments for medical care.

Pursuant to this mandate and in compliance with the federal acts and federal regulations, the Department of Social Services and Housing developed the State Plan for Medical Assistance, State of Hawaii. The following categories of persons are eligible for medical assistance in the State:[100]

(1) All individuals receiving aid or assistance under the State's approved plans under Titles IV and XVI (AFDC, and combined AA, AB, and AFDC programs).

(2) All residents of the State who would be eligible for aid or assistance under one of the other state plans except for the durational residence requirements for the particular program.

(3) All persons who would be eligible for aid and assistance under one of the other State plans except for any other eligibility condition or other requirement in such plan that is specifically prohibited in a program for medical assistance under Title XIX.

(4) Individuals who meet the conditions of eligibility, including financial eligibility, under the State's approved plans for Title IV (AFDC) and Title XVI (combined AA, AB, and APTD) but who are not receiving assistance.

(5) Persons in medical facilities, except those in medical institutions for mental diseases and turberculosis, who if they left such facilities would be eligible for financial assistance under one of the other State's approved plans.

(6) Children under 21 who qualify on the basis of need but who, do not qualify as dependent children under the State's Title IV plan.

(7) Caretaker relatives meeting the degree of relationship specified in the State's Title IV plan who have in their care one or more dependent children under the age of 21.

(8) Spouses of recipients of financial assistance under the State's approved plan for Title XVI who are determined to be essential to the well being of such recipients.

(9) Persons 21 and over receiving financial assistance under the State's General Assistance Program.

(10) Persons who except for income and resources are eligible under the State's General Assistance Program.

The largest group of persons covered are categorically needy persons for whom federal participation may be claimed. The principal classes of persons entitled to medical assistance are persons who are receiving financial assistance under the State's General Assistance Program and persons who, except for income and resources, are eligible under the State's General Assistance Program.

The Department has established a special "Modified Assistance Standard", also called Medical Assistance Standard, to determine eligibility for medical assistance of persons who do not receive money payments under one of the other existing programs.[101] A person shall be eligible for "Medical Assistance Only", if his income and resources are equal to or less than the Modified Assistance Standard (Medical Assistance Standard) which currently are the following amounts:[102]

Table 10
MEDICAL ASSISTANCE STANDARDS 1970

Number of Persons	Monthly Maintenance Costs
1	$135
2	225
3	255
4	300
5	350
6	380
7	450

Add $40 for each additional member.

EXAMINATION OF A NEED FOR LEGISLATIVE ACTION

The monthly maintenance costs used for the Medical Assistance Standard are not substantially different from the Total Monthly Requirements computed on the basis of the applicable General Assistance Standard established by the Department of Social Services and Housing.[103]

In other words, while Hawaii has adopted a broad coverage in terms of covered groups (categorically and categorically needy), the State has not covered broad strata of medically needy over and above the income limits set for categorically needy and has chosen not to exhaust the 133-1/3 per cent limits of federal sharing.[104]

Nevertheless the costs of medicaid and the amount of Hawaii's share have mounted steadily, primarily because of growing utilization and the spiralling costs of medical care.[105] The State's share is the difference between the total cost of the program and the federal share, the latter consisting of three items:[106]

(a) The federal medical assistance percentage;

(b) Seventy-five per cent of so much of the administrative expenses as are attributable to compensation or training of skilled professional medical personnel and staff directly supporting such personnel;

(c) Fifty per cent of the other administrative expenses.

The federal medical assistance percentage ranges between 50 and 83 per cent, depending upon the relationship between the per capita income of the State to the per capita income of the United States excluding the insular possessions.[107] It should be noted, however, that the federal government does not contribute to the expenses of medicaid for persons who are general assistance recipients and persons categorically linked to the G.A. program (so-call M-Gs).

The following table (Table 11) shows the total costs and the federal share and the State's share of such costs of medicaid for the fiscal years 1966-1967 to 1971-1972.

Table 11

EXPENDITURES FOR MEDICAID IN HAWAII
1966-1967 to 1971-1972

Fiscal Year	Total Cost	Federal Share	State Share
1966-1967	$ 7,395,939	$ 4,567,205	$ 2,828,734
1967-1968	10,296,878	4,593,947	5,702,931
1968-1969	12,948,760	5,261,194	7,687,566
1969-1970	16,421,236	7,425,788	8,995,448
1970-1971*	19,024,386	10,003,949	9,020,437
1971-1972*	27,233,933	12,288,212	14,945,721

*Estimated

Source: Executive Budgets

1968/1969 p. C-225 and D-17
1969/1970 p. C-228 and D-17
1970/1971 p. C-242 and D-16
1971/1972 p. C-232 and D-18

The segment of the population annually reached by medicaid is not readily determinable from published statistics since the relevant reports are published on a monthly basis[108] and, in the case of the monthly statistics of the State, do not segregate recipients of money payments who were also recipients of medical care and those who were not.

Fortunately, however the unduplicated number of medical care recipients per calendar year, is available from the annual reports submitted by the Department of Social Services and Housing to the Department of Health, Education and Welfare on Form FS-2082.2.[109]

According to the Statistical Report on Medical Care: Recipients, Payments, Services for Calendar Year 1969, a total of 44,044 unduplicated individuals received medical vendor payments during the reporting period. These 44,044 consisted of the following groups:

Table 12

MEDICAID RECIPIENTS
CALENDAR YEAR 1969

Category	Money Payments Authorized	Money Payments Not Authorized	Total
65 and over	1,631	4,363	5,994
Blind	88	12	100
Permanently and totally disabled	2,512	837	3,349
Dependent children	19,129	2,380	21,509
Adults in AFDC families	8,197	1,057	9,254
Others	2,689 (Essential Adults)	1,149	3,838
Totals	34,246	9,798	44,044

The numbers show a sharp increase with respect to 1968 when the corresponding total was only 30,540. Hence the percentage increase from one calendar year to the other was 44.5 per cent. Deducting the 5,463 persons 65 and over from the total results in a total of 38,581 persons under 65 as recipients of medical assistance, of whom 30,763 belong in the AFDC category. The number of individuals under 21 receiving medical assistance totalled 23,783 of whom 21,519 received such aid under the AFDC category.

Although the number of persons who received medical assistance during 1969 constitutes a large fraction of the number of individuals who did not possess prepayment plan coverage for hospital, surgical, or medical insurance, it cannot be assumed that the persons who received medical assistance for various health services represented the total or at least substantially the total number of individuals who actually needed the respective services but lacked voluntary prepayment coverage therefor. This becomes evident by comparing the number of persons receiving physicians' services under medicaid with the number of persons without insurance for medical services. In Part II-A of this report it was estimated that the number of individuals without medical insurance in 1969 was 116,381; physicians' services under medicaid during 1969 were rendered to 30,177 recipients under 65. It seems unreasonable to believe the the remaining 86,204 individuals were so healthy as not to require any physicians' services throughout the year.

The preceding paragraph involves an estimate of the number of persons who were eligible for medical assistance, i.e., of persons who would have been entitled to medical assistance if sickness had required them to seek medical care and public assistance for its defrayal.

The concept of eligibility for medical assistance is rather complex and varies from state to state. In Hawaii an individual is entitled to medical assistance, if he

(1) actually receives money payments under the special categorical assistance programs or the General Assistance Program, or

(2) is in need of "medical assitance only" because his income and resources are equal to or less than the medical assistance standard and meet the specific requirements under any categorical assistance programs (including categorical assistance).[110]

This signifies that a person must belong to the substandard income and resources group and meet the other prerequisites for the four categorical programs of the State (AABD, AFDC, CWFC, and GA). Since Hawaii has a broad categorical assistance program, including adults as well as children, the financial condition of adults who are incapacitated by illness is the paramount eligibility requirement.[111] This explains the fact that in Hawaii in February 1970, 14.7 per cent of medical care recipients were adults between 21 and 64, while the national average was only 2.6 per cent.[112] Adults who are not covered by the special categorical programs and who are not incapacitated or unemployable by reason of age and lack of skills nor have children under 18, however, are in general not entitled to medical assistance under General Assistance.[113]

Because of the complexity of the categorical conditions and the lack of reliable data on income distribution by family size, it seems to be impossible to arrive at a reliable estimate of the number of persons eligible for medical assistance in a given year.

State income tax data do not furnish a reliable basis for estimates for the intended purpose. On the other hand, the tax returns of single persons (unrelated individuals) include a substantial number of persons who are listed as dependents in the returns of other taxpayers. Hence the number of persons reporting low incomes is not a usable indicator of the number of families with low incomes and would reflect a high degree of duplication which cannot be

adjusted downward without excessive margin of error. On the other hand, the state income tax returns do not include all income. Excluded are retirement pay, pensions, and social security benefits. Hence in the case of aged persons, a substantial overcount may be produced. Finally a number of individuals may have no income but resources which exclude them from being potentially eligible for public assistance.

All these factors lead to the conclusion that the number of persons who could have received medical assistance had they applied therefore is not a vast one and that the coverage gap estimated in Part II-A of this report is not filled by medicaid even on the basis of the assumption that the number of eligibles exceeds that of the actual unduplicated recipients.

Most of all medicaid at present is primarily a "horse-out-of-the-barn type" of coverage. Although Title XIX authorizes prepayment plan coverage of persons in need of medical assistance[114] and includes expenditures for premiums in the scope of the Federal Medical Percentage and although the Handbook contains elaborate provisions relating to coverage by health insuring organizations or pooled funds,[115] the coverage of medical assistance clients is still in its incipiency. The State of Hawaii has embarked on a limited program providing prepayment coverage (at the rate of $82.38 for a subscriber with three dependents) of 500 families receiving aid under the State's AFDC and Child Welfare Foster Care programs.

Extending this type of coverage to the total population <u>now</u> entitled to medical assistance would present a number of technical difficulties. In the first place the different components of the current load (families with children, aged, blind, and permanently and totally disabled) would require different categorical rates. In the second place the coverage of the medical-assistance-only cases would necessitate advance determinations of eligibility which would result in a considerable increase of the social work case load, in contrast to the case of current money recipients where the eligibility results automatically. The total cost of such prepayment coverage is likewise difficult to assess, since such a system would most likely increase the number of individuals seeking to avail themselves of the coverage as well as the utilization of medical services per person. At present levels the net cost of medicaid, assuming an annual cost of $20,000,000 for 44,000 nonduplicated recipients, is $455 per person. The cost of a system of prepayment at current standards of eligibility might be substantially higher, until prepayment care lowers the frequency and severity rates. Even at that it would not close the present coverage gap.

Part III

RECOMMENDED MEASURES

A. General Aspects

The foregoing parts of the report concluded that at present voluntary prepayment plan coverage does not extend to a substantial portion of the population the size of which varies with the type of care, being smallest with respect to hospital insurance (11.7 per cent) and largest with respect to medical insurance (17.2 per cent).

It was also shown that medicaid at the present level of medical assistance standards would not close the whole gap, although eligibility for medicaid might benefit between 40 to 60 per cent of the persons concerned.

Against this background available options must be discussed. Of course, the spectrum of options is extremely broad, ranging from "no action whatsoever" to a total remodelling of the existing arrangements for the delivery and financing of medical care, i.e., establishment of a state health service system patterned after the British model.

Basically, however, two intermediate approaches deserve practical attention:

(a) Increase of the medical assistance standards to cover a much larger segment of the population, with or without introduction of prepayment arrangements;

(b) Extension of the existing system of prepayment plan coverage to additional categories of employees on a contributory basis, with or without a premium supplementation scheme.

The report recommends the second alternative because of its greater feasibility and fairness to the population as a whole.

Alternative (a), i.e., expansion of medicaid by an increase of the eligibility for medical aid, would not only be an extremely costly but also an impolitic measure, especially since the long-range benefits of prepayment coverage would be hard to achieve. Although the federal government would contribute a portion to the increased burden, the respective proportion of its share would decline sharply. In the first place the federal government does not contribute at all to the general assistance category, and this category might occupy a greater percentage of the total if eligibility were increased. Secondly, the 133-1/3 per cent rule, of the current General Assistance Standards,

would limit the federal share to a family income (2 adult family of four) of $4,300,[1] and any increase beyond that amount would either be unmatched by a federal contribution or necessitate a concomitant increase in the General Assistance Standards. Moreover, an attempt to cover the whole population entitled to medicaid would necessitate a constant surveillance of eligibility requiring a host of social workers and thus a substantial increase in administrative costs.

Since medicaid coverage must provide for comprehensive medical services, an increase in medicaid may create the real danger of an imbalance in utilization of medical facilities and overtaxing of the available delivery system. Finally, the provision of liberal free care might be an attraction to less fortunate families on the mainland which, under current constitutional construction, could not be stemmed by residence requirements.

Universal medical health insurance with an overhaul of the delivery system can only come on the federal level and even a truncated system in the form of liberalized medicaid is fraught with inherent limitations and inequities.

As a result it is recommended to establish an independent scheme of mandatory prepayment coverage which avoids disturbance and overlap with the presently existing medical assistance system, in particular, with those categories thereof that are entitled to federal contributions, i.e.:

(a) Aged,

(b) Blind and disabled,

(c) AFDC families, i.e., families with children and without or with unemployed fathers,

(d) Children under 21 in need of medical care.

Any overlap with these categories would result in a loss of the federal share of the burden and result in federal taxation upon the citizens of Hawaii without commensurate benefits. An overlap with general assistance coverage for medically needy would not be harmful and, in fact, be beneficial, since it would transform the coverage into the desirable prepayment type.

The most feasible scheme to accomplish the desired goals would be a mandatory prepayment coverage for employees under 65.

Such a system would have a number of desirable features. It would in effect be an extension of the existing arrangements, some sort of a "bringing up the rear" measure. It could use the available delivery system and employ the prevailing community standards as a norm. It would thus prevent an overtaxing of the facilities and exercise only minimal inflationary pressures. It would not be available to newly arriving welfare families, without violation of the constitutional prohibition against residence requirements.

Unfortunately, such a system would not only perpetuate the existing medical assistance system (which is unavoidable), but, in addition, might not reach certain deserving categories of persons with irregular or multiple employment and leave them to general assistance in case of incapacitating illness and after depletion of their resources. It would seem, however, that certain unavoidable shortcomings should not militate against the attempt to protect at least the preponderant majority of employees now without or without adequate prepayment coverage.

B. Mandatory Prepaid Health Care Coverage for Employees

The basic principles of the recommended scheme is quite simple:

(1) Every regular employee in private employment shall be protected by a prepaid plan providing for hospital, surgical, and medical benefits.

(2) The level of benefits should conform with the prevailing community standards.

(3) Unless a collective bargaining agreement or self-initiated employer's policy provides for an allocation of the costs more beneficial to the employee, the costs shall be shared equally by the employer and the employee.

(4) The prescribed coverage may be provided with any of the existing prepayment plan operators, regardless of whether they provide services, such as Kaiser or other medical group plans, or reimbursement either on a nonprofit principle, such as HMSA or similar organizations, or on the profit principle, as the commercial carriers.

(5) The scheme does not intend to interfere with the collective bargaining process or interfere with the services provided pursuant to such collective agreements, as in the sugar industry.

(6) The free choice of his physician by the employee shall be protected.

(7) In order to avoid an oppressive burden on low-wage earners and their employers, the mandatory scheme should be coupled with a plan for premium supplementation from general revenues.

Although the basic principles are easily stated, their implementation requires a number of difficult decisions regarding eligibility, governing rules for cases of irregular and multiple employment, prevention of duplicate coverage, and administration. These choices become particularly difficult and pressing if the system is coupled, as is envisaged, with a premium supplementation scheme.

By way of preface, it may be recalled that President Nixon announced plans for the introduction of a Family Health Insurance Program, submitted to the Senate Finance Committee, which provided for a government share of 100 per cent for families with incomes under $1,600, of 95 per cent for families with incomes between $1,600 and $3,000, of 90 per cent for families with incomes between $3,000 and $4,500, and 75 per cent for families with incomes between $4,500 and $5,620.[2] Of course, a state-supported supplementation scheme would have to be much more modest.

The State of Hawaii currently operates a rent supplementation scheme under sections 359-121 to 359-126, Hawaii Revised Statutes, as amended by Act 105, section 3, Session Laws of Hawaii 1970. The governing provisions provide for annual rent supplements on behalf of "qualified tenants" in amounts not to exceed $70 a month. The current net costs of this program are $318,755.[3] A similar system in the field of health protection seems appropriate.

Scope in Coverage

It is recommended that mandatory prepayment plan coverage extend to substantially all regular employees in private employment.

Federal employees could not be reached by a contributory scheme for constitutional reasons. State employees likewise may be excluded since group coverage on the contributory principle is available to them, and they are represented by various bargaining units.

A regular employee for the purposes of this recommended measure shall be an individual who is in the employ of any one employer for at least 20 hours per week.

The employer shall provide group coverage for a regular employee after he has been in his employ for four consecutive weeks. The coverage shall commence at the earliest date following that period at which the prepaid health care plan operator enrolls new subscribers.

Eligibility shall extend to all employees who receive at least an annual cash wage of $1,680 or a monthly wage of $140 from their regular employers. This figure is based on two considerations: It corresponds to the minimum wage, rounded off for ease of computation.[4] It dovetails reasonably with the medical assistance standard of $135 per month for single adults.

Exemptions

Certain groups of employees should be exempted from coverage either because of constitutional doubts or other policy reasons. This applies to:

(1) Family employment,

(2) Seamen,

(3) Employees of employees' benefit associations open only to federal employees,

(4) Insurance agents,

(5) Employment exempted from unemployment insurance coverage by the Federal Economic Opportunity Act of 1964.[5]

Avoidance of Duplicate Coverage

It is possible that an employee may enjoy prepaid health plan coverage apart from the mandatory coverage of the recommended legislation. Hence it is recommended that no duplicate coverage be required.

Coverage, apart from the required coverage under the recommended legislation, may exist because:

(1) The employee is covered under any other legislation of the State or the United States (e.g., medicare);

(2) The employee receives public assistance under any economic assistance program or is covered by a prepayment plan established under medicaid;

(3) The employee is covered as a dependent under the prepaid health care plan of his or her spouse or parent.

Required Health Benefits

It is recommended not to prescribe a rigid catalogue of items that must be included in a prepaid health care plan in order to qualify under the recommended act. It is felt that the prescribed coverage should be equal or medically equivalent to the health services offered under the prepayment plans that currently are most prevalent in the State, as for instance HMSA Plan 4 and Kaiser Plan O. The only requirements should be that the coverage include a combination of hospital, surgical, and medical benefits and that the hospital benefits extend to at least 150 days in each calendar year. To the extent that the prevailing plans provide for co-insurance or limits on reimbursability, the existing system shall not be changed and shall remain flexible.

Provision of Coverage by Principal Employer; Contributory Financing

It is recommended that each (principal) employer provide group prepaid health care plan coverage for his regular employees and that the premium therefor be paid on a contributory basis, i.e., one-half by the employer and one-half by the employee, unless the employer agrees to pay all or a greater share. In no case shall the employee be required to pay more than half of the cost.

A requirement that the employer (within limits) pay at least one-half of the cost of subscriber coverage would not constitute a radical innovation.

The questionnaire sent to the employers showed that out of 1,157 firms:

615 paid 100 per cent of the costs of subscriber coverage,

75 paid between 51 and 90 per cent thereof,

183 paid 50 per cent thereof,

22 paid between 14 and 48 per cent thereof, and

262 paid *nothing*.

In addition, 367 firms paid the whole costs of dependents coverage, while 254 contributed at least half of such costs.

At the lower wage brackets, however, the *imposition of the* costs of subscriber coverage upon the employee in the form of wage withholding and upon the employer as some sort of a payroll tax may become oppressive. At present the premium for the most prevalent health care prepayment plan providing for services is $160 per year. Hence at a low annual wage, a comparatively high percentage thereof would have to be allocated to health insurance, descending to lower figures as the income increases. The following table shows the relation between annual wage and percentage of premium costs:

$1,680:	9.52%
2,000:	8.00%
3,000:	5.33%
4,000:	4.00%
5,000:	3.20%
5,333:	3.00%

It would seem that there should be a limit on the percentage of wages which an employee and his employer should be required by statute to devote to the employee's health insurance. Otherwise the mandatory features might become too burdensome and not only restrict unduly the disposable income of the employee as well as curtail job opportunities. Hence at some limit a premium supplementation scheme should become operative.

Premium Supplementation

In order to prevent oppressiveness of the mandatory coverage, it *is recommended that the contributory system be coupled with a program* of premium supplementation, payable from state general revenues. Such a program would enhance the fairness of the distribution of the costs of compulsory health insurance, since Hawaii ranks only no. 35 (out of 51) in average weekly earnings from manufacturing[6] but no. 13 in

per capita personal income.[7]

The concrete features of such a premium supplementation program depend, of course, on a legislative judgment of fairness and feasibility. A system which supplements the premium costs above 3 per cent of the wages would be substantially more expensive than one that supplements premium costs above the 4 per cent level.

A system based on a 4 per cent maximum combined contribution would require annual supplementations ranging from $96.80[8] to $1 covering regular employees with annual earnings between $1,680 and $4,000, while a system based on a 3 per cent combined maximum would require annual contributions ranging from $109.60[9] to $1 covering regular employees with annual earnings between $1,680 and $5,334, i.e., require higher supplements to a greater number of people. An even larger supplement, in terms of persons entitled thereto and of maximum amounts, would flow from a 2.5 per cent combined maximum. In that case the supplement would start at the $6,400 bracket and reach $118.00 at the $1,680 level.

Unfortunately, it is well-nigh impossible to arrive at definite estimates of the costs of a supplementation program at various support levels. On the one hand there exist no reliable data with respect to the number of regular employees in the relevant wage brackets. On the other hand, it is difficult to estimate the number of employees in the various lower wage brackets who have coverage either as military dependents or as dependents of employees in the higher wage brackets with dependents' coverage and who therefore will not require any premium supplementation. It must be expected, however, that at least some of the employees who now have coverage paid entirely by them or jointly by them and their employers will claim premium supplementation, once it becomes available. It cannot be assumed that premium supplementation will only be claimed by employees in the lower wage brackets who at present have no coverage whatsoever or lack coverage for medical services.

The safest way to approach the problem is by calculating the uppermost limits of the costs of a supplementation program on the basis of wage and salary distribution figures derived from the state income tax returns, and then to make downward adjustments for the reason that the figures include wage earners that are excluded from the program, such as:

(a) Government employees,

(b) Maritime employees,

(c) Employees in the sugar industry,

(d) Part-time workers,

(e) Employees age 65 and over,

(f) Employees covered by Champus,

(g) Employees covered as dependents of workers, in the higher wage groups, and

(h) Welfare recipients.

It is safe to assume that most of the part-time employees and of the employees age 65 and over will belong to the lower income brackets, while the preponderant majority of the government workers will be above the $5,000 level.

Mr. Gordon Frazier of the Department of Labor and Industrial Relations has extended the State Income Patterns (Individual) between 1959 and 1967 to 1971 and arrived at the following results:[10]

$1,000 to $1,999:	20,500
2,000 to 2,999:	12,000
3,000 to 3,999:	11,000
4,000 to 4,999:	11,500
5,000 to 5,999:	13,000
6,000 to 6,999:	13,000

This would include approximately 31,200 wage earners in the $1,680 to $4,000 brackets, 47,000 in the $1,680 to $5,334 brackets, and 60,900 in the $1,680 to $6,400 brackets. The average annual wage in the State for 1969/1970 was slightly above $6,600.

Assuming an 8.0 per cent downward correction for employees age 65 and over and part-time employees would result in an estimate of the maximum cost of supplementation programs at various levels without downward correction for dependents' coverage under Champus or a pre-payment plan of a spouse or parent as subscriber or protection under medicaid.

The following tables show the maximum costs of premium supplementation programs at current wage and premium levels.

A. Premium Supplementation to Premiums in Excess of 3 Per Cent of Wages

Wage Bracket	No. of Employees	Average Annual Supplement	Costs Per Bracket
$1,680-$1,999	7,544	$104.80	$ 790,611
2,000- 2,999	11,040	85.00	938,400
3,000- 3,999	10,120	55.00	556,600
4,000- 4,999	10,580	25.00	264,500
5,000- 5,334	3,986	5.00	19,930
$1,680-$5,334	43,270		$2,570,041

B. Premium Supplementation to Premiums in Excess of 4 Per Cent of Wages

Wage Bracket	No. of Employees	Average Annual Supplement	Costs Per Bracket
$1,680-$1,999	7,544	$ 86.40	$ 651,802
2,000- 2,999	11,040	60.00	662,400
3,000- 3,999	10,120	20.00	202,400
$1,680-$4,000	28,704		$1,516,602

C. Premium Supplementation to Premiums in Excess of 2.5 Per Cent of Wages

Wage Bracket	No. of Employees	Average Annual Supplement	Costs Per Bracket
$1,680-$1,999	7,544	$114.50	$ 863,788
2,000- 2,999	11,040	97.50	1,076,400
3,000- 3,999	10,120	72.50	733,700
4,000- 4,999	10,580	47.50	502,550
5,000- 5,999*	13,000	22.50	292,500
6,000- 6,399*	5,200	5.00	26,000
$1,680-$6,399	57,484		$3,494,938

*No adjustment for aged and part-time employees.

Of course, it could be decided to adopt a staggered system: supplementation to premiums in excess of 2.5 per cent for wage earners under $3,999 and in excess of 3.00 per cent for wage earners between $4,000 and $5,334.

D. Premium Supplementation to Premiums in Excess of 2.5 Per Cent for Wage Earners Below $3,999 and of 3 Per Cent for Earnings Above

Wage Bracket	No. of Employees	Average Annual Supplement	Costs Per Bracket
$1,680-$1,999	7,544	$114.50	$ 863,788
2,000- 2,999	11,040	97.50	1,076,400
3,000- 3,999	10,120	72.50	733,700
4,000- 4,999	10,580	25.00	264,500
5,000- 5,334	3,986	5.00	19,930
$1,680-$5,334	43,270		$2,958,318

RECOMMENDED MEASURES

As was pointed out before the figures in the tables express outer limits and require downward adjustments because of the inclusion of:

(a) Employed welfare mothers and other employed adult welfare recipients;

(b) Employed military dependents; and

(c) Employed dependents of employed wage earners with dependents' coverage, especially in the higher brackets.

In Part I an effort was made to arrive at an estimate of employed persons with dependents' coverage and it was concluded that 21.3 per cent of the employed labor force could be considered as protected by such coverage.

On that basis it can be concluded that the net costs of the premium supplementation program set forth under Table A would be in the neighborhood of $2 million, rather than $2½ million and that program B would cost $1.2 million rather than $1.52 million. In other words extension of the existing system by mandatory coverage with premium supplementation at lower-wage brackets would involve about one-tenth of the cost of medicaid.

It is recommended that the Legislature adopt Plan A. While, of course, this report does not presume to invade the province of legislative judgment, it would seem that 3 per cent of the wages (split into shares of 1.5 and 1.5) could be afforded by single wage earners even at annual wages in low brackets. An employed woman with a dependent child might be entitled to AFDC benefits and therefore exempt from compulsory coverage, if her annual wage is less than $2,400.

The figure of 3 per cent seems to be in consonance with the federal tax policy. Medical expenses below 3 per cent are not deductible. Of course, one-half of the employee's share of health insurance premiums (not in excess of $150) are deductible regardless of the limitation of medical expenses to amounts in excess of 3 per cent.

Primary and Secondary Employers

It is recommended that the duty to provide group coverage and to contribute at least one-half to the premium not in excess of 1.5 per cent of the wages (unless otherwise provided by collective bargaining agreement or employment policy) be imposed upon the primary employer. "Primary employer" is the employer of a regular employee who pays the highest monthly wage.

Secondary employers are relieved from the duty to provide group coverage, but they should contribute 3 per cent of the wages of such employee (1.5 per cent to be raised by withholding), if (a) the employee is a regular employee of such secondary employer, (b) he receives monthly wages of $140 or more, and (c) the Premium Supplementation and Continuation Fund had to supplement the premium payable in respect to such employee by the primary employer.

In such case the contributions of the secondary employer should be payable to the Fund, subject to the limitation that he contribute no more than the actual supplementation.

Premium Continuation in Case of Prolonged Illness

Group policies require monthly premium payments regardless of whether the employee is hospitalized or otherwise incapacitated at the due date. Group policies contain no waiver of premium clauses. Since the system recommended is predicated on actual employment and wages earned, it could happen that the group coverage might lapse during hospitalization or other loss of wage-earning capacity, unless provision is made for premium continuation during prolonged illness. If, for example, an employee is hospitalized before the next premium falls due, the employee would earn no wages at that time and the hospitalization coverage would lapse, rendering the entitlement to 150 days of hospitalization illusory.

It is recommended that the employer pay the premium or the obligatory portion of the premium (including the employee's share) for the month following the employee's loss of wage-earning capacity. If the employee returns to work the withholding of 1.5 per cent, if appropriate, would be resumed.

If the loss of wage-earning capacity continues beyond the end of that grace period, the future premiums should be paid by the Premium Supplementation and Continuation Fund until the employee

returns to work, but not in excess of four months, thus covering the whole period of insured hospitalization.

It is recommended that the premium continuation program be limited to the earning groups that require premium supplementation, i.e., the low-wage brackets. Higher earnings brackets have means to protect themselves, especially as TDI supplies additional income.

If the continuation program is restricted to wage-earners in the brackets below the earnings level, 3 per cent of which are less than the premium for individual coverage, the total additional burden on the Premium Supplementation and Continuation Fund would be relatively light since:

(1) The incidence of disabling illness beyond 30 days is not high; and

(2) The amount payable is the amount of the premium minus the supplement payable in any case.

It is safe to estimate that the additional costs would be around $50,000.

On the basis of Table A used in the section on premium supplementation, the remaining monthly balance would be:

$ 4.60	for	the	earners	in	the	bracket	$1,680-$1,999
6.25	"	"	"	"	"	"	2,000- 2,999
8.75	"	"	"	"	"	"	3,000- 3,999
11.25	"	"	"	"	"	"	4,000- 4,999
12.92	"	"	"	"	"	"	5,000- 5,334

Unfortunately, only the continuation rates for incapacity due to hospitalization are known for Hawaii.

According to information obtained from the largest prepayment plan operator in the State, 8 per cent of the subscribers require hospitalization. Of this number (80 per 1,000), 3.3 per cent (2.64 per 1,000) remain hospitalized for more than 30 days, 8 per cent (.64 per 1,000) for more than 60 days and 4 per cent (.32 per 1,000) for more than 90 days.

If hospitalization alone were the basis of premium continuation, the burden on the Fund would be minimal, involving 3.92 monthly

payments in the respective brackets, resulting in the following amounts on the basis of the number of employees estimated to constitute the respective brackets:

Brackets	No. of Payments	Amount
$1,680-$1,999	30	$ 138.00
2,000- 2,999	43	268.75
3,000- 3,999	40	350.00
4,000- 4,999	40	450.00
5,000- 5,334	15	193.80
Total		$1,400.55

Of course, many persons may be confined and unable to earn wages without being hospitalized. An estimate of the additional number of persons thus afflicted is difficult because of the absence of data on that matter relative to Hawaii.

The issue of continuation tables relating to temporary disability was discussed at great length in the study on Temporary Disability, published by the Bureau in 1969.[11] These tables relate to the duration of compensated disability after expiration of one week's waiting period. They permit an estimate of the costs of premium continuation after one month of confinement has expired. In California 90 per 1,000 covered persons were disabled for one week. The original number decreased to 60 per cent at the beginning of the second month, 34 per cent at the beginning of the third month, 20 per cent at the beginning of the fourth month and 13.5 per cent at the beginning of the fifth month. Hence, a continuation program of four months beginning after the first month of confinement would involve 117 payments per 1,000 workers. On that basis the cost of the additional program would be:

Wage Brackets	No. of Payments	Amount of Payment	Total
$1,680-$1,999	883	$ 4.60	$ 4,061.80
2,000- 2,999	1,292	6.25	8,075.00
3,000- 3,999	1,184	8.75	10,360.00
4,000- 4,999	1,238	11.25	13,927.50
5,000- 5,334	466	12.92	6,021.72
Total			$42,446.02

Hence, the total cost of the burden on the Fund from the combined premium supplementation and continuation program would be $2,050,000 without costs of administration.

Freedom of Collective Bargaining

As was stated before the mandatory coverage should not interfere with the collective bargaining process.

Collective programs which provide different health benefits, different allocation of the premium costs, or dependents' coverage are not intended to be affected.

This rule applies even with respect to eligibility conditions especially different probationary periods.

There is, however, one important limitation: if the collective agreement does not provide coverage for certain service categories, such as clerical workers, custodial employees, etc. the mandatory coverage of the recommended measure should apply.

Administration

The administration of the program should be located in the Department of Labor and Industrial Relations and affiliated with the administration of T.D.I. In some respect the measures are twins.

Only one aspect, the medical equivalency of plans, should be determined by another agency: the Department of Health.

The chief administrative work will result from:

(a) The special status of secondary employers;

(b) The exclusion of employees who have coverage under other programs; and

(c) The premium supplementation and continuation program.

The program should be self-administering to the largest extent possible. Proper notice forms should greatly reduce the work.

Employees should receive notice forms at their place of employment or the departmental offices.

Forms should be developed for:

(1) Notice that a particular employer is not the primary employer;

(2) Notice that exemption from coverage is claimed because the employee already has coverage,

(a) as military dependent,

(b) as dependent of another employee,

(c) because he is entitled under another program providing protection (medicare, medicaid).

Notices by employees should be deemed to be true and should not infringe upon the employee's privacy.

Multiple employment is to be notified only to the secondary employer (with a copy to the Department)

The employee need not specify whether he receives welfare payments or medicare. A general reference to such exemption should suffice.

The premium supplementation program should be mainly administered by the prepayment plan operators themselves. They should submit lists of premium deficiencies stating the names of the subscriber employees and the amount of the deficiency, at intervals determined by the Department, preferably in accord with the principal prepayment plan operators.

They shall be entitled to a service charge, payable from the Fund.

Collection of premiums from secondary employers shall be in the discretion of the Department, in order to prevent useless work with no substantial recovery.

Employers should be audited, according to the general practice of the Department.

C. Unfinished Business: The Next Steps

The bill as recommended creates mandatory prepaid health plan coverage for every regular employee in private employment earning not less than $1,680 from one employer, coupled with premium supplementation for low-wage earners. It thus falls short of the goal of universal prepayment coverage.

As a result, the health service protection in the State will consist of a three-strata arrangement:

(1) Medicaid;

(2) Minimum mandatory prepayment plan coverage for individuals above the medicaid level;

(3) Voluntary prepayment plan coverage for dependents and self-employed.

The reasons for this composite scheme are the federal matching system for the lowest income levels and the need for disposable income and avoidance of excessive payroll taxes in the case of wages, 3 per cent whereof would not yield even a subscriber premium.

Of course, dependents' coverage in higher wage brackets could easily be made mandatory by providing that employees earning more than a specified amount must be protected by a prepayment plan, including dependents. The proper base line, for example, could be earnings 5 per cent of which yield at least the premium for one dependent, i.e., $6,400 at current rates. There is, however, the question of whether there is a real need for such a protection, since it exists apparently anyhow on a voluntary basis.

The real gaps exist with respect to certain categories in or related to the low-income brackets, in particular:

(a) Self-employed with low incomes (and their dependents);

(b) Wage earners who customarily have several employers none of whom employs the wage earner for at least 20 hours a week (cleaning helpers);

(c) Full-time students aged 21 and above;

(d) Nonworking wives of low-wage earners and to a lesser degree minor children of such wage earners.

Children (including all persons under 21) enjoy much better medicaid protection than adults since all needy children (not only children of AFDC families) are entitled to medical assistance if the family income is below a level varying with size ($2,700 for a family of 2, $3,060 for a family of 3, $3,600 for a family of 4, and $4,200 for a family of 5).

It is very difficult to provide mandatory coverage for the categories listed above under (a) to (c) since the devise of wage withholding is not applicable.

While a mandatory scheme using taxes with offset credits or penalties could be devised (although its constitutionality would need some study), it would probably be more advisable to create an optional scheme, using supplementation as an incentive. Obviously, if wage earners with regular employers are entitled to premium supplementation, self-employed and wage earners in multiple employment with low earnings should likewise be entitled to such benefits. An arrangement of this type could use either the Premium Supplementation Fund as a vehicle or a tax credit system similar to that provided in section 235-56.5, Hawaii Revised Statutes. It could, for instance, be provided that any person whose income results principally from self-employment or multiple employment and is more than $1,680 and less than $5,334 shall be entitled to a tax credit in the amount of receipted health prepayment plan premiums paid minus 3 per cent of such income, returns being due on a quarterly basis.[12]

Similar provisions could be made for dependents' coverage.

No provisions of that type are included in the bill recommended at this time, but its speedy supplementation by the creation of an optional scheme providing premium supplementation for some or all of the persons in low-income groups still lacking coverage should be kept in mind. It should be instituted after experience has been gained with the operation of the compulsory minimum coverage plan.

In the hope that the Legislature may take one of the next steps immediately, a Part V to the suggested legislation, Tax Credits for Optional Coverage of Low-Income Subscribers is included.

Part IV

(To be made one and ten copies) **PROPOSED BILL**

HOUSE OF REPRESENTATIVES
SIXTH LEGISLATURE, 1971
STATE OF HAWAII

H.B. NO.

A BILL FOR AN ACT

RELATING TO THE HAWAII HEALTH PREPAYMENT ACT.

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

SECTION 1. The Hawaii Revised Statutes is amended by adding a new chapter to be appropriately numbered and to read as follows:

"CHAPTER

PREPAID HEALTH CARE LAW

PART I. SHORT TITLE; PURPOSE; DEFINITIONS

Sec. -1 Short title. This chapter shall be known as the Hawaii Prepaid Health Care Law.

Sec. -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 to provide this type of protection for the employees in this State. In view of the spiralling cost of comprehensive medical care, only a limited basic protection can be achieved without federal action in this field. 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 interfere with or diminish any protection already provided pursuant to collective bargaining agreements or employer-sponsored plans that is more favorable to the employees benefited thereby than the protection provided by this chapter or at least equivalent thereto.

Sec. -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 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 -4 and -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 engaged in the employment of any one employer for at least twenty hours per week.

The director by regulation may establish comparable standards for those employments which call for irregular work schedules.

(9) "Wages" means all cash remuneration for services from whatever source, including commissions, bonuses, and tips and gratuities paid directly to any individual by a customer of his employer.

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 from tips shall be deemed to be at least equal to the wage required by chapter 387 or a greater sum as determined by regulation of the director.

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

Sec. -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.

Sec. -5 Excluded services. "Employment" as defined in section -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 members of the association or their dependents or their designated beneficiaries, if (A) admission to membership in the association is limited to individuals who are officers or employees of the United States government, and (B) no part of the net earnings of the association inures (other than through such payments) to the benefits of any private shareholder or individual.

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

(5) 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.

Sec. -6 Principal and secondary employer defined. If an individual is concurrently a regular employee of two or more employers as defined in this chapter, the employer who pays the highest monthly wage shall be the principal employer of the employee. His other employers are secondary employers.

If an individual is concurrently a regular employee of a public entity which is not an employer as defined in section -3 and of an employer as defined in section -3 the latter shall be deemed to be a secondary employer if the monthly wage paid by him to the individual is less than the monthly remuneration paid to the individual by the public entity.

Sec. -7 Required health care benefits. (a) The extent of the health care benefits provided by a prepaid health care plan required by section -11 shall be equal or equivalent to the benefits provided by prepaid health plans of the same type which are prevalent in the State. This applies to the types and quantity

of benefits as well as to limitations on reimbursability and to required amounts of co-insurance.

(b) A prepaid health care plan qualifying under this chapter shall include the following benefits:

(1) Hospital benefits:

(A) In-patient care for a period of at least one hundred and fifty 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;

(B) After-care visits for a reasonable period;

(C) Anesthesiologist services.

(3) Medical benefits:

(A) Necessary home, office, and hospital visits;

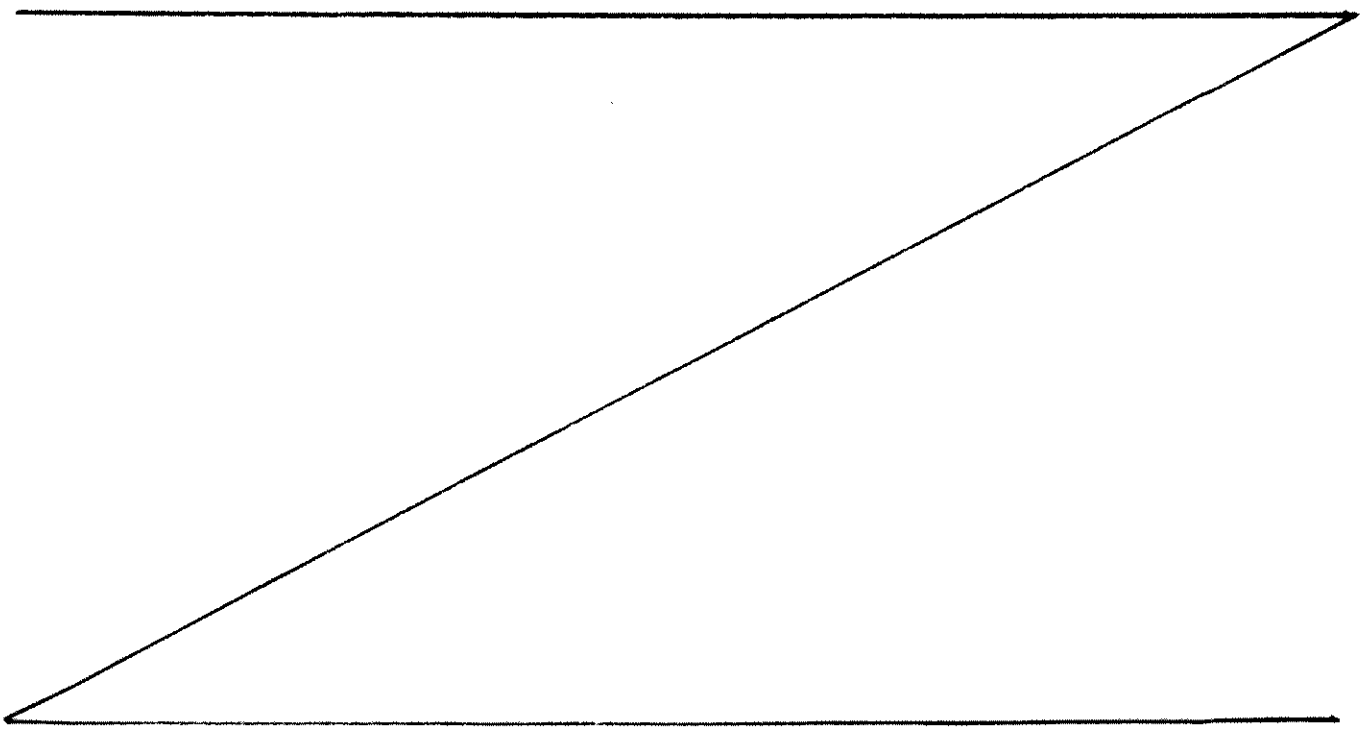
(B) Intensive medical care while hospitalized;

(C) Medical or surgical consultations while confined.

(4) Diagnostic laboratory services, x-ray films, and radiotherapeutic 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.

(c) If necessary, the director of health shall determine if a prepaid health care plan meets the standards specified in subsections (a) and (b).



PART II. MANDATORY COVERAGE

Sec. -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, as rounded off by regulation of the director, shall provide coverage of such employee by a group prepaid health care plan entitling the employee to the required health care benefits with a prepaid health care plan contractor in accordance with the provisions of this chapter.

Sec. -12 Choice of plan and of contractor. (a) Unless the employer pays the total amount of the premium for coverage under a plan operating on the reimbursement principle, every employee entitled to coverage 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.

(b) If the employee elects a plan which obligates the prepaid health care plan contractor to furnish the required health care benefits and several prepaid health care plan contractors in the State provide the required benefits by such type of plan, the employee may elect the particular contractor but the employer shall not be

obligated to contribute a greater amount to the premium than he would have to contribute had the employee elected coverage with the contractor providing the prevailing coverage of this type in the State.

(c) If the employee elects a plan which obligates the prepaid health care plan contractor to defray or reimburse the expenses of health care, the employer may select the contractor with whom such coverage shall be provided but an employee shall not be obligated to contribute a greater amount to the premium than he would have to contribute had the employer selected coverage with the contractor providing the prevailing coverage of this type in the State.

(d) If the contributions of the employer and employee are not sufficient to pay the premium charged for coverage under a particular plan and premium supplementation is required as provided in this chapter, the amount of the supplementation shall not exceed the amount required had coverage with the contractor providing the prevailing coverage of the type selected in the State been chosen. Any excess shall be paid by the party making the selection.

Sec. -13 Liability for payment of premium in general. Except as otherwise provided in section -12 and subject to the limitation provided in section -14, 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.

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

Sec. -14 Limitation on liability; premium supplementation. Unless an applicable collective bargaining agreement specifies otherwise, an employer may not withhold more than 1.5 per cent of the employee's wages for the purposes of this chapter and the employer's share may likewise be limited to this percentage.

If the combined contributions of the employer and the employee are not sufficient to pay the premium the balance shall be paid by the premium supplementation and continuation fund established by this chapter subject to the provisions of section -12(d).

Sec. -15 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 weeks, at the earliest time thereafter at which coverage may be provided with the prepaid health care plan contractor selected pursuant to this chapter.

Sec. -16 Continuation of coverage in case of inability to earn wages. (a) If an employee is hospitalized or otherwise prevented by sickness from working the employer shall continue the coverage of the employee for the month following the employee's sickness by paying his and the employee's share of the premium as required by sections -13 and -14 and the premium supplementation and continuation fund shall pay any balance as provided in section -14. If the employee returns to work during this month the employer may withhold 1.5 per cent of the wages earned after

his return, unless an applicable collective bargaining agreement provides otherwise.

(b) If the employee is still hospitalized or otherwise prevented by sickness from working after the expiration of the month specified in subsection (a) the premium supplementation and continuation fund shall continue the coverage by paying the required premium until the employee is able to return to work but not in excess of four additional months.

Sec. -17 Liability of secondary employer. (a) 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 -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 -19 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.

(b) If a secondary employer of an individual who has been his regular employee for at least four weeks, pays to such employee monthly wages of at least the amount specified in section -11, he shall be liable to contribute to the premium supplementation and continuation fund for premium deficiencies as provided in section -37.

Sec. -18 Exemption of certain employees. (a) In addition to the exemption specified in section -17, an employer shall be relieved of his duty under section -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.

Sec. -19 Termination of exemption. (a) If an exemption which has been claimed by an employee pursuant to section -18 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, including the relation of the wages received in concurrent

employment, 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.

Sec. -20 Freedom of collective bargaining. (a) Nothing in this chapter shall be construed to limit the freedom of employees to bargain collectively for different prepaid health care plan coverage or for a different allocation of the costs thereof. A collective bargaining agreement may provide that the employer himself undertakes to provide the health care specified in the agreement.

(b) If 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, but 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.

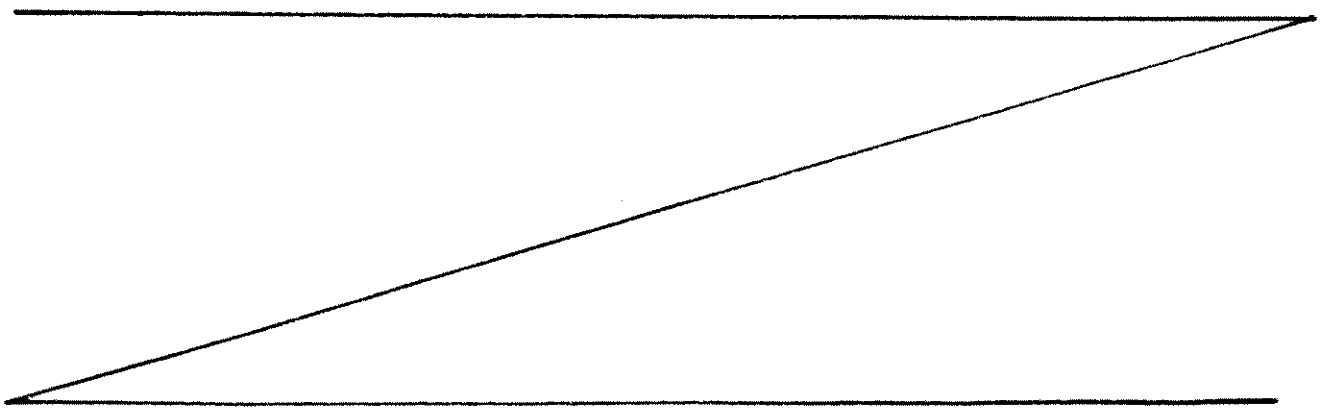
Sec. -21 Adjustment of employer-sponsored plans. Where employees subject to the coverage of this chapter are included in the coverage provisions of an employer-sponsored prepaid health care plan covering similar employees employed outside the State

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.

Sec. -22 Individual waivers prohibited. An employee shall not be permitted to waive individually all or a part of the required health care benefits or to agree to pay a greater share of the premium than is required by this chapter.

Sec. -23 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.

Sec. -24 Regular group rates for coverage under this chapter. Every prepaid health care plan contractor authorized to provide prepaid health care plan coverage in the State shall provide the coverage required by this chapter at the community premium group rate charged by him for the applicable type of coverage.



PART III. PREMIUM SUPPLEMENTATION AND CONTINUATION

Sec. -31 Establishment of special premium supplementation and continuation 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 and continuation which shall be administered exclusively for the purposes of this chapter. All contributions by secondary employers pursuant to this part shall be paid into the fund and all premium supplementations and continuation 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 and continuation under this part, (2) all moneys collected from secondary employers pursuant to this part, and (3) all fines and penalties collected pursuant to this chapter.

Sec. -32 Management of the fund. The director of finance shall be the treasurer and custodian of the premium supplementation and continuation fund and shall administer the fund in accordance with the directions of the director of labor and industrial relations. All moneys in the fund shall be held in trust for the purposes of this part only and shall not be expended, released, or appropriated or otherwise disposed of for any other purpose. Moneys in the fund may be deposited in any depositary bank in which general funds of the State may be deposited but such moneys shall not be commingled with other state funds and shall be maintained in separate accounts on the books of the depositary bank. Such moneys shall be secured

by the depositary bank to the same extent and in the same manner as required by the general depositary law of the State; and collateral pledged for this purpose shall be kept separate and distinct from any other collateral pledged to secure other funds of the State. The director of finance shall be liable for the performance of his duties under this section as provided in chapter 37.

Sec. -33 Disbursements from the fund. Expenditures of moneys in the premium supplementation and continuation fund shall not be subject to any provisions of law requiring specific appropriations or other formal release by state officers of money in their custody. All payments to prepaid health care plan contractors shall be paid from the fund upon warrants drawn upon the director of finance by the comptroller of the State supported by vouchers approved by the director.

Sec. -34 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 and continuation fund as are in excess of the amount deemed necessary for the payment of benefits for a reasonable future period. Such moneys may be invested in bonds of any political or municipal corporation or subdivision of the State, or any of the outstanding bonds of the State, or invested in bonds or interest-bearing notes or obligations of the State (including state director of finance's warrant notes issued pursuant to chapter 40), or of the United States, or those

for which the faith and credit of the United States, are pledged for the payment of principal and interest, or in federal land bank bonds or joint stock farm loan bonds. The investments shall at all times be so made that all the assets of the fund shall always be readily convertible into cash when needed for the payment of benefits. The director of finance shall dispose of securities or other properties belonging to the fund only under the direction of the director of labor and industrial relations.

Sec. -35 Premium supplement, when and how payable. (a) When three per cent of the monthly wages of an employee are less than the monthly premium for the prepaid health care plan coverage required by this chapter and when the payments by the employer, including the share of the employee withheld from his wages, to the prepaid health care plan contractor are not sufficient to pay in full the premium payable under the plan with respect to that employee, the premium supplementation fund shall pay the balance, subject to the limitation specified in section -12(d), upon certification of such deficiency by the contractor, as prescribed by regulation of the director.

(b) A prepaid health care plan contractor shall not certify any deficiency with respect to any employee who according to its records is already covered, either as an employee or as a dependent, under another prepaid health care plan.

Sec. -36 Premium continuation when and how payable. (a) If an employee covered by this chapter is hospitalized or otherwise prevented by sickness from working and the continuation of the premium payments by the employer has ended the premium supplementation and continuation fund shall pay the premium as provided by section -16(b).

(b) The employer shall promptly notify the prepaid health care plan contractor that he is relieved from further premium payment because of the continued hospitalization or sickness of the employee and the contractor thereupon shall certify the need for premium continuation to the director as provided by regulation of the director.

Sec. -37 Collection of deficiency payments from secondary employers. (a) When the premium supplementation and continuation fund has been obliged to pay a premium supplementation with respect to any employee and a secondary employer of such employee is liable for premium deficiencies pursuant to section -17(b), the director may collect such deficiency from the secondary employer, but the liability of such employer for any monthly deficiency shall not exceed three per cent of the employee's monthly wages half of which amount may be withheld from the employee's wages.

(b) Where an employee has more than one secondary employer liable under section -17(b), the deficiency payments under subsection (a) shall be prorated among the secondary employers in proportion to the monthly wages paid by them to the employee.

PART IV. ADMINISTRATION AND ENFORCEMENT

Sec. -41 Enforcement by the director. Except as otherwise provided in section -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.

Sec. -42 Rule making and other powers of the director. (a) 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.

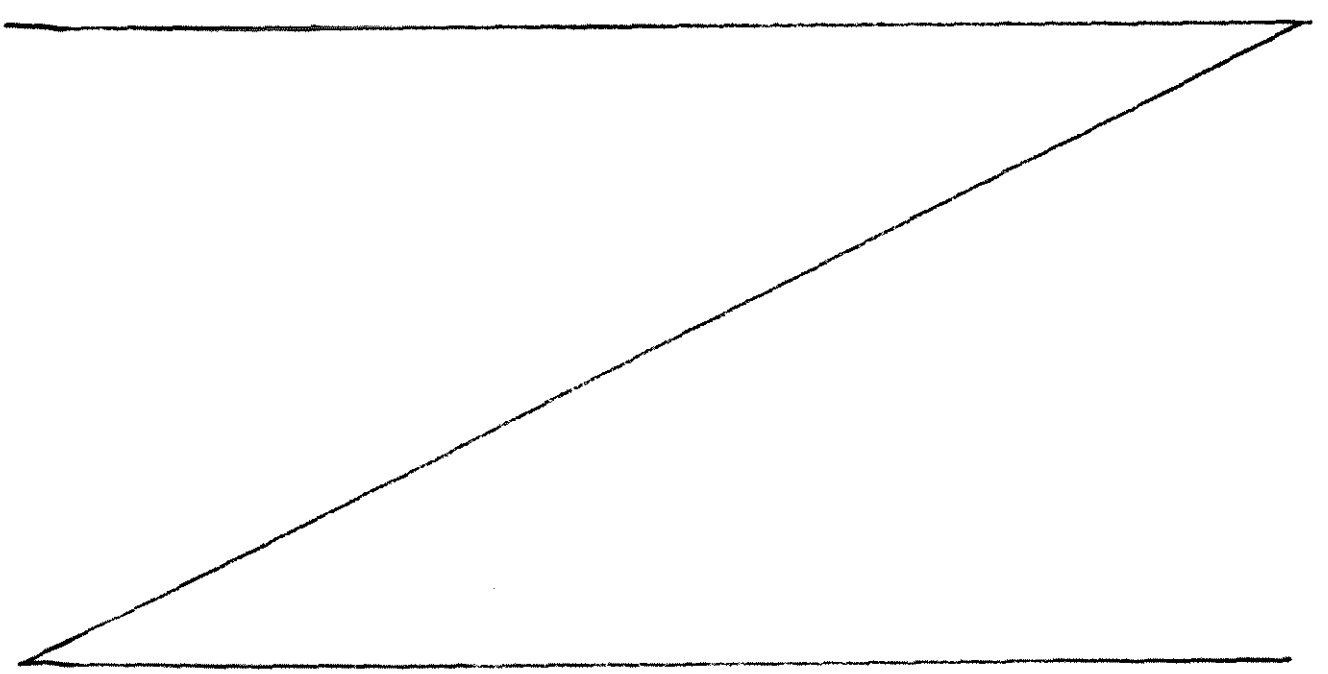
The director may round off the amounts specified in this chapter for the purpose of eliminating payments from the premium supplementation and continuation fund in other than even dollar amounts or other purposes.

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

(b) The director may make arrangements with prepaid health care plan contractors, including the payment of a service fee, for the proper keeping of records and other duties necessary for the administration of the provisions relating to premium supplementation and continuation.

Sec. -43 Penalties. (a) If an employer fails to comply with sections -11, -12, -13, or -36 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 and continuation established by section -31. 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 wilfully 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.



PART V. TAX CREDITS FOR OPTIONAL COVERAGE OF LOW INCOME SUBSCRIBERS

Sec. -51 Entitlement to tax credits for prepaid health care plan premiums. A resident taxpayer ninety per cent of whose income consists either of income from business or profession, or of wages none of which is paid by an employer employing the taxpayer as a regular employee as defined in section -3(8), shall be entitled to a tax credit for premiums paid by him for coverage of himself by a group prepaid health care plan as hereinafter provided.

Sec. -52 Income limits entitling to tax credit. A resident taxpayer who has received income of the type specified in section -51 shall be entitled to the tax credit under this part, if this income is at least the amount specified in section -11 and does not equal or exceed an amount three per cent of which suffices to pay the premium at the rate prevailing in the State for the selected type of plan.

Sec. -53 Amount of tax credit. The amount of the tax credit so provided shall be the difference between the premium, not exceeding the amount specified in section -52 and three per cent of the income of the type specified in section -51.

Sec. -54 Tax credits in joint returns. In cases of joint returns each spouse shall be entitled to the tax credit for the premium paid for his or her coverage on the basis of his or her income of the type specified in section -51.

Sec. -55 Tax credit how effected. (a) The tax credit claimed by a taxpayer under this part shall be applied to the taxpayer's net income tax liability, if any, for the tax year in which such tax credit is properly claimed. In the event the tax credits claimed by, and allowed to a taxpayer, exceed the amount of the income tax payments due from the taxpayer, the excess of such credits over payments due shall be refunded to the taxpayer; provided that tax credits properly claimed by and allowed to an individual who has no income tax liability, shall be paid to the individual; and provided further that no refunds or payments on account of the tax credits allowed under this part shall be made for an amount less than $1.

(b) All of the provisions relating to assessments and refunds under chapter 235 and section 231-23(d)(1) shall apply to tax credits under this part.

Sec. -56 Form of claiming tax credit; rules for administration. The director of taxation shall prepare and prescribe the appropriate forms to be used by taxpayers in filing claims for tax credits under this part. He may prescribe the type of proof that the taxpayer must furnish for the payment by him of premiums paid under a group prepaid health care plan and promulgate any rules and regulations, pursuant to chapter 91, necessary to effectuate the purposes of this part.

Sec. -57 Determination of prevailing premium rates. The director of taxation, after consultation with the director of labor and industrial relations, shall determine for each tax year the premium rate prevailing in the State for group prepaid health care plans of the types specified in section -3(6)(A) and (B).

Sec. -58 Group coverage made available to individuals desiring optional coverage under this part. Every prepaid health care plan contractor authorized to provide prepaid health care plan coverage in this State shall provide group prepaid health care plan coverage for individuals desiring optional coverage under this chapter at the community group rate charged by him for the applicable type of coverage.

Sec. -59. Time for filing claims for tax credit. Claims for tax credits under this part, including any amended claims thereof, must be filed on or before the end of the twelth month following the taxable year for which the credit may be claimed."

SECTION 2. There is appropriated out of the general revenues of the State the sum of $, or so much thereof as may be necessary, for the purposes of this Act.

SECTION 3. This Act shall take effect upon its approval, except that the coverage by group prepaid health care plans required by this Act and the payment of premiums for such coverage shall commence January 1, 1972, and except that tax credits provided for in part V shall be effective for taxable years beginning on and after January 1, 1972.

FOOTNOTES

Part I

1. For the story of the drive for compulsory health insurance in the United States, see Armstrong, Insuring the Essentials, pp. 370-375 (1932); Riesenfeld and Maxwell, Modern Social Legislation, p. 449 (1950); Sinai, Anderson and Dollar, Health Insurance in the United States, pp. 7-21 (1946); Wilson, Compulsory Health Insurance (National Industrial Conference Board, Studies in Individual and Collective Security, No. 3) (1947); Anderson, "Compulsory Medical Care Insurance, 1910-1950," The Annals of the American Academy of Political and Social Science, January 1951, p. 106.

2. The German law is discussed in Armstrong, op. cit. supra note 1, p. 304.

3. The English law is discussed in Armstrong, op. cit. supra note 1, p. 315.

4. See Riesenfeld and Maxwell, op. cit. supra note 1, p. 294. The California Compensation Act of 1911 was probably the first law containing such provision.

5. Stefan A. Riesenfeld, Study of the Workmen's Compensation Law in Hawaii, University of Hawaii, Legislative Reference Bureau, Report No. 1 (1963), p. 8.

6. 6 Am. Lab. Leg. Rev. 237 (1916); Rubinow, Standards of Health Insurance (1916).

7. See Riesenfeld and Maxwell, op. cit. supra note 1, p. 449.

8. Study commissions were appointed in ten states, viz. California, Connecticut, Illinois, Massachusetts, New Hampshire, New Jersey, New York, Ohio, Pennsylvania, and Wisconsin. Massachusetts and California had two successive commissions. The reports of these commissions (with the exception of that of New Hampshire) are discussed by Lapp, "The Findings of Official Health Insurance Commissions," 10 Am. Lab. Leg. Rev. 27 (1920). For the methods applied by these commissions, see also "Problems and Methods of Legislative Investigating Commissions," 8 Am. Lab. Leg. Rev. 83 (1918).

9. The study commissions of California, New Jersey, New York, and Ohio favored the introduction of compulsory health insurance, while the commissions of Connecticut, Illinois, Massachusetts (in its second report), and Pennsylvania rejected it. See Wilson, op. cit. supra note 1, pp. 2 and 3.

10. Medical Care for the American People, Final Report of the Committee on the Costs of Medical Care (University of Chicago Press, 1932).

11. For a discussion of the work and findings of the commission, see Sinai, Anderson and Dollar, op. cit. supra note 1, p. 12; Anderson, op. cit. supra note 1, p. 108.

12. Riesenfeld and Maxwell, op. cit. supra note 1, pp. 10 and 450.

13. See Reed, "Legislative Proposals for Compulsory Health Insurance," 6 Law and Contemporary Problems 628, 629 (1939); Wilson, op. cit. supra note 1, p. 7.

14. S. 1620, 76th Cong., 1st Sess. (1939), proposing inter alia to add a Title XIII to the Social Security Act, providing for federal grants-in-aid to state measures for the extension and improvement of medical care, including compulsory health insurance, see Maslow, "The Background of the Wagner National Health Bill," 6 Law and Contemporary Problems 606 (1939); Cavers, "Public Medical Services Under Title XIII of the National Health Bill," id. at 619; Reed, "Legislative Proposals for Compulsory Health Insurance," id. at 628.

15. The National Health Bill, op. cit. supra note 14, proposed to add a separate title (XIV) to the Social Security Act, providing for T.D.I. benefits.

16. See Reed, op. cit. supra note 13, and Wilson, op. cit. supra note 1, p. 7. Consult also, Sinai, Anderson and Dollar, op. cit. supra note 1, p. 18, referring to the state bills introduced in California and New York, as well as Connecticut, Illinois, Michigan, Missouri, Nebraska, Oregon, Pennsylvania, Washington, and Wisconsin. The proposed state bills during the period 1933 to 1944 are also discussed by Stucke, "Note on Compulsory Sickness Insurance Legislation in the States, 1933-1944," 60 Public Health Reports, pp. 1551, 1557 (1945).

17. S. 1161, 78th Cong., 1st Sess. (1943); S. 1050, 79th Cong., 1st Sess. (1945); see the discussion of these bills in 4 Lawyers Guild Rev. 24 (1944) and 5 id. at 221 (1945); Wilson, op. cit. supra note 1, pp. 13 and 19.

18. Message of November 19, 1945 and subsequent messages, see Follmann, Medical Care and Health Insurance, p. 451 (1963); Riesenfeld and Maxwell, op. cit. supra note 1, p. 450.

19. S. 1606, 79th Cong., 1st Sess. (1945).

20. See Follmann, Medical Care and Health Insurance, p. 450 (1963). Epstein and Callison, "Financing Health Care for the Aged," 27 Law and Contemporary Problems 102, 104 (1962).

21. A.B. 800, California, 1 Journal of the Assembly 324 (1945).

22. Report of the Interim Committee of the Assembly, California State Legislature, on Health Insurance (1945). The report recited the defeat of similar proposals in 1918, 1935 and 1939.

23. The history of the defeat is told in detail by Donnelly, "The Health Insurance Movement in California, 1938-1948" (Master's thesis, U.C. Library, Berkeley).

24. Governor's Committee on the Study of Medical Aid and Health, Health Care for California (State of California, Department of Public Health, 1960).

25. Recommendation nos. 1 and 2, id., p. 22.

26. Id., pp. 32, 33.

27. Recommendation no. 14, id., pp. 23 and 33.

28. California Unemployment Insurance Code, sec. 2801. In 1960, the hospital benefit was fixed at $12.00 per day, not exceeding 20 days. The maximum earning base at that time was $3,600. Hospital benefits amounted to .16 per cent of the net taxable wages.

29. Health Care for California, op. cit. supra note 24, p. 33.

30. New York, Regulations Under the Disability Law, No. 41 (4).

31. New York Laws 1944, ch. 387.

32. New York (State), Legislative Commission on Medical Care, Medical Care for the People of New York State (1946).

33. Id., pp. 454-476.

34. Id., pp. 342-347.

35. Id., p. 1.

36. Id., p. 499.

37. The Task Force consisted of Rockwell Perkins as Chairman, the Industrial Commissioner, the Commissioner of Health, Social Welfare and Commerce, and the Superintendent of Insurance.

38. New York (State), Report to Governor Nelson A. Rockefeller of the Special Task Force to Study Catastrophic Expense Health Insurance, Vols. One and Two (1960). The actual report is contained in volume one. The second volume contained data relating to coverage under existing plans.

39. New York (State), Report of the Joint Legislative Committee on Health Insurance Plans, pp. 83-183 (1960).

40. Id., p. 180.

41. The bills are reprinted, id., pp. 333-353. See especially the bill introduced by Senator Metcalf (No. 2694, Int. 2586), id., p. 345.

42. New York (State), Report of the Joint Legislative Committee on Health Insurance Plans, pp. 137-150 (1962).

43. New York (State), Report of the Joint Legislative Committee on Health Insurance Plans, p. 16 (1963).

44. New York (State), Report of the Joint Legislative Committee on Health Insurance Plans, pp. 123-157 (1964). The bill (Senate Print 2184, Intro. 2103) provided hospital benefits not exceeding 31 days during a period of 52 calendar weeks and specified diagnostic services.

45. New York (State), Report of the Joint Committee on Health Insurance Plans, p. 90 (1965).

46. New York (State), Report of the Governor's Committee on Hospital Costs (1965).

47. Id., p. 47, especially p. 52.

48. New York Laws 1965, ch. 795, adding article 28 to the public health law (the so-called Folsum Act).

49. P.L. 89-97; 79 Stat. 286.

50. For the history of the legislation establishing hospital and medical benefits for veterans, see "Brief History Pertaining to Veterans' Benefits," 38 U.S.C.A. 27 (1959).

51. Annual Report (1967), Administrator of Veterans Affairs (Washington: U.S. Government Printing Office, 1967), pp. 14 and 27.

52. For a list and brief discussion of these bills up to 1957, see Brewster, Health Insurance and Related Proposals for Financing Personal Health Services, A Digest of Major Legislation and Proposals for Federal Action, 1937-1957, U.S. Department of Health, Education and Welfare, Social Security Administration, at 24 (1958), see also Epstein and Callison, "Financing Health Care for the Aged," 27 Law and Contemporary Problems, No. 1, at 102, 104 (1962); Myers and Baughman, History of Cost Estimates for Hospital Insurance, U.S. Department of Health, Education and Welfare, Social Security Administration, Office of the Actuary, Actuarial Study No. 61, p. 5 (1966).

53. Especially H.R. 4765, 85th Cong., 1st Sess. (1957) (Dingell); H.R. 9448, 85th Cong., 1st Sess. (1957) (Roberts).

54. S. 3001, 82d Cong., 1st Sess. (1952).

55. H.R. 7485, 82d Cong., 1st Sess. (1952).

56. H.R. 7484, 82d Cong., 1st Sess. (1952).

57. H.R. 9467, 85th Cong., 1st Sess. (1957).

58. Social Security Legislation, Hearings Before the Committee on Ways and Means, House of Representatives, 85th Cong., 2d Sess., on Titles of the Social Security Act, especially p. 598 (1958).

59. See Epstein and Callison, op. cit. supra note 52, at 107; Mitchel, "Social Security Legislation in the 86th Congress," 23 Soc. Sec. Bull., November, 1960, 3 at 5.

60. The pressure for compulsory health insurance for the aged, however, prompted the so-called Kerr-Mills amendments of 1960, creating medical assistance for the aged, P.L. 86-778, 74 Stat. 924.

61. Special Message of February 9, 1961, 107 Cong. Rec. 1904, H. Doc. No. 85, 87th Cong., 1st Sess. (1961).

62. H.R. 4222, S. 909, 87th Cong., 1st Sess. (1961).

63. For a description of and cost estimates relating to this bill, see History of Cost Estimates for Hospital Insurance, op. cit. supra note 52, p. 11.

64. H.R. 3920, S. 880, 88th Cong., 1st Sess. (1963). See the description in History of Cost Estimates for Hospital Insurance, op. cit. supra note 52, p. 25.

65. See the account in Cohen and Ball, "Social Security Amendments of 1965: Summary and Legislative History," 28 Soc. Sec. Bull., No. 9, 3 at 4 (1965).

66. H.R. 1, S. 1, 89th Cong., 1st Sess. (1965).

67. See Cohen and Ball, op. cit. supra note 65, at 5.

68. See Cohen and Ball, op. cit. supra note 65, at 6-9.

69. Social Security Act, sections 1902(a)(17) (last sentence) and 1903(a)(1); Medical Assistance Programs Under Title XIX of the Social Security Act, U.S. Department of Health, Education and Welfare, Handbook of Public Assistance Administration, Supplement D, at D-5520 (1966).

70. New York (State), Report of the Senate and Assembly Committees on Public Health 1965-1966, Leg. Doc. (1966), No. 21, pp. 5 and 42-47.

71. Quoted in The Task Before Us, Report of the New York State Joint Legislative Committee on the Problems of Public Health and Medicare, Leg. Doc. (1967), No. 40, p. 171.

72. Id., at 81.

73. S. 4268, A. 5876, summarized in id., p. 81.

74. Id., p. 94.

75. Id., p. 92.

76. The Special Message was reproduced in a press release of March 20, 1968, State of New York, Executive Chamber.

77. S. 5417.

78. For a summary of the provisions of the bill, see New York (State), Joint Legislative Committee on the Problems of Public Health, Medicare, Medicaid and Compulsory Health and Hospital Insurance, 1968 Annual Report, Leg. Doc. (1968), No. 14, p. 15. The bill provided for employee's contributions not to exceed half of the cost or two per cent of his wages whichever is less. The employer was to bear the remainder, but not in excess of four per cent of his payroll. Any balance was covered by a state subsidy, Proposed Health Security Act, Sections 912 and 914.

79. 1968 Annual Report, op. cit supra note 78, p. 21.

80. S. 4998 (1969).

81. New York (State), Joint Legislative Committee on the Problems of Public Health, Medicare, Medicaid and Compulsory Health and Hospital Insurance, 1969 Annual Report, Leg. Doc. (1969), No. 19, p. 106.

82. S. 9181 (1970). Section 1 of this bill incorporates the Universal Health Insurance Act.

83. Universal Health Insurance Act, Section 7.

84. Universal Health Insurance Act, Section 12(2).

85. S. 9181, Section 3.

86. Universal Health Insurance Act, Section 4.

87. S. 9187, Section 24.

88. Universal Health Insurance Act, Section 14.

89. Universal Health Insurance Act, Section 15.

90. Universal Health Insurance Act, Section 16.

91. Universal Health Insurance Act, Section 12(2).

92. U.S. Department of Health, Education and Welfare, "Background Paper, June, 1970, Amendments to the Family Assistance Act" (June 1970).

93. U.S. Department of Health, Education and Welfare, Recommendations of the Task Force on Medical and Related Programs (June, 1970), p. 54.

Part II

1. Dickerson, Health Insurance (3d ed., 1968), pp. 228, 248.

2. Health Insurance Institute, 1969 Source Book of Health Insurance Data, pp. 20, 21, 22. The data for 1967 and 1968 include people covered by Medicare, parts A and B.

3. State of Hawaii, Department of Planning and Economic Development, Statistical Report 69, January 13, 1970, Table 1.

4. The State of Hawaii Data Book 1970, A Statistical Abstract (Department of Planning and Economic Development) (1970), Table 2.

5. The State of Hawaii Data Book 1970, Table 63.

6. The State of Hawaii Data Book 1970, Table 5.

7. State of Hawaii, Department of Labor and Industrial Relations, "Labor Force Estimates 1968-1969" (May, 1970).

8. See Appendix for correspondence with Bureau of Labor Statistics.

9. U.S. Department of Labor, Bureau of Labor Statistics, Employment and Earnings, October, 1969, Table A-17.

10. 33 Soc. Sec. Bull., January, 1970, Table M-29.

11. The State of Hawaii Data Book 1970, Table 55.

12. The noninstitutional population 65 and over at the relevant time was estimated at 34,927. The State of Hawaii Data Book 1970, Table 55. The institutional population in 1960 was 1,093. U.S. Department of Commerce, Bureau of the Census, United States Census of Population: 1960 Detailed Characteristics, Hawaii, Table 107, pp. 13-150 (1962). Hence, the approximate population age 65 and over underlying these reports totaled 36,020.

13. U.S. Department of Commerce, Bureau of the Census, United States Census of Population: 1960 Detailed Characteristics, Hawaii, Table 115, pp. 13-165 (1962).

14. State of Hawaii, Department of Planning and Economic Development, Statistical Report 57, May 16, 1968, Table 1.

15. State of Hawaii, Department of Planning and Economic Development, Statistical Report 63, January 6, 1969, Table 1.

16. State of Hawaii, Department of Planning and Economic Development, Statistical Report 69, January 13, 1970, Table 5.

17. The State of Hawaii Data Book 1970, Table 2.

18. See Johnston and Wetzel, "Effect of the Census Undercount on Labor Force Estimates," Monthly Labor Review, March, 1969, p. 3.

19. See the discussion of HIAA method of correcting for duplication in Reed, The Extent of Health Insurance Coverage in the U.S., U.S. Department of Health, Education and Welfare, Social Security Administration, Office of Research and Statistics, Research Report No. 10 (1965), p. 10. The same method was followed for 1966 in Health Insurance Association of America, A Profile of Group Health Insurance in Force in the U.S., December 31, 1966, p. 9. The computations in this report were as follows: inter-industry duplication amounted to 10,484,000 persons (67,546,000 x .06 = 4,053,000 + 35,729,000 x .18 = 6,431,000), while commercial and noncommercial duplication amounted to 12,354,000 (67,546,000 x .13 = 8,781,000 + 35,729,000 x .10 = 3,573,000).

20. Reed, op. cit. supra note 19, pp. 20-32.

21. Reed and Carr, "Private Health Insurance: Enrollment, Premiums and Benefit Expense, by Region and State, 1966," U.S. Department of Health, Education and Welfare, Social Security Administration, Office of Research and Statistics, Research and Statistics Note 14 (1968), pp. 2 and 12.

22. This was the HIAA's correction factor for commercial insurance in Hawaii.

23. The derivation of the factor is given in the study cited supra, note 21.

24. 589,661 - 522,538.

25. This estimate is based on the simplistic assumption that the figure of the net coverage arrived at by method 1 is 7.3 per cent too high.

26. This assumption is buttressed by the disparity between the dependents/subscribers ratios existing for group plans and for individual plans. The dependents/subscribers ratio for group plans equals $\frac{308,446}{177,309} = 1.74$, while the respective ratio for individual plans equals $\frac{28,360}{42,385} = .67$. Assuming that nonduplicative individual policies should have a comparable respective ratio, it could be concluded that $\frac{28,360}{1.74} = 16,299$ individual policies are nonduplicative, while the balance or 26,086 individual policies are duplicative. (Note that a "duplicative" policy does not mean "duplicative" coverage; it may mean supplementary coverage, additional to that offered by the "basic" policy.) A similar conclusion was reached on a nationwide basis by the HEW Division of Economic and Long-Range Studies, Reed, "Private Health Insurance 1968: Enrollment, Coverage and Financial Experience," 32 Soc. Sec. Bull., December 1969, p. 22.

27. 609,744 - 526,204.

28. Reed, op. cit. supra note 19, p. 10.

29. Reed and Carr, op. cit. supra note 21, Table 2. According to that table, the inter-industry duplication is 2.1 per cent of the gross and the overall duplication is 7.4 per cent of the reduced gross.

30. (114,582 x 0.021) + (545,862 x 0.074) = 42,800.

31. Health Insurance Association of America, A Profile of Group Health Insurance in Force in the United States, December 31, 1966, p. 20.

32. Major medical expense insurance policies usually have a deductible amount, above which coverage begins. See op. cit. supra note 31, p. 12.

33. See Reed, op. cit. supra note 19, p. 10.

34. A similar approach was pursued by the Department itself in estimating health insurance coverage other than for hospital and surgical expenditures, Reed, "Private Health Insurance 1968: Enrollment, Coverage, and Financial Experience," 32 Soc. Sec. Bull., No. 12, pp. 19 et seq., at 20 (1969); see also the state-by-state analysis of commercial health insurance by Reed and Carr, "The Health Insurance Business of Insurance Companies, 1948-1966," U.S. Department of Health, Education and Welfare, Social Security Administration, Office of Research and Statistics, Research and Statistics Note 15 (1968), Table 5.

35. Replies to questionnaires sent to employers covered by the Hawaii Employment Security Law indicated that some of the employers are covered under group plans.

36. The total of self-employed as of July, 1969, was 28,461 after allowance for self-employed holding secondary jobs as employees. It is further assumed that persons aged 65 and over constitute the same percentage (2.2 per cent) of this group as they do of the civilian labor force as a whole.

37. No attempt is made to adjust the gross subscriber coverage for duplication. It is assumed that most duplication within group insurance is due to the fact that the same individual is covered as a subscriber and as a dependent and that multiple group coverage as a subscriber is practically nonexistent.

38. This is the HIAA's constant duplication factor for individual policies, see note 19, supra.

39. Of the total individual hospital policies in the State (42,385), 24,022 are allocated to the self-employed, and of the remaining 18,363, 72 per cent are considered nonduplicative, yielding the figure in the text.

40. The method applied results in an allocation of 16,354 policies out of the total of the 39,875 individual surgical policies to wage-earner subscribers, of which 72 per cent are nonduplicative.

41. Of the total individual medical policies in the State (26,697), 22,519 are allocated to the self-employed and 72 per cent of the remaining 4,178 are nonduplicative.

42. In 1965 the weighted average of women in the active civilian labor force of the State was 39.3 per cent, a figure computed from the data in The State of Hawaii Data Book 1970, Table 55, p. 52.

43. U.S. Department of Commerce, Bureau of the Census, United States Census of Population: 1960 Detailed Characteristics, Hawaii, Table 116, pp. 13-170 (1962).

44. Id., Table 129, pp. 13-238 (1962).

45. Id., Tables 115 and 116, pp. 13-165 and 13-170 (1962).

46. Married women within the meaning of the statistics relating thereto are defined as married women with husband present.

47. The number of persons over 65 among the unemployed constituted 3.7 per cent according to data compiled for Oahu in 1965 and the other islands in 1967. The State of Hawaii Data Book 1970, Table 55.

48. In 1965 (the latest data available) the number of military dependents in the labor force was 4,873 out of a total of 56,576. 710 out of the 4,873 were reported as unemployed. State of Hawaii, Department of Planning and Economic Development, Statistical Report 33, July 26, 1965, Tables 1 and 7.

49. In 1965 (Oahu) and 1967 (Neighbor Islands) the total number of unemployed was 8,390, consisting of 7,020 in Oahu and 1,370 in the Neighbor Islands, 3,055 unemployed in Oahu were between 17 and 24, out of a civilian work force in that age group of 37,440; i.e., 8.2 per cent. The total civilian labor force under 65 in Oahu at that time was 204,360. The total number of unemployed under 65 was 6,760, i.e., 3.3 per cent. The State of Hawaii Data Book 1970, Table 55.

50. This class includes the self-employed as well as wage earners. In 1969 the number of self-employed under 65 was estimated at 27,835, see supra text at call to fn. 36.

51. If one could assume that the ratio of persons in the active labor force to the total number of persons in the uncovered group equals the ratio of the persons in the active labor force to the total civilian population under 65, the ratio would be 46.2 per cent, or, counting only wage earners, 42.0 per cent; hence, the number of wage earners without coverage for hospital expense would be 35,100; i.e., in excess of 31,100.

52. State of Hawaii, Department of Labor and Industrial Relations, "Labor Force Estimates, 1968-1969" (May, 1970).

53. 5 U.S.C. sections 8901-8913.

54. 5 U.S.C. section 8901(1).

55. 5 U.S.C. section 8902(a), in conjunction with sections 8903(3) and (4).

56. 5 U.S.C. section 8903(1) and (2). At present the approved government-wide service benefit is the plan offered by Blue Cross-Blue Shield and the approved government-wide indemnity benefit plan, a plan offered by the Aetna Life and Casualty Co.; U.S. Civil Service Commission, Bureau of Retirement, Insurance and Occupational Health, The Federal Employees Health Benefits Program (Form No. 2809-A, 1969) at p. 5.

57. 5 U.S.C. section 8906(a) and (c).

58. 5 U.S.C. section 8901(5).

59. As of June 30, 1968, when the number of federal employees in the State was estimated at 35,940, the number of employees and annuitants and their dependents covered by approved health benefit plans was estimated at 24,900 enrollees and 61,200 dependents. U.S. Civil Service Commission, Bureau of Retirement and Insurance, Report for Fiscal Year Ended June 30, 1968, p. 35. This would amount to a subscriber coverage of 69.3 per cent.

60. The Governor's Commission on the Status of Women gave the percentage of women in federal employment as 17.4 per cent, in contrast to an overall percentage of 37.1 per cent, see State of Hawaii, Governor's Commission on the Status of Women, Women, p. 41 (1966).

61. The total number of state employees regardless of age was 36,960. State of Hawaii, Department of Labor and Industrial Relations, "Labor Force Estimates, 1968-1969" (May, 1970). It is assumed that the percentage of employees over 65 in public employment is less than in private employment.

62. State of Hawaii, Governor's Commission on the Status of Women, Women, p. 41 (1966).

63. Hawaii Rev. Stat., Ch. 87, as amended by S.B. No. 1261-70.

64. The figures furnished by Kaiser and HMSA gave a higher total but included retired state employees.

65. The number is arrived at by deducting from the active civilian nonduplicated labor force (309,350), the number of self-employed under 65 (27,835) and the number of federal employees under 65 (estimated at 35,000) and state employees under 65 (36,600).

66. The figures are based on the assumption that the group coverage in each of the two classes of employment has the same extent for the three benefit types, as prescribed by the underlying statutes.

67. Details are confidential information.

68. Social Security Amendments of 1965, P.L. 89-97, 79 Stat. 286.

69. Social Security Amendments of 1965, House Report No. 213, 89th Cong., 1st Sess. (Ways and Means Committee) at pp. 3 and 75; Senate Report No. 404, Part I, 89th Cong., 1st Sess. (Finance Committee) at pp. 3 and 85 (1965).

70. The table allocated $898,000 to Hawaii.

71. See "The Big Sleeper in the Medicare Law," 43 Medical Economics 110 (1966), quoting Professor Somers. The Director of Family Services of HEW quickly concurred with this assessment quoted in Medicaid: State Programs After Two Years, at p. 51, fn. 8 (Tax Foundation, Inc., 1968).

The prediction was based on the estimate on the number of poor and near-poor in the nation.

72. In 1970, the Task Force on Medicaid and Related Programs estimated that "the total of the poor and the near-poor could be about 40 million, or one-fifth of the population" but that "only about one-third of the 30 or 40 million indigent and medically indigent who could potentially be covered by Title XIX of the Social Security Act will, in fact, receive services, "Report of the Task Force on Medicaid and Related Programs," at pp. 2 and 10 (Department of Health, Education and Welfare, 1970).

73. 42 U.S.C.A. sec. 1396.

74. 42 U.S.C.A. sec. 1396b(f)B(i), as added by the Social Security Amendments of 1967 sec. 220. The amendments limited federal participation to medical aid payments for families whose income level does not exceed 133-1/3 per cent of the highest amount of aid ordinarily paid by the State to a family of the same size under its AFDC program.

75. 42 U.S.C.A. secs. 1396a(a)(10)(A) and (B), 1396a(b) and 1396d(a).

76. "Medical Assistance Programs Under Title XIX of the Social Security Act," U.S. Department of Health, Education and Welfare, Handbook of Public Assistance Administration, Supplement D (1966-1968) (hereafter cited as Handbook).

77. Code of Federal Regulations, Title 45, Chapter II, Parts 248 and 249.

78. 42 U.S.C.A. sec. 1396a(a)(10)(A) and sec. 1396a(b).

79. 42 U.S.C.A. sec. 1396a(a)(10)(B) and sec. 1396d(a).

80. 42 U.S.C.A. sec. 1396b(e).

81. Handbook, Suppl. D, 4020, 1 and 2a, 4040A.

82. Handbook, Suppl. D, 4020, 2b and 4040B.

83. The Handbook defines and uses the term "categorically needy" in a much broader sense than it is used in the literature, for example, in the Report of the Advisory Commission on Intergovernmental Relations on "Intergovernmental Problems in Medicaid," p. 10 (1968). The latter report (pp. 10 and 11) restricts the term categorically needy to actual recipients of aid under OAA, AB, AFDC, and APTD and refers to other categories as categorically related needy, noncategorically related needy, categorically related medically needy, and noncategorically related medically needy. The Handbook conversely extends the term "categorically needy" to individuals who could be covered by the categorical assistance programs as well as to individuals who are not even related to such programs such as general assistance recipients and persons eligible for general assistance. Similarly, "medically needy" within the meaning of the Handbook covers categorically related medically needy as well as noncategorically related needy, as the terms are used in the Report of the Advisory Commission on Intergovernmental Relations.

84. Handbook, Suppl. D, 4020(1) and (2)(a) and 4040A.

85. 42 U.S.C.A. sec. 1396a(a)(10).

86. 42 U.S.C.A. sec. 1396a(b)(2).

87. 42 U.S.C.A. sec. 1396a(b)(1) and (4).

88. 42 U.S.C.A. sec. 1396d(a).

89. 42 U.S.C.A. sec. 1396d(15).

90. 42 U.S.C.A. sec. 1396d(a).

91. 42 U.S.C.A. sec. 1396a(b)(2).

92. 42 U.S.C.A. sec. 1396d(a)(i). This provision originated in the Senate amendments proposed by Senator Ribicoff (21 Cong. Quarterly Almanac 265 (1965)) and was accepted by the Committee of Conference, 89th Cong., 1st Sess., Conference Report No. 682, Congressional and Administrative News, 2246 (1965).

93. 42 U.S.C.A. sec. 1396d(a)(ii).

94. 42 U.S.C.A. sec. 1396d(a)(vi).

95. Handbook, Suppl. D, 4040A, last two paragraphs.

96. 42 U.S.C.A. sec. 1396a(10)B, C.F.R. Title 45, sec. 248.21.

97. Supra, note 7.

98. Indiana, Massachusetts, Michigan, Minnesota, Montana, Nebraska, Nevada, New York, Rhode Island, Wisconsin.

99. Medicaid, Selected Statistics, 1951-1966, HEW, MCSS Report B-6 (1951-1969), Table III-5.

100. State of Hawaii, State Plan for Medical Assistance, III, Coverage and Conditions of Eligibility, A.

101. State Plan for Medical Assistance, III-B; Hawaii, D.S.S. Manual, secs. 3412, 3421, 3424(2)b.

102. Hawaii, D.S.S. Manual, sec. 3424(2)(b).

103. Hawaii, D.S.S. Manual, secs. 3300 et. seq., especially sec. 3320.

104. See the comments to that effect in Audit of the Medical Assistance Program of the State of Hawaii (Audit Report No. 70-3, 1970), pp. 83-88.

105. See the comments to that effect in State of Hawaii, Department of Social Services, Operational Expenditure Plan, Fiscal Year 1970-1971, pp. 3-5. Other factors involved are a liberalization in eligibility standards and population increase, the latter factor, however, is slightly inflated owing to overestimation.

106. 42 U.S.C.A. sec. 1396b.

107. 42 U.S.C.A. sec. 1396d(b).

108. The principal monthly statistics are State of Hawaii, Department of Social Services and Housing, Statistics in Public Welfare, Corrections, Paroles and Pardons, Housing, Vocational Rehabilitation and Criminal Injuries (monthly) and U.S. Department of Health, Education and Welfare, Social and Rehabilitation Service, National Center for Social Statistics, Medical Assistance (Medicaid) Financed Under Title XIX of the Social Security Act (4 months per year).

109. The Department of Social Services and Housing kindly provided the Bureau with a copy of Report F.S. 2082.2, Part II for Calendar Year 1969.

110. Hawaii, D.S.S. Manual, sec. 3412.

111. Hawaii, D.S.S. Manual, secs. 3113 et. seq.

112. Department of Health, Education and Welfare, NCSS Report B1 (2/70), Tables 12 and 1.

113. Hawaii, D.S.S. Manual, sec. 3113(1)(a), (b), (c), and 2(a), (b), and (c).

114. 42 U.S.C.A. sec. 1396b(a)(1).

115. U.S. Department of Health, Education and Welfare, Handbook of Public Assistance Administration, Suppl. D, secs. 5520A, 5530, 5830, 5840.

Part III

1. This amount constitutes 133-1/3 of the current general assistance standard for a comparable family. In New York there had to be a continuous roll-back from the original $6,000 standard. It was reduced to $5,300 for a family of four by amendments of 1968, N.Y. Laws 1968, ch. 32, sec. 1 and further reduced to $5,000 by amendments of 1969, N.Y. Laws 1969, ch. 184, sec. 18.

2. Department of Health, Education and Welfare, Office of the Assistant Secretary for Welfare Legislation, Background Paper dated June 10, 1970.

3. State of Hawaii, Department of Social Services, Operational Expenditure Plan, 1970-1971, p. C-21.

4. 52 x 20 x 1.60 = 1,664.

5. 42 U.S.C.A. sec. 2727.

6. U.S. Department of Labor, Employment and Earnings, November 1970, p. 100.

7. U.S. Department of Commerce, Survey of Current Business 1970, No. 8, pp. 33 and 35.

8. $160 - 1,680 x .04.

9. $160 - 1,680 x .03.

10. Communication, January 18, 1971.

11. Temporary Disability Insurance, Legislative Reference Bureau, Report No. 1 (1969), pp. 73-77.

12. The costs in tax credits for such a program would be in the neighborhood of $175,000.

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Statement of
BRENNA H. HASHIMOTO
Director, Department of Human Resources Development

Before the
SENATE COMMITTE ON LABOR AND TECHNOLOGY
Monday, March 24, 2025
3:00 PM
State Capitol, Conference Room 224

In consideration of
SCR 145/SR 117 REQUESTING THE SENATE STANDING COMMITTEE ON LABOR AND TECHNOLOGY AND HOUSE OF REPRESENTATIVES STANDING COMMITTEE ON LABOR TO CONVENE A LEGISLATIVE WORKING GROUP TO DEVELOP RECOMMENDATIONS FOR ESTABLISHING AND IMPLEMENTING A PAID FAMILY AND MEDICAL LEAVE PROGRAM FOR THE STATE.

Chair Aquino, Vice Chair Lee, and the members of the committee.

The Department of Human Resources Development (HRD) offers the following comments for SCR 145/SR117 requesting the Senate standing Committee on Labor and Technology and House of Representatives standing committee on Labor to convene a legislative working group to develop recommendations for establishing and implementing a paid family and medical leave program for the state.

The resolution requests a working group be established for the purpose of:

- Recommend parameters for a statewide paid family and medical leave program that benefits both public and private sector workers;
- Review the impact of federal and state regulations on the establishment of a paid family and medical leave program;
- Develop an implementation plan that outlines an administrative framework for paid family and medical leave, including departmental oversight, projected costs, employer and employee contribution rates, staffing needs, outreach to employers and employees, and potential timelines for program enactment and the initiation of benefits distribution; and

- Examine and address how the State's Temporary Disability Insurance (TDI) program may interface with or complement the paid family and medical leave program, including the feasibility, cost-benefit analysis, and a general roadmap for transitioning the existing private TDI program to an expanded public program that includes or complements paid family and medical leave benefits.

We recommend the following amendment to ensure there is input from both the State and County governments. On page 5, line 7:

> (4) The Director of the Department of Human Resources Development, the directors of the central personnel agencies of the State, the city and county of Honolulu, the county of Hawaii, the county of Maui, the county of Kauai, the judiciary, the department of education, the University of Hawaii, and the Hawaii health systems corporation, or their designees;

We are available to answer any questions or provide further information as needed.

JOSH GREEN, M.D.
GOVERNOR

SYLVIA LUKE
LIEUTENANT GOVERNOR

JADE T. BUTAY
DIRECTOR

WILLIAM G. KUNSTMAN
DEPUTY DIRECTOR

STATE OF HAWAIʻI
KA MOKUʻĀINA O HAWAIʻI
DEPARTMENT OF LABOR AND INDUSTRIAL RELATIONS
KA ʻOIHANA PONO LIMAHANA

March 24, 2025

To: The Honorable Henry J.C. Aquino, Chair
The Honorable Chris Lee, Vice Chair, and
Members of the Labor and Technology Committee

Date: Monday, March 24, 2025
Time: 3:00 p.m.
Place: Conference Room 224, State Capitol

From: Jade T. Butay, Director
Department of Labor and Industrial Relations (DLIR)

Re: S.C.R. 145 LEGISLATIVE WORKING GROUP PAID FAMILY AND MEDICAL LEAVE

Chair Aquino, Vice Chair Lee, and Members of the Senate Committee on Labor and Technology:

The DLIR has historically supported the intent of Paid Family and Medical Leave (PFML) measures considered by the Legislature because the department's statutory mission includes administering programs designed to enhance the economic security, physical and economic well-being, and productivity of workers, as well as fostering positive labor-management relations. However, as the saying goes, "the devil is in the details." The department has consistently raised concerns about these proposals, particularly because they could jeopardize Hawaii's Prepaid Health Care Law (Prepaid). Additionally, the department has explained that, as the administrator of both Prepaid and the Hawaii Family Leave Law, it lacks the expertise necessary to determine how to avoid jeopardizing the Prepaid Law.

Unlike other states and jurisdictions, Hawaii has a unique situation: it is the only state that requires employers to provide workers with adequate medical coverage for non-work-related illness or injury through the Prepaid Health Care Law (PHC Act). Additionally, Hawaii requires employers to provide Temporary Disability Insurance (TDI) coverage, which offers partial wage replacement for non-work-related injury or sickness, including pregnancy.

The Prepaid and TDI laws were enacted after years of advocacy by organized labor and other stakeholders. Furthermore, the Legislature passed these laws only after comprehensive studies,[1,2] including an actuarial component, were conducted through

an appropriation to the Legislative Reference Bureau (LRB) in 1967. These appropriations were made to procure the expertise necessary for the research and to provide model legislation for enactment. The studies were led by the eminent jurist Stefan Riesenfeld, who conducted an in-depth analysis of both national and local health insurance markets, covering public and private insurance offerings and enrollment. Dr. Riesenfeld's model legislation was largely adapted into HRS Chapter 392 (TDI) in 1969 and HRS Chapter 393 (Prepaid) in 1974 (study attached).

However, in 1974, Congress also enacted the Employee Retirement Income Security Act (ERISA), which is administered by the U.S. Department of Labor. ERISA regulates pension and employee benefit programs, including employment-based health insurance coverage provided by private employers or unions. It was enacted to address fraud and mismanagement in private pension plans by establishing comprehensive federal standards to protect employee pension and benefit programs.

ERISA contains a Preemption Clause (29 U.S. Code § 1144) that essentially preempts any state law that conflicts with ERISA and prohibits states from enacting statutes contrary to ERISA:

> (a) Supersedure; effective date
>
> Except as provided in subsection (b) of this section, the provisions of this subchapter and subchapter III shall supersede any and all State laws insofar as they may now or hereafter relate to any employee benefit plan described in section 1003(a) of this title and not exempt under section 1003(b) of this title. This section shall take effect on January 1, 1975.

ERISA preemption prevents states from requiring employers to offer health coverage or dictating the terms of their health plans, as outlined in the Prepaid Health Care Act, HRS Chapter 393. However, to avoid ERISA's preemption and preserve Hawaii's Prepaid Health Care Law, Hawaii's Congressional Delegation successfully secured an exemption, which was signed into law by President Ronald Reagan in 1982. This gave Hawaii the only waiver to the ERISA preemption as follows:

> (B) Nothing in subparagraph (A) shall be construed to exempt from subsection (a)—
> (i) any State tax law relating to employee benefit plans, or
> (ii) any amendment of the Hawaii Prepaid Health Care Act enacted after September 2, 1974, to the extent it provides for more than the effective administration of such Act as in effect on such date.

PFML proposals have contained a provision for continuing health care benefits throughout the duration of the proposed PFML leave. However, this provision directly conflicts with the Prepaid Health Care Law, HRS 393-15, which limits an employer's obligation to continue coverage once an employee is no longer able to earn wages.

PFML proposals have also frequently included provisions that conflict with or raise issues regarding other laws administered by the DLIR, including TDI, the Hawaii Family Leave Law, and the Employment Security Law (unemployment insurance). Moreover, these proposals often contain contradictory, ambiguous, or erroneous provisions that would hinder the department's ability to administer them (see DLIR testimony on HB755 (2025), HB2757 (2024), and SB360 (2023)).

A key shortcoming of previous Paid Family Leave studies is their failure to adequately address ERISA preemption issues through a thorough legal review. The 2016 study did not discuss ERISA, while the 2019 study stated, "…and avoiding Employee Retirement Income Security Act (ERISA) status is also advised."

Both studies significantly underestimated the staffing required to administer a Paid Family Leave program. One study estimated 22 staff members, and the other estimated 30, while the department has consistently testified that approximately 120 staff would be needed to implement and administer such a program. The department was not consulted in developing these staffing estimates, which were not based on Hawaii-specific data regarding employers, employees, and wages. Similarly, these studies did not adequately address Information Technology (IT) requirements or costs, nor did they consider whether and how the Office of Enterprise Technology Services (ETS) would support the IT program. Furthermore, commercial off-the-shelf solutions for the IT needs of a PFML program do not currently exist.

For all the reasons outlined above, the DLIR recommends conducting a comprehensive study, including an actuarial component, like the Riesenfeld studies that led to the creation of the TDI and Prepaid Laws. Importantly, this study should detail how to implement a PFML law without jeopardizing the Prepaid Law. Such a study would inform all stakeholders, including the Legislature and the DLIR, about how a PFML law could operate without significantly undermining the intent and benefits of existing laws. Additionally, the study should provide an accurate assessment of the costs to employers, employees, and the State associated with establishing and administering a PFML law.

The department believes that neither the Legislature, the DLIR, nor the other stakeholders suggested in SCR 145 have the expertise required to accomplish what is outlined in the previous paragraphs as the only realistic path forward for creating a PFML law in Hawaii.

In addition, the DLIR is nearly 60% reliant on federal funds for operating its programs and uses a portion of that funding to support the central services functions of HR, IT, and fiscal. The department prefers to have flexibility to respond to federal initiatives and potential changes in federal funding levels. The department is currently preparing for potential changes in federal funding as part of the executive-wide effort led by the Department of Budget and Finance. Moreover, the department has recently been assigned responsibility for the Office of the State Fire Marshall as well as the Hawaii Retirement Savings Program.

Lastly, DLIR programs that administer current laws, such as the Disability Compensation Division (TDI, Prepaid, Workers' Compensation) and the Wage Standards Division (Child Labor, Wage & Hour, Payment of Wages, Hawaii Family Leave, Prevailing Wages, Unlawful Termination), have struggled to enforce these laws and have not had their capacity restored to previous levels, including those before the last major Reduction-in-Force in 2009.

1 https://lrb.hawaii.gov/wp-content/uploads/1971_PrepaidHealthCareInHawaii.pdf
2 https://lrb.hawaii.gov/wp-content/uploads/1969_TemporaryDisabilityInsurance.pdf

PREPAID HEALTH CARE IN HAWAII

Stefan A. Riesenfeld
Professor of Law
University of California

Report No. 2, 1971

LEGISLATIVE REFERENCE BUREAU

UNIVERSITY OF HAWAII
Honolulu, Hawaii 96822

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FOREWORD

Prepaid Health Care in Hawaii completes the assignment made to the Legislative Reference Bureau by Act 198, Session Laws of Hawaii 1967. The first portion of that legislative request produced Bureau Report No. 1, 1969, Temporary Disability Insurance, which proved instrumental in the enactment of the Hawaii Temporary Disability Insurance Law (Act 148, Session Laws of Hawaii 1969; Chapter 392, Hawaii Revised Statutes). As in the case of the earlier study and report, the study on Prepaid Health Care in Hawaii was conducted by Professor Stefan A. Riesenfeld, and he is the author of the Report. The Bureau expresses its great appreciation to Professor Riesenfeld, Emanuel S. Heller Professor of Law at the University of California, for carrying out this project. It has been a distinct honor and pleasure again to have the Professor associated with the Legislative Reference Bureau.

Many individuals and agencies have been most helpful and cooperative in supplying data and information necessary for this study and report. The Bureau is especially indebted for the contributions of Robert Schmitt, State Statistician, Department of Planning and Economic Development; Gordon Frazier, Chief Research and Statistics Officer, and Orlando Watanabe, Temporary Disability Insurance Administrator, Department of Labor and Industrial Relations; Jack T. Wakayama, Chief of Research and Statistics, Department of Social Services and Housing; Iola Rhyne, Tax Research and Planning Officer, Department of Taxation; J. R. Veltmann, Executive Vice President, Hawaii Medical Service Association; Irving Hutkins, Vice President and Manager, Hawaii Region, Kaiser Foundation Health Plan, Inc.; and the Health Insurance Association of America.

Carroll Taylor, Douglas Ige, and Patricia K. Putman of the Bureau staff assisted in the study and preparation of this Report.

Henry N. Kitamura
Director

January, 1971

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Part I

THE QUEST FOR COMPULSORY HEALTH INSURANCE IN THE UNITED STATES IN HISTORICAL PERSPECTIVE

The history of the establishment of compulsory health insurance in the United States is a tale of wasted efforts and slow progress.[1] While Germany enacted pioneering legislation establishing compulsory insurance against medical and hospital costs for broad segments of the population as early as 1883[2] and England took a similar step in 1911,[3] efforts toward similar legislation on either the federal level or the state level in the United States have remained unsuccessful. Compulsory health insurance has been achieved only for limited categories of the civilian population, viz. workers suffering from industrial injuries and individuals having attained the age of 65 years. Provisions entitling workmen suffering industrial injuries to medical care or compensation for its costs were included in a number of the early workmen's compensation laws, enacted in 1911 and thereafter.[4] While at first the protection afforded was drastically limited in duration or amount, or both, these restrictions were progressively relaxed and finally eliminated. Today, most workmen's compensation acts provide for unlimited medical benefits. Hawaii removed such restrictions in 1923.[5] Compulsory hospital insurance for the aged (medicare) was the great step taken in 1965[6] which represents the beginning of a new era. Hence it seems appropriate to organize the discussion of the efforts toward compulsory health insurance in the United States into two phases, one covering the era from 1910 to 1965 and the other beginning with medicare.

A. From 1910 to 1965

Encouraged by the adoption of compulsory health insurance legislation abroad, the early advocates of social insurance in the United States included protection against the costs of medical care as an essential part of their program. The American Association for Labor Legislation (organized in 1909) developed in 1914 a set of widely discussed Health Insurance Standards,[7] followed by a Tentative Draft of a Health Insurance Act.[8] Efforts were made in fifteen states to introduce that or a similar type of legislation, resulting in the appointment of study commissions in the majority of these states.[9] Ultimately, however, all these efforts were aborted.

In the early thirties the interest in governmental programs providing protection against the costs of medical care revived, especially after the publication in 1932 of the final report of the Committee on the Costs of Medical Care, appointed on the initiative of

President Hoover in 1927.[10] The Committee, however, cautioned against the introduction of compulsory public health insurance as a general program but favored group pre-payment programs through the use of private insurance or taxation, or a combination of both methods.[11] In 1934 President Roosevelt appointed the celebrated Committee on Economic Security which studied the inclusion of compulsory public health insurance within the framework of the federal social security system which was to be newly created. The Committee decided not to recommend any action with respect to compulsory health insurance at that time in order to avoid the risk of a rejection of the whole program.[12]

After the passage of the Social Security Act in 1935, new efforts were launched to secure health insurance either on the state level or in form of a joint federal-state system. Symptomatic of the former approach was the elaboration in 1935 of a model bill for state compulsory health insurance by the American Association for Social Security, under the leadership of Abraham Epstein.[13] The joint state-federal approach was adopted in Senator Wagner's all-inclusive National Health Bill of 1939 which provided for federal participation in state compulsory health insurance schemes.[14] It should be noted that the Model Bill of the American Association for Social Security, as well as the National Health Bill, contemplated medical cost benefits and wage-loss benefits[15] and that most of the numerous state bills that were introduced between 1936 and 1945 included both types of benefits.[16]

Toward the end of World War II, the drive for compulsory health insurance on the federal level received new vigor, climaxing in the two Wagner-Murray-Dingell bills introduced in Congress in 1943 and 1945[17] and the repeated efforts of President Truman to secure congressional adoption of compulsory health insurance,[18] prompting the proposal of a revised Wagner-Murray-Dingell bill in 1945.[19] Although bills of this type were extensively debated in Congress between 1946 and 1950, the resistance of powerful interest groups led to the defeat of the program. By 1950 the idea of a federal general compulsory health insurance program had been shelved for all practical purposes although bills of this type continued to be introduced by a few Congressmen.[20]

Between 1952 and 1965, the main efforts at the federal level focused on health insurance for the aged, culminating ultimately in the adoption of the medicare program. There persisted, however, efforts toward compulsory health insurance on a broader basis at the state level.

Noteworthy among the efforts at the state level have been the repeated drives in that direction in California and New York. In 1945 Governor Earl Warren of California launched an intensive campaign to secure the adoption of a compulsory health insurance program in his state. The administration bill[21] as well as certain competing bills were the subject of extensive hearings held by the Assembly Interim Committee on Public Health. The Committee reported adversely on any compulsory health insurance scheme,[22] and the bill died in the Committee on Public Health to which it was referred.[23] In 1959 Governor Brown of California appointed a Committee on the Study of Medical Aid and Health under the chairmanship of Dr. Egeberg. In 1960 that Committee submitted its report which was published under the title, "Health Care for California".[24] The report, which ranged over a broad spectrum of problems relating to the health needs of the citizens and the means of meeting them, included a special chapter focusing on the methods of financing the costs of personal health services. The Committee recommended, by way of long-range goals, that "prepayment for health services be extended to cover substantially the entire population of California" and that "necessary financing to assure [the availability of comprehensive health care of high quality to everyone in the State] be provided from individual, private or public sources".[25] Although the Committee discussed various avenues for securing additional funds needed to broaden the prepayment of health services, including employer/employee payroll taxes,[26] it refrained from recommending or endorsing a particular system, but limited itself to calling for a study "aimed particularly at the problem of financing a minimum of prepaid health service for substantially the entire population".[27] The Committee took note of the fact that a limited hospital benefit, provided by the State Unemployment Compensation Disability Law,[28] was already financed by an employee-financed payroll tax and pointed out that a moderate increase of this tax, coupled with an increase of the maximum earning base of such tax, could provide minimum health benefits for the employee himself.[29] It may be mentioned that the California approach differed materially in that respect from the position taken by New York in its Disability Benefits Law of 1949 which permits a credit for medical and hospital benefits up to 40 per cent of the actuarial value of the temporary disability benefits provided by the Act.[30]

In New York, the year 1945 likewise marked the start of renewed efforts toward compulsory health insurance. The New York legislature had established, the year before, a temporary Commission on Medical Care for the purpose of developing programs for medical care for the inhabitants of the state.[31] The Commission submitted its report, entitled "Medical Care for the People of the State of New York", in

1946.[32] The report discussed in great detail various plans for compulsory health insurance and the financing thereof[33] and analyzed in particular two sets of bills for the establishment of compulsory health insurance introduced in 1945: one by Assembly Majority Leader I. M. Ives (A. 2542) and the other by Senator Joseph and Assemblymen Austin and Jack (S. 479 and A. 261 and A. 141).[34] The majority of the Commission rejected any plan for compulsory health insurance in view of its tremendous costs,[35] despite the fact that in an opinion poll conducted by the Commission, 51.9 per cent of the sample had voted for, and only 35.6 per cent against, such a system.[36]

Efforts for the introduction of compulsory health insurance in New York thereafter became more or less dormant until 1958 when Governor Rockefeller decided to revive the idea. As part of his platform he proposed to add major medical expense insurance to the protection afforded by the Temporary Disability Law and appointed a Special Task Force to study the problem.[37] Although this body issued a negative report[38] in view of the limited coverage of the Temporary Disability Law, the existing coverage under voluntary plans, the freezing effects of a mandatory system, and the possible adverse effects on economic expansion and job opportunities, the gubernatorial idea was taken up by the Joint Legislative Committee on Health Insurance Plans even prior to the release of the task force report.[39] The Joint Legislative Committee endorsed the gubernatorial idea in principle but considered mandatory basic hospital and surgical coverage as demanding a higher priority than protection against catastrophic expenses.[40] Bills to that effect were introduced in the Senate primarily for study purposes.[41] The bills evoked little interest until 1962 when organized labor indicated its support of mandatory health insurance. Hearings were held, and the New York Insurance Department submitted a study of the impact of a revised version of the principal bill by Senator Metcalf, introduced in 1960.[42] As a result, in 1963 a modified bill was introduced which afforded somewhat different benefits and coverage but again provided essentially only hospitalization insurance.[43] The changes were made mainly to meet certain objections raised by industry and insurance companies spokesmen on the one hand and organized labor on the other. Although the bill failed to achieve passage, the Committee instructed the chairman to reintroduce the bill in 1964.[44] The year 1965 brought further support for the idea of compulsory hospitalization insurance. Not only did the Joint Legislative Committee on Health Insurance Plans continue its efforts in behalf of the establishment of compulsory hospitalization insurance by the reintroduction of a mandatory hospitalization bill and additional hearings thereon,[45] but the Governor's Committee on Hospital Costs under the chairmanship of

Mr. Marion Folsom likewise strongly advocated the passage of a state hospitalization insurance law including also coverage of home and long-term care.[46] The report referred to both lack and inadequacy of coverage as the chief reasons for mandatory legislation of that type.[47] The Folsom committee report resulted in the adoption of the recommendations relating to the improvement of hospital facilities and services,[48] but the recommendations relating to compulsory health insurance were not implemented on the legislative level. Among other factors, the enactment of the medicare and medicaid provisions in the Social Security Amendments of 1965[49] had substantially changed the picture so as to make a revision of the original ideas, though not an abandonment thereof, necessary.

As a result on the eve of the reform of 1965, compulsory medical care insurance existed only within the framework of workmen's compensation. In addition, there were state programs of public medical care for certain groups of patients and, above all, the medical care programs for veterans on the federal level. Legislation to that effect reached back to the early days of national existence and received major impetus in connection with World War I. In 1930 the Veterans Administration was established and all programs for medical, hospital, and domiciliary care of veterans suffering from service-connected disabilities brought under its responsibility.[50] The pertinent legal provisions are now consolidated in the U.S. Code, Title 38. During 1967 over 750,000 patients were treated in Veterans Administration hospitals, and 6,268,000 medical visits to outpatients were furnished by the program.[51]

B. Period Since the Establishment of Medicare and Medicaid

The establishment of the federal medicare and medicaid programs by the Social Security Amendments of 1965 constituted a major change of the health care scene, since it profoundly modified the status of the two segments of the population in need of the costliest type of medical care: the aged and the indigent. Especially medicare, which adopted the social insurance rather than the social assistance approach, constituted a real departure from the pre-existing pattern.

As was pointed out before, by 1951, the idea of universal comprehensive national health insurance had been shelved for all practical purposes. The advocates of compulsory health insurance came to focus on a more limited goal and, beginning in 1952, the principal efforts in Congress centered around compulsory health care insurance, especially hospital insurance, for social security (OASI) recipients. The pertinent bills proposed hospitalization insurance, including medical care during hospitalization, for persons eligible for benefits under the OASI program, i.e., the aged and their dependents or survivors.[52] After the addition of disability insurance by the Social Security Amendments of 1956, some bills included the disabled in the proposed health insurance scheme,[53] but the majority continued to exclude them. The original bills of this type were introduced by Senator Murray[54] and Representatives Cellar[55] and Dingell[56] in 1952. The Eisenhower Administration, however, did not endorse this approach. Nevertheless, the proposals reached a more active state when Congressman Forrand, an influential member of the Ways and Means Committee, also introduced such a bill,[57] providing hospital benefits of up to 60 days per calendar year, nursing home care following discharge from a hospital, and surgical benefits for OASI (but not disability insurance) eligibles. The various bills became the subject of hearings held in 1958 by the Committee on Ways and Means, in the context of a series of hearings on all titles of the Social Security Act.[58] The Committee, however, did not make any proposals for the extension of the social security system so as to include hospital insurance for the aged or OASI eligibles. Subsequent efforts[59] also suffered defeat.[60]

The picture changed materially in 1961 when President Kennedy included health insurance for the aged through social security in the legislative program of his administration and made it part of a special message to Congress.[61] The administration proposals crystallized in the so-called King-Anderson bill,[62] providing limited hospital care, nursing home services, home-health services, and outpatient hospital-diagnostic services (subject to a deductible) for

persons aged 65 and over.[63] A slightly broader coverage was proposed in the second Kerr-Anderson bill, introduced in 1963.[64] The provisions of this bill were added by the Senate to other proposed Social Security Amendments that had passed the House, but the whole measure died in the Conference Committee at the end of the Eighty-Eighth Congress.[65]

A new Kerr-Anderson bill providing insurance for the aged against hospital and related health care costs was introduced in the next Congress[66] and finally resulted in the adoption of the medicare and medicaid programs. The system of compulsory health insurance for the aged as detailed in the Kerr-Anderson bills was modified after hearings before the House Ways and Means Committee. The new program, as embodied in the Mills bill (H.R. 6675), created two related health insurance programs, i.e., a compulsory basic program covering hospital and related health care costs and a voluntary supplementary program affording protection against the costs of physicians' care and of certain other items of personal health care not covered by the basic program.[67] H.R. 6675 succeeded in being passed by both houses.[68] The two medicare programs formed a new Title XVIII of the Social Security Act. In addition, a greatly expanded system of medical aid to the needy was incorporated in a new Title XIX.

Although medicare brought mandatory health insurance for the aged, the remainder of the population was left, apart from the classical payment for service system, either to voluntary prepayment plans (including those on a collectively bargained basis) or to public provision, primarily under Title XIX. To be sure Title XIX envisages and authorizes prepayment coverage of medical assistance, either in toto or in part,[69] but no extensive resort to this form of coverage has been possible owing to the stringent coverage requirements and practical difficulties caused by the provisions of the Act relating to eligibility determinations. As a result, the quest for legislation requiring mandatory prepayment plan coverage for the population under 65 continued to have vitality.

Noteworthy is the fact that the adoption of the medicare and medicaid provisions by Congress did not halt the efforts in New York toward compulsory health insurance endorsed by the Rockefeller administration. Even in the immediate wake of congressional legislation, the newly established Senate and Assembly Committee on Public Health felt that the need for statewide compulsory health insurance called for further hearings and, as a result thereof, recommended legislation requiring mandatory extension of hospital insurance coverage to the entire work force and its dependents as a condition of employment.[70]

In his January, 1967, annual message, Governor Rockefeller reaffirmed his view that the problem of catastrophic expenses of illness required public action, although he doubted whether such action could be taken on the individual state level without federal intervention.[71] On February 22, 1967, the Governor, the Assembly Speaker, and Majority and Minority Leaders called for the study of "a program which would require basic health service insurance for the great majority of employees" of the State of New York.[72] A draft of a bill entitled "Health Insurance Benefits Law" (to constitute a new chapter of the State Workmen's Compensation Law) was introduced in both houses and assigned for hearings to the Joint Legislative Committee on the Problems of Public Health and Medicare.[73] As a result of the hearings, the committee staff drafted some major substantive amendments, including one providing a state subsidy for low-income families.[74] The Committee, however, felt unable to complete its task and scheduled the bill for further hearings during 1967 and 1968.[75] While such hearings were still being held and ten days prior to the date of the Committee's 1968 report, Governor Rockefeller, on March 20, 1968, sent a message to the legislature urging adoption of a revised system of compulsory health benefits, incorporated in an accompanying bill, entitled "Health Security Act".[76] The bill was introduced by the Committee on Rules on March 21, 1968.[77] It was designed to meet some of the objections raised by various groups, especially labor, against the prior bill. The measure, which was to form a new chapter of the New York Public Health Law, provided specified compulsory health insurance or health plan benefits, not including surgical and medical benefits, for employees and their dependents.[78] Due to the lack of time, the Joint Legislative Committee on the Problems of Public Health, Medicare, Medicaid and Compulsory Health and Hospital Insurance could do no more than to back the principles of the new bill without endorsing any of its specific provisions.[79] No positive legislative action ensued.

In 1969, the measure was reintroduced with certain modifications, mainly designed to conform the benefits provided to those available under medicare Part A and to exempt small employers.[80] While the majority of the Joint Legislative Committee continued to support the legislation, no attempt to secure legislative action was taken.[81]

In 1970, Governor Rockefeller proposed a further revision of his plan for compulsory health insurance, now entitled "Universal Health Insurance Act", which was introduced on April 1, 1970.[82] The new bill, the fate of which is still undetermined, provides mandatory health insurance benefits for all employees and their dependents, as well as noncorporate employers,[83] voluntary coverage for persons without employment after the termination of their coverage as employees

(limited to 180 days),[84] and mandatory coverage of persons receiving public assistance or determined to be eligible for public assistance.[85] The proposed act is to be administered by a newly established public corporation, called state health insurance corporation, vested with vast regulatory and managerial powers.[86] The insurance is provided by the employer through contracts with commercial insurance carriers, nonprofit insurance corporations, or the newly created[87] health service corporation. Employee benefits normally are financed by joint, but not equal, contributions of the employee and the employer. Unless a lesser percentage is stipulated by agreement, employees earning annual wages of $6,000 or more contribute 35 per cent of the cost of their coverage, employees earning at least $5,000 but less than $6,000 contribute 20 per cent, and employees earning less than $5,000 are not liable for contributions.[88] Employers pay at least 65 per cent of the premium costs but need not make aggregate contributions (including wages withheld from the employees) in excess of four per cent of their annual payroll.[89] Any balance is paid, as a subvention, by the state health insurance corporation.[90] In the case of voluntary temporary insurance of persons out of employment, the individual and the state health insurance corporation share the cost on an equal basis.[91]

The newest development in the field of compulsory health insurance is the President's announcement of his Family Health Insurance Plan for poor families with children. The plan envisages health benefits insurance coverage having a premium value of $500. Families having an income between $1,600 and $3,000 would contribute 5 per cent of the cost, families having an income between $3,000 and $4,500 would contribute 10 per cent, and families with incomes from $4,500 to $5,620 would contribute 25 per cent. Legislative proposals are promised for January 1971.[92]

Finally, it should be noted that the general desirability of prepayment plan protection against medical cost was again strongly stressed in the June, 1970, Recommendations of the United States Department of Health, Education and Welfare, Task Force on Medicaid and Related Programs.[93]

Part II

EXAMINATION OF A NEED FOR LEGISLATIVE ACTION IN HAWAII

Although prepayment plans covering the costs of hospital and medical expenses originated in the United States as early as 1880,[1] the spectacular rise of prepayment coverage by commercial insurance carriers, nonprofit insurance corporations, and medical groups occurred only in the three decades since 1940. Between 1940 and 1968, the number of persons with hospital expense protection rose from 12.3 million to 169.5 million, the number of persons with surgical expense protection rose from 5.4 million to 155.7 million, and the number of persons with regular medical expense coverage from 3.0 million to 129.1 million.[2] Hence the need for public action depends on the size of the coverage gap still existing and the adequacy of the coverage provided.

The following inquiry focuses on the situation in the State.

A. Estimated Size of the Coverage Gap

Basic Data

Any estimate of the coverage gap existing in Hawaii is vitally affected by great uncertainty with respect to the three basic sets of figures which determine the result:

a. The size of the resident civilian population;

b. The size and composition of the civilian labor force;

c. The extent of commercial health insurance protection and its overlap with other pre-payment plans.

Unfortunately, the greatest doubts relate to the fundamental reference quantity: the size of the resident civilian population. When original estimates of the coverage gap were made early in 1970 by the Legislative Reference Bureau, the resident civilian population, as of July 1, 1969, was estimated at 736,750 persons.[3] The preliminary census figures for 1970, however, indicate that the 1969 data were overestimated by 44,392 persons and that the resident civilian population as of that date was actually only 692,358 persons.[4] This latter figure, therefore, must be the basic reference for the new estimate.

The figure 692,358 does not include 56,282 members of the armed forces stationed in the Islands but does include both 59,697 dependents of military personnel[5] and an estimated 43,000 people over 65.[6] Since the military dependents are covered by a special federal health insurance program called CHAMPUS and the aged are subject to the medicare program, the potential universe for general coverage programs totals 589,661.

The civilian labor force as of July, 1969, is now estimated to have been 340,750, including 9,650 unemployed.[7] Therefore, the active civilian labor force as of that date was 331,100. This estimate is based both on the returns of employers covered by the Hawaii Employment Security Law and on estimates of employment for those employers excluded from coverage under that law. The figure 331,100, therefore, indicates jobs rather than persons and requires a downward revision to adjust for employees holding more than one job. Unfortunately, there are no local data indicating how many of these jobs are occupied by people holding more than one job. The United States Bureau of Labor Statistics, however, has made available to the Legislative Reference Bureau national data on the percentage of jobs as of May, 1969, in each industry classification which are secondary jobs. By applying these percentages to the total number of jobs in the various industries in Hawaii and by making an upward adjustment to reflect the people holding more than two jobs, it can be estimated that the number of jobs occupied by moonlighters in July, 1969, was 14,758.[8] Hence, the number of persons actively pursuing employment as of the indicated date was 316,342.

Since this report excludes persons entitled to medicare from its purview, a further downward adjustment is required to estimate the size of the active civilian labor force under 65. The number of people over 65 in the labor force is not known, but there are methods of estimating this figure. In 1969, the number of persons over 65 in active civilian employment in the United States totaled 3,233,000,[9] or 16.6 per cent of the total population in that age group (19,463,000).[10] If the national percentage were applicable to Hawaii, the data would indicate that the number of employed persons aged 65 and over in the State would total 7,138. This figure is in agreement with estimates arrived at in a different fashion. The Department of Planning and Economic Development estimated that in 1965 on Oahu, 4,420 individuals of age 65 and over were in the labor force and that in 1967 on the neighbor islands, 1,417 persons in that age group were in active civilian employment.[11] The population of persons aged 65 and over during those periods was estimated at 36,020.[12] This would yield a percentage of 16.2 for the people age 65 and over in active civilian employment. Applying this percentage to the current 65 and

Table 1

EXTENT OF GROSS COVERAGE OF PREPAID HEALTH PLANS
IN THE STATE (1969)

Type Name of Plan	Hospital			Surgical		
	Subscribers	Dependents	Total	Subscribers	Dependents	Total
HMSA (Group)[1]	110,308	202,973	313,281	110,308	202,973	313,281
HMSA (Individual)[1]	18,349	8,336	26,685	18,349	8,336	26,685
Kaiser (Group)[2,3]	19,155	38,366	57,521	19,155	38,366	57,521
Kaiser (Individual)[2]	3,773	3,675	7,448	3,773	3,675	7,448
Commercial Carrier (Group)[4]	37,720	48,482	86,202	37,760	47,888	85,648
Commercial Carrier (Individual)[4]	20,263	16,349	36,612	17,753	11,181	28,934
Independent Sugar Plans	10,126	18,625	28,751	10,126	18,625	28,751
Total	219,694	336,806	556,500	217,224	331,044	548,268

Type Name of Plan	Medical		
	Subscribers	Dependents	Total
HMSA (Group)	110,308	202,973	313,281
HMSA (Individual)[5]	18,349	8,336	26,685
Kaiser (Group)[2,3]	19,155	38,366	57,521
Kaiser (Individual)[2]	3,773	3,675	7,448
Commercial Carrier (Group)[4,6]	33,456	41,804	75,260
Commercial Carrier (Individual)[4,6]	4,575	4,548	9,123
Independent Sugar Plans	10,126	18,625	28,751
Total	199,742	318,327	518,069

1. Data for July, 1969.
2. Data for June, 1969.
3. Excludes sugar plan coverage.
4. 12/31/68 figures.
5. Only in-hospital visits.
6. Data are for nonsurgical medical expenses, but do not cover major medical expenses and, in a number of policies, cover only in-hospital visits.

over population results in an estimate of 6,966 of this age group in employment. In addition, the 1960 census data showed that 16.1 per cent of the 65 and over were employed (or 6,923 based on 1969 population figures).[13] Hence, it is safe to estimate that the number of employed persons aged 65 and over is around 7,000.

As a result, it can be concluded that the active civilian labor force under 65 in July, 1969, consisted of approximately 309,350 individuals.

Responses from the various types of prepaid health plan operators in the State indicating the gross coverage of individuals under 65 as of the summer and fall of 1969 (excluding the 59,697 individuals who have coverage as military dependents under the CHAMPUS program) are tabularized on Table 1.

It should be noted that these data indicate gross coverage and that they need adjustment for duplication and that, in addition, the data for medical coverage require further refinement, since some of this coverage extends only to in-hospital visits of physicians and therefore may cause an exaggerated picture of the scope of protection afforded by this type of coverage.

Adjustments for duplication are particularly crucial in the case of hospital insurance because otherwise the desirable but over-optimistic picture would be created that out of an estimated total resident civilian population of 692,358 individuals, 659,197 were protected by prepayment coverage against hospital expenses (43,000 under medicare, 59,697 as military dependents, and 556,500 under general private plans), leaving a coverage gap of only 33,161 individuals, i.e., only 4.8 per cent. On the basis of a population universe that excludes individuals 65 and over and military dependents (a potential coverage group of 589,661), the coverage gap would be 5.6 per cent. In the case of the other health expenses, the coverage gap widens. Excluding persons 65 and over and the military dependents, the coverage gap in the case of surgical expenses would be 41,393 or 7.0 per cent and, in the case of medical expenses (regardless of actual scope), 71,592 or 12.1 per cent of the relevant population universe.

The Under-Count and Duplication Issues

A fundamental assumption of this report is that the population estimate based on the preliminary 1970 census data is a reliable quantity. Unfortunately, this assumption can only be made with great

hesitation. Early in 1968, the resident population of Hawaii (exclusive of the armed forces) was estimated at 777,462 people.[14] In 1969 the estimate of the 1968 resident civilian population was adjusted downward in order to eliminate a discrepancy between the estimates of the United States Census Bureau and the State of Hawaii Department of Planning and Economic Development. The new preliminary figure was 724,989.[15] Subsequently, it was further adjusted downward to a final figure of 717,640.[16] As a result of the 1970 census data, still further downward adjustment was deemed to be called for. The estimated population for July 1, 1968, is now set at 670,117; for July 1, 1969, at 692,358; and for April 1, 1970, at 706,820.[17] In other words, within two years the estimates for 1968 underwent a downward adjustment by 107,345 people or 13.8 per cent. Certainly it is discomforting to work with reference data of such uncertitude.

In addition, the 1960 census (like other census data before) suffered from a sizeable undercount which--nationwide--is estimated at 3.1 per cent of the true total (5.7 million people).[18] Hence, it reasonably can be surmised that the 1970 census suffered from similar deficiencies and that the true resident civilian population probably exceeds the adjusted estimate. If the 1960 and the 1970 census count missed 3 per cent of the civilian population in Hawaii, the true count for 1969 would be 713,771. Hence, any narrowness of the estimated coverage gap based on the 692,358 mark must be viewed with appropriate reservations.

Similar difficulties exist with respect to ascertaining the extent of duplication of prepayment protection, especially with reference to the hospital insurance data. Table 1 shows that the gross hospital coverage consists of group insurance, covering subscribers and dependents totalling 485,755 or 87.3 per cent, and individual insurance, covering 70,745 or 12.7 per cent. Table 1 shows further that noncommercial carriers cover 433,686 or 77.9 per cent, while commercial carriers cover 122,814 or 22.1 per cent. Undoubtedly, duplication exists both between individual and group coverage and between commercial and noncommercial coverage. There is practically no duplication of coverage within the HMSA or the Kaiser coverage, but duplication may exist between group and individual commercial coverage (inter-industry duplication) and between commercial and noncommercial coverage. The difficulty relates to the quantification of these overlaps.

On a nationwide basis, the Health Insurance Association of America (HIAA) estimated in 1967 that the inter-industry duplication amounted to 6 per cent for group insurance and 18 per cent for individual insurance, and that the duplication with noncommercial

insurance was 13 per cent for group insurance and 10 per cent for individual insurance.[19] On that basis, the gross hospital coverage for Hawaii (556,500) would have to be reduced by 26,629 since the non-duplicative commercial coverage would be reduced to 96,185 from a duplicative total of 122,814, resulting in a net coverage of 529,871. The coverage gap on that basis, assuming no census undercount, would be 59,790 residents.

The Department of Health, Education and Welfare has taken the view that this correction is too conservative because household survey findings, made at various dates between 1953 and 1963, showed a consistently lower coverage than that based on the HIAA estimates.[20] Moreover, the Department found that the nationwide correction figures used by HIAA did not apply uniformly from state to state but required variations according to the ratio of gross enrollment to the population covered.[21] In 1966 when the raw gross coverage of people under 65 in Hawaii was reported as 508,000 the Department made a duplication estimate (hereinafter called estimate no. 1) by applying first an inter-industry correction of 2.7 per cent[22] and after that an overall correction of 5.54 per cent.[23] Applying these factors to present coverage data, the inter-industry duplication would require a deduction of 3,316 persons and the overall correction, an additional deduction of 30,646 individuals or a total deduction of 33,962 persons, resulting in a net coverage of 522,538 or a coverage gap of 67,123.[24] Applying another method, the Department of Health, Education and Welfare arrived at a second estimate (hereinafter called estimate no. 2), reflecting the findings of the household surveys, under which the coverage gap would be even larger, amounting to 105,268.[25] Estimate no. 2 seems to be unrealistic and is based on data which are contradicted by the known realities. Actually, the main sources of duplication are simultaneous protection as "subscriber" and as "dependent" and simultaneous protection by individual and group plans. In Hawaii, the latter is probably the major source of duplication.[26] Hence, a correction lying midway between the figures arrived at by using the industry's nationwide factors (26,629) and by the Department's low estimate (33,962) is probably the fairest assumption, resulting in net hospital coverage of 526,204 and leaving a coverage gap of 63,457 based on the unadjusted preliminary 1970 census data. Allowing for a 3 per cent undercount of both the total population and the 65 and over, and assuming that there was no undercount of military dependents since this figure is not derived from census data, the actual coverage gap for hospital insurance would amount to 83,540 persons.[27]

Similar corrections apply to surgical and medical policies. According to HIAA's correction method, the inter-industry correction factors for surgical policies are again 6 per cent for group policies

and 18 per cent for individual policies, while the factors correcting for duplication between commercial and noncommercial policies are 12 per cent and 10 per cent, respectively.[28] On that basis, the figures for surgical coverage in Table 1 (548,268) must be corrected by subtracting 23,519 (85,648 x .18 + 28,934 x .28). Hence, the estimated net coverage for surgical protection would be 524,729, resulting in a coverage gap of 64,912 persons (on the basis of the unadjusted census figures). Using the HEW correction methods underlying estimate no. 1,[29] the total duplication would amount to 42,800 persons,[30] resulting in a net coverage of 505,468 individuals or in a coverage gap of 84,193. Taking the median of the HIAA correction for duplication and the HEW correction for duplication, the deduction to be applied would total 33,160 persons, resulting in net surgical coverage of 515,108 and leaving a coverage gap of 74,553 on the basis of the unadjusted census. Adjusted for undercount the coverage gap for surgical insurance, therefore, is estimated at 94,636 persons.

The greatest difficulties in the adjustment for duplication are presented by the protection against regular medical expenses, even apart from the fact that the classification "regular medical" includes both policies that cover only in-hospital physicians' visits as well as policies that provide also for home and office visits. Thus, all HMSA individual policies listed in Table 1 provide only for in-hospital visits, and the same is true with respect to four-fifths of the persons covered by group medical expense policies.[31] Obviously, policies of that type provide "some" but not "adequate" coverage against medical expenses. On the other hand, in addition to the regular medical commercial policies listed in Table 1, substantial major medical expense coverage exists,[32] as indicated in Table 2.

Table 2

MAJOR MEDICAL INSURANCE

Type	Primary Insured	Dependents	Total
Commercial Group Policies	22,733	37,388	60,121
Individual Policies	2,381	3,926	6,307
HMSA			
Group	106,513	198,602	305,115
Individual	18,349	8,336	26,685
Total	149,976	248,252	398,228

Source: Citation HIAA letter, figures from HMSA.

For purposes of this report, the coverage gap is estimated on the basis of persons without any medical (other than surgical) coverage, not on the basis of persons lacking adequate medical coverage. An estimate on the latter basis would be quite conjectural, although elimination of the individual HMSA coverage and four-fifths of the commercial group coverage might constitute a reasonable approximation.

The method applied by the HIAA to correct for duplication on a nationwide basis computes the inter-industry factors at 5 per cent for group insurance and 18 per cent for individual insurance and the inter-types factor at 10 per cent for group insurance and 10 per cent for individual insurance.[33] Application of these factors to the medical coverage data set forth in Table 1 yields 11,289 (75,260 x .15) for group insurance and 2,554 (9,123 x .28) for individual insurance or a total reduction of 13,843. Hence, the net coverage on that basis would amount to 504,226 individuals, resulting in a coverage gap of 85,435 persons (on the basis of the unadjusted census figures). Unfortunately, HEW has not published a state-by-state estimate of medical coverage on the basis of the methodology developed by it for hospital and surgical coverage. Using, therefore, the median of the factors used by HEW for the other types of coverage (i.e., 2.4 per cent for inter-industry duplication and 6.5 per cent for overall reduction),[34] the applicable correction would be 35,568 yielding an estimated net coverage of 482,501 individuals. The coverage gap on that basis would be 107,160. Taking again the median of the corrections computed on the basis of the two methods, the duplication would be estimated at a total of 24,706 persons, resulting in a net medical coverage of 493,363 and leaving a coverage gap of 96,298 persons on the basis of the unadjusted census. Adjusted for undercount, the coverage gap for any kind of medical insurance, therefore, is estimated at 116,381.

Hence, the estimated coverage gaps for the various types of health costs, after allowing for a census undercount, are estimated to be at the following magnitudes or within the following limits:

Hospital	83,540	or	13.7%	(79,873 - 87,206)
Surgical	94,636	or	15.5%	(84,995 - 104,276)
Regular Medical	116,381	or	19.1%	(105,518 - 127,243)

According to the most recent adjusted population estimates for Hawaii, as contained in Statistical Report 79 of the Department of Planning and Economic Development, the resident civilian population of the State in 1969 totalled 698,445 persons. Excluding persons over 65 and armed forces dependents but not adjusting for undercount, the relevant universe would be 595,748. On that basis the coverage gaps would be:

Hospital Insurance	69,544	or	11.7%
Surgical Insurance	80,640	or	13.5%
Regular Medical Insurance	102,385	or	17.2%

Coverage in Relation to Employment

One of the crucial problems to be answered is the determination of the number of employees who have no health insurance coverage, whether as "subscriber" or "dependent", and hence what portion of the coverage gap is comprised of employees. Unfortunately, the question is not susceptible of an accurate answer and can be resolved only on the basis of general estimates and assumptions. Since group insurance normally is employment-generated (regardless of whether the employer assumes all or part of the premium required), it is fair to assume that practically all the subscribers covered by group insurance are wage earners. To be sure some of the employers are covered by group plans,[35] but an estimate of how many is difficult to make. It should be noted that omission of an allowance for group coverage of employers and other self-employed results in a slight overestimate of employee's coverage.

As reported above, the active civilian labor force as of July, 1969, after deduction of the employed aged 65 and over and after correction for multiple jobholders, totaled 309,350 individuals under 65. Deducting self-employed under 65, estimated at 27,835[36] from that figure, it is estimated that the number of employed wage earners under 65 totaled 281,515 individuals. The number of individuals covered by group plans as subscribers[37] at that date was:

Hospital Expenses	177,309 or 63.0%
Surgical Expenses	177,349 or 63.0%
Regular Medical	173,045 or 61.5%

In addition to these figures relating to group insurance, a proper portion of the individual nonduplicative policies must be allocated to subscriber wage earners. An estimate of this number must take account of the fact that the self-employed will primarily be covered by the policies of this type and that, in addition, a sizeable percentage of individual policies are duplicative, with group protection. If it is assumed that the self-employed are as likely to have prepayment protection as the population as a whole, then 86.3, 84.5, and 80.9 per cent of the self-employed have individual hospital, surgical, and medical protection, respectively, and that for each category of insurance, 28 per cent[38] of the remaining policies are duplicating policies, then the number of additional wage earner subscribers covered by nonduplicative individual policies would total 13,221,[39] 11,775,[40] and 3,008[41] for hospital, surgical, and medical insurance, respectively.

Hence, the total subscriber coverage of wage earners by health insurance policies is estimated to be as follows:

Hospital Expenses	190,530 or 67.7%
Surgical Expenses	189,124 or 67.2%
Medical Expenses	176,053 or 62.5%

Hence, noncoverage of wage earners as subscribers is estimated at 90,985 for hospital insurance, 92,391 for surgical insurance, and 105,462 for medical insurance.

It is reasonable to conclude that a substantial portion of the wage-earners who are not covered as subscribers are nevertheless covered as dependents, and the principal task therefore is to arrive at a plausible estimate of the extent of the coverage of wage earners as dependents. Dependents coverage may arise either from plans of subscriber-wage earners or from the special plan for military dependents. While the extent of the gross coverage of dependents is known on the basis of the replies of the insurance organizations (see Table 1) and an adjustment for net coverage is possible within acceptable limits, an estimate of the number of wage earners among these dependents must remain somewhat conjectural.

The wage-earners most likely to be covered as dependents are married women and workers under 19. Some employed husbands might be covered as dependents, but it can be assumed the number so covered would be statistically insignificant. Women regardless of marital status constitute approximately 40 per cent of the total labor force (123,740),[42] 63 per cent of whom are estimated to be married with husband present.[43] The task is to determine how many of these married women are wage earners. In 1960, female wage earners comprised 91.6 per cent of all employed women.[44] Assuming this ratio to be the same in 1969, and assuming that married women comprise an aliquot portion of the female wage earners, then 113,346 women were wage earners in 1969, of whom 71,408 were married.

Similarly, 1960 census data indicate that employed single persons under 19 comprised 4.9 per cent of the persons under 65 in active employment.[45] It can be assumed that practically all people in the under 19 class are wage earners and are not self-employed. Applying this percentage to current employment figures produces an estimate of 15,158 employed single wage earners under 19. Under applicable policies, these 15,158 single wage earners under 19 as well as the 71,408 married women with husband present could be covered as dependents. As indicated before, an effort is made to estimate how many of the

single wage earners under 19 and of the married female wage earners under 65 are in fact so covered.

If one were to engage in the extreme assumption that all of the single wage earners under 19 and all of the married female employees under 65 are covered either as dependents of employed male wage-earners or as military dependents and that all other employees under 65 have subscriber coverage to the extent that such coverage is possible under the figures for subscriber coverage indicated above, the number of employees lacking coverage would be insignificant. Since the total number of wage earners under 65 was estimated at 281,515, the elimination of the 71,408 married women employees under 65 and of the unmarried employees under 19 would leave 194,949 employees as the potential universe for subscriber coverage. Hence, the number of employed lacking subscriber coverage would be 4,419 with respect to hospital insurance, 5,825 with respect to surgical insurance, and 18,896 for medical insurance. Of course, as indicated, this is only an extreme assumption. On a rational basis it can hardly be assumed that the total civilian labor force under 65 in active employment is covered either as subscribers or as dependents and that practically the whole population universe coverage gap of 83,540 persons (for the case of hospital insurance) must be allocated to dependents not in the active labor force and the families of the unemployed.

Conversely, it could be assumed that married women under 65 and single persons under 19 constitute a portion of the covered wage earner subscribers proportional to their participation in the labor force. In that case, the number of employed married women under 65 having subscriber coverage would be 23.1 per cent of the total or 44,012 with respect to hospital insurance, 43,688 with respect to surgical insurance, and 40,668 for regular medical insurance. In the case of the single employees under 19, the share in the subscriber coverage would be 4.9 per cent, or 9,336 with respect to hospital insurance, 9,267 for surgical insurance, and 8,627 for medical insurance. If all the remaining married female wage earners under 65 and employed single persons under 19 were covered as dependents, the number so covered would be, accordingly, for the married women, 27,396, 27,720, and 30,740 with respect to the three classes of health insurance and for the employed under 19 years of age, 5,822, 5,891, and 6,531, respectively. Hence, the total dependency coverage of employed individuals who are either married women under 65 or single persons under 19 would total 33,218, 33,611, and 37,271 for hospital, surgical, and regular medical insurance, respectively.

On that basis, the number of wage earners other than married women under 65 and single persons under 19 would be 281,515 - (71,408 + 15,158) = 194,949 persons, including married men whose wives are also in employment. On the basis of the data for subscriber coverage set forth above, the deficiency in subscriber coverage would be 194,949 - (190,530 - (44,012 + 9,336)) = 57,767 for hospital insurance, 194,949 - (189,124 - (43,688 + 9,267)) = 58,780 for surgical insurance, and 194,949 - (176,053 - (40,668 + 8,627)) = 68,191 for regular medical insurance.

The above figures are predicated on the further assumption that none of the husbands of the employed married women under 65 who have subscriber coverage are covered as dependents of such women. If it were assumed that all married women[46] with subscriber coverage have employed husbands covered as their dependents, the number of employees not covered as subscribers or dependents would be 57,767 - 44,012 = 13,755 for hospital insurance, 58,780 - 43,688 = 15,092 for surgical insurance, and 68,191 - 40,668 = 27,523 for regular medical insurance. In other words, on the assumption that married women under 65 and single persons under 19 contribute to the subscriber coverage in proportion to their share in the wage-earner labor force, the number of employees not covered either as subscribers or dependents would lie between 57,767 and 13,755 for hospital insurance, between 58,780 and 15,092 for surgical insurance, and between 68,191 and 27,523 for regular medical insurance.

On the basis of these two extreme assumptions, it may be concluded that the truth lies probably somewhere in the middle between the upper limit of assumption 2 and the figures resulting from assumption 1, i.e., the number of employees lacking coverage either as subscribers or dependent is 31,093 for hospital insurance, 32,303 for surgical insurance, and 43,544 for regular medical insurance.

The previous estimates are supported by a different set of considerations. The total coverage gap in the population of the State was estimated at 83,540 individuals for hospital insurance, 94,636 individuals for surgical insurance, and 116,381 individuals for regular medical insurance. The problem sought to be determined is an estimate of the number of individuals in the active labor force, and in particular wage earners, within these coverage gap groups.

Actually, the population classes without health insurance coverage within the gaps consist primarily of:

(a) Persons in the active labor force without subscriber or dependents coverage and their dependents;

(b) The unemployed, whose coverage has run out, and their dependents;

(c) Dependents of persons in the labor force who have only self-coverage; and

(d) Individuals not in the labor force, other than dependents of persons in the labor force and military dependents, and their dependents.

Unfortunately, it is not possible to estimate the size of some of these groups with sufficient certainty.

The size of the groups listed under (c) and (d) is probably quite small.

The number of unemployed in July, 1969, was estimated at 9,650. This estimate includes persons over 65[47] and persons under 19 who may be covered as dependents.[48] In addition, statistics show that the incidence of unemployment among young wage earners is much higher than in the labor force at large.[49] Hence, it is reasonable to assume that the unemployed have a lower dependents' ratio than the members of the labor force at large. In the light of these considerations, it does not seem unreasonable to conclude that persons in the active labor force and their dependents[50] constitute the largest part of the total coverage gap in hospital insurance and that an estimate that the number of wage earners in that group amounts to a figure of 31,100 is quite plausible,[51] particularly if it can be assumed that a larger percentage of these wage earners consists of single persons and other persons without dependents than among the wage earners with self and dependents coverage.

The same considerations apply to the number of uncovered wage earners in the gaps relating to surgical and regular medical insurance.

Estimating, accordingly, that the number of wage earners without coverage as either subscriber or dependents amounts to 31,100 for hospital insurance, 32,300 for surgical insurance, and 43,600 for regular medical insurance, the number of employees having dependents coverage would be 59,900 (or 65.8 per cent of the employees lacking subscriber coverage) for hospital insurance, 60,100 (or 65.0 per cent)

for surgical insurance, and 61,900 (or 58.7 per cent) for regular medical insurance.

In other words, the total percentage of wage earners without subscriber or dependents coverage is estimated at 11 per cent for hospital insurance, 11.5 per cent for surgical insurance, and 15.5 per cent for regular medical insurance.

The Subscribers and the Non-Subscribers: Who Are They?

In the foregoing section, an attempt was made to arrive at an estimate of the number of employees who are:

(a) Covered as subscribers;

(b) Not covered as subscribers but covered as dependents; and

(c) Not covered either as subscribers or as dependents.

It was estimated on the basis of gross coverage data relating to subscriber coverage that in 1969 190,530 (or 67.7 per cent) of the employees had hospital coverage, 189,124 (or 67.2 per cent) had surgical coverage, and 176,053 (or 62.5 per cent) had regular medical coverage. Correspondingly, it was estimated that the number of employees with dependents or no coverage totaled 90,985 for hospital insurance, 92,391 for surgical insurance, and 105,462 for medical insurance.

On the basis of the figures of married women and young persons under 19 years, it was estimated that dependents coverage was in the neighborhood of 65.0 per cent of the persons without subscriber coverage.

In the following section an attempt is made to study in greater detail the coverage situation with respect to certain categories of employment, differentiating between:

(a) Federal employees,

(b) State and municipal employees, and

(c) Wage earners in private employment.

Federal employees. As of July, 1969, the number of federal civilian employees in the State (including persons 65 and over) was estimated at 35,540 of whom 11,460 were nondefense workers, and 24,080 were defense workers.[52] Assuming that the percentage of employed over 65 among the defense workers is the overall percentage prevailing in the State (2.2 per cent) and that the number of persons over 65 among the federal nondefense employees is practically zero, the number of federal civilian employees under 65 is estimated at 35,000.

Health benefits for federal employees in the form of group coverage are governed by the Federal Employees Health Benefits Act of 1959.[53] The law covers all federal employees (as defined in section 8901 in conjunction with section 2105 as amended in 1968)[54] and empowers the Civil Service Commission to contract for or approve prepayment health benefit coverage under employee organization plans or group or individual practice prepayment plans.[55] In addition, the Civil Service Commission may contract for or approve one government-wide plan offered by a carrier providing for service benefits and one government-wide plan offered by a carrier providing for indemnity benefits.[56]

The coverage may be subscriber only coverage (self-coverage) or subscriber and dependents coverage. The coverage is financed jointly by withholdings from the pay of the subscriber and by government contributions. The bi-weekly contribution of the government is $1.62 for the subscriber only coverage and $3.94 for family coverage, but not more than half of the total subscription costs. In addition, the federal government pays one-half of the administrative expenses.[57] Family includes unmarried children under 22 years of age.[58]

According to the statistics supplied by the local health benefit organizations, the enrollment of federal employees in their plans covers 21,742 subscribers and 53,154 dependents. 5,223 have subscriber only coverage. Accordingly, subscriber coverage, excluding coverage by nonlocal organizations,[59] extends to 62.1 per cent of the total federal labor force.

Hence, the subscriber coverage shows a coverage gap of a ratio which is 9 per cent larger than the statewide figures. It cannot be explained by assuming that all nonsubscribers have dependents coverage under plans covering the spouse, especially since the percentage of married women (who might thought to be covered as dependents rather than subscribers) among the federal employees is considerably less than the

state average,[60] a fact which is explainable by the high percentage of defense workers.

The foregoing data do not account for any nonduplicative coverage which may exist by virtue of individual policies that are secured by federal employees. A proportionate allocation of the total nonduplicative policies allocated above to nonself-employed employees would entail an addition of 1,639 individual hospital insurance policies and 1,460 surgical and 373 medical policies.

State employees. The number of state and local employees under 65 as of July, 1969, was estimated at 36,600.[61] The percentage of women among this class of workers is substantially above the state average and was estimated at 58.6 per cent in 1965 (at a time when the state average was 37.1 per cent).[62] If the ratio of married women in the labor force to all women in the labor force can be assumed to be the general ratio, i.e., 63 per cent, it would follow that 36.9 per cent of state and municipal employees are married women.

Health benefits for state and local employees are provided by the State Public Employees Health Fund Law of 1961[63] which to a large degree is modeled after the federal pattern. The State makes a monthly contribution of $5 for each employee beneficiary and $15 for each employee beneficiary with dependents, with the qualification, however, that the State's total contribution is $15 when both husband and wife are employee beneficiaries.

According to the figures obtained from the state fund, 22,580 state and local employees under 65 in active service were covered by group plans by either HMSA or Kaiser; 7,474 had coverage as subscribers only; and the remaining 15,106 had subscriber and dependents coverage.[64] Accordingly, of the total number of active state employees (under 65), 61.7 per cent had subscriber coverage. This is somewhat lower than the statewide percentage which was estimated to be 63.0 per cent (for hospital insurance). This disparity is explainable by the high percentage of married women in this category which might entail a greater percentage of coverage as dependents. This factor is important because it would lead to the conclusion that the statewide estimate that 21 per cent of all employees have hospital coverage as dependents is the weighted result of a higher percentage of dependents coverage among the state employees and a lower percentage of such coverage among the employees in private employment.

The foregoing data do not account for nonduplicative individual policies that may be held by state employees. Proportionate allocation to this class of employees would result in an additional coverage of 1,719 employees with hospital insurance, 1,531 with surgical coverage, and 391 with regular medical coverage.

Employees in private employment. The number of employees under 65 years of age in private employment (including those employed in the sugar industry) is estimated at 209,915.[65] In view of the fact that (1) the total number of employees under 65 years of age covered as subscriber by either group or individual policies was estimated at 190,530, 189,124, and 176,053, respectively, for hospital, surgical, and regular medical benefits and that (2) the number of federal employees so covered was estimated at 23,381, 23,202, and 22,115 and the number of state employees so covered was estimated at 24,299, 24,111, and 22,971 for the three risk classes;[66] it must be concluded that the total subscriber coverage of private employees is of the following extent:

Hospital insurance	142,850
Surgical insurance	141,811
Regular medical insurance	130,967

Hence, the numbers of employees in private employment not covered as subscribers are estimated at:

Hospital insurance	67,065 or 31.95%
Surgical insurance	68,104 or 32.44%
Regular medical insurance	78,948 or 37.61%

As pointed out before, a high percentage of these wage earners lacking subscriber coverage might be covered as dependents. Taking the unweighted state averages estimated before, i.e., 65.8 per cent, 65.0 per cent, and 58.7 per cent for the health benefit classes, respectively, the number of employees with dependents coverage would be:

Hospital insurance	44,129
Surgical insurance	44,268
Regular medical insurance	46,342

Accordingly, the number of employees in private employment without subscriber or dependents coverage would have the following magnitude:

Hospital coverage	22,936 or 10.93%
Surgical coverage	23,836 or 11.36%
Regular medical coverage	32,606 or 15.53%

It should be noted that these percentages are calculated on the basis of two assumptions which are not wholly supported on a judgment basis and require adjustments in opposite directions: viz. the assumptions:

a. That the percentage of public employees having non-duplicatory individual policies is the same as the percentage of private employees (an assumption which may inflate the number of public employees having subscriber coverage); and

b. That the percentage of employees covered as dependents is the same for state employees as for private employees (an assumption which is too low and may result in a lowering of the percentage of private employees covered as dependents).

Accordingly, as a valid overall estimate, it may be estimated that 11 per cent of private employees lack hospital and surgical coverage and 15 per cent regular medical coverage.

Efforts were made to ascertain further details with respect to group coverage in private employment. For that purpose, two approaches were pursued:

(1) A questionnaire was sent to employers covered by the Hawaii Employment Security Law, soliciting information as to the availability, scope, and nature of group coverage for employees, classes and number of employees so protected, employer's share in the costs, etc.

(2) The unions operating in Hawaii were contacted for information as to the number of union members covered by health benefit plans established pursuant to collective bargaining agreement.

The latter approach resulted in the ascertainment that 57,500 employees in private employment are covered as subscribers under union negotiated health benefit plans.[67] Hence, coverage so provided extends to 27.4 per cent of the estimated number of wage earners in private employment (209,915).

The questionnaire sent to the employers was designed to provide detailed information as to the type of employers (in terms of type of business and size of firm) who provide coverage, the categories of employees who are covered or excluded from existing coverage, the method of financing, type of plan, and other matters. A sample of the questionnaire is included in the Appendix.

The questionnaire was mailed to 14,075 addresses obtained from the Department of Labor and Industrial Relations, after exclusion of the sugar industry which was contacted directly. The addresses included different units of the same firm, former employers who have gone out of business, and some individuals who no longer employed others. Unfortunately, the response was poor. Only 3,842 completed questionnaires were received, including answers from 368 individuals who either had gone out of business or ceased to be employers. Slightly more than 300 replies were erroneously completed or otherwise not susceptible to analysis.

3,020 returned questionnaires were responsive to the questions and analyzed with the aid of SWIS. Of the 3,020 firms replying validly, 1,124 reported some kind of coverage, while 1,896 reported no health benefit coverage of any kind. The firms responding to the 3,020 questionnaires had 62,191 individuals under 65 in their employment. On the basis of the estimate that there were approximately 14,000 active firms in the State with 199,789 employees (not counting the sugar industry), the replies covered 21.6 per cent of the employers and 31.1 per cent of the labor force in private employment. This indicates, of course, that the sample is not representative but biased toward the larger size firms.

The 1,896 firms without coverage had 10,030 employees, while the 1,124 firms affording coverage to all, or certain categories of their employees had 52,161 individuals under 65 in their employ. The number of employees with coverage in this group of 52,161 totaled 47,051, while the remaining 5,110 were excluded from coverage because of the type of their employment (probationary, part-time, temporary, custodial, etc.). The figures show that of the total of 62,191 employees accounted for in the sample, 15,140 had no coverage, while 47,051 had coverage. In other words, 75.7 per cent of all employees

constituting the population of the sample had group coverage as subscribers. This exceeds the estimates of the first part of the report which supported an estimate of subscriber groups coverage in private employment, excluding the sugar industry, of 61.5 per cent for hospital insurance, 61.5 per cent for surgical insurance, and 59.4 per cent for regular medical insurance. The difference, of course, is explainable by the fact that the replies to the questionnaire, as shown on Table 4, were biased toward large size firms, which tend to be firms providing coverage.

An effort was made, by means of the questionnaire, to correlate the coverage or noncoverage pattern to business type and size of firm. The following tables and comments are designed to show the resulting conclusions.

Table 5 shows that 61.8 per cent of the 1,896 employers without coverage had 3 or less employees and that 88.8 per cent had less than 10 employees. Conversely, Table 6 shows that among the firms with coverage, only 16.9 per cent had 3 or less employees and only 45.0 per cent had less than 10. In other words, noncoverage tends to concentrate among the smaller employers. This conclusion is substantiated further by Table 7, which shows that 86.0 per cent of the firms with 3 or less employees and 61.8 per cent of the firms with 4 to 9 employees do not have medical plans for their employees.

Looking at the distribution of coverage and noncoverage by type of business, Table 7 shows that the percentage of noncoverage was highest in the service industries (69.9 per cent) and in the wholesale and retail trades (64.1 per cent), while the highest percentages of coverage existed in construction and moving (61.9 per cent) and transportation, communication, and utility (58.1 per cent).

Noncoverage, therefore, depended both on the type of business and the firm size. Table 7 indicates that the highest percentage of noncoverage was in the small service industries (3 or less: 91.5 per cent; 4 to 9: 60.6 per cent) followed by the small wholesale or retail trades (3 or less: 86.0 per cent; 4 to 9: 69.6 per cent) and the small transportation and communication (3 or less: 82.8 per cent; 4 to 9: 50.0 per cent).

Hence, the impact of any compulsory coverage would primarily benefit employees in the small firms engaged in trade and commerces, especially the single women employed by them.

Table 3

TOTAL NUMBER OF FIRMS ANALYZED (SAMPLE FIRMS)
BY SIZE AND TYPE OF BUSINESS

Type of Business	Size of Business				Total
	3 or less	4-9	10-19	20 or more	
Wholesale or Retail Trade	352	312	174	138	976
Technical or Nontechnical Service	613	325	128	110	1,176
Finance, Insurance, Real Estate	183	68	25	45	321
Construction or Moving	89	76	29	74	268
Manufacturing	32	28	25	33	118
Transportation, Communication, Utility	29	16	15	33	93
Others	64	3	1	--	68
Total	1,362	828	397	433	3,020

Table 4

COMPARISON OF NUMBER OF FIRMS ANALYZED
TO NUMBER OF FIRMS IN THE STATE AS OF MARCH, 1967,
BY SIZE OF BUSINESS

Size of Business	Number of Firms in the State as of March, 1967	Firms Analyzed					
		Total		With Plan		Without Plan	
		Number	Per Cent	Number	Per Cent	Number	Per Cent
3 or less	6,040	1,362	22.5	190	3.1	1,172	19.4
4-9	3,129	828	26.5	316	10.1	512	16.4
10-19	1,469	397	27.0	232	15.8	165	11.2
20 and over	1,496	433	28.9	386	25.8	47	3.1
Total	12,134	3,020	24.9	1,124	9.3	1,896	15.6

Table 5

FIRMS WITHOUT PLAN BY SIZE AND TYPE OF BUSINESS

Type of Business	Size of Business				Total	Per Cent
	3 or less	4-9	10-19	20 and over		
Wholesale or Retail Trade	305	217	84	20	626	33.0
Technical or Nontechnical Services	561	197	50	14	822	43.4
Finance, Insurance, Real Estate	145	37	7	1	190	10.0
Construction or Moving	54	33	8	7	102	5.4
Manufacturing	21	17	9	4	51	2.7
Transportation, Communication, Utility	24	8	6	1	39	2.0
Others	62	3	1	--	66	3.5
Total	1,172	512	165	47	1,896	100.0
Per Cent	61.8	27.0	8.7	2.5	100.0	

Table 6

FIRMS WITH PLAN BY SIZE AND TYPE OF BUSINESS

Type of Business	Size of Business				Total	Per Cent
	3 or less	4-9	10-19	20 and over		
Wholesale or Retail Trade	47	95	90	118	350	31.1
Technical or Nontechnical Services	52	128	78	96	354	31.5
Finance, Insurance, Real Estate	38	31	18	44	131	11.7
Construction or Moving	35	43	21	67	166	14.8
Manufacturing	11	11	16	29	67	5.9
Transportation, Communication, Utility	5	8	9	32	54	4.8
Others	2	--	--	--	2	0.2
Total	190	316	232	386	1,124	100.0
Per Cent	16.9	28.1	20.6	34.4	100.0	

Table 7

FIRMS WITH PLAN AS PERCENTAGE OF
TOTAL SAMPLE FIRMS BY TYPE AND SIZE OF BUSINESS

Type of Business	Size of Business				Total
	3 or less	4-9	10-19	20 or more	
Wholesale or Retail Trade	13.4	30.4	51.7	85.5	35.9
Technical or Nontechnical Services	8.5	39.4	60.9	87.3	30.1
Finance, Insurance, Real Estate	20.8	45.6	72.0	97.8	40.8
Construction or Moving	39.3	56.6	72.4	90.5	61.9
Manufacturing	34.4	39.3	64.0	87.9	56.8
Transportation, Communication, Utility	17.2	50.0	60.0	97.0	58.1
Others	3.1	--	--	--	2.9
Total	14.0	38.2	58.4	89.1	37.2

B. The Coverage Gap and Medicaid

In the foregoing part it was pointed out that the relevant population group for which health care coverage is a matter of concern consists of the resident civilian population under 65 with the exclusion of military dependents.

On that basis (unadjusted for under-count), it was found that the following number of persons in 1969 lacked health care insurance, depending on the kind of care:

hospital insurance:	69,544 or 11.7%
surgical insurance:	80,640 or 13.5%
medical insurance:	102,385 or 17.2%

Relating the coverage gap to persons in private employment not covered either as subscriber or as individual, it was estimated that the number of employees in private employment with respect to the various types of care is:

hospital insurance:	22,936 or 10.93%
surgical insurance:	23,836 or 11.36%
medical insurance:	32,606 or 15.53%

Since voluntary coverage for hospital insurance which is the costliest part of the basic protection is almost 90 per cent, it must be asked where the gap is not already substantially filled by Medicaid. Despite the heavy burden of that program, however, its reaches are severely curtailed.

General Features of Medicaid Coverage

Medicaid was established as a new federal public assistance program as a part of the amendments to the Social Security Act which also provided medicare for the aged.[68] At that time medicaid received only limited public attention, particularly since the responsible congressional committees had grossly underestimated the financial implications of the new Title XIX. Thus the Reports of the Committee on Ways and Means of the House and of the Finance Committee of the Senate gave the following predictions as to the numerical and financial effects of the amendments:[69]

> The expanded medical assistance (Kerr-Mills) program is estimated to provide new or increased medical assistance to about 8 million needy persons during an early year of operation. States could, in the future, provide aid to as many as twice this number who need help with medical costs. . . .
>
> As the accompanying table[70] shows, if all States took full advantage of provisions of the proposed title XIX, the additional Federal participation would amount to $238 million. However, because all States cannot be expected to act immediately to establish programs under the new title and because of provisions of the bill which permit States to receive the additional funds only to the extent that they increase the total expenditures, the Department of Health, Education and Welfare estimates that additional Federal costs in the first year of operation will not exceed $200 million.

Unfortunately it became almost immediately clear that the predictions suffered from three glaring forecasting miscalculations

(a) as to the number of persons affected;

(b) as to the level of aid granted; and

(c) as to the development of the costs of medical care.

Thus soon after the adoption of the law, one of the recognized experts in the field concluded that the total number of persons potentially eligible for medical aid would soon exceed the 35 million mark.[71] Of course, reliable actual estimates were impossible owing to the broad range of discretion left to the states in defining medical indigency and their eligibility standards for medical aid.[72]

In view of the far reaching potential of the coverage provisions of the federal law and their impact on policy choices on the state level, it is important to outline the basic federal requirements and limitations.

Scope of Title XIX

Title XIX aimed at "enabling each State, as far as practicable under the conditions of such State, to furnish medical assistance on behalf of families with dependent children and of aged, blind or permanently and totally disabled individuals, whose income and resources are insufficient to meet the costs of necessary medical services."[73] As originally enacted[74] it specified no ceilings on

financial eligibility of individuals belonging to the enumerated categories which would limit federal financial participation in state plans. Income limitations were solely dependent on the states' ideas on the criteria for the "medically needy". Title XIX focussed on setting floors, proscribing discriminations, and defining the area of federal participation. The amendments of 1967, however, introduced income limitations with respect to the extent of federal participation.

The area of federal participation is not easily described, and the governing provisions of Title XIX[75] are subject to elaborate interpretations[76] and regulations[77] issued by the Department of Health, Education and Welfare.

Federal participation requires a minimum compulsory coverage of certain categories by the State plan,[78] but is available also to optional coverage of specified additional classes of persons.[79] In addition, however, the federal act contains the important mandate to the states to gradually and before July 1, 1977, include all persons meeting the plan's eligibility standards whether or not the aid so provided is entitled to federal sharing.[80]

The federal interpretations differentiate between "categorically needy"[81] and "medically needy".[82] Categorically needy[83] are:[84]

(1) All individuals receiving aid or assistance under the state's approved plans under Titles I, IV, X, and XIV (Old-Age Assistance, Aid to Families with Dependent Children, Aid to the Blind, Aid to the Permanently and Totally Disabled);[85]

(2) All residents of the state who would be eligible under one of the state programs under these titles but for the durational requirements of the particular program;[86]

(3) All persons who would be eligible for aid or assistance under the state plans, except for any other eligibility condition or other requirement in such plan that is expressly prohibited in a medical assistance program under Title XIX;[87]

(4) Persons who meet all the conditions of eligibility, including financial eligibility, of one of the state's approved plans under Titles I, IV, X, and XIV, but have not applied for such assistance;[88]

(5) Persons in a medical facility who but for such confinement would be eligible for financial assistance under one of the state's approved plans under Titles I, IV, X, and XIV;[89]

(6) Persons who would be eligible for financial assistance under another state public assistance plan, except that the relevant state plan imposes eligibility conditions more stringent than, or in addition to, those required by the Social Security Act;[90]

(7) Children under 21 who except for age, would be dependent children under the state's AFDC plan;[91]

(8) Individuals under 21 who qualify on the basis of financial eligibility, but do not qualify as dependent children;[92]

(9) Caretaker relatives who have in their care one or more children under 21, who except for age, would be dependent children under the state's AFDC plan;[93]

(10) Spouses essential to recipients of old age assistance, aid to the blind, or aid to the permanently and totally disabled;[94]

(11) General assistance recipients and persons who would be eligible for general assistance but have not applied therefore.[95]

"Medically needy" are persons who, except for income and resources, belong to the same group of persons as the individuals covered as categorically needy.[96]

The Act differentiates between compulsory and optional coverage. Compulsory coverage is prescribed for those classes of "categorically" needy listed above under number 1, 2, 3, and 7. All other classes listed above may be included as optional coverage.

Federal participation in the cost of medicaid is available for the four classes subject to compulsory coverage listed above and all other classes of categorically needy listed above, except general assistance recipients (supra, number 11). Federal participation is also provided for coverage of medically needy, falling within the classes enumerated (supra, numbers 1 to 10) subject, however, to the income limitations introduced by the 1967 amendments.[97]

The most important groups of optional coverage without federal participation under a state plan are therefore:

(1) The recipients of general assistance,

(2) Self-supporting individuals between 21 and 65 years of age, whose income and resources cover their maintenance needs according to the income and resources level of the medically needy, but not their needs for medical care.

Actually the states have made varying use of the optional coverage possibilities, in particular for individuals who are not categorically but only medically needy. Although quantitative data for various states are not truely comparable, since they are the result of too many variables, it is not without significance that for the various states the per inhabitant costs of medical assistance and maintenance assistance and the relation of both items to one another show wide variations and furnish an indicator of the relative extent of medical assistance.

During the calendar year 1968, for example, in ten states the per inhabitant expenditures for medical assistance exceeded the per inhabitant expenditures for maintenance assistance,[98] the top burden in both categories being borne by the residents of New York. The following table (Table 8) shows the respective data for New York, California, the national average, and Hawaii.

Table 8

EXPENDITURES PER INHABITANT FOR MAINTENANCE AND MEDICAL ASSISTANCE: CALENDAR YEAR 1968

State	Medical Assistance	Maintenance Assistance
New York	$63.95	$56.65
California	34.85	54.60
National Average	20.20	27.95
Hawaii	13.65	22.05

Source: U.S. Department of Health, Education and Welfare Medicaid, Selected Statistics, 1951-1969 (N.C. SS Report B-6), Table II-8.

Hawaii during 1968 ranked 22nd in the nation on the basis of per inhabitant cost of maintenance assistance and 23rd on the basis of medical assistance.

The same picture is obtained by a comparison of the number of recipients who are entitled to both maintenance and medical assistance with the number of recipients of medical assistance only, see Table 9.

Table 9

RECIPIENTS OF MEDICAL VENDOR PAYMENTS BY FORM OF MEDICAL VENDOR PAYMENTS AND MONEY PAYMENT STATUS
August 1969

State	Total	Money and Medical Assistance	Medical Only	4:2
U.S. Total (Title XIX)	4,071,000	2,764,000	1,308,000	32.1
New York	831,000	438,000	393,000	47.3
California	800,000	708,000	91,700	11.5
Massachusetts	248,000	105,000	144,000	58.1
Hawaii	10,300	8,400	1,800	17.5

Source: U.S. Department of Health, Education and Welfare, Medical Assistance Financed Under Public Assistance Titles of the Social Security Act, August 1969 (NCSS Report B-1 (8/69)), Table 7.

In assessing the significance of these data it must be understood that the "medical only" category includes not only the "medically needy" but also persons who are categorically needy but fail to qualify under the governing state law for other than income limitation. Moreover, the relative numbers reflect also the comparative liberality of the state plans under the other titles, especially Titles I and IV. Thus the low ratio of medical assistance only recipients in California reflects also the broad coverage of California's OAA program. In New York only 27.7 per cent of the aged who receive Title XIX assistance also receive money payments while in California the percentage is 79.1.[99]

Medicaid in Hawaii

Medicaid in Hawaii has its statutory basis in section 346-14(1) Hawaii Revised Statutes, which requires the Department of Social Services and Housing to:

> Administer, establish programs and standards, and promulgate rules as deemed necessary for all public assistance, including payments for medical care.

Pursuant to this mandate and in compliance with the federal acts and federal regulations, the Department of Social Services and Housing developed the State Plan for Medical Assistance, State of Hawaii. The following categories of persons are eligible for medical assistance in the State:[100]

(1) All individuals receiving aid or assistance under the State's approved plans under Titles IV and XVI (AFDC, and combined AA, AB, and AFDC programs).

(2) All residents of the State who would be eligible for aid or assistance under one of the other state plans except for the durational residence requirements for the particular program.

(3) All persons who would be eligible for aid and assistance under one of the other State plans except for any other eligibility condition or other requirement in such plan that is specifically prohibited in a program for medical assistance under Title XIX.

(4) Individuals who meet the conditions of eligibility, including financial eligibility, under the State's approved plans for Title IV (AFDC) and Title XVI (combined AA, AB, and APTD) but who are not receiving assistance.

(5) Persons in medical facilities, except those in medical institutions for mental diseases and turberculosis, who if they left such facilities would be eligible for financial assistance under one of the other State's approved plans.

(6) Children under 21 who qualify on the basis of need but who, do not qualify as dependent children under the State's Title IV plan.

(7) Caretaker relatives meeting the degree of relationship specified in the State's Title IV plan who have in their care one or more dependent children under the age of 21.

(8) Spouses of recipients of financial assistance under the State's approved plan for Title XVI who are determined to be essential to the well being of such recipients.

(9) Persons 21 and over receiving financial assistance under the State's General Assistance Program.

(10) Persons who except for income and resources are eligible under the State's General Assistance Program.

The largest group of persons covered are categorically needy persons for whom federal participation may be claimed. The principal classes of persons entitled to medical assistance are persons who are receiving financial assistance under the State's General Assistance Program and persons who, except for income and resources, are eligible under the State's General Assistance Program.

The Department has established a special "Modified Assistance Standard", also called Medical Assistance Standard, to determine eligibility for medical assistance of persons who do not receive money payments under one of the other existing programs.[101] A person shall be eligible for "Medical Assistance Only", if his income and resources are equal to or less than the Modified Assistance Standard (Medical Assistance Standard) which currently are the following amounts:[102]

Table 10
MEDICAL ASSISTANCE STANDARDS 1970

Number of Persons	Monthly Maintenance Costs
1	$135
2	225
3	255
4	300
5	350
6	380
7	450

Add $40 for each additional member.

EXAMINATION OF A NEED FOR LEGISLATIVE ACTION

The monthly maintenance costs used for the Medical Assistance Standard are not substantially different from the Total Monthly Requirements computed on the basis of the applicable General Assistance Standard established by the Department of Social Services and Housing.[103]

In other words, while Hawaii has adopted a broad coverage in terms of covered groups (categorically and categorically needy), the State has not covered broad strata of medically needy over and above the income limits set for categorically needy and has chosen not to exhaust the 133-1/3 per cent limits of federal sharing.[104]

Nevertheless the costs of medicaid and the amount of Hawaii's share have mounted steadily, primarily because of growing utilization and the spiralling costs of medical care.[105] The State's share is the difference between the total cost of the program and the federal share, the latter consisting of three items:[106]

(a) The federal medical assistance percentage;

(b) Seventy-five per cent of so much of the administrative expenses as are attributable to compensation or training of skilled professional medical personnel and staff directly supporting such personnel;

(c) Fifty per cent of the other administrative expenses.

The federal medical assistance percentage ranges between 50 and 83 per cent, depending upon the relationship between the per capita income of the State to the per capita income of the United States excluding the insular possessions.[107] It should be noted, however, that the federal government does not contribute to the expenses of medicaid for persons who are general assistance recipients and persons categorically linked to the G.A. program (so-call M-Gs).

The following table (Table 11) shows the total costs and the federal share and the State's share of such costs of medicaid for the fiscal years 1966-1967 to 1971-1972.

Table 11

EXPENDITURES FOR MEDICAID IN HAWAII
1966-1967 to 1971-1972

Fiscal Year	Total Cost	Federal Share	State Share
1966-1967	$ 7,395,939	$ 4,567,205	$ 2,828,734
1967-1968	10,296,878	4,593,947	5,702,931
1968-1969	12,948,760	5,261,194	7,687,566
1969-1970	16,421,236	7,425,788	8,995,448
1970-1971*	19,024,386	10,003,949	9,020,437
1971-1972*	27,233,933	12,288,212	14,945,721

*Estimated

Source: Executive Budgets

1968/1969 p. C-225 and D-17
1969/1970 p. C-228 and D-17
1970/1971 p. C-242 and D-16
1971/1972 p. C-232 and D-18

The segment of the population annually reached by medicaid is not readily determinable from published statistics since the relevant reports are published on a monthly basis[108] and, in the case of the monthly statistics of the State, do not segregate recipients of money payments who were also recipients of medical care and those who were not.

Fortunately, however the unduplicated number of medical care recipients per calendar year, is available from the annual reports submitted by the Department of Social Services and Housing to the Department of Health, Education and Welfare on Form FS-2082.2.[109]

According to the Statistical Report on Medical Care: Recipients, Payments, Services for Calendar Year 1969, a total of 44,044 unduplicated individuals received medical vendor payments during the reporting period. These 44,044 consisted of the following groups:

Table 12

MEDICAID RECIPIENTS
CALENDAR YEAR 1969

Category	Money Payments Authorized	Money Payments Not Authorized	Total
65 and over	1,631	4,363	5,994
Blind	88	12	100
Permanently and totally disabled	2,512	837	3,349
Dependent children	19,129	2,380	21,509
Adults in AFDC families	8,197	1,057	9,254
Others	2,689 (Essential Adults)	1,149	3,838
Totals	34,246	9,798	44,044

The numbers show a sharp increase with respect to 1968 when the corresponding total was only 30,540. Hence the percentage increase from one calendar year to the other was 44.5 per cent. Deducting the 5,463 persons 65 and over from the total results in a total of 38,581 persons under 65 as recipients of medical assistance, of whom 30,763 belong in the AFDC category. The number of individuals under 21 receiving medical assistance totalled 23,783 of whom 21,519 received such aid under the AFDC category.

Although the number of persons who received medical assistance during 1969 constitutes a large fraction of the number of individuals who did not possess prepayment plan coverage for hospital, surgical, or medical insurance, it cannot be assumed that the persons who received medical assistance for various health services represented the total or at least substantially the total number of individuals who actually needed the respective services but lacked voluntary prepayment coverage therefor. This becomes evident by comparing the number of persons receiving physicians' services under medicaid with the number of persons without insurance for medical services. In Part II-A of this report it was estimated that the number of individuals without medical insurance in 1969 was 116,381; physicians' services under medicaid during 1969 were rendered to 30,177 recipients under 65. It seems unreasonable to believe the the remaining 86,204 individuals were so healthy as not to require any physicians' services throughout the year.

The preceding paragraph involves an estimate of the number of persons who were eligible for medical assistance, i.e., of persons who would have been entitled to medical assistance if sickness had required them to seek medical care and public assistance for its defrayal.

The concept of eligibility for medical assistance is rather complex and varies from state to state. In Hawaii an individual is entitled to medical assistance, if he

(1) actually receives money payments under the special categorical assistance programs or the General Assistance Program, or

(2) is in need of "medical assitance only" because his income and resources are equal to or less than the medical assistance standard and meet the specific requirements under any categorical assistance programs (including categorical assistance).[110]

This signifies that a person must belong to the substandard income and resources group and meet the other prerequisites for the four categorical programs of the State (AABD, AFDC, CWFC, and GA). Since Hawaii has a broad categorical assistance program, including adults as well as children, the financial condition of adults who are incapacitated by illness is the paramount eligibility requirement.[111] This explains the fact that in Hawaii in February 1970, 14.7 per cent of medical care recipients were adults between 21 and 64, while the national average was only 2.6 per cent.[112] Adults who are not covered by the special categorical programs and who are not incapacitated or unemployable by reason of age and lack of skills nor have children under 18, however, are in general not entitled to medical assistance under General Assistance.[113]

Because of the complexity of the categorical conditions and the lack of reliable data on income distribution by family size, it seems to be impossible to arrive at a reliable estimate of the number of persons eligible for medical assistance in a given year.

State income tax data do not furnish a reliable basis for estimates for the intended purpose. On the other hand, the tax returns of single persons (unrelated individuals) include a substantial number of persons who are listed as dependents in the returns of other taxpayers. Hence the number of persons reporting low incomes is not a usable indicator of the number of families with low incomes and would reflect a high degree of duplication which cannot be

adjusted downward without excessive margin of error. On the other hand, the state income tax returns do not include all income. Excluded are retirement pay, pensions, and social security benefits. Hence in the case of aged persons, a substantial overcount may be produced. Finally a number of individuals may have no income but resources which exclude them from being potentially eligible for public assistance.

All these factors lead to the conclusion that the number of persons who could have received medical assistance had they applied therefore is not a vast one and that the coverage gap estimated in Part II-A of this report is not filled by medicaid even on the basis of the assumption that the number of eligibles exceeds that of the actual unduplicated recipients.

Most of all medicaid at present is primarily a "horse-out-of-the-barn type" of coverage. Although Title XIX authorizes prepayment plan coverage of persons in need of medical assistance[114] and includes expenditures for premiums in the scope of the Federal Medical Percentage and although the Handbook contains elaborate provisions relating to coverage by health insuring organizations or pooled funds,[115] the coverage of medical assistance clients is still in its incipiency. The State of Hawaii has embarked on a limited program providing prepayment coverage (at the rate of $82.38 for a subscriber with three dependents) of 500 families receiving aid under the State's AFDC and Child Welfare Foster Care programs.

Extending this type of coverage to the total population <u>now</u> entitled to medical assistance would present a number of technical difficulties. In the first place the different components of the current load (families with children, aged, blind, and permanently and totally disabled) would require different categorical rates. In the second place the coverage of the medical-assistance-only cases would necessitate advance determinations of eligibility which would result in a considerable increase of the social work case load, in contrast to the case of current money recipients where the eligibility results automatically. The total cost of such prepayment coverage is likewise difficult to assess, since such a system would most likely increase the number of individuals seeking to avail themselves of the coverage as well as the utilization of medical services per person. At present levels the net cost of medicaid, assuming an annual cost of $20,000,000 for 44,000 nonduplicated recipients, is $455 per person. The cost of a system of prepayment at current standards of eligibility might be substantially higher, until prepayment care lowers the frequency and severity rates. Even at that it would not close the present coverage gap.

Part III

RECOMMENDED MEASURES

A. General Aspects

The foregoing parts of the report concluded that at present voluntary prepayment plan coverage does not extend to a substantial portion of the population the size of which varies with the type of care, being smallest with respect to hospital insurance (11.7 per cent) and largest with respect to medical insurance (17.2 per cent).

It was also shown that medicaid at the present level of medical assistance standards would not close the whole gap, although eligibility for medicaid might benefit between 40 to 60 per cent of the persons concerned.

Against this background available options must be discussed. Of course, the spectrum of options is extremely broad, ranging from "no action whatsoever" to a total remodelling of the existing arrangements for the delivery and financing of medical care, i.e., establishment of a state health service system patterned after the British model.

Basically, however, two intermediate approaches deserve practical attention:

(a) Increase of the medical assistance standards to cover a much larger segment of the population, with or without introduction of prepayment arrangements;

(b) Extension of the existing system of prepayment plan coverage to additional categories of employees on a contributory basis, with or without a premium supplementation scheme.

The report recommends the second alternative because of its greater feasibility and fairness to the population as a whole.

Alternative (a), i.e., expansion of medicaid by an increase of the eligibility for medical aid, would not only be an extremely costly but also an impolitic measure, especially since the long-range benefits of prepayment coverage would be hard to achieve. Although the federal government would contribute a portion to the increased burden, the respective proportion of its share would decline sharply. In the first place the federal government does not contribute at all to the general assistance category, and this category might occupy a greater percentage of the total if eligibility were increased. Secondly, the 133-1/3 per cent rule, of the current General Assistance Standards,

would limit the federal share to a family income (2 adult family of four) of $4,300,[1] and any increase beyond that amount would either be unmatched by a federal contribution or necessitate a concomitant increase in the General Assistance Standards. Moreover, an attempt to cover the whole population entitled to medicaid would necessitate a constant surveillance of eligibility requiring a host of social workers and thus a substantial increase in administrative costs.

Since medicaid coverage must provide for comprehensive medical services, an increase in medicaid may create the real danger of an imbalance in utilization of medical facilities and overtaxing of the available delivery system. Finally, the provision of liberal free care might be an attraction to less fortunate families on the mainland which, under current constitutional construction, could not be stemmed by residence requirements.

Universal medical health insurance with an overhaul of the delivery system can only come on the federal level and even a truncated system in the form of liberalized medicaid is fraught with inherent limitations and inequities.

As a result it is recommended to establish an independent scheme of mandatory prepayment coverage which avoids disturbance and overlap with the presently existing medical assistance system, in particular, with those categories thereof that are entitled to federal contributions, i.e.:

(a) Aged,

(b) Blind and disabled,

(c) AFDC families, i.e., families with children and without or with unemployed fathers,

(d) Children under 21 in need of medical care.

Any overlap with these categories would result in a loss of the federal share of the burden and result in federal taxation upon the citizens of Hawaii without commensurate benefits. An overlap with general assistance coverage for medically needy would not be harmful and, in fact, be beneficial, since it would transform the coverage into the desirable prepayment type.

The most feasible scheme to accomplish the desired goals would be a mandatory prepayment coverage for employees under 65.

Such a system would have a number of desirable features. It would in effect be an extension of the existing arrangements, some sort of a "bringing up the rear" measure. It could use the available delivery system and employ the prevailing community standards as a norm. It would thus prevent an overtaxing of the facilities and exercise only minimal inflationary pressures. It would not be available to newly arriving welfare families, without violation of the constitutional prohibition against residence requirements.

Unfortunately, such a system would not only perpetuate the existing medical assistance system (which is unavoidable), but, in addition, might not reach certain deserving categories of persons with irregular or multiple employment and leave them to general assistance in case of incapacitating illness and after depletion of their resources. It would seem, however, that certain unavoidable shortcomings should not militate against the attempt to protect at least the preponderant majority of employees now without or without adequate prepayment coverage.

B. Mandatory Prepaid Health Care Coverage for Employees

The basic principles of the recommended scheme is quite simple:

(1) Every regular employee in private employment shall be protected by a prepaid plan providing for hospital, surgical, and medical benefits.

(2) The level of benefits should conform with the prevailing community standards.

(3) Unless a collective bargaining agreement or self-initiated employer's policy provides for an allocation of the costs more beneficial to the employee, the costs shall be shared equally by the employer and the employee.

(4) The prescribed coverage may be provided with any of the existing prepayment plan operators, regardless of whether they provide services, such as Kaiser or other medical group plans, or reimbursement either on a nonprofit principle, such as HMSA or similar organizations, or on the profit principle, as the commercial carriers.

(5) The scheme does not intend to interfere with the collective bargaining process or interfere with the services provided pursuant to such collective agreements, as in the sugar industry.

(6) The free choice of his physician by the employee shall be protected.

(7) In order to avoid an oppressive burden on low-wage earners and their employers, the mandatory scheme should be coupled with a plan for premium supplementation from general revenues.

Although the basic principles are easily stated, their implementation requires a number of difficult decisions regarding eligibility, governing rules for cases of irregular and multiple employment, prevention of duplicate coverage, and administration. These choices become particularly difficult and pressing if the system is coupled, as is envisaged, with a premium supplementation scheme.

By way of preface, it may be recalled that President Nixon announced plans for the introduction of a Family Health Insurance Program, submitted to the Senate Finance Committee, which provided for a government share of 100 per cent for families with incomes under $1,600, of 95 per cent for families with incomes between $1,600 and $3,000, of 90 per cent for families with incomes between $3,000 and $4,500, and 75 per cent for families with incomes between $4,500 and $5,620.[2] Of course, a state-supported supplementation scheme would have to be much more modest.

The State of Hawaii currently operates a rent supplementation scheme under sections 359-121 to 359-126, Hawaii Revised Statutes, as amended by Act 105, section 3, Session Laws of Hawaii 1970. The governing provisions provide for annual rent supplements on behalf of "qualified tenants" in amounts not to exceed $70 a month. The current net costs of this program are $318,755.[3] A similar system in the field of health protection seems appropriate.

Scope in Coverage

It is recommended that mandatory prepayment plan coverage extend to substantially all regular employees in private employment.

Federal employees could not be reached by a contributory scheme for constitutional reasons. State employees likewise may be excluded since group coverage on the contributory principle is available to them, and they are represented by various bargaining units.

A regular employee for the purposes of this recommended measure shall be an individual who is in the employ of any one employer for at least 20 hours per week.

The employer shall provide group coverage for a regular employee after he has been in his employ for four consecutive weeks. The coverage shall commence at the earliest date following that period at which the prepaid health care plan operator enrolls new subscribers.

Eligibility shall extend to all employees who receive at least an annual cash wage of $1,680 or a monthly wage of $140 from their regular employers. This figure is based on two considerations: It corresponds to the minimum wage, rounded off for ease of computation.[4] It dovetails reasonably with the medical assistance standard of $135 per month for single adults.

Exemptions

Certain groups of employees should be exempted from coverage either because of constitutional doubts or other policy reasons. This applies to:

(1) Family employment,

(2) Seamen,

(3) Employees of employees' benefit associations open only to federal employees,

(4) Insurance agents,

(5) Employment exempted from unemployment insurance coverage by the Federal Economic Opportunity Act of 1964.[5]

Avoidance of Duplicate Coverage

It is possible that an employee may enjoy prepaid health plan coverage apart from the mandatory coverage of the recommended legislation. Hence it is recommended that no duplicate coverage be required.

Coverage, apart from the required coverage under the recommended legislation, may exist because:

(1) The employee is covered under any other legislation of the State or the United States (e.g., medicare);

(2) The employee receives public assistance under any economic assistance program or is covered by a prepayment plan established under medicaid;

(3) The employee is covered as a dependent under the prepaid health care plan of his or her spouse or parent.

Required Health Benefits

It is recommended not to prescribe a rigid catalogue of items that must be included in a prepaid health care plan in order to qualify under the recommended act. It is felt that the prescribed coverage should be equal or medically equivalent to the health services offered under the prepayment plans that currently are most prevalent in the State, as for instance HMSA Plan 4 and Kaiser Plan O. The only requirements should be that the coverage include a combination of hospital, surgical, and medical benefits and that the hospital benefits extend to at least 150 days in each calendar year. To the extent that the prevailing plans provide for co-insurance or limits on reimbursability, the existing system shall not be changed and shall remain flexible.

Provision of Coverage by Principal Employer; Contributory Financing

It is recommended that each (principal) employer provide group prepaid health care plan coverage for his regular employees and that the premium therefor be paid on a contributory basis, i.e., one-half by the employer and one-half by the employee, unless the employer agrees to pay all or a greater share. In no case shall the employee be required to pay more than half of the cost.

A requirement that the employer (within limits) pay at least one-half of the cost of subscriber coverage would not constitute a radical innovation.

The questionnaire sent to the employers showed that out of 1,157 firms:

615 paid 100 per cent of the costs of subscriber coverage,

75 paid between 51 and 90 per cent thereof,

183 paid 50 per cent thereof,

22 paid between 14 and 48 per cent thereof, and

262 paid *nothing*.

In addition, 367 firms paid the whole costs of dependents coverage, while 254 contributed at least half of such costs.

At the lower wage brackets, however, the *imposition of the* costs of subscriber coverage upon the employee in the form of wage withholding and upon the employer as some sort of a payroll tax may become oppressive. At present the premium for the most prevalent health care prepayment plan providing for services is $160 per year. Hence at a low annual wage, a comparatively high percentage thereof would have to be allocated to health insurance, descending to lower figures as the income increases. The following table shows the relation between annual wage and percentage of premium costs:

$1,680:	9.52%
2,000:	8.00%
3,000:	5.33%
4,000:	4.00%
5,000:	3.20%
5,333:	3.00%

It would seem that there should be a limit on the percentage of wages which an employee and his employer should be required by statute to devote to the employee's health insurance. Otherwise the mandatory features might become too burdensome and not only restrict unduly the disposable income of the employee as well as curtail job opportunities. Hence at some limit a premium supplementation scheme should become operative.

Premium Supplementation

In order to prevent oppressiveness of the mandatory coverage, it *is recommended that the contributory system be coupled with a program* of premium supplementation, payable from state general revenues. Such a program would enhance the fairness of the distribution of the costs of compulsory health insurance, since Hawaii ranks only no. 35 (out of 51) in average weekly earnings from manufacturing[6] but no. 13 in

per capita personal income.[7]

The concrete features of such a premium supplementation program depend, of course, on a legislative judgment of fairness and feasibility. A system which supplements the premium costs above 3 per cent of the wages would be substantially more expensive than one that supplements premium costs above the 4 per cent level.

A system based on a 4 per cent maximum combined contribution would require annual supplementations ranging from $96.80[8] to $1 covering regular employees with annual earnings between $1,680 and $4,000, while a system based on a 3 per cent combined maximum would require annual contributions ranging from $109.60[9] to $1 covering regular employees with annual earnings between $1,680 and $5,334, i.e., require higher supplements to a greater number of people. An even larger supplement, in terms of persons entitled thereto and of maximum amounts, would flow from a 2.5 per cent combined maximum. In that case the supplement would start at the $6,400 bracket and reach $118.00 at the $1,680 level.

Unfortunately, it is well-nigh impossible to arrive at definite estimates of the costs of a supplementation program at various support levels. On the one hand there exist no reliable data with respect to the number of regular employees in the relevant wage brackets. On the other hand, it is difficult to estimate the number of employees in the various lower wage brackets who have coverage either as military dependents or as dependents of employees in the higher wage brackets with dependents' coverage and who therefore will not require any premium supplementation. It must be expected, however, that at least some of the employees who now have coverage paid entirely by them or jointly by them and their employers will claim premium supplementation, once it becomes available. It cannot be assumed that premium supplementation will only be claimed by employees in the lower wage brackets who at present have no coverage whatsoever or lack coverage for medical services.

The safest way to approach the problem is by calculating the uppermost limits of the costs of a supplementation program on the basis of wage and salary distribution figures derived from the state income tax returns, and then to make downward adjustments for the reason that the figures include wage earners that are excluded from the program, such as:

(a) Government employees,

(b) Maritime employees,

(c) Employees in the sugar industry,

(d) Part-time workers,

(e) Employees age 65 and over,

(f) Employees covered by Champus,

(g) Employees covered as dependents of workers, in the higher wage groups, and

(h) Welfare recipients.

It is safe to assume that most of the part-time employees and of the employees age 65 and over will belong to the lower income brackets, while the preponderant majority of the government workers will be above the $5,000 level.

Mr. Gordon Frazier of the Department of Labor and Industrial Relations has extended the State Income Patterns (Individual) between 1959 and 1967 to 1971 and arrived at the following results:[10]

$1,000 to $1,999:	20,500
2,000 to 2,999:	12,000
3,000 to 3,999:	11,000
4,000 to 4,999:	11,500
5,000 to 5,999:	13,000
6,000 to 6,999:	13,000

This would include approximately 31,200 wage earners in the $1,680 to $4,000 brackets, 47,000 in the $1,680 to $5,334 brackets, and 60,900 in the $1,680 to $6,400 brackets. The average annual wage in the State for 1969/1970 was slightly above $6,600.

Assuming an 8.0 per cent downward correction for employees age 65 and over and part-time employees would result in an estimate of the maximum cost of supplementation programs at various levels without downward correction for dependents' coverage under Champus or a pre-payment plan of a spouse or parent as subscriber or protection under medicaid.

The following tables show the maximum costs of premium supplementation programs at current wage and premium levels.

A. Premium Supplementation to Premiums in Excess of 3 Per Cent of Wages

Wage Bracket	No. of Employees	Average Annual Supplement	Costs Per Bracket
$1,680-$1,999	7,544	$104.80	$ 790,611
2,000- 2,999	11,040	85.00	938,400
3,000- 3,999	10,120	55.00	556,600
4,000- 4,999	10,580	25.00	264,500
5,000- 5,334	3,986	5.00	19,930
$1,680-$5,334	43,270		$2,570,041

B. Premium Supplementation to Premiums in Excess of 4 Per Cent of Wages

Wage Bracket	No. of Employees	Average Annual Supplement	Costs Per Bracket
$1,680-$1,999	7,544	$ 86.40	$ 651,802
2,000- 2,999	11,040	60.00	662,400
3,000- 3,999	10,120	20.00	202,400
$1,680-$4,000	28,704		$1,516,602

C. Premium Supplementation to Premiums in Excess of 2.5 Per Cent of Wages

Wage Bracket	No. of Employees	Average Annual Supplement	Costs Per Bracket
$1,680-$1,999	7,544	$114.50	$ 863,788
2,000- 2,999	11,040	97.50	1,076,400
3,000- 3,999	10,120	72.50	733,700
4,000- 4,999	10,580	47.50	502,550
5,000- 5,999*	13,000	22.50	292,500
6,000- 6,399*	5,200	5.00	26,000
$1,680-$6,399	57,484		$3,494,938

*No adjustment for aged and part-time employees.

Of course, it could be decided to adopt a staggered system: supplementation to premiums in excess of 2.5 per cent for wage earners under $3,999 and in excess of 3.00 per cent for wage earners between $4,000 and $5,334.

D. Premium Supplementation to Premiums in Excess of 2.5 Per Cent for Wage Earners Below $3,999 and of 3 Per Cent for Earnings Above

Wage Bracket	No. of Employees	Average Annual Supplement	Costs Per Bracket
$1,680-$1,999	7,544	$114.50	$ 863,788
2,000- 2,999	11,040	97.50	1,076,400
3,000- 3,999	10,120	72.50	733,700
4,000- 4,999	10,580	25.00	264,500
5,000- 5,334	3,986	5.00	19,930
$1,680-$5,334	43,270		$2,958,318

RECOMMENDED MEASURES

As was pointed out before the figures in the tables express outer limits and require downward adjustments because of the inclusion of:

(a) Employed welfare mothers and other employed adult welfare recipients;

(b) Employed military dependents; and

(c) Employed dependents of employed wage earners with dependents' coverage, especially in the higher brackets.

In Part I an effort was made to arrive at an estimate of employed persons with dependents' coverage and it was concluded that 21.3 per cent of the employed labor force could be considered as protected by such coverage.

On that basis it can be concluded that the net costs of the premium supplementation program set forth under Table A would be in the neighborhood of $2 million, rather than $2½ million and that program B would cost $1.2 million rather than $1.52 million. In other words extension of the existing system by mandatory coverage with premium supplementation at lower-wage brackets would involve about one-tenth of the cost of medicaid.

It is recommended that the Legislature adopt Plan A. While, of course, this report does not presume to invade the province of legislative judgment, it would seem that 3 per cent of the wages (split into shares of 1.5 and 1.5) could be afforded by single wage earners even at annual wages in low brackets. An employed woman with a dependent child might be entitled to AFDC benefits and therefore exempt from compulsory coverage, if her annual wage is less than $2,400.

The figure of 3 per cent seems to be in consonance with the federal tax policy. Medical expenses below 3 per cent are not deductible. Of course, one-half of the employee's share of health insurance premiums (not in excess of $150) are deductible regardless of the limitation of medical expenses to amounts in excess of 3 per cent.

Primary and Secondary Employers

It is recommended that the duty to provide group coverage and to contribute at least one-half to the premium not in excess of 1.5 per cent of the wages (unless otherwise provided by collective bargaining agreement or employment policy) be imposed upon the primary employer. "Primary employer" is the employer of a regular employee who pays the highest monthly wage.

Secondary employers are relieved from the duty to provide group coverage, but they should contribute 3 per cent of the wages of such employee (1.5 per cent to be raised by withholding), if (a) the employee is a regular employee of such secondary employer, (b) he receives monthly wages of $140 or more, and (c) the Premium Supplementation and Continuation Fund had to supplement the premium payable in respect to such employee by the primary employer.

In such case the contributions of the secondary employer should be payable to the Fund, subject to the limitation that he contribute no more than the actual supplementation.

Premium Continuation in Case of Prolonged Illness

Group policies require monthly premium payments regardless of whether the employee is hospitalized or otherwise incapacitated at the due date. Group policies contain no waiver of premium clauses. Since the system recommended is predicated on actual employment and wages earned, it could happen that the group coverage might lapse during hospitalization or other loss of wage-earning capacity, unless provision is made for premium continuation during prolonged illness. If, for example, an employee is hospitalized before the next premium falls due, the employee would earn no wages at that time and the hospitalization coverage would lapse, rendering the entitlement to 150 days of hospitalization illusory.

It is recommended that the employer pay the premium or the obligatory portion of the premium (including the employee's share) for the month following the employee's loss of wage-earning capacity. If the employee returns to work the withholding of 1.5 per cent, if appropriate, would be resumed.

If the loss of wage-earning capacity continues beyond the end of that grace period, the future premiums should be paid by the Premium Supplementation and Continuation Fund until the employee

returns to work, but not in excess of four months, thus covering the whole period of insured hospitalization.

It is recommended that the premium continuation program be limited to the earning groups that require premium supplementation, i.e., the low-wage brackets. Higher earnings brackets have means to protect themselves, especially as TDI supplies additional income.

If the continuation program is restricted to wage-earners in the brackets below the earnings level, 3 per cent of which are less than the premium for individual coverage, the total additional burden on the Premium Supplementation and Continuation Fund would be relatively light since:

(1) The incidence of disabling illness beyond 30 days is not high; and

(2) The amount payable is the amount of the premium minus the supplement payable in any case.

It is safe to estimate that the additional costs would be around $50,000.

On the basis of Table A used in the section on premium supplementation, the remaining monthly balance would be:

$ 4.60	for	the	earners	in	the	bracket	$1,680-$1,999
6.25	"	"	"	"	"	"	2,000- 2,999
8.75	"	"	"	"	"	"	3,000- 3,999
11.25	"	"	"	"	"	"	4,000- 4,999
12.92	"	"	"	"	"	"	5,000- 5,334

Unfortunately, only the continuation rates for incapacity due to hospitalization are known for Hawaii.

According to information obtained from the largest prepayment plan operator in the State, 8 per cent of the subscribers require hospitalization. Of this number (80 per 1,000), 3.3 per cent (2.64 per 1,000) remain hospitalized for more than 30 days, 8 per cent (.64 per 1,000) for more than 60 days and 4 per cent (.32 per 1,000) for more than 90 days.

If hospitalization alone were the basis of premium continuation, the burden on the Fund would be minimal, involving 3.92 monthly

payments in the respective brackets, resulting in the following amounts on the basis of the number of employees estimated to constitute the respective brackets:

Brackets	No. of Payments	Amount
$1,680-$1,999	30	$ 138.00
2,000- 2,999	43	268.75
3,000- 3,999	40	350.00
4,000- 4,999	40	450.00
5,000- 5,334	15	193.80
Total		$1,400.55

Of course, many persons may be confined and unable to earn wages without being hospitalized. An estimate of the additional number of persons thus afflicted is difficult because of the absence of data on that matter relative to Hawaii.

The issue of continuation tables relating to temporary disability was discussed at great length in the study on Temporary Disability, published by the Bureau in 1969.[11] These tables relate to the duration of compensated disability after expiration of one week's waiting period. They permit an estimate of the costs of premium continuation after one month of confinement has expired. In California 90 per 1,000 covered persons were disabled for one week. The original number decreased to 60 per cent at the beginning of the second month, 34 per cent at the beginning of the third month, 20 per cent at the beginning of the fourth month and 13.5 per cent at the beginning of the fifth month. Hence, a continuation program of four months beginning after the first month of confinement would involve 117 payments per 1,000 workers. On that basis the cost of the additional program would be:

Wage Brackets	No. of Payments	Amount of Payment	Total
$1,680-$1,999	883	$ 4.60	$ 4,061.80
2,000- 2,999	1,292	6.25	8,075.00
3,000- 3,999	1,184	8.75	10,360.00
4,000- 4,999	1,238	11.25	13,927.50
5,000- 5,334	466	12.92	6,021.72
Total			$42,446.02

Hence, the total cost of the burden on the Fund from the combined premium supplementation and continuation program would be $2,050,000 without costs of administration.

Freedom of Collective Bargaining

As was stated before the mandatory coverage should not interfere with the collective bargaining process.

Collective programs which provide different health benefits, different allocation of the premium costs, or dependents' coverage are not intended to be affected.

This rule applies even with respect to eligibility conditions especially different probationary periods.

There is, however, one important limitation: if the collective agreement does not provide coverage for certain service categories, such as clerical workers, custodial employees, etc. the mandatory coverage of the recommended measure should apply.

Administration

The administration of the program should be located in the Department of Labor and Industrial Relations and affiliated with the administration of T.D.I. In some respect the measures are twins.

Only one aspect, the medical equivalency of plans, should be determined by another agency: the Department of Health.

The chief administrative work will result from:

(a) The special status of secondary employers;

(b) The exclusion of employees who have coverage under other programs; and

(c) The premium supplementation and continuation program.

The program should be self-administering to the largest extent possible. Proper notice forms should greatly reduce the work.

Employees should receive notice forms at their place of employment or the departmental offices.

Forms should be developed for:

(1) Notice that a particular employer is not the primary employer;

(2) Notice that exemption from coverage is claimed because the employee already has coverage,

(a) as military dependent,

(b) as dependent of another employee,

(c) because he is entitled under another program providing protection (medicare, medicaid).

Notices by employees should be deemed to be true and should not infringe upon the employee's privacy.

Multiple employment is to be notified only to the secondary employer (with a copy to the Department)

The employee need not specify whether he receives welfare payments or medicare. A general reference to such exemption should suffice.

The premium supplementation program should be mainly administered by the prepayment plan operators themselves. They should submit lists of premium deficiencies stating the names of the subscriber employees and the amount of the deficiency, at intervals determined by the Department, preferably in accord with the principal prepayment plan operators.

They shall be entitled to a service charge, payable from the Fund.

Collection of premiums from secondary employers shall be in the discretion of the Department, in order to prevent useless work with no substantial recovery.

Employers should be audited, according to the general practice of the Department.

C. Unfinished Business: The Next Steps

The bill as recommended creates mandatory prepaid health plan coverage for every regular employee in private employment earning not less than $1,680 from one employer, coupled with premium supplementation for low-wage earners. It thus falls short of the goal of universal prepayment coverage.

As a result, the health service protection in the State will consist of a three-strata arrangement:

(1) Medicaid;

(2) Minimum mandatory prepayment plan coverage for individuals above the medicaid level;

(3) Voluntary prepayment plan coverage for dependents and self-employed.

The reasons for this composite scheme are the federal matching system for the lowest income levels and the need for disposable income and avoidance of excessive payroll taxes in the case of wages, 3 per cent whereof would not yield even a subscriber premium.

Of course, dependents' coverage in higher wage brackets could easily be made mandatory by providing that employees earning more than a specified amount must be protected by a prepayment plan, including dependents. The proper base line, for example, could be earnings 5 per cent of which yield at least the premium for one dependent, i.e., $6,400 at current rates. There is, however, the question of whether there is a real need for such a protection, since it exists apparently anyhow on a voluntary basis.

The real gaps exist with respect to certain categories in or related to the low-income brackets, in particular:

(a) Self-employed with low incomes (and their dependents);

(b) Wage earners who customarily have several employers none of whom employs the wage earner for at least 20 hours a week (cleaning helpers);

(c) Full-time students aged 21 and above;

(d) Nonworking wives of low-wage earners and to a lesser degree minor children of such wage earners.

Children (including all persons under 21) enjoy much better medicaid protection than adults since all needy children (not only children of AFDC families) are entitled to medical assistance if the family income is below a level varying with size ($2,700 for a family of 2, $3,060 for a family of 3, $3,600 for a family of 4, and $4,200 for a family of 5).

It is very difficult to provide mandatory coverage for the categories listed above under (a) to (c) since the devise of wage withholding is not applicable.

While a mandatory scheme using taxes with offset credits or penalties could be devised (although its constitutionality would need some study), it would probably be more advisable to create an optional scheme, using supplementation as an incentive. Obviously, if wage earners with regular employers are entitled to premium supplementation, self-employed and wage earners in multiple employment with low earnings should likewise be entitled to such benefits. An arrangement of this type could use either the Premium Supplementation Fund as a vehicle or a tax credit system similar to that provided in section 235-56.5, Hawaii Revised Statutes. It could, for instance, be provided that any person whose income results principally from self-employment or multiple employment and is more than $1,680 and less than $5,334 shall be entitled to a tax credit in the amount of receipted health prepayment plan premiums paid minus 3 per cent of such income, returns being due on a quarterly basis.[12]

Similar provisions could be made for dependents' coverage.

No provisions of that type are included in the bill recommended at this time, but its speedy supplementation by the creation of an optional scheme providing premium supplementation for some or all of the persons in low-income groups still lacking coverage should be kept in mind. It should be instituted after experience has been gained with the operation of the compulsory minimum coverage plan.

In the hope that the Legislature may take one of the next steps immediately, a Part V to the suggested legislation, Tax Credits for Optional Coverage of Low-Income Subscribers is included.

Part IV

(To be made one and ten copies) **PROPOSED BILL**

HOUSE OF REPRESENTATIVES
SIXTH LEGISLATURE, 1971
STATE OF HAWAII

H.B. NO.

A BILL FOR AN ACT

RELATING TO THE HAWAII HEALTH PREPAYMENT ACT.

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

SECTION 1. The Hawaii Revised Statutes is amended by adding a new chapter to be appropriately numbered and to read as follows:

"CHAPTER

PREPAID HEALTH CARE LAW

PART I. SHORT TITLE; PURPOSE; DEFINITIONS

Sec. -1 Short title. This chapter shall be known as the Hawaii Prepaid Health Care Law.

Sec. -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 to provide this type of protection for the employees in this State. In view of the spiralling cost of comprehensive medical care, only a limited basic protection can be achieved without federal action in this field. 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 interfere with or diminish any protection already provided pursuant to collective bargaining agreements or employer-sponsored plans that is more favorable to the employees benefited thereby than the protection provided by this chapter or at least equivalent thereto.

Sec. -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 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 -4 and -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 engaged in the employment of any one employer for at least twenty hours per week.

The director by regulation may establish comparable standards for those employments which call for irregular work schedules.

(9) "Wages" means all cash remuneration for services from whatever source, including commissions, bonuses, and tips and gratuities paid directly to any individual by a customer of his employer.

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 from tips shall be deemed to be at least equal to the wage required by chapter 387 or a greater sum as determined by regulation of the director.

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

Sec. -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.

Sec. -5 Excluded services. "Employment" as defined in section -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 members of the association or their dependents or their designated beneficiaries, if (A) admission to membership in the association is limited to individuals who are officers or employees of the United States government, and (B) no part of the net earnings of the association inures (other than through such payments) to the benefits of any private shareholder or individual.

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

(5) 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.

Sec. -6 Principal and secondary employer defined. If an individual is concurrently a regular employee of two or more employers as defined in this chapter, the employer who pays the highest monthly wage shall be the principal employer of the employee. His other employers are secondary employers.

If an individual is concurrently a regular employee of a public entity which is not an employer as defined in section -3 and of an employer as defined in section -3 the latter shall be deemed to be a secondary employer if the monthly wage paid by him to the individual is less than the monthly remuneration paid to the individual by the public entity.

Sec. -7 Required health care benefits. (a) The extent of the health care benefits provided by a prepaid health care plan required by section -11 shall be equal or equivalent to the benefits provided by prepaid health plans of the same type which are prevalent in the State. This applies to the types and quantity

of benefits as well as to limitations on reimbursability and to required amounts of co-insurance.

(b) A prepaid health care plan qualifying under this chapter shall include the following benefits:

(1) Hospital benefits:

(A) In-patient care for a period of at least one hundred and fifty 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;

(B) After-care visits for a reasonable period;

(C) Anesthesiologist services.

(3) Medical benefits:

(A) Necessary home, office, and hospital visits;

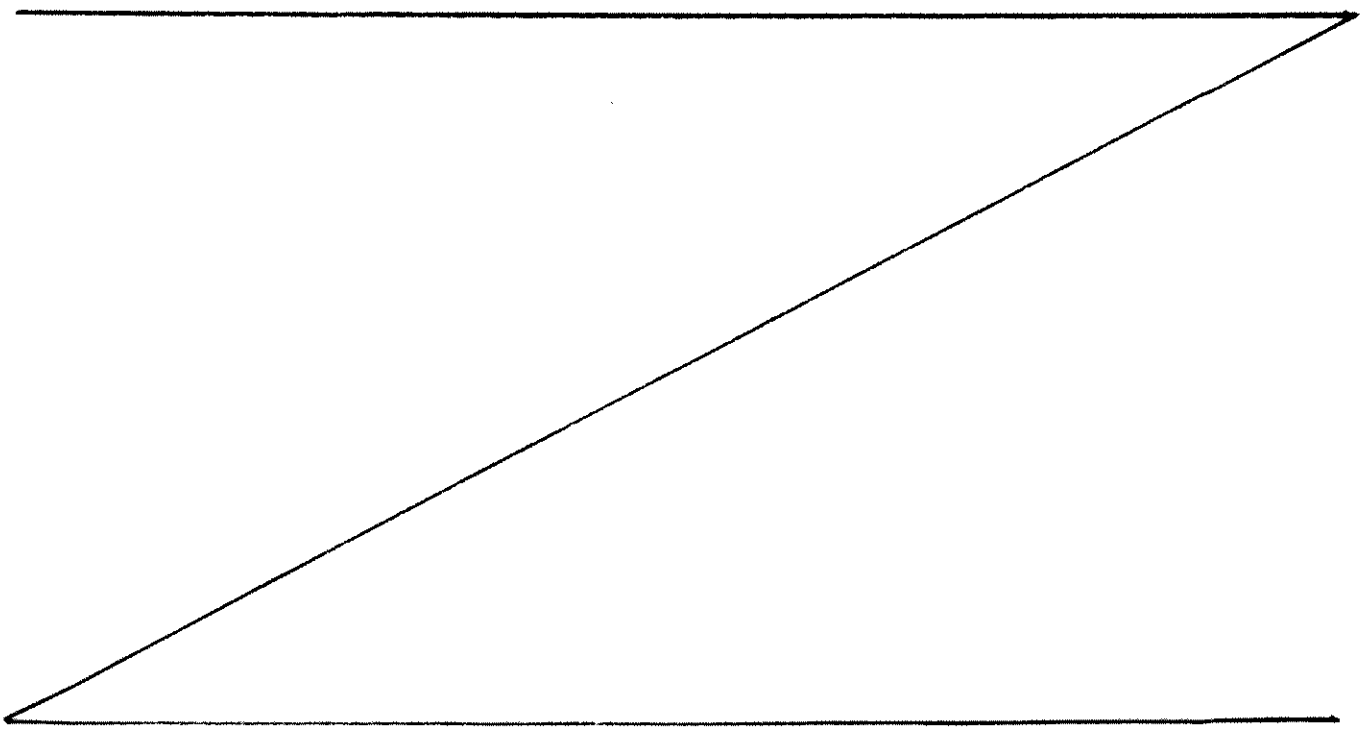
(B) Intensive medical care while hospitalized;

(C) Medical or surgical consultations while confined.

(4) Diagnostic laboratory services, x-ray films, and radiotherapeutic 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.

(c) If necessary, the director of health shall determine if a prepaid health care plan meets the standards specified in subsections (a) and (b).



PART II. MANDATORY COVERAGE

Sec. -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, as rounded off by regulation of the director, shall provide coverage of such employee by a group prepaid health care plan entitling the employee to the required health care benefits with a prepaid health care plan contractor in accordance with the provisions of this chapter.

Sec. -12 Choice of plan and of contractor. (a) Unless the employer pays the total amount of the premium for coverage under a plan operating on the reimbursement principle, every employee entitled to coverage 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.

(b) If the employee elects a plan which obligates the prepaid health care plan contractor to furnish the required health care benefits and several prepaid health care plan contractors in the State provide the required benefits by such type of plan, the employee may elect the particular contractor but the employer shall not be

obligated to contribute a greater amount to the premium than he would have to contribute had the employee elected coverage with the contractor providing the prevailing coverage of this type in the State.

(c) If the employee elects a plan which obligates the prepaid health care plan contractor to defray or reimburse the expenses of health care, the employer may select the contractor with whom such coverage shall be provided but an employee shall not be obligated to contribute a greater amount to the premium than he would have to contribute had the employer selected coverage with the contractor providing the prevailing coverage of this type in the State.

(d) If the contributions of the employer and employee are not sufficient to pay the premium charged for coverage under a particular plan and premium supplementation is required as provided in this chapter, the amount of the supplementation shall not exceed the amount required had coverage with the contractor providing the prevailing coverage of the type selected in the State been chosen. Any excess shall be paid by the party making the selection.

Sec. -13 Liability for payment of premium in general. Except as otherwise provided in section -12 and subject to the limitation provided in section -14, 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.

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

Sec. -14 Limitation on liability; premium supplementation. Unless an applicable collective bargaining agreement specifies otherwise, an employer may not withhold more than 1.5 per cent of the employee's wages for the purposes of this chapter and the employer's share may likewise be limited to this percentage.

If the combined contributions of the employer and the employee are not sufficient to pay the premium the balance shall be paid by the premium supplementation and continuation fund established by this chapter subject to the provisions of section -12(d).

Sec. -15 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 weeks, at the earliest time thereafter at which coverage may be provided with the prepaid health care plan contractor selected pursuant to this chapter.

Sec. -16 Continuation of coverage in case of inability to earn wages. (a) If an employee is hospitalized or otherwise prevented by sickness from working the employer shall continue the coverage of the employee for the month following the employee's sickness by paying his and the employee's share of the premium as required by sections -13 and -14 and the premium supplementation and continuation fund shall pay any balance as provided in section -14. If the employee returns to work during this month the employer may withhold 1.5 per cent of the wages earned after

his return, unless an applicable collective bargaining agreement provides otherwise.

(b) If the employee is still hospitalized or otherwise prevented by sickness from working after the expiration of the month specified in subsection (a) the premium supplementation and continuation fund shall continue the coverage by paying the required premium until the employee is able to return to work but not in excess of four additional months.

Sec. -17 Liability of secondary employer. (a) 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 -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 -19 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.

(b) If a secondary employer of an individual who has been his regular employee for at least four weeks, pays to such employee monthly wages of at least the amount specified in section -11, he shall be liable to contribute to the premium supplementation and continuation fund for premium deficiencies as provided in section -37.

Sec. -18 Exemption of certain employees. (a) In addition to the exemption specified in section -17, an employer shall be relieved of his duty under section -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.

Sec. -19 Termination of exemption. (a) If an exemption which has been claimed by an employee pursuant to section -18 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, including the relation of the wages received in concurrent

employment, 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.

Sec. -20 Freedom of collective bargaining. (a) Nothing in this chapter shall be construed to limit the freedom of employees to bargain collectively for different prepaid health care plan coverage or for a different allocation of the costs thereof. A collective bargaining agreement may provide that the employer himself undertakes to provide the health care specified in the agreement.

(b) If 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, but 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.

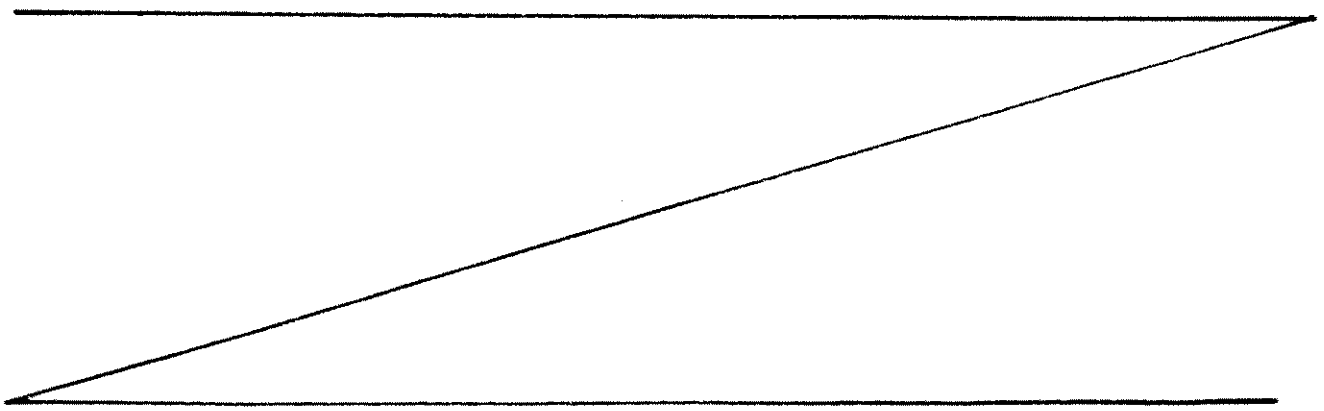
Sec. -21 Adjustment of employer-sponsored plans. Where employees subject to the coverage of this chapter are included in the coverage provisions of an employer-sponsored prepaid health care plan covering similar employees employed outside the State

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.

Sec. -22 Individual waivers prohibited. An employee shall not be permitted to waive individually all or a part of the required health care benefits or to agree to pay a greater share of the premium than is required by this chapter.

Sec. -23 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.

Sec. -24 Regular group rates for coverage under this chapter. Every prepaid health care plan contractor authorized to provide prepaid health care plan coverage in the State shall provide the coverage required by this chapter at the community premium group rate charged by him for the applicable type of coverage.



PART III. PREMIUM SUPPLEMENTATION AND CONTINUATION

Sec. -31 Establishment of special premium supplementation and continuation 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 and continuation which shall be administered exclusively for the purposes of this chapter. All contributions by secondary employers pursuant to this part shall be paid into the fund and all premium supplementations and continuation 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 and continuation under this part, (2) all moneys collected from secondary employers pursuant to this part, and (3) all fines and penalties collected pursuant to this chapter.

Sec. -32 Management of the fund. The director of finance shall be the treasurer and custodian of the premium supplementation and continuation fund and shall administer the fund in accordance with the directions of the director of labor and industrial relations. All moneys in the fund shall be held in trust for the purposes of this part only and shall not be expended, released, or appropriated or otherwise disposed of for any other purpose. Moneys in the fund may be deposited in any depositary bank in which general funds of the State may be deposited but such moneys shall not be commingled with other state funds and shall be maintained in separate accounts on the books of the depositary bank. Such moneys shall be secured

by the depositary bank to the same extent and in the same manner as required by the general depositary law of the State; and collateral pledged for this purpose shall be kept separate and distinct from any other collateral pledged to secure other funds of the State. The director of finance shall be liable for the performance of his duties under this section as provided in chapter 37.

Sec. -33 Disbursements from the fund. Expenditures of moneys in the premium supplementation and continuation fund shall not be subject to any provisions of law requiring specific appropriations or other formal release by state officers of money in their custody. All payments to prepaid health care plan contractors shall be paid from the fund upon warrants drawn upon the director of finance by the comptroller of the State supported by vouchers approved by the director.

Sec. -34 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 and continuation fund as are in excess of the amount deemed necessary for the payment of benefits for a reasonable future period. Such moneys may be invested in bonds of any political or municipal corporation or subdivision of the State, or any of the outstanding bonds of the State, or invested in bonds or interest-bearing notes or obligations of the State (including state director of finance's warrant notes issued pursuant to chapter 40), or of the United States, or those

for which the faith and credit of the United States, are pledged for the payment of principal and interest, or in federal land bank bonds or joint stock farm loan bonds. The investments shall at all times be so made that all the assets of the fund shall always be readily convertible into cash when needed for the payment of benefits. The director of finance shall dispose of securities or other properties belonging to the fund only under the direction of the director of labor and industrial relations.

Sec. -35 Premium supplement, when and how payable. (a) When three per cent of the monthly wages of an employee are less than the monthly premium for the prepaid health care plan coverage required by this chapter and when the payments by the employer, including the share of the employee withheld from his wages, to the prepaid health care plan contractor are not sufficient to pay in full the premium payable under the plan with respect to that employee, the premium supplementation fund shall pay the balance, subject to the limitation specified in section -12(d), upon certification of such deficiency by the contractor, as prescribed by regulation of the director.

(b) A prepaid health care plan contractor shall not certify any deficiency with respect to any employee who according to its records is already covered, either as an employee or as a dependent, under another prepaid health care plan.

Sec. -36 Premium continuation when and how payable. (a) If an employee covered by this chapter is hospitalized or otherwise prevented by sickness from working and the continuation of the premium payments by the employer has ended the premium supplementation and continuation fund shall pay the premium as provided by section -16(b).

(b) The employer shall promptly notify the prepaid health care plan contractor that he is relieved from further premium payment because of the continued hospitalization or sickness of the employee and the contractor thereupon shall certify the need for premium continuation to the director as provided by regulation of the director.

Sec. -37 Collection of deficiency payments from secondary employers. (a) When the premium supplementation and continuation fund has been obliged to pay a premium supplementation with respect to any employee and a secondary employer of such employee is liable for premium deficiencies pursuant to section -17(b), the director may collect such deficiency from the secondary employer, but the liability of such employer for any monthly deficiency shall not exceed three per cent of the employee's monthly wages half of which amount may be withheld from the employee's wages.

(b) Where an employee has more than one secondary employer liable under section -17(b), the deficiency payments under subsection (a) shall be prorated among the secondary employers in proportion to the monthly wages paid by them to the employee.

PART IV. ADMINISTRATION AND ENFORCEMENT

Sec. -41 Enforcement by the director. Except as otherwise provided in section -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.

Sec. -42 Rule making and other powers of the director. (a) 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.

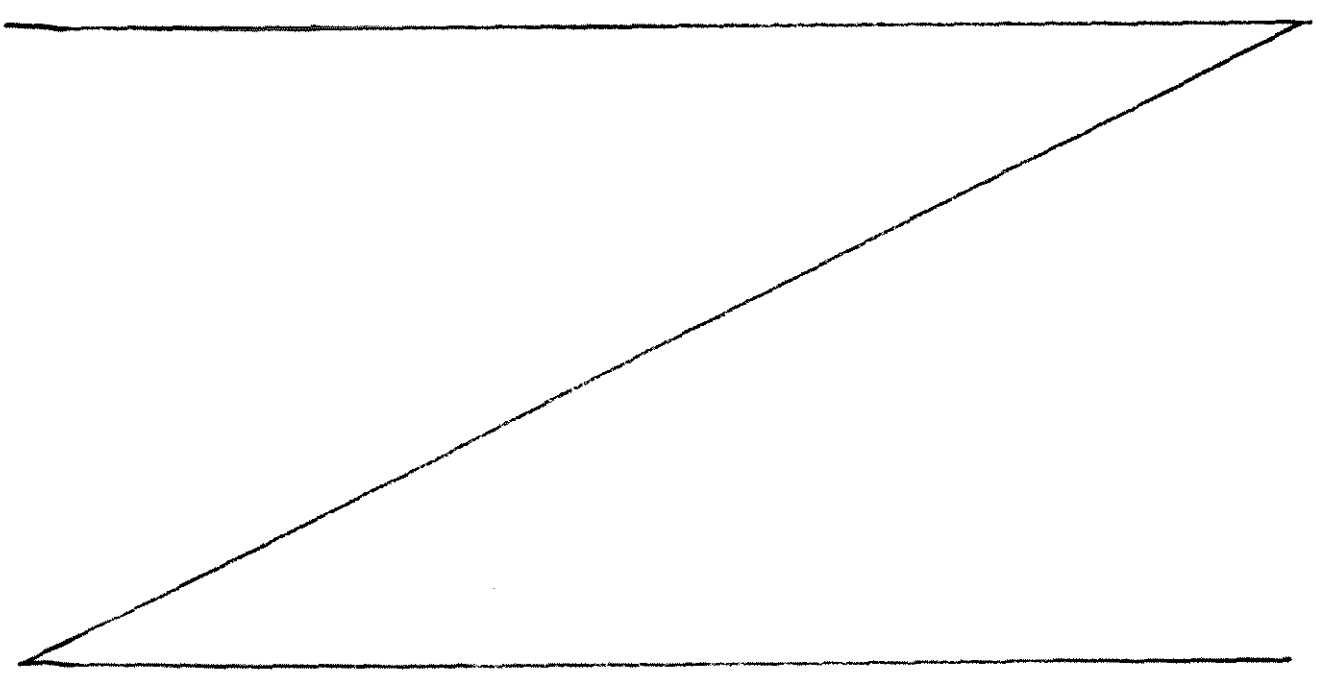
The director may round off the amounts specified in this chapter for the purpose of eliminating payments from the premium supplementation and continuation fund in other than even dollar amounts or other purposes.

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

(b) The director may make arrangements with prepaid health care plan contractors, including the payment of a service fee, for the proper keeping of records and other duties necessary for the administration of the provisions relating to premium supplementation and continuation.

Sec. -43 Penalties. (a) If an employer fails to comply with sections -11, -12, -13, or -36 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 and continuation established by section -31. 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 wilfully 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.



PART V. TAX CREDITS FOR OPTIONAL COVERAGE OF LOW INCOME SUBSCRIBERS

Sec. -51 Entitlement to tax credits for prepaid health care plan premiums. A resident taxpayer ninety per cent of whose income consists either of income from business or profession, or of wages none of which is paid by an employer employing the taxpayer as a regular employee as defined in section -3(8), shall be entitled to a tax credit for premiums paid by him for coverage of himself by a group prepaid health care plan as hereinafter provided.

Sec. -52 Income limits entitling to tax credit. A resident taxpayer who has received income of the type specified in section -51 shall be entitled to the tax credit under this part, if this income is at least the amount specified in section -11 and does not equal or exceed an amount three per cent of which suffices to pay the premium at the rate prevailing in the State for the selected type of plan.

Sec. -53 Amount of tax credit. The amount of the tax credit so provided shall be the difference between the premium, not exceeding the amount specified in section -52 and three per cent of the income of the type specified in section -51.

Sec. -54 Tax credits in joint returns. In cases of joint returns each spouse shall be entitled to the tax credit for the premium paid for his or her coverage on the basis of his or her income of the type specified in section -51.

Sec. -55 Tax credit how effected. (a) The tax credit claimed by a taxpayer under this part shall be applied to the taxpayer's net income tax liability, if any, for the tax year in which such tax credit is properly claimed. In the event the tax credits claimed by, and allowed to a taxpayer, exceed the amount of the income tax payments due from the taxpayer, the excess of such credits over payments due shall be refunded to the taxpayer; provided that tax credits properly claimed by and allowed to an individual who has no income tax liability, shall be paid to the individual; and provided further that no refunds or payments on account of the tax credits allowed under this part shall be made for an amount less than $1.

(b) All of the provisions relating to assessments and refunds under chapter 235 and section 231-23(d)(1) shall apply to tax credits under this part.

Sec. -56 Form of claiming tax credit; rules for administration. The director of taxation shall prepare and prescribe the appropriate forms to be used by taxpayers in filing claims for tax credits under this part. He may prescribe the type of proof that the taxpayer must furnish for the payment by him of premiums paid under a group prepaid health care plan and promulgate any rules and regulations, pursuant to chapter 91, necessary to effectuate the purposes of this part.

Sec. -57 Determination of prevailing premium rates. The director of taxation, after consultation with the director of labor and industrial relations, shall determine for each tax year the premium rate prevailing in the State for group prepaid health care plans of the types specified in section -3(6)(A) and (B).

Sec. -58 Group coverage made available to individuals desiring optional coverage under this part. Every prepaid health care plan contractor authorized to provide prepaid health care plan coverage in this State shall provide group prepaid health care plan coverage for individuals desiring optional coverage under this chapter at the community group rate charged by him for the applicable type of coverage.

Sec. -59. Time for filing claims for tax credit. Claims for tax credits under this part, including any amended claims thereof, must be filed on or before the end of the twelth month following the taxable year for which the credit may be claimed."

SECTION 2. There is appropriated out of the general revenues of the State the sum of $, or so much thereof as may be necessary, for the purposes of this Act.

SECTION 3. This Act shall take effect upon its approval, except that the coverage by group prepaid health care plans required by this Act and the payment of premiums for such coverage shall commence January 1, 1972, and except that tax credits provided for in part V shall be effective for taxable years beginning on and after January 1, 1972.

FOOTNOTES

Part I

1. For the story of the drive for compulsory health insurance in the United States, see Armstrong, Insuring the Essentials, pp. 370-375 (1932); Riesenfeld and Maxwell, Modern Social Legislation, p. 449 (1950); Sinai, Anderson and Dollar, Health Insurance in the United States, pp. 7-21 (1946); Wilson, Compulsory Health Insurance (National Industrial Conference Board, Studies in Individual and Collective Security, No. 3) (1947); Anderson, "Compulsory Medical Care Insurance, 1910-1950," The Annals of the American Academy of Political and Social Science, January 1951, p. 106.

2. The German law is discussed in Armstrong, op. cit. supra note 1, p. 304.

3. The English law is discussed in Armstrong, op. cit. supra note 1, p. 315.

4. See Riesenfeld and Maxwell, op. cit. supra note 1, p. 294. The California Compensation Act of 1911 was probably the first law containing such provision.

5. Stefan A. Riesenfeld, Study of the Workmen's Compensation Law in Hawaii, University of Hawaii, Legislative Reference Bureau, Report No. 1 (1963), p. 8.

6. 6 Am. Lab. Leg. Rev. 237 (1916); Rubinow, Standards of Health Insurance (1916).

7. See Riesenfeld and Maxwell, op. cit. supra note 1, p. 449.

8. Study commissions were appointed in ten states, viz. California, Connecticut, Illinois, Massachusetts, New Hampshire, New Jersey, New York, Ohio, Pennsylvania, and Wisconsin. Massachusetts and California had two successive commissions. The reports of these commissions (with the exception of that of New Hampshire) are discussed by Lapp, "The Findings of Official Health Insurance Commissions," 10 Am. Lab. Leg. Rev. 27 (1920). For the methods applied by these commissions, see also "Problems and Methods of Legislative Investigating Commissions," 8 Am. Lab. Leg. Rev. 83 (1918).

9. The study commissions of California, New Jersey, New York, and Ohio favored the introduction of compulsory health insurance, while the commissions of Connecticut, Illinois, Massachusetts (in its second report), and Pennsylvania rejected it. See Wilson, op. cit. supra note 1, pp. 2 and 3.

10. Medical Care for the American People, Final Report of the Committee on the Costs of Medical Care (University of Chicago Press, 1932).

11. For a discussion of the work and findings of the commission, see Sinai, Anderson and Dollar, op. cit. supra note 1, p. 12; Anderson, op. cit. supra note 1, p. 108.

12. Riesenfeld and Maxwell, op. cit. supra note 1, pp. 10 and 450.

13. See Reed, "Legislative Proposals for Compulsory Health Insurance," 6 Law and Contemporary Problems 628, 629 (1939); Wilson, op. cit. supra note 1, p. 7.

14. S. 1620, 76th Cong., 1st Sess. (1939), proposing inter alia to add a Title XIII to the Social Security Act, providing for federal grants-in-aid to state measures for the extension and improvement of medical care, including compulsory health insurance, see Maslow, "The Background of the Wagner National Health Bill," 6 Law and Contemporary Problems 606 (1939); Cavers, "Public Medical Services Under Title XIII of the National Health Bill," id. at 619; Reed, "Legislative Proposals for Compulsory Health Insurance," id. at 628.

15. The National Health Bill, op. cit. supra note 14, proposed to add a separate title (XIV) to the Social Security Act, providing for T.D.I. benefits.

16. See Reed, op. cit. supra note 13, and Wilson, op. cit. supra note 1, p. 7. Consult also, Sinai, Anderson and Dollar, op. cit. supra note 1, p. 18, referring to the state bills introduced in California and New York, as well as Connecticut, Illinois, Michigan, Missouri, Nebraska, Oregon, Pennsylvania, Washington, and Wisconsin. The proposed state bills during the period 1933 to 1944 are also discussed by Stucke, "Note on Compulsory Sickness Insurance Legislation in the States, 1933-1944," 60 Public Health Reports, pp. 1551, 1557 (1945).

17. S. 1161, 78th Cong., 1st Sess. (1943); S. 1050, 79th Cong., 1st Sess. (1945); see the discussion of these bills in 4 Lawyers Guild Rev. 24 (1944) and 5 id. at 221 (1945); Wilson, op. cit. supra note 1, pp. 13 and 19.

18. Message of November 19, 1945 and subsequent messages, see Follmann, Medical Care and Health Insurance, p. 451 (1963); Riesenfeld and Maxwell, op. cit. supra note 1, p. 450.

19. S. 1606, 79th Cong., 1st Sess. (1945).

20. See Follmann, Medical Care and Health Insurance, p. 450 (1963). Epstein and Callison, "Financing Health Care for the Aged," 27 Law and Contemporary Problems 102, 104 (1962).

21. A.B. 800, California, 1 Journal of the Assembly 324 (1945).

22. Report of the Interim Committee of the Assembly, California State Legislature, on Health Insurance (1945). The report recited the defeat of similar proposals in 1918, 1935 and 1939.

23. The history of the defeat is told in detail by Donnelly, "The Health Insurance Movement in California, 1938-1948" (Master's thesis, U.C. Library, Berkeley).

24. Governor's Committee on the Study of Medical Aid and Health, Health Care for California (State of California, Department of Public Health, 1960).

25. Recommendation nos. 1 and 2, id., p. 22.

26. Id., pp. 32, 33.

27. Recommendation no. 14, id., pp. 23 and 33.

28. California Unemployment Insurance Code, sec. 2801. In 1960, the hospital benefit was fixed at $12.00 per day, not exceeding 20 days. The maximum earning base at that time was $3,600. Hospital benefits amounted to .16 per cent of the net taxable wages.

29. Health Care for California, op. cit. supra note 24, p. 33.

30. New York, Regulations Under the Disability Law, No. 41 (4).

31. New York Laws 1944, ch. 387.

32. New York (State), Legislative Commission on Medical Care, Medical Care for the People of New York State (1946).

33. Id., pp. 454-476.

34. Id., pp. 342-347.

35. Id., p. 1.

36. Id., p. 499.

37. The Task Force consisted of Rockwell Perkins as Chairman, the Industrial Commissioner, the Commissioner of Health, Social Welfare and Commerce, and the Superintendent of Insurance.

38. New York (State), Report to Governor Nelson A. Rockefeller of the Special Task Force to Study Catastrophic Expense Health Insurance, Vols. One and Two (1960). The actual report is contained in volume one. The second volume contained data relating to coverage under existing plans.

39. New York (State), Report of the Joint Legislative Committee on Health Insurance Plans, pp. 83-183 (1960).

40. Id., p. 180.

41. The bills are reprinted, id., pp. 333-353. See especially the bill introduced by Senator Metcalf (No. 2694, Int. 2586), id., p. 345.

42. New York (State), Report of the Joint Legislative Committee on Health Insurance Plans, pp. 137-150 (1962).

43. New York (State), Report of the Joint Legislative Committee on Health Insurance Plans, p. 16 (1963).

44. New York (State), Report of the Joint Legislative Committee on Health Insurance Plans, pp. 123-157 (1964). The bill (Senate Print 2184, Intro. 2103) provided hospital benefits not exceeding 31 days during a period of 52 calendar weeks and specified diagnostic services.

45. New York (State), Report of the Joint Committee on Health Insurance Plans, p. 90 (1965).

46. New York (State), Report of the Governor's Committee on Hospital Costs (1965).

47. Id., p. 47, especially p. 52.

48. New York Laws 1965, ch. 795, adding article 28 to the public health law (the so-called Folsum Act).

49. P.L. 89-97; 79 Stat. 286.

50. For the history of the legislation establishing hospital and medical benefits for veterans, see "Brief History Pertaining to Veterans' Benefits," 38 U.S.C.A. 27 (1959).

51. Annual Report (1967), Administrator of Veterans Affairs (Washington: U.S. Government Printing Office, 1967), pp. 14 and 27.

52. For a list and brief discussion of these bills up to 1957, see Brewster, Health Insurance and Related Proposals for Financing Personal Health Services, A Digest of Major Legislation and Proposals for Federal Action, 1937-1957, U.S. Department of Health, Education and Welfare, Social Security Administration, at 24 (1958), see also Epstein and Callison, "Financing Health Care for the Aged," 27 Law and Contemporary Problems, No. 1, at 102, 104 (1962); Myers and Baughman, History of Cost Estimates for Hospital Insurance, U.S. Department of Health, Education and Welfare, Social Security Administration, Office of the Actuary, Actuarial Study No. 61, p. 5 (1966).

53. Especially H.R. 4765, 85th Cong., 1st Sess. (1957) (Dingell); H.R. 9448, 85th Cong., 1st Sess. (1957) (Roberts).

54. S. 3001, 82d Cong., 1st Sess. (1952).

55. H.R. 7485, 82d Cong., 1st Sess. (1952).

56. H.R. 7484, 82d Cong., 1st Sess. (1952).

57. H.R. 9467, 85th Cong., 1st Sess. (1957).

58. Social Security Legislation, Hearings Before the Committee on Ways and Means, House of Representatives, 85th Cong., 2d Sess., on Titles of the Social Security Act, especially p. 598 (1958).

59. See Epstein and Callison, op. cit. supra note 52, at 107; Mitchel, "Social Security Legislation in the 86th Congress," 23 Soc. Sec. Bull., November, 1960, 3 at 5.

60. The pressure for compulsory health insurance for the aged, however, prompted the so-called Kerr-Mills amendments of 1960, creating medical assistance for the aged, P.L. 86-778, 74 Stat. 924.

61. Special Message of February 9, 1961, 107 Cong. Rec. 1904, H. Doc. No. 85, 87th Cong., 1st Sess. (1961).

62. H.R. 4222, S. 909, 87th Cong., 1st Sess. (1961).

63. For a description of and cost estimates relating to this bill, see History of Cost Estimates for Hospital Insurance, op. cit. supra note 52, p. 11.

64. H.R. 3920, S. 880, 88th Cong., 1st Sess. (1963). See the description in History of Cost Estimates for Hospital Insurance, op. cit. supra note 52, p. 25.

65. See the account in Cohen and Ball, "Social Security Amendments of 1965: Summary and Legislative History," 28 Soc. Sec. Bull., No. 9, 3 at 4 (1965).

66. H.R. 1, S. 1, 89th Cong., 1st Sess. (1965).

67. See Cohen and Ball, op. cit. supra note 65, at 5.

68. See Cohen and Ball, op. cit. supra note 65, at 6-9.

69. Social Security Act, sections 1902(a)(17) (last sentence) and 1903(a)(1); Medical Assistance Programs Under Title XIX of the Social Security Act, U.S. Department of Health, Education and Welfare, Handbook of Public Assistance Administration, Supplement D, at D-5520 (1966).

70. New York (State), Report of the Senate and Assembly Committees on Public Health 1965-1966, Leg. Doc. (1966), No. 21, pp. 5 and 42-47.

71. Quoted in The Task Before Us, Report of the New York State Joint Legislative Committee on the Problems of Public Health and Medicare, Leg. Doc. (1967), No. 40, p. 171.

72. Id., at 81.

73. S. 4268, A. 5876, summarized in id., p. 81.

74. Id., p. 94.

75. Id., p. 92.

76. The Special Message was reproduced in a press release of March 20, 1968, State of New York, Executive Chamber.

77. S. 5417.

78. For a summary of the provisions of the bill, see New York (State), Joint Legislative Committee on the Problems of Public Health, Medicare, Medicaid and Compulsory Health and Hospital Insurance, 1968 Annual Report, Leg. Doc. (1968), No. 14, p. 15. The bill provided for employee's contributions not to exceed half of the cost or two per cent of his wages whichever is less. The employer was to bear the remainder, but not in excess of four per cent of his payroll. Any balance was covered by a state subsidy, Proposed Health Security Act, Sections 912 and 914.

79. 1968 Annual Report, op. cit supra note 78, p. 21.

80. S. 4998 (1969).

81. New York (State), Joint Legislative Committee on the Problems of Public Health, Medicare, Medicaid and Compulsory Health and Hospital Insurance, 1969 Annual Report, Leg. Doc. (1969), No. 19, p. 106.

82. S. 9181 (1970). Section 1 of this bill incorporates the Universal Health Insurance Act.

83. Universal Health Insurance Act, Section 7.

84. Universal Health Insurance Act, Section 12(2).

85. S. 9181, Section 3.

86. Universal Health Insurance Act, Section 4.

87. S. 9187, Section 24.

88. Universal Health Insurance Act, Section 14.

89. Universal Health Insurance Act, Section 15.

90. Universal Health Insurance Act, Section 16.

91. Universal Health Insurance Act, Section 12(2).

92. U.S. Department of Health, Education and Welfare, "Background Paper, June, 1970, Amendments to the Family Assistance Act" (June 1970).

93. U.S. Department of Health, Education and Welfare, Recommendations of the Task Force on Medical and Related Programs (June, 1970), p. 54.

Part II

1. Dickerson, Health Insurance (3d ed., 1968), pp. 228, 248.

2. Health Insurance Institute, 1969 Source Book of Health Insurance Data, pp. 20, 21, 22. The data for 1967 and 1968 include people covered by Medicare, parts A and B.

3. State of Hawaii, Department of Planning and Economic Development, Statistical Report 69, January 13, 1970, Table 1.

4. The State of Hawaii Data Book 1970, A Statistical Abstract (Department of Planning and Economic Development) (1970), Table 2.

5. The State of Hawaii Data Book 1970, Table 63.

6. The State of Hawaii Data Book 1970, Table 5.

7. State of Hawaii, Department of Labor and Industrial Relations, "Labor Force Estimates 1968-1969" (May, 1970).

8. See Appendix for correspondence with Bureau of Labor Statistics.

9. U.S. Department of Labor, Bureau of Labor Statistics, Employment and Earnings, October, 1969, Table A-17.

10. 33 Soc. Sec. Bull., January, 1970, Table M-29.

11. The State of Hawaii Data Book 1970, Table 55.

12. The noninstitutional population 65 and over at the relevant time was estimated at 34,927. The State of Hawaii Data Book 1970, Table 55. The institutional population in 1960 was 1,093. U.S. Department of Commerce, Bureau of the Census, United States Census of Population: 1960 Detailed Characteristics, Hawaii, Table 107, pp. 13-150 (1962). Hence, the approximate population age 65 and over underlying these reports totaled 36,020.

13. U.S. Department of Commerce, Bureau of the Census, United States Census of Population: 1960 Detailed Characteristics, Hawaii, Table 115, pp. 13-165 (1962).

14. State of Hawaii, Department of Planning and Economic Development, Statistical Report 57, May 16, 1968, Table 1.

15. State of Hawaii, Department of Planning and Economic Development, Statistical Report 63, January 6, 1969, Table 1.

16. State of Hawaii, Department of Planning and Economic Development, Statistical Report 69, January 13, 1970, Table 5.

17. The State of Hawaii Data Book 1970, Table 2.

18. See Johnston and Wetzel, "Effect of the Census Undercount on Labor Force Estimates," Monthly Labor Review, March, 1969, p. 3.

19. See the discussion of HIAA method of correcting for duplication in Reed, The Extent of Health Insurance Coverage in the U.S., U.S. Department of Health, Education and Welfare, Social Security Administration, Office of Research and Statistics, Research Report No. 10 (1965), p. 10. The same method was followed for 1966 in Health Insurance Association of America, A Profile of Group Health Insurance in Force in the U.S., December 31, 1966, p. 9. The computations in this report were as follows: inter-industry duplication amounted to 10,484,000 persons (67,546,000 x .06 = 4,053,000 + 35,729,000 x .18 = 6,431,000), while commercial and noncommercial duplication amounted to 12,354,000 (67,546,000 x .13 = 8,781,000 + 35,729,000 x .10 = 3,573,000).

20. Reed, op. cit. supra note 19, pp. 20-32.

21. Reed and Carr, "Private Health Insurance: Enrollment, Premiums and Benefit Expense, by Region and State, 1966," U.S. Department of Health, Education and Welfare, Social Security Administration, Office of Research and Statistics, Research and Statistics Note 14 (1968), pp. 2 and 12.

22. This was the HIAA's correction factor for commercial insurance in Hawaii.

23. The derivation of the factor is given in the study cited supra, note 21.

24. 589,661 - 522,538.

25. This estimate is based on the simplistic assumption that the figure of the net coverage arrived at by method 1 is 7.3 per cent too high.

26. This assumption is buttressed by the disparity between the dependents/subscribers ratios existing for group plans and for individual plans. The dependents/subscribers ratio for group plans equals $\frac{308,446}{177,309} = 1.74$, while the respective ratio for individual plans equals $\frac{28,360}{42,385} = .67$. Assuming that nonduplicative individual policies should have a comparable respective ratio, it could be concluded that $\frac{28,360}{1.74} = 16,299$ individual policies are nonduplicative, while the balance or 26,086 individual policies are duplicative. (Note that a "duplicative" policy does not mean "duplicative" coverage; it may mean supplementary coverage, additional to that offered by the "basic" policy.) A similar conclusion was reached on a nationwide basis by the HEW Division of Economic and Long-Range Studies, Reed, "Private Health Insurance 1968: Enrollment, Coverage and Financial Experience," 32 Soc. Sec. Bull., December 1969, p. 22.

27. 609,744 - 526,204.

28. Reed, op. cit. supra note 19, p. 10.

29. Reed and Carr, op. cit. supra note 21, Table 2. According to that table, the inter-industry duplication is 2.1 per cent of the gross and the overall duplication is 7.4 per cent of the reduced gross.

30. (114,582 x 0.021) + (545,862 x 0.074) = 42,800.

31. Health Insurance Association of America, A Profile of Group Health Insurance in Force in the United States, December 31, 1966, p. 20.

32. Major medical expense insurance policies usually have a deductible amount, above which coverage begins. See op. cit. supra note 31, p. 12.

33. See Reed, op. cit. supra note 19, p. 10.

34. A similar approach was pursued by the Department itself in estimating health insurance coverage other than for hospital and surgical expenditures, Reed, "Private Health Insurance 1968: Enrollment, Coverage, and Financial Experience," 32 Soc. Sec. Bull., No. 12, pp. 19 et seq., at 20 (1969); see also the state-by-state analysis of commercial health insurance by Reed and Carr, "The Health Insurance Business of Insurance Companies, 1948-1966," U.S. Department of Health, Education and Welfare, Social Security Administration, Office of Research and Statistics, Research and Statistics Note 15 (1968), Table 5.

35. Replies to questionnaires sent to employers covered by the Hawaii Employment Security Law indicated that some of the employers are covered under group plans.

36. The total of self-employed as of July, 1969, was 28,461 after allowance for self-employed holding secondary jobs as employees. It is further assumed that persons aged 65 and over constitute the same percentage (2.2 per cent) of this group as they do of the civilian labor force as a whole.

37. No attempt is made to adjust the gross subscriber coverage for duplication. It is assumed that most duplication within group insurance is due to the fact that the same individual is covered as a subscriber and as a dependent and that multiple group coverage as a subscriber is practically nonexistent.

38. This is the HIAA's constant duplication factor for individual policies, see note 19, supra.

39. Of the total individual hospital policies in the State (42,385), 24,022 are allocated to the self-employed, and of the remaining 18,363, 72 per cent are considered nonduplicative, yielding the figure in the text.

40. The method applied results in an allocation of 16,354 policies out of the total of the 39,875 individual surgical policies to wage-earner subscribers, of which 72 per cent are nonduplicative.

41. Of the total individual medical policies in the State (26,697), 22,519 are allocated to the self-employed and 72 per cent of the remaining 4,178 are nonduplicative.

42. In 1965 the weighted average of women in the active civilian labor force of the State was 39.3 per cent, a figure computed from the data in The State of Hawaii Data Book 1970, Table 55, p. 52.

43. U.S. Department of Commerce, Bureau of the Census, United States Census of Population: 1960 Detailed Characteristics, Hawaii, Table 116, pp. 13-170 (1962).

44. Id., Table 129, pp. 13-238 (1962).

45. Id., Tables 115 and 116, pp. 13-165 and 13-170 (1962).

46. Married women within the meaning of the statistics relating thereto are defined as married women with husband present.

47. The number of persons over 65 among the unemployed constituted 3.7 per cent according to data compiled for Oahu in 1965 and the other islands in 1967. The State of Hawaii Data Book 1970, Table 55.

48. In 1965 (the latest data available) the number of military dependents in the labor force was 4,873 out of a total of 56,576. 710 out of the 4,873 were reported as unemployed. State of Hawaii, Department of Planning and Economic Development, Statistical Report 33, July 26, 1965, Tables 1 and 7.

49. In 1965 (Oahu) and 1967 (Neighbor Islands) the total number of unemployed was 8,390, consisting of 7,020 in Oahu and 1,370 in the Neighbor Islands, 3,055 unemployed in Oahu were between 17 and 24, out of a civilian work force in that age group of 37,440; i.e., 8.2 per cent. The total civilian labor force under 65 in Oahu at that time was 204,360. The total number of unemployed under 65 was 6,760, i.e., 3.3 per cent. The State of Hawaii Data Book 1970, Table 55.

50. This class includes the self-employed as well as wage earners. In 1969 the number of self-employed under 65 was estimated at 27,835, see supra text at call to fn. 36.

51. If one could assume that the ratio of persons in the active labor force to the total number of persons in the uncovered group equals the ratio of the persons in the active labor force to the total civilian population under 65, the ratio would be 46.2 per cent, or, counting only wage earners, 42.0 per cent; hence, the number of wage earners without coverage for hospital expense would be 35,100; i.e., in excess of 31,100.

52. State of Hawaii, Department of Labor and Industrial Relations, "Labor Force Estimates, 1968-1969" (May, 1970).

53. 5 U.S.C. sections 8901-8913.

54. 5 U.S.C. section 8901(1).

55. 5 U.S.C. section 8902(a), in conjunction with sections 8903(3) and (4).

56. 5 U.S.C. section 8903(1) and (2). At present the approved government-wide service benefit is the plan offered by Blue Cross-Blue Shield and the approved government-wide indemnity benefit plan, a plan offered by the Aetna Life and Casualty Co.; U.S. Civil Service Commission, Bureau of Retirement, Insurance and Occupational Health, The Federal Employees Health Benefits Program (Form No. 2809-A, 1969) at p. 5.

57. 5 U.S.C. section 8906(a) and (c).

58. 5 U.S.C. section 8901(5).

59. As of June 30, 1968, when the number of federal employees in the State was estimated at 35,940, the number of employees and annuitants and their dependents covered by approved health benefit plans was estimated at 24,900 enrollees and 61,200 dependents. U.S. Civil Service Commission, Bureau of Retirement and Insurance, Report for Fiscal Year Ended June 30, 1968, p. 35. This would amount to a subscriber coverage of 69.3 per cent.

60. The Governor's Commission on the Status of Women gave the percentage of women in federal employment as 17.4 per cent, in contrast to an overall percentage of 37.1 per cent, see State of Hawaii, Governor's Commission on the Status of Women, Women, p. 41 (1966).

61. The total number of state employees regardless of age was 36,960. State of Hawaii, Department of Labor and Industrial Relations, "Labor Force Estimates, 1968-1969" (May, 1970). It is assumed that the percentage of employees over 65 in public employment is less than in private employment.

62. State of Hawaii, Governor's Commission on the Status of Women, Women, p. 41 (1966).

63. Hawaii Rev. Stat., Ch. 87, as amended by S.B. No. 1261-70.

64. The figures furnished by Kaiser and HMSA gave a higher total but included retired state employees.

65. The number is arrived at by deducting from the active civilian nonduplicated labor force (309,350), the number of self-employed under 65 (27,835) and the number of federal employees under 65 (estimated at 35,000) and state employees under 65 (36,600).

66. The figures are based on the assumption that the group coverage in each of the two classes of employment has the same extent for the three benefit types, as prescribed by the underlying statutes.

67. Details are confidential information.

68. Social Security Amendments of 1965, P.L. 89-97, 79 Stat. 286.

69. Social Security Amendments of 1965, House Report No. 213, 89th Cong., 1st Sess. (Ways and Means Committee) at pp. 3 and 75; Senate Report No. 404, Part I, 89th Cong., 1st Sess. (Finance Committee) at pp. 3 and 85 (1965).

70. The table allocated $898,000 to Hawaii.

71. See "The Big Sleeper in the Medicare Law," 43 Medical Economics 110 (1966), quoting Professor Somers. The Director of Family Services of HEW quickly concurred with this assessment quoted in Medicaid: State Programs After Two Years, at p. 51, fn. 8 (Tax Foundation, Inc., 1968).

The prediction was based on the estimate on the number of poor and near-poor in the nation.

72. In 1970, the Task Force on Medicaid and Related Programs estimated that "the total of the poor and the near-poor could be about 40 million, or one-fifth of the population" but that "only about one-third of the 30 or 40 million indigent and medically indigent who could potentially be covered by Title XIX of the Social Security Act will, in fact, receive services, "Report of the Task Force on Medicaid and Related Programs," at pp. 2 and 10 (Department of Health, Education and Welfare, 1970).

73. 42 U.S.C.A. sec. 1396.

74. 42 U.S.C.A. sec. 1396b(f)B(i), as added by the Social Security Amendments of 1967 sec. 220. The amendments limited federal participation to medical aid payments for families whose income level does not exceed 133-1/3 per cent of the highest amount of aid ordinarily paid by the State to a family of the same size under its AFDC program.

75. 42 U.S.C.A. secs. 1396a(a)(10)(A) and (B), 1396a(b) and 1396d(a).

76. "Medical Assistance Programs Under Title XIX of the Social Security Act," U.S. Department of Health, Education and Welfare, Handbook of Public Assistance Administration, Supplement D (1966-1968) (hereafter cited as Handbook).

77. Code of Federal Regulations, Title 45, Chapter II, Parts 248 and 249.

78. 42 U.S.C.A. sec. 1396a(a)(10)(A) and sec. 1396a(b).

79. 42 U.S.C.A. sec. 1396a(a)(10)(B) and sec. 1396d(a).

80. 42 U.S.C.A. sec. 1396b(e).

81. Handbook, Suppl. D, 4020, 1 and 2a, 4040A.

82. Handbook, Suppl. D, 4020, 2b and 4040B.

83. The Handbook defines and uses the term "categorically needy" in a much broader sense than it is used in the literature, for example, in the Report of the Advisory Commission on Intergovernmental Relations on "Intergovernmental Problems in Medicaid," p. 10 (1968). The latter report (pp. 10 and 11) restricts the term categorically needy to actual recipients of aid under OAA, AB, AFDC, and APTD and refers to other categories as categorically related needy, noncategorically related needy, categorically related medically needy, and noncategorically related medically needy. The Handbook conversely extends the term "categorically needy" to individuals who could be covered by the categorical assistance programs as well as to individuals who are not even related to such programs such as general assistance recipients and persons eligible for general assistance. Similarly, "medically needy" within the meaning of the Handbook covers categorically related medically needy as well as noncategorically related needy, as the terms are used in the Report of the Advisory Commission on Intergovernmental Relations.

84. Handbook, Suppl. D, 4020(1) and (2)(a) and 4040A.

85. 42 U.S.C.A. sec. 1396a(a)(10).

86. 42 U.S.C.A. sec. 1396a(b)(2).

87. 42 U.S.C.A. sec. 1396a(b)(1) and (4).

88. 42 U.S.C.A. sec. 1396d(a).

89. 42 U.S.C.A. sec. 1396d(15).

90. 42 U.S.C.A. sec. 1396d(a).

91. 42 U.S.C.A. sec. 1396a(b)(2).

92. 42 U.S.C.A. sec. 1396d(a)(i). This provision originated in the Senate amendments proposed by Senator Ribicoff (21 Cong. Quarterly Almanac 265 (1965)) and was accepted by the Committee of Conference, 89th Cong., 1st Sess., Conference Report No. 682, Congressional and Administrative News, 2246 (1965).

93. 42 U.S.C.A. sec. 1396d(a)(ii).

94. 42 U.S.C.A. sec. 1396d(a)(vi).

95. Handbook, Suppl. D, 4040A, last two paragraphs.

96. 42 U.S.C.A. sec. 1396a(10)B, C.F.R. Title 45, sec. 248.21.

97. Supra, note 7.

98. Indiana, Massachusetts, Michigan, Minnesota, Montana, Nebraska, Nevada, New York, Rhode Island, Wisconsin.

99. Medicaid, Selected Statistics, 1951-1966, HEW, MCSS Report B-6 (1951-1969), Table III-5.

100. State of Hawaii, State Plan for Medical Assistance, III, Coverage and Conditions of Eligibility, A.

101. State Plan for Medical Assistance, III-B; Hawaii, D.S.S. Manual, secs. 3412, 3421, 3424(2)b.

102. Hawaii, D.S.S. Manual, sec. 3424(2)(b).

103. Hawaii, D.S.S. Manual, secs. 3300 et. seq., especially sec. 3320.

104. See the comments to that effect in Audit of the Medical Assistance Program of the State of Hawaii (Audit Report No. 70-3, 1970), pp. 83-88.

105. See the comments to that effect in State of Hawaii, Department of Social Services, Operational Expenditure Plan, Fiscal Year 1970-1971, pp. 3-5. Other factors involved are a liberalization in eligibility standards and population increase, the latter factor, however, is slightly inflated owing to overestimation.

106. 42 U.S.C.A. sec. 1396b.

107. 42 U.S.C.A. sec. 1396d(b).

108. The principal monthly statistics are State of Hawaii, Department of Social Services and Housing, Statistics in Public Welfare, Corrections, Paroles and Pardons, Housing, Vocational Rehabilitation and Criminal Injuries (monthly) and U.S. Department of Health, Education and Welfare, Social and Rehabilitation Service, National Center for Social Statistics, Medical Assistance (Medicaid) Financed Under Title XIX of the Social Security Act (4 months per year).

109. The Department of Social Services and Housing kindly provided the Bureau with a copy of Report F.S. 2082.2, Part II for Calendar Year 1969.

110. Hawaii, D.S.S. Manual, sec. 3412.

111. Hawaii, D.S.S. Manual, secs. 3113 et. seq.

112. Department of Health, Education and Welfare, NCSS Report B1 (2/70), Tables 12 and 1.

113. Hawaii, D.S.S. Manual, sec. 3113(1)(a), (b), (c), and 2(a), (b), and (c).

114. 42 U.S.C.A. sec. 1396b(a)(1).

115. U.S. Department of Health, Education and Welfare, Handbook of Public Assistance Administration, Suppl. D, secs. 5520A, 5530, 5830, 5840.

Part III

1. This amount constitutes 133-1/3 of the current general assistance standard for a comparable family. In New York there had to be a continuous roll-back from the original $6,000 standard. It was reduced to $5,300 for a family of four by amendments of 1968, N.Y. Laws 1968, ch. 32, sec. 1 and further reduced to $5,000 by amendments of 1969, N.Y. Laws 1969, ch. 184, sec. 18.

2. Department of Health, Education and Welfare, Office of the Assistant Secretary for Welfare Legislation, Background Paper dated June 10, 1970.

3. State of Hawaii, Department of Social Services, Operational Expenditure Plan, 1970-1971, p. C-21.

4. 52 x 20 x 1.60 = 1,664.

5. 42 U.S.C.A. sec. 2727.

6. U.S. Department of Labor, Employment and Earnings, November 1970, p. 100.

7. U.S. Department of Commerce, Survey of Current Business 1970, No. 8, pp. 33 and 35.

8. $160 - 1,680 x .04.

9. $160 - 1,680 x .03.

10. Communication, January 18, 1971.

11. Temporary Disability Insurance, Legislative Reference Bureau, Report No. 1 (1969), pp. 73-77.

12. The costs in tax credits for such a program would be in the neighborhood of $175,000.

PUBLISHED REPORTS OF THE LEGISLATIVE REFERENCE BUREAU

1961
1. Disaster Relief: Considerations for State Action. 60 p. $1
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JOSH GREEN, M.D.
GOVERNOR OF HAWAI'I

TIA L.R. HARTSOCK, MSW, MSCJA
DIRECTOR OF OFFICE OF WELLNESS AND RESILIENCE

STATE OF HAWAII
OFFICE OF WELLNESS AND RESILIENCE
KE KE'ENA KŪPA'A MAULI OLA
OFFICE OF THE GOVERNOR
415 S.BERETANIA ST. #415
HONOLULU, HAWAII 96813

Testimony in SUPPORT of S.C.R. 145 & S.R. 117

Senator Henry Aquino, Chair
Senator Chris Lee, Vice Chair
Senate Committee on Labor and Technology
March 24th, 2025, at 3:00 p.m. Room Number: 224

The Office of Wellness and Resilience (OWR) in the Governor's Office **SUPPORTS** resolutions S.C.R. 145 and S.R. 117.

Established through Act 291 (Session Laws of Hawai'i 2022) the overall aim of the OWR is to make Hawai'i a trauma-informed state. OWR is focused on breaking down barriers that impact the physical, social, and emotional well-being of Hawai'i's people. OWR explores avenues to increase access and availability to mental, behavioral, social, and emotional health services and support. In this effort, the OWR is dedicated to addressing adverse childhood experiences (ACEs) from keiki to kupuna.

Research shows that paid family leave is one of the most concrete supports for families to avoid ACEs. Studies show that states with extended family leave policies were associated with increase in health of the child by the additional time in breastfeeding duration, parental engagement, and parental mental health.[1] Infancy and childhood are extremely important times in contributing to physical health, mental health, learning, and overall well-being in life. When families are provided with an environment where they can nurture their infant without fear of losing their income, they can attend to their children in a stress-free and attentive environment in this crucial time of their child's life. Providing family leave is one of the most concrete supports families can be provided to mitigate trauma and address their well-being.

In addition to paid family leave being one way to address overall well-being, paid family leave can serve as a strategy improve worker recruitment and retention. The OWR conducted the Hawai'i Quality of Life and Well-Being Survey[2], with more than 10,000 residents from our state responding, resulting in it being the largest statewide survey on health and well-being in Hawai'i ever. In this survey, we asked our State workers what are the most important benefits to them. Paid family leave was identified as very important by 4 of 5 state employees, making it one of the top 5 most important benefits for this group.

[1] Lindsey Rose Bullinger, The Effect of Paid Family Leave on Infant and Parental Health in the United States, Journal of Health Economics, Volume 66, 2019, Pages 101-116, ISSN 0167-6296, https://doi.org/10.1016/j.jhealeco.2019.05.006.

[2] Barile, J. P., Orimoto, T., Kook, J., Chae, S. W., Dgheim, D., Rivera, C., Helfner, S., Turner, H., Thompson, K., Yamauchi, E., Leipold, N., & Hartsock, T. (2024). Hawai'i quality of life and well-being dashboard. Partnership for Wellness & Resilience, Health Policy Initiative, University of Hawai'i at Mānoa.

S.C.R. 145 and S.R. 117 provide an important and unique opportunity for the Legislature, State departments, unions, and community partners to collectively analyze and put forward an action plan to implement paid family leave in our state in a feasible manner.

Thank you for hearing these measures and for the opportunity to testify.

Tia L.R. Hartsock, MSW, MSCJA
Director, Office of Wellness & Resilience
Office of the Governor

Charlotte A. Carter-Yamauchi
Director

Shawn K. Nakama
First Assistant

Research 808-587-0666
Revisor 808-587-0670
Fax 808-587-0681

LEGISLATIVE REFERENCE BUREAU
State of Hawaii
State Capitol, Room 446
415 S. Beretania Street
Honolulu, Hawaii 96813

Written Comments

SCR145/SR117

REQUESTING THE SENATE STANDING COMMITTEE ON LABOR AND TECHNOLOGY AND HOUSE OF REPRESENTATIVES STANDING COMMITTEE ON LABOR TO CONVENE A LEGISLATIVE WORKING GROUP TO DEVELOP RECOMMENDATIONS FOR ESTABLISHING AND IMPLEMENTING A PAID FAMILY AND MEDICAL LEAVE PROGRAM FOR THE STATE.

Charlotte A. Carter-Yamauchi, Director
Legislative Reference Bureau

Presented to the Senate Committee on Labor and Technology

Monday, March 24, 2025, 3:00 p.m.
Conference Room 224

Chair Henry J.C. Aquino and Members of the Committee:

Good afternoon, Chair Aquino and members of the Committee. My name is Charlotte Carter-Yamauchi, and I am the Director of the Legislative Reference Bureau (Bureau). Thank you for providing the opportunity to submit written **comments** on S.C.R. No. 145 and S.R. No. 117, Requesting the Senate Standing Committee on Labor and Technology and House of Representatives Standing Committee on Labor to Convene a Legislative Working Group to Develop Recommendations for Establishing and Implementing a Paid Family and Medical Leave Program for the State.

The purpose of this measure is to request the Senate Standing Committee on Labor and Technology and House of Representatives Standing Committee on Labor to convene a legislative working group to develop recommendations for establishing and implementing a paid family and medical leave program for the State.

The measure specifically requests the working group to:

(1) Recommend parameters for a statewide paid family and medical leave program that benefits both public and private sector workers;

(2) Review the impact of federal and state regulations on the establishment of a paid family and medical leave program;

(3) Develop an implementation plan that outlines an administrative framework for paid family and medical leave, including departmental oversight, projected costs, employer and employee contribution rates, staffing needs, outreach to employers and employees, and potential timelines for program enactment and the initiation of benefits distribution;

(4) Examine and address how the State's Temporary Disability Insurance (TDI) program may interface with or complement the paid family and medical leave program, including the feasibility, cost-benefit analysis, and a general roadmap for transitioning the existing private TDI program to an expanded public program that includes or complements paid family and medical leave benefits; and

(5) Identify parameters for a paid family and medical leave program, including:

(A) A minimum duration of leave that meets the needs of the State's workers;

(B) A system of wage replacement;

(C) Coverage for a worker's serious illness, caring for a loved one with a serious illness, bonding with a new child, and needs arising from military deployment and the effects of domestic violence, stalking, and sexual assault;

(D) Coverage for all employees of employers who employ one or more employees, and a mechanism for the participation of the self-employed;

(E) A definition of "family" or "family member" for whom an individual may take leave for purposes of providing care that is at least as broad as the definition in chapter 398, Hawaii Revised Statutes, the existing Hawaii Family Leave Law; and

(F) Employment protections to ensure use of paid family and medical leave does not adversely impact employment.

The measure further requests the working group to review independent studies, research, and other information regarding paid family and medical leave; and to utilize independent consultants and administrative facilitators, including the Legislative Reference Bureau, as needed to assist in the performance of its duties, including but not limited to the

preparation of the report to the Legislature. The measure requests that the working group submit its findings and recommendations, including any proposed legislation, to the Legislature no later than twenty days prior to the convening of the Regular Session of 2026.

The Bureau takes no position on this measure but submits the following comments for your consideration.

As a general matter, the Bureau notes that certain items that the working group is requested to examine, including projected costs of a paid family leave program, were examined by a previous study on this issue. Specifically, we note that Act 109, Session Laws of Hawaii, 2018 required the Bureau to conduct a sunrise analysis to assist the Legislature in determining the most appropriate framework or model for the establishment of paid family leave for the State and relative potential impacts and safeguard measures. The Bureau was specifically requested to include in its study:

(1) A comparative analysis of other state paid leave models, including a review of temporary disability insurance usage and other state temporary disability insurance models;

(2) Hawaii-based cost breakdowns by model on projected impacts to employers by size, impacts to employees, and estimated impacts on the cost of compliance as it relates to other employer mandates; and

(3) An examination of options for compliance and enforcement of the proposed paid family leave program with recommendations for additional staffing and support for the Department of Labor and Industrial Relations to effectuate the program.

Act 109 appropriated $350,000 to the Bureau to contract with a consultant to perform the sunrise analysis.

Following a competitive Request for Proposals process, the Bureau contracted with Spring Consulting Group to perform the study. Following the conclusion of its work, the Bureau forwarded Spring Consulting Group's 155-page final report to the Legislature in December 2019. The report, which is available on the Bureau's website at https://lrb.hawaii.gov/wp-content/uploads/2019_PaidFamilyLeaveProgramImpactStudy.pdf and attached to these written comments, includes summaries and comparative analyses of the paid family leave programs of California, District of Columbia, Massachusetts, New Jersey, New York, Rhode Island, and Washington; and estimates of the costs to establish comparable paid family leave programs in Hawaii based on the existing programs in each of those states, including projections of the number of claims filed, denied, and paid; benefit weeks; weekly benefit amounts, average weekly benefit amounts, and total benefits per claimants; and projected administrative costs.

Notably, Spring Consulting Group estimated that average weekly benefit amounts could range from a low of $523 per week if Hawaii adopted a paid family leave program based on New York's paid family leave model, up to a high of $691 per week if Hawaii adopted a paid family leave program based on Washington's paid family leave model. Spring Consulting Group also estimated that, depending on the model of paid family leave adopted, the State would need to establish between 7.5 and 22.5 positions to administer the program and pay start-up costs of between $660,000 and $1,100,000. Estimates of annual operational costs were estimated to be between $930,000 and $2,216,000, depending on the model of paid family leave adopted.

The Bureau notes that the costs estimated by Spring Consulting Group were submitted to the Legislature prior to the Regular Session of 2020. Accordingly, if the Legislature desires for the cost estimates and other findings from Spring Consulting Group's report to be updated, the Bureau would require a general fund appropriation to contract with a consultant to perform this requested work.

Regarding the specific duties requested of the Bureau by this measure, the Bureau notes that it can assist the working group with drafting legislation necessary to implement the working group's recommendations and finalizing its report to the Legislature. However, the Bureau has no control over meeting space in the State Capitol and is not equipped or staffed to provide other administrative support duties, such as booking meeting facilities, arranging needed transportation, staffing working group meetings, taking meeting minutes, etc.

Accordingly, the Bureau respectfully requests that the measure be amended to limit the scope of the Bureau's involvement to assisting the working group with finalizing its report and the drafting of any legislation necessary to implement the recommendations of the working group. If the Committee chooses to amend the measure in this manner, the Bureau also requests that the working group be instructed to finalize its deliberations and submit to the Bureau, not later than October 31, 2025, its draft report, any request for proposed legislation, and necessary supporting documents, information, and materials so that work on finalizing the report and the proposed legislation would not adversely impact our ability to provide our core services to the Legislature in preparation for the Regular Session of 2026.

If these requested amendments are made, then the Bureau believes that the services requested under the amended measure would be manageable, provided that the Bureau's interim workload is not adversely impacted by too many other studies or additional responsibilities, such as conducting studies, writing or finalizing other reports, drafting legislation, or any combination of these for the Legislature or for other state agencies, task forces, or working groups that may be requested or required under other legislative measures.

Thank you again for your consideration.

Jennifer Kagiwada
Council Member District 2 South Hilo

Office:(808) 961-8272
jennifer.kagiwada@hawaiicounty.gov

HAWAIʻI COUNTY COUNCIL - DISTRICT 2

25 Aupuni Street · Hilo, Hawaiʻi 96720

DATE: March 21, 2025
TO: Senate Committee on Labor and Technology
FROM: Jennifer Kagiwada, Council Member
Council District 2
SUBJECT: SCR 145/SR 117

Aloha Chair Aquino, Vice Chair Lee, and Committee Members,

I write in support of SCR 145/SR 117 which will establish a working group to continue the discussion around paid family leave. This year's bills have been deferred, but the need for stronger programs to protect our working families continues to grow. The economic success of our state is linked to the well-being of our workforce, and similar programs in other states demonstrate that paid family leave benefits businesses and workers. In 2018, only 17 percent of workers in the United States had access to paid family leave through their employers. Women, who are often the primary caregivers of infants, children, and elderly parents, are significantly and disproportionately affected by the absence of paid family leave. No one should have to sacrifice their financial well-being to care for their keiki or kupuna. The majority of Hawai'i's workforce cannot afford to take unpaid leave to care for a new child or assist a family member with a serious health condition. Hawai'i law only provides a four-week extension of unpaid leave to employees of large employers with more than one hundred employees.

All workers deserve access to family leave, which is essential in allowing parents to care for newborn keiki and family members who are seriously ill. Hawai'i has one of the fastest growing populations over the age of 65 in the nation. From 2020 to 2030, the percentage of people aged 65 and over is expected to increase to 22.5 percent of the state's population. Nearly one-third of workers who do not have access to family leave will need time off to care for an ill spouse or elderly parent. Multiple studies have shown that family leave programs can be established in a manner that is affordable for small businesses and our state. When medical emergencies arise, no one should be forced to choose between caring for their loved ones or earning a paycheck.

Please support these resolutions to work towards a solution.

Mahalo,

Jenn Kagiwada

holomua
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Committee: **Senate Committee on Labor and Technology**
Bill Number: **SCR 145/SR117**
REQUESTING THE SENATE STANDING COMMITTEE ON LABOR AND TECHNOLOGY AND HOUSE OF REPRESENTATIVES STANDING COMMITTEE ON LABOR TO CONVENE A LEGISLATIVE WORKING GROUP TO DEVELOP RECOMMENDATIONS FOR ESTABLISHING AND IMPLEMENTING A PAID FAMILY AND MEDICAL LEAVE PROGRAM FOR THE STATE.
Hearing Date and Time: **March 24, 2025, 3:00pm (Room 224)**
Re: **Testimony of Holomua Collaborative – Support**

Aloha Chair Aquino, Vice Chair Lee, and Members of the Committee:

Mahalo for the opportunity to submit testimony **in support** of SCR145 and SR117, which requests this Committee and the House Committee on Labor to convene a Legislative Working Group to develop recommendations for establishing and implementing a Paid Family and Medical Leave (PFML) program for the State.

Our organization is devoted to finding ways to keep all local working families in Hawai'i by making sure they can afford to stay.

As stated by the resolution, PFML programs "are associated with improved outcomes in the earliest years of life for individuals, including higher rates of breastfeeding and immunization and lower rates of child abuse, domestic violence, and financial instability" and "would incentivize individuals to join the labor market and improve employee retention, filling gaps and saving employers long-term recruitment and training costs."

In a recent survey of 1500 local residents, around 60 percent of respondents expressed concern about not being able to pay monthly bills, and 63 percent expressed difficultly in saving money from a paycheck.[1] State and County workers do not have access to PFML, and about 3 in every 4 private sector workers in Hawai'i do not have access to PFML.[2] For these workers without access to PFML, facing a serious illness, welcoming a new child, or needing to care for a loved one can mean missing out on a paycheck. And that could be financially devastating to many local workers.

[1] https://holomuacollective.org/survey/

[2] Paid Leave Means a Stronger Hawai'i. National Partnership for Women & Families. (Feb. 2025) https://nationalpartnership.org/wp-content/uploads/2023/04/paid-leave-means-a-stronger-hawaii.pdf.

holomua
COLLABORATIVE

Concurrently, local businesses are struggling. In the same survey, only 21 percent of respondents agreed that "Hawai'i is a good place to do business," with 43 percent *disagreeing* that Hawai'i is a good place to do business.[3] Providing PFML to employees can be costly, especially for small businesses operating on tight margins. The expense of providing paid leave benefits deters many employers from offering such program.

For decades, the Legislature has considered legislation relating to PFML, including the completion of a comprehensive impact study for the Legislative Reference Bureau in 2019.[4] Convening a Legislative Working Group with representatives from a diverse cross-section of interested parties to study and make recommendations about the establishment and implementation of paid family and medical leave in Hawai'i would be beneficial. It could make recommendations to customize the policy to fit local needs. A Legislative Working Group could consider the unique aspects of our workforce, cost of living, and local families' caregiving needs and expectations. And it could ensure that any suggested policy would not put small local businesses at risk of closing.

This Legislative Working Group could help find a balance between the effects on both businesses and employees by looking into funding and staffing options that are suitable for Hawai'i's economy.

We urge you to pass these resolutions and find a way to make a reasonable and fair paid family and medical program a reality in our state.

Sincerely,

Joshua Wisch
President & Executive Director

[3] See note 1.

[4] Paid Family Leave Program Impact Study: In Accordance with Act 109, Session Laws of Hawaii 2018. (Dec. 2019). https://lrb.hawaii.gov/wp-content/uploads/2019_PaidFamilyLeaveProgramImpactStudy.pdf

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TESTIMONY TO THE HAWAI'I SENATE COMMITTEE ON LABOR AND TECHNOLOGY

Item: SCR145/SR117

Position: Support

Hearing: Monday, March 24, 2025, 3:00 pm, Room 224

Submitter: Osa Tui, Jr., President - Hawai'i State Teachers Association

Dear Chair Aquino, Vice Chair Lee, and members of the committee,

The Hawai'i State Teachers Association (HSTA) **supports** SCR145/SR117 which calls for the establishment of a legislative working group to develop recommendations for implementing a paid family and medical leave program in Hawai'i. We believe that access to paid family leave is essential for the well-being of Hawai'i's working families. Currently, many of our keiki and their families face significant challenges balancing work and caregiving responsibilities. The high cost of living in Hawai'i exacerbates these challenges, with a significant portion of Hawaii residents struggling to make ends meet, as highlighted by ALICE data.

Further, the absence of a paid family leave program disproportionately affects women and people of color, who often bear a greater caregiving burden. This not only creates financial strain but also hinders career advancement and economic stability. In addition, Hawai'i faces critical workforce challenges, needing to recruit and retain over 1,200 teachers and experiencing high vacancy rates in state and county employment. A paid family leave program can serve as an important tool to attract and retain valuable employees in these crucial sectors.

This working group is crucial to bringing together diverse stakeholders to create a comprehensive and effective paid family leave program tailored to Hawai‘i’s unique needs. By examining various parameters, including duration of leave, wage replacement systems, and coverage for all employees, the working group can develop a unified plan that benefits both public and private sector workers. HSTA is committed to participating in this process and advocating for a program that supports Hawai‘i’s families and strengthens our community.

Mahalo.

To: Senate Committee on Labor and Technology
Re: **SCR 145 / SR 117 – Requesting the Senate Standing Committee on Labor and Technology and House of Representatives Standing Committee on Labor to convene a legislative working group to develop recommendations for establishing and implementing a Paid Family and Medical Leave Program for the state**
Hawai'i State Capitol & Via Videoconference
March 24, 2025, 3:00 PM

Dear Chair Aquino, Vice Chair Lee, and Committee Members,

On behalf of Hawai'i Children's Action Network Speaks!, I am submitting this testimony in **SUPPORT of SCR 145 / SR 117**. These resolutions request the Senate Standing Committee on Labor and Technology and House of Representatives Standing Committee on Labor to convene a legislative working group to develop recommendations for establishing and implementing a Paid Family and Medical Leave Program for the state.

Paid family and medical leave allows **workers to take time off and still receive part of their income** when they need to care for their own serious health needs or those of a loved one, or to bond with a new child.

The United States is the only developed country without national paid family leave.[1] The average amount of paid family leave in OECD nations is about one year. **To fill that gap, thirteen states plus the District of Columbia have passed paid family leave laws.**[2] California was the first state to pass paid family leave, about 20 years ago. Hawai'i should join them.

Paid family and medical leave is financed by small payroll deductions that go into a state fund, which workers apply to when they need leave. **Since employees are paid from the state fund while taking leave, employers do not need to pay them while they are on leave.**

In addition, paid leave helps children by helping their parents. Research has found that states with paid family leave have seen significant **health, social and economic benefits**.[3] Families who have access to paid leave – especiallyworking women – are healthier, more economically secure, more likely to stay in the workforce, and **less likely to need public benefits**.

These resolutions request the establishment of a working group composed of legislators, family advocates, nonprofit organizations and government agencies. The working group could figure out how to enact and implement paid family and medical leave to support Hawai'i families.

Mahalo for the opportunity to provide this testimony. Please pass these resolutions.

Sincerely,

Nicole Woo
Director of Research and Economic Policy

[1] https://bipartisanpolicy.org/explainer/paid-family-leave-across-oecd-countries/
[2] https://bipartisanpolicy.org/explainer/state-paid-family-leave-laws-across-the-u-s/
[3] https://www.abetterbalance.org/wp-content/uploads/2021/09/PFML_Health-Case_Fact-Sheet_11.30.21.pdf

The Senate Committee on Labor, and Technology
March 24, 2025
Room 224
3:00 PM

RE: SCR 145/SR 117, Requesting the Senate Standing Committee on Labor and Technology and House of Representatives Standing Committee on Labor to Convene a Legislative Working Group to Develop Recommendations for Establishing and Implementing a Paid Family and Medical Leave Program for the State

Attention: Chair Henry Aquino, Vice Chair Chris Lee and
Members of the Committee

The University of Hawaii Professional Assembly (UHPA), the exclusive bargaining representative for all University of Hawai'i faculty members across Hawai'i's statewide 10-campus system, provides **comments for SCR 145/SR 117**, Requesting the Senate Standing Committee on Labor and Technology and House of Representatives Standing Committee on Labor to Convene a Legislative Working Group to Develop Recommendations for Establishing and Implementing a Paid Family and Medical Leave Program for the State.

As paid family leave is a priority for our faculty members, UHPA is in support of the formation of this working group and its overall objectives. In order to ensure full representation of all public sector unions, we respectfully request the Resolutions be amended to include UHPA as a member of the working group. As BU 07 serves an essential and unique demographic of state workers, who impact all communities and professions across the State of Hawaii, the inclusion of UHPA will add a valuable perspective to this needed discussion.

UHPA requests the passage of SCR 145/SR 117 with the suggested amendment.

Respectfully submitted,

Christian L. Fern
Executive Director
University of Hawaii Professional Assembly

University of Hawaii
Professional Assembly

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Website: www.uhpa.org

UNITED PUBLIC WORKERS

AFSCME Local 646, AFL-CIO

THE SENATE
KA ʻAHA KENEKOA

THE THIRTY-THIRD LEGISLATURE
REGULAR SESSION OF 2025

COMMITTEE ON LABOR AND TECHNOLOGY
Senator Henry J.C. Aquino, Chair
Senator Chris Lee, Vice Chair

Monday, March 24, 2025, 3:00 PM
Conference Room 224 & Videoconference

Re: Testimony on SCR145/SR117 – REQUESTING THE SENATE STANDING COMMITTEE ON LABOR AND TECHNOLOGY AND HOUSE OF REPRESENTATIVES STANDING COMMITTEE ON LABOR TO CONVENE A LEGISLATIVE WORKING GROUP TO DEVELOP RECOMMENDATIONS FOR ESTABLISHING AND IMPLEMENTING A PAID FAMILY AND MEDICAL LEAVE PROGRAM FOR THE STATE.

Chair Aquino, Vice Chair Lee, and Members of the Committee:

The United Public Workers, AFSCME Local 646, AFL-CIO ("UPW") is the exclusive bargaining representative for approximately 14,000 public employees, which includes blue collar, non-supervisory employees in Bargaining Unit 1 and institutional, health, and correctional employees in Bargaining Unit 10, in the State of Hawaii and various counties. UPW also represents nearly 1,500 healthcare workers in the private sector.

UPW **supports** SCR145/SR117, which requests the Senate and House standing labor committees convene a legislative working group to develop recommendations for establishing and implementing a paid family and medical leave program for the State.

Hawaii's current family leave laws only offer unpaid leave, which excludes many working families who must choose between keeping their jobs and caring for a child, a sick loved one, or managing a personal health crisis. It is clear that Hawaii's workforce urgently needs a statewide paid family and medical leave program. However, such a program should not require the participation of public workers who, unlike their counterparts in the private sector, are saddled with mandatory retirement contributions and higher healthcare costs.

It is our hope that including public sector union representatives as members of the proposed working group will ultimately help to establish a paid family and medical leave that is fair.

Mahalo for the opportunity to testify in support of this measure.

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HAWAII GOVERNMENT EMPLOYEES ASSOCIATION
AFSCME Local 152, AFL-CIO

RANDY PERREIRA, Executive Director • Tel: 808.543.0011 • Fax: 808.528.0922

The Thirty-Third Legislature, State of Hawaii
The Senate
Committee on Labor and Technology

Testimony by
Hawaii Government Employees Association

March 24, 2025

S.C.R 145/S.R 117 — REQUESTING THE SENATE STANDING COMMITTEE ON LABOR AND TECHNOLOGY AND HOUSE OF REPRESENTATIVES STANDING COMMITTEE ON LABOR TO CONVENE A LEGISLATIVE WORKING GROUP TO DEVELOP RECOMMENDATIONS FOR ESTABLISHING AND IMPLEMENTING A PAID FAMILY AND MEDICAL LEAVE PROGRAM FOR THE STATE.

The Hawaii Government Employees Association, AFSCME Local 152, AFL-CIO supports S.C.R. 145/S.R. 117, which convenes a working group to develop recommendations for establishing and implementing a paid family leave program for the state.

As Hawaii's largest union with roughly 35,000 active and retiree members, we appreciate the inclusion of being a-part of this working group. While the Federal Family and Medical Leave Act allows employees up to 12 weeks of unpaid family leave each year, many employees cannot afford to survive without compensation for that long and are forced with a hard choice: take much needed time to care for yourself, your child or family member, or return to work. Paid Family and Medical Leave is a twenty-first century workforce benefit that can allow employees personal and professional flexibility.

Furthermore, our state's workforce is facing a 24% vacancy rate – our state must explore ways to develop modern and attractive benefits to recruit and retain qualified employees. We believe that an equitable program can serve as one of many tools, to help accomplish this.

Thank you for the opportunity to provide testimony in support of S.C.R. 145/S.R. 117.

Respectfully submitted,

Randy Perreira
Executive Director

Senate Committee On Labor and Technology
Testimony on Senate Resolution 145/SR 117
Relating to Family Leave Working Group

Aloha Chair Aquino and Members of the Committee:

My name is Deborah M. Oyakawa, and I was a caregiver for my mother who had dementia. I am in STRONG SUPPORT of SCR 145/SR 117. The resolution establishes a working group to recommend family leave insurance program that can help working caregivers with paid time off to care for their loved ones at home.

Due to the stress of being a caregiver, my focus and energy level were taxed and I was not performing well at work. I had to reduce my hours significantly. To supplement my income, I tapped into my retirement plan and eventually drained the funds. I am now in my sixties with no retirement money to help support me.

There are many family caregivers who find themselves in similar situations. They sacrifice their own financial security to provide countless hours of care that range from bathing, preparing meals and escorting loved ones for medical visits. They lovingly perform these daily tasks so that their family member can remain in their homes and age in place. In addition, family caregivers often pay out of their own pockets for needed health care supplies and additional assistance. Like me, they have to draw down from their personal and retirement savings. They shouldn't have to choose between their own livelihood or take care their families. Please continue the efforts to support these unsung heroes by passing SCR 145/SR 117.

Mahalo for the opportunity to testify!

Deborah M. Oyakawa
Waikoloa, HI 96738
Email: deboyakawa@gmail.com

Testimony on Senate Bill No. 145/SR 117
RELATING TO WORKING GROUP FOR PAID FAMILY LEAVE
MONDAY, March 24, 2025 at 3:00 pm
Conference Room 224 & Videoconference
State Capitol
415 South Beretania Street

Chair Aquino and Members of the Committee:

My name is Lynnette Sakamoto, and I am a former caregiver. I am in STRONG SUPPORT of SCR 145/SR 117 which establishes a working group to work on a family and medical leave insurance program for working family caregivers.

From 2001 to 2014 I took care of both my parents. After my mom passed, I took care of my dad for 4 more years, a total of 17 years. While the physical and mental aspects of caregiving took its toll on me while I was caregiving, the financial toll is an ongoing challenge. I retired early from my primary job with the airlines which resulted in my retirement income being reduced, and I had to quit my secondary job in real estate because it was impossible to be on top of that while facing the daily challenges of caregiving.

The high cost of hiring caregivers to relieve me prevented us from using them as often as needed, and I'm amazed that I survived all those years of caregiving. I now watch as my cousins and friends struggle as I did as they care for their loved ones. Unfortunately, they, too, will experience future financial hardships because of the sacrifices they made for their loved ones.

Family caregivers are the backbone of Hawaii's long term care system. They provide countless hours of care that range from bathing, preparing meals, and escorting loved ones for medical visits. Many are juggling their family responsibilities while working to pay for their household expenses to keep a roof over their heads. Some are the sandwich generation caring for both aging kupuna and younger keiki in school. A proposed paid leave would allow working family caregivers to care for their loved ones without sacrificing their jobs and future retirement income. Please pass SCR 145/ SR 117 to work on a program for Hawaii families.

Mahalo for the opportunity to testify.

Lynnette Sakamoto
Kailua, HI

NOTICE OF HEARING
Monday, March 24, 2025

SCR 145/SR 117 - RELATING TO WORKING GROUP FOR PAID FAMILY LEAVE

Aloha Chair Aquino,Vice Chair Lee and members of the Committee on Labor and Technology. My name is Carol Wakayama and I wish to submit testimony in favor of S.C.R 145/ S.R. 117.

Volunteer family caregivers come forward to provide help to those they love. Although associated costs - to provide help - can range from hundreds to thousands of dollars, family caregivers currently provide this care without any compensation or tax credits. Family caregivers provide help such as preparing meals, providing hygiene and transportation. It could also be something relatively simple like reading to or talking story with their loved ones.

SCR 145/SR 117 establishes a working group for a paid family leave program to help working families who are working while providing caregiving for their loved ones. If passed, the working group could help recommend a program that would assist family caregivers to provide care/help to those they love without losing their jobs or paychecks.

I humbly request that SCR 145/SR 117 be considered for passage. Thank you.

Carol Wakayama
1011 Prospect Street #804
Honolulu, HI 96822
ckwakayama@gmail.com

HAWAII STATE COMMISSION
ON THE STATUS OF WOMEN

March 23, 2025

Position: Support of SCR145/SR117

To: Senator Henry J.C. Aquino, Chair
Senator Chris Lee, Vice Chair
Members of the Senate Committee on Labor and Technology

From: Llasmin Chaine, LSW, Executive Director, Hawai'i State Commission on the Status of Women

Re: Testimony in Support of SCR145/SR117, Requesting LBT Convene a Legislative Working Group to Develop Recommendations for Establishing and Implementing a Paid Family and Medical Leave Program for the State

Hearing: Monday, March 24, 2025, 3:00 p.m.
Conference Room 224, State Capitol

On behalf of the Hawai'i State Commission on the Status of Women (HSCSW), I would like to thank the committee for hearing these important resolutions. I would like to offer comments in support of SCR145/SR117.

As the state entity responsible for gender equality and equity advocacy activities, policy and program development efforts, available economic and educational opportunities, governmental and nongovernmental activities and information relating to the status of women, the HSCSW has previously collaborated on paid family and medical leave efforts**. It engages with State agencies and community stakeholders to address the emotional and financial strain that the state's caregivers experience and participates in legislative advocacy to address the inequity within our existing socio-economic infrastructures, which disproportionally impacts working women.**

I would appreciate being **included in the working group** and **an opportunity to collaborate on the development of recommendations for the establishment and implementation of a paid family and medical leave program for the State, shifting some of the socio-economic infrastructure inequities towards equality and lead to better outcomes for Hawai'i's girls and women.** Given the Legislature's desire for "a continuing body to aid in the implementation of its recommendations, to develop long-range goals, and to coordinate research planning, programming, and action on the opportunities, needs, problems, and contributions of women in Hawai'i", as stated in HRS 367, sections 1-5, and the **HSCSW Executive Director's experience with statewide outreach efforts**, inclusion of the HSCSW would align with its mandate and be advantageous, given the working group's stated scope and goals.

I offer the following amendments to these resolutions for your consideration, with the **HSCSW Executive Director added** to the **working group.:**

- **SCR145**:
  - Proposed resolution amendment to workgroup members, on page 5, lines 9-40, and page 6, lines 1-5:

    (5) The Executive Director of the Hawaii State Commission on the Status of Women;
    ~~(5)~~ **(6)** A representative from the Hawaii State Teachers Association, to be invited by the chairperson of the working group;
    ~~(6)~~ **(7)** A representative from the United Public Workers, AFSCME Local 646, AFL-CIO, to be invited by the chairperson of the working group;
    ~~(7)~~ **(8)** A representative from the Hawaii Government Employees Association, to be invited by the chairperson of the working group;
    ~~(8)~~ **(9)** A representative from Aloha United Way, to be invited by the chairperson of the working group;
    ~~(9)~~ **(10)** A representative from the American Association of University Women of Hawaii, to be invited by the chairperson of the working group;
    ~~(10)~~ **(11)** A representative from an organization representing the interests of businesses with fewer than fifty employees, to be selected and invited by the Senate President;
    ~~(11)~~ **(12)** A representative from an organization representing the interests of businesses with fewer than fifty employees, to be selected and invited by the Speaker of the House of Representatives;
    ~~(12)~~ **(13)** A representative from TIARP Hawaii, to be invited by the chairperson of the working group;
    ~~(13)~~ **(14)** A representative from Hawaii Children's Action Network Speaks!, to be invited by the chairperson of the working group; and
    ~~(14)~~ **(15)** A representative from a private insurance company offering Temporary Disability Insurance benefits in the State or an association of insurers, to be selected and invited by the Governor; and

- **SR117**:
  - Proposed resolution amendment to workgroup members, on page 5, lines 6-41, and page 6, line 1:

    (5) The Executive Director of the Hawaii State Commission on the Status of Women;
    ~~(5)~~ **(6)** A representative from the Hawaii State Teachers Association, to be invited by the chairperson of the working group;
    ~~(6)~~ **(7)** A representative from the United Public Workers, AFSCME Local 646, AFL-CIO, to be invited by the chairperson of the working group;
    ~~(7)~~ **(8)** A representative from the Hawaii Government Employees Association, to be invited by the chairperson of the working group;
    ~~(8)~~ **(9)** A representative from Aloha United Way, to be invited by the chairperson of the working group;
    ~~(9)~~ **(10)** A representative from the American Association of University Women of Hawaii, to be invited by the chairperson of the working group;

~~(10)~~ **(11)** A representative from an organization representing the interests of businesses with fewer than fifty employees, to be selected and invited by the Senate President;
~~(11)~~ **(12)** A representative from an organization representing the interests of businesses with fewer than fifty employees, to be selected and invited by the Speaker of the House of Representatives;
~~(12)~~ **(13)** A representative from TIARP Hawaii, to be invited by the chairperson of the working group;
~~(13)~~ **(14)** A representative from Hawaii Children's Action Network Speaks!, to be invited by the chairperson of the working group; and
~~(14)~~ **(15)** A representative from a private insurance company offering Temporary Disability Insurance benefits in the State or an association of insurers, to be selected and invited by the Governor; and

We are grateful for the Legislature's ongoing investment in our keiki, working mothers and their families. I respectfully urge this Committee to **pass SCR145/SR117**. Thank you for this opportunity to submit testimony and comments.

MAUI
CHAMBER OF COMMERCE
VOICE OF BUSINESS

HEARING BEFORE THE SENATE COMMITTEE ON
LABOR AND TECHNOLOGY
HAWAII STATE CAPITOL, SENATE CONFERENCE ROOM 224
Monday, March 24, 2025 AT 3:00 P.M.

To The Honorable Senator Henry J.C. Aquino, Chair
The Honorable Senator Chris Lee, Vice Chair
Members of the committee on Labor and Technology

COMMENTS ON SCR145

The Maui Chamber of Commerce respectfully submits **COMMENTS on SCR145**, which requests that the Senate Standing Committee on Labor and Technology and the House of Representatives Standing Committee on Labor convene a legislative working group to develop recommendations for establishing and implementing a paid family and medical leave program for the State of Hawai‘i.

The Chamber notes that only two (2) members of the proposed working group represent small businesses (defined as businesses with fewer than 50 employees). We respectfully request that two representatives from businesses (one from a small business and one from a larger business) and/or business organizations from each island be included, as there are significant economic differences and conditions unique to each island that merit representation in this important discussion.

Mahalo for the opportunity to **COMMENT on SCR145**.

Sincerely,

Pamela Tumpap

Pamela Tumpap
President

To advance and promote a healthy economic environment for business, advocating for a responsive government and quality education, while preserving Maui’s unique community characteristics.

HAWAII STATE AFL-CIO

888 Mililani Street, Suite 501 • Honolulu, Hawaii 96813
Telephone: (808) 597-1441 • Fax: (808) 593-2149

The Thirty-Third Legislature
The Senate
Committee on Labor and Technology

Testimony by
Hawaii State AFL-CIO

March 24, 2025

TESTIMONY IN SUPPORT OF SCR145/SR117 – REQUESTING THE SENATE STANDING COMMITTEE ON LABOR AND TECHNOLOGY AND HOUSE OF REPRESENTATIVES STANDING COMMITTEE ON LABOR TO CONVENE A LEGISLATIVE WORKING GROUP TO DEVELOP RECOMMENDATIONS FOR ESTABLISHING AND IMPLEMENTING A PAID FAMILY AND MEDICAL LEAVE PROGRAM FOR THE STATE

Chair Aquino, Vice Chair Lee, and members of the committee:

The Hawaii State AFL-CIO is a state federation of 76 affiliated labor organizations representing more than 69,000 union members across Hawaii in government and industries such as healthcare, construction, hospitality, entertainment, and transportation. We serve our affiliates by advocating for the rights of working families, promoting fair wages, ensuring safe working conditions, and supporting policies that strengthen Hawaii's workforce.

We support SCR145/SR117 because Hawaii's workforce urgently needs a comprehensive, statewide paid family and medical leave program. Too many working families are forced to choose between keeping their jobs and caring for a child, a sick loved one, or managing a personal health crisis. Current family leave laws in Hawaii only offer unpaid leave and exclude most workers. Many simply cannot afford to take time off without pay.

Rising costs of living and health care make unpaid time off even more damaging. Without paid leave, a temporary emergency can quickly lead to long-term financial hardship. Hawaii cannot afford to continue to ignore this problem. A legislative working group is a step forward to develop a fair, sustainable solution. A strong public program will improve retention, support small businesses, and strengthen economic stability for working families. We urge the committee to pass this measure.

Respectfully submitted,

Randy Perreira
President

Testimony to the Senate Committee on Labor and Technology
Monday, March 24, 2025
3:00 p. m.
State Capitol Conference Room 224 and via videoconference

Re: SCR 145 / SR 117 Requesting the Senate Standing Committee on Labor and Technology and the House of Representatives Standing Committee on Labor to convene a legislative working group to develop recommendations for establishing and implementing a paid family and medical leave program for the State.

Dear Chair Aquino, Vice Chair Lee, and Honorable Members of the Senate Committee on Labor and Technology:

I am Gary Simon, a member of the board of the Hawai'i Family Caregiver Coalition, whose mission is to improve the quality of life of those who give and receive care by increasing community awareness of caregiver issues through continuing advocacy, education, and training. I am offering testimony on behalf of the Hawai'i Family Caregiver Coalition.

The Hawai'i Family Caregiver Coalition strongly supports SCR 145 / SR 117.

Up to 40 percent of people in the workforce are not eligible for leave under the Family Medical Leave Act — and many cannot afford to take unpaid leave. Lack of paid family leave can lead to financial strain and negative workplace impacts for caregivers. Paid leave programs result in better health outcomes and lower overall health care system costs.

Developing a paid family leave policy and program will allow working family caregivers to care for their loved ones without sacrificing their job and income. Family caregivers and their care recipients deserve our support.

We urge you to support paid family leave and SCR 145 / SR 117, and we urge you to recommend its passage.

Mahalo for seriously considering the resolutions.

Very sincerely,

Gary Simon
Hawai'i Family Caregiver Coalition
Email garysimon@hawaii.rr.com

Hawai'i Nurses' association
The Voice That Makes The Difference
OPEIU Local 50

Rosalee Agas Yuu, RN
President

1600 Ala Moana Blvd Suite 100
Honolulu, HI 96815

Tel: (808) 531-1628
Fax: (808) 524-2760

The Thirty-Third Legislature
Hawai'i State Senate
Committee on Labor & Technology

Testimony by
Hawaii Nurses Association

TESTIMONY IN SUPPORT OF SCR 145 – RELATING TO THE PAID FAMILY
March, 2024, 3:00 PM
Conference Room 224, Hawaii State Capitol

Aloha Chair Aquino and Vice Chair Lee, and Honorable Members of the Senate Committee Labor and Technology:

The Hawai'i Nurses Association – OPEIU Local 50 is affiliated with the AFL-CIO, was founded in 1917, and represents 4,000 nurses in the State of Hawai'i.

The Hawaii Nurses' Association wholeheartedly **supports SCR 145**, as it represents a vital step forward in addressing the challenges faced by our healthcare workforce and the families they serve. Nurses are not only the backbone of the long-term care system but also play a critical role in caring for their own families, often balancing demanding work schedules with significant caregiving responsibilities. Establishing a state-administered paid family and medical leave program will provide the necessary support to help nurses and other workers manage these dual responsibilities without sacrificing their financial security or quality of patient care.

By ensuring that all workers, regardless of employer size, have access to paid leave, this resolution directly addresses the disparities inherent in the current system. Many of our nurses and their colleagues work for smaller organizations that do not qualify for federal unpaid leave protections, leaving them vulnerable during personal or family health crises. A comprehensive paid leave program would not only alleviate the immediate financial and emotional burdens on these individuals but also contribute to better long-term health outcomes for families and the broader community by reducing stress and promoting recovery.

Furthermore, the implementation of this program is essential to sustaining and strengthening our healthcare workforce. With persistent staffing shortages and increasing demands on nurses, providing reliable paid family and medical leave can improve employee retention and recruitment. This resolution will enable nurses to take necessary time off without fear of job loss or diminished income, ensuring that they remain healthy and focused on delivering the highest quality care. The Hawaii Nurses' Association believes that supporting this resolution will lead to a more resilient healthcare system and a healthier state overall.

Mahalo for the opportunity to testify.

Sincerely,

Carol Philips, Legislative Specialist
Hawaii Nurses' Association

COMMITTEE ON LABOR AND TECHNOLOGY
Senator Henry J.C. Aquino, Chair Senator Chris Lee, Vice Chair

Monday, March 24, 225
3:00 PM
Conference Room 224
Via Videoconference

Support: SCR 145/ SR117

Senator Aquino, Chair Senator Lee Vice Chair and members of the Committee:

I am Beverly Ann Gotelli, Chair, of the Policy Advisory Board for Elder Affairs (PABEA), which is an appointed board tasked with advising the Executive Office on Aging (EOA). My testimony does not represent the views of the EOA but of PABEA.

I STRONG SUPPORT of SCR 145 /SR 117 which convenes a legislative working group for a paid family and medical leave program for the state.

We are an aging population and must rely on our children to help with our well-being at the cost of losing their jobs.

It is important that the working group develop recommendations on a paid family leave policy and program that supports working family caregivers to better balance their job and family responsibilities, reducing their stress and allowing them to better support their loved ones

As I age, I wonder what will happen if I need my children to relocate so they can be my caregiver. Will this mean they will lose their current employment; will they be able to find a new job should they relocate. Will they be able to take paid family leave if available at their job site.

Having the working group may help alleviate some of the uncertainties that we are facing.

Thank you for the opportunity to testify in support of SCR145/SR 117.

Beverly Ann Gotelli
Chair, PABAEA
6286 Opaekaa Road
Kapaa, HI 96746

CATHOLIC CHARITIES HAWAIʻI

TESTIMONY IN SUPPORT OF SCR 145/SR 117: REQUESTING THE SENATE STANDING COMMITTEE ON LABOR AND TECHNOLOGY AND HOUSE OF REPRESENTATIVES STANDING COMMITTEE ON LABOR TO CONVENE A LEGISLATIVE WORKING GROUP TO DEVELOP RECOMMENDATIONS FOR ESTABLISHING AND IMPLEMENTING A PAID FAMILY AND MEDICAL LEAVE PROGRAM FOR THE STATE.

TO: Senate Committee on Labor and Technology
FROM: Tina Andrade, President and CEO, Catholic Charities Hawaiʻi
Hearing: Monday, 3/24/25; 3:00 pm; via Videoconference or Room 224

Chair Aquino, Vice Chair Lee, and Members, Committee on Labor and Technology:

Catholic Charities Hawai`i **Strongly Supports SCR 145/ SR 117 ,** which would convene a legislative working group to develop recommendations for establishing and implementing a paid family and medical leave program.

Catholic Charities Hawaiʻi (CCH), a community-based organization, has provided social services in Hawaiʻi for over 77 years, assisting 40,000 people annually. Our services target the most vulnerable in Hawaiʻi, including elders, veterans, children, families, houseless individuals, and immigrants. This resolution targets one of our economic justice priorities.

Catholic Charities Hawaiʻi urges the legislature to develop recommendations that would best implement a paid family and medical leave program. This working group would be one step forward to help ensure a healthier and more productive local workforce. It would assist our working families to meet their basic needs in times of family crises.

Middle class, ALICE, and low-income families face severe burdens when they undergo situations when they cannot work but do not have paid family or medical leave. Paid leave is also a critical public health tool to combat disease and can result in significant savings in health care costs**.** Low-income workers are less likely to have paid family or medical leave than other members of the workforce. Hawai`i' cost of living is so high that sudden or long-term family crises may result in great stress and even the risk of homelessness. Many of the vulnerable in Hawai`i are the working poor, people who work hard, but due to our high cost of living, struggle to make ends meet. We serve these workers in our programs. They are often barely able to avoid homelessness, working several jobs to juggle the basic expenses of their families. They often have little or no reserves when a crisis strikes.

Paid family and medical leave supports the State's priority to assist workers to remain in Hawai`i. We urge your support for this working group**.**

If you have any questions, please contact our Legislative Liaison, Betty Lou Larson at (808) 527-4813.

TESTIMONY IN SUPPORT OF SCR 145/SR 117

TO: Chair Aquino, Vice-Chair Lee, & Members,
Senate Committee on Labor and Technology
FROM: Ryan Kusumoto, President & CEO
DATE: March 24, 2025 at 3:00 PM

Parents and Children Together (PACT) **offers testimony in support of SCR 145/SR 117**, which requests the convening of a legislative working group to develop recommendations for establishing and implementing a paid family and medical leave program for the state. Paid Family Leave supports family well-being and the economy. It increases health equity among different racial and socioeconomic groups AND helps to increase worker retention and loyalty. The need for stronger programs to protect our working families continues to grow.

Founded in 1968, PACT is a statewide community-based organization providing a wide array of innovative and educational social services to families in need. Assisting more than 15,000 people across the state annually, we help identify, address, and successfully resolve challenges through our 20 programs. Among our services are early education programs, domestic violence prevention and intervention programs, child abuse prevention and intervention programs, childhood sexual abuse supportive group services, child and adolescent behavioral health programs, sex trafficking intervention, poverty prevention and community building programs.

Thank you for the opportunity to testify. Please contact me at (808) 847-3285 or rkusumoto@pacthawaii.org if you have any questions.

SCR 145/SR 117, REQUESTING THE SENATE STANDING COMMITTEE ON LABOR AND TECHNOLOGY AND HOUSE OF REPRESENTATIVES STANDING COMMITTEE ON LABOR TO CONVENE A LEGISLATIVE WORKING GROUP TO DEVELOP RECOMMENDATIONS FOR ESTABLISHING AND IMPLEMENTING A PAID FAMILY AND MEDICAL LEAVE PROGRAM FOR THE STATE

MARCH 24, 2025 · LBT HEARING

POSITION: Support.

RATIONALE: Imua Alliance **supports** SCR 145/SR 117, which establishes a working group to develop recommendations for establishing a paid family and medical leave program. It is time to *finally* establish a family leave insurance program for Hawai'i's workers that provides paid time off to address family emergencies, including care for newborn keiki and kūpuna care. Once effectuated, family leave insurance should also provide progressive wage replacement, allowing low-income workers to receive a higher percentage of their weekly wages (ideally, up to 90 percent) to make the benefit accessible to everyone.

Hawaii's workers need this benefit. In a 2017 public poll, 62 percent of Hawaii respondents reported that they had wanted to take leave in the past in order to care for a new child or family member. Currently, though, only one in four private sector workers has access to paid family and medical leave. Lower-income workers in Hawai'i, who are more likely to be Native Hawaiian or Pacific Islander, are the least likely to have paid family leave, while they need support the most.

The federal Family Medical Leave Act (which leaves out 40 percent of the state's workforce) provides for only *unpaid* leave with up to 12 weeks for employers with 50 or more employees. The

Hawai'i Family Leave Law (HFLL) only applies to employers with 100 or more employees and provides up to four weeks of *unpaid* leave to workers.

Hawai'i has the fastest growing aging population in the nation. Our senior (age 65+) population is expected to grow 81 percent by 2030. Our state currently has 154,000 unpaid caregivers providing care to kūpuna or seriously ill adult relatives, which can lead to financial and emotional strain. Hawai'i caregivers provide 144 million hours of unpaid care a year, worth $2.6 billion annually. Notably, 34,898 residents of Hawai'i moved to states that passed paid leave laws in 2021, further showing our population's desire for family leave support.

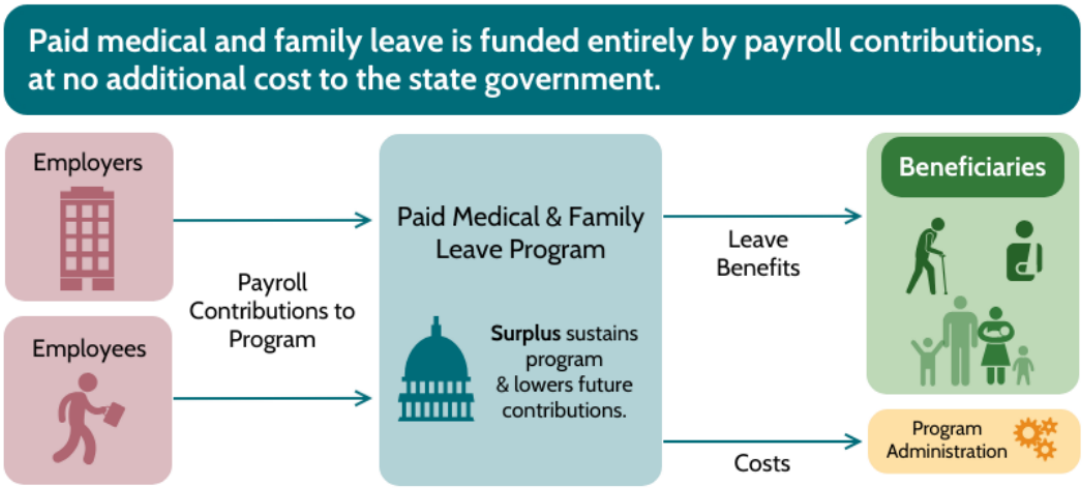
This program would help Hawaii's businesses. Family leave insurance increases worker retention and loyalty. Workers who have access to family leave benefits are more likely to return to work after their leave is over. In a 10-year study of the California family leave insurance program, businesses reported that family leave had either a positive or a neutral effect on their business. Small businesses were less likely than large businesses to report any negative effects.

Statewide paid family and medical leave also helps even the playing field for small businesses. Most small businesses cannot afford to offer adequate paid family and medical leave to their employees, which puts them at a disadvantage in attracting and retaining the best workers. Under a statewide paid family and medical leave program, however, small payroll deductions would go into a state fund, which workers would apply to when they need to take leave. A survey conducted by the small business advocacy organization Small Business Majority revealed that two-thirds of small business owners support paid family and medical leave.

Providing paid time off for family caregiving strongly promotes gender equity. Women are often disproportionately impacted by the lack of paid leave, as they are the primary caregivers of infants, children, and aging parents. The lack of paid family leave exacerbates the gender wage gap for women and adversely impacts the economic stability of both male and female caregivers. Most working mothers who give birth can get partial pay through Hawai'i Temporary Disability Insurance (TDI) to recover from childbirth, but TDI cannot be used by non-birth parents or to care for other family members.

We know this can work in Hawai'i. Top experts on family leave have studied the usage, cost, and feasibility of implementing a family leave insurance program for the islands. Multiple studies have been performed about the establishment of family leave for Hawai'i, all of which have found that paid family leave is a cost-effective way for workers to take adequate time off to care for their families without facing financial ruin or jeopardizing their careers, and that a statewide program can be implemented without significant cost to the state.

According to a study conducted by Prenatal-to-3 Policy Impact Center at Vanderbilt University, instituting paid family leave in Hawai'i would cost just 0.7 percent of payroll. **A worker earning $62,000/year would pay $217 *per year* in premiums for a return of $930 *per week* in benefits.** Critically, the cost to administer a paid family leave program is minimal according to the Vanderbilt analysis, at between $8 million and $10 million, **which would be entirely financed through revenue generated by premiums paid by workers and/or employers.**



It's a stark reality when employees face the dire choice of caring for newborn or sick children, spouses, or parents or working to sustain their family's income. We must offer a smart, affordable solution that empowers workers to care for their families, while preserving their incomes.

Contact us at imuaalliance.org/contact.

SCR 145/SR 117, REQUESTING THE SENATE STANDING COMMITTEE ON LABOR AND TECHNOLOGY AND HOUSE OF REPRESENTATIVES STANDING COMMITTEE ON LABOR TO CONVENE A LEGISLATIVE WORKING GROUP TO DEVELOP RECOMMENDATIONS FOR ESTABLISHING AND IMPLEMENTING A PAID FAMILY AND MEDICAL LEAVE PROGRAM FOR THE STATE

MARCH 24, 2025 · LBT HEARING

POSITION: Support.

RATIONALE: The Democratic Party of Hawai'i Education Caucus **supports** SCR 145/SR 117, which establishes a paid family and medical leave working group.

Hawai'i needs to pass paid family leave to uplift hardworking families. Here is why.

Paid family leave saves the lives of our keiki. A study published in *Contemporary Economic Policy* in October of 2022 found that when California mandated six weeks of paid parental leave from 2004 to 2008, 339 fewer infant deaths occurred on average when compared with states that did not mandate paid parental leave. The researchers estimated that three months of paid parental leave for the whole U.S. would save nearly one thousand infant lives per year.

Another study published in Children and Youth Services Review in 2020 concluded in 35 countries that belong to the Organization for Economic Cooperation and Development (OECD) that have launched or expanded paid leave policies, paid leave was associated with a decrease in mortality of infants and all children under 5. Specifically, paid maternity leave was associated with a 5.2

percent decrease in newborn death rates, a 2.4 percent decrease in infant death rates, and a 1.9 percent decrease in death rates for children under 5 years.

Paid family leave is essential for the physical and mental health of parents. Paid leave has been linked with improved blood pressure, healthier BMI, and less pain in mothers. Research has found that infants of women with paid leave are 47 percent less likely to end up back in the hospital and mothers are 51 percent less likely to end up back in the hospital compared to women with no paid leave or women with no leave at all. Family leave is also linked with a lower risk for depression and psychological distress.

Paid family leave has long-term benefits Researchers from the Institute for Labor Economics have concluded that when parents have paid leave, children are more likely to graduate high school, attend college, and even earn more money as adults. Other analyses have found that paid family leave results in parents spending increased time with their infants—**not only during the leave period but also after returning to work, up until 3 years of age.** This includes mothers spending increased time reading to, talking to, and helping with homework and fathers playing with children for more hours per week.

Paid family leave does not negatively impact employers. One of the only arguments against paid leave is that harms employers, especially small businesses, and the overall economy. Yet, women with paid leave are persistently shown to be less likely to leave the workforce, which saves businesses the high expense of finding and training new employees. Furthermore, employers in numerous studies have reported that paid leave increased their ease of dealing with extended employee absences. After California enacted a paid family leave policy, for example, 90 percent of employers reported no negative impacts on their profitability, turnover, or employee morale.

According to an analysis performed by PN3 Policy Center at Vanderbilt University, instituting paid family leave in Hawai'i would cost just 0.7 percent of payroll. **A worker earning $62,000/year would pay $217 *per year* in premiums for a return of $930 *per week* in benefits.**

Contact: educationcaucusdph@gmail.com

Date: March 22, 2025

To: Senator Henry J.C. Aquino, Chair
Senator Chris Lee, Vice Chair
Members of the Senate Committee on Labor and Technology

RE: Support for SCR 145/SR 117, Requesting the Senate Standing Committee on Labor and Technology and House of Representatives Standing Committee on Labor to convene a legislative working group to develop recommendations for establishing and implementing a paid family and medical leave program

Hrg: Monday, March 24, 2025, at 3:00 PM, Conference Room 224

The Healthy Eating Active Living (HEAL) Coalition, convened by the Hawai'i PublicHealth Institute, **supports SCR 145/SR 117,** which requests the Senate Standing Committee on Labor and Technology and House of Representatives Standing Committee on Labor to convene a legislative working group to develop recommendations for establishing and implementing a paid family and medical leave program for the state.

It is time for Hawai'i to pass a strong family leave insurance program. Employees need paid time off to care for a newborn, newly adopted or foster child, ill family member, or other unexpected health emergency. Paid family leave guarantees that employees can cover their basic living costs, while also providing care to family members when they need it most. Thirteen states and Washington, D.C., have passed legislation providing partial wage replacement for family and medical leave purposes.[1]

Improved Health for Mothers and Babies

Studies have shown that paid family leave is associated with a reduced risk for medical conditions that put children at risk. For example, a 2015 study in the Journal of Health Economics found that paid family leave was correlated with a 3.2 percent reduced risk of being low birthweight and a 6.6 percent lower risk of an "early term" or premature birth.[2]

Paid family leave is essential in uplifting the health of parents and infants. It has been linked with improved blood pressure, healthier BMI, and less pain in mothers. Researchers found that infants of women with paid leave are 47 percent less likely, and mothers themselves are 51 percent less likely, to end up

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[1] https://www.americanprogress.org/article/the-state-of-paid-family-and-medical-leave-in-the-u-s-in-2023

[2] https://www.sciencedirect.com/science/article/abs/pii/S0167629615000533

back in the hospital after birth compared to women without access to paid family leave or other paid leave programs.

Financial Stability
Studies have found that paid family leave significantly impacts the economic security of families after a child is born. A 2019 report published in Social Science Review concluded that for families of 1-year-old children, paid family leave decreased the risk of poverty by an estimated 10.2 percent and increased household income by an estimated 4.1 percent. The analysis found that these gains were especially concentrated for low-income mothers, who have fewer social supports for caregiving than more affluent families.[3]

Kūpuna Care
As our kūpuna population continues to grow, paid family leave will be a vital tool in empowering families to care for their loved ones without jeopardizing their financial well-being. Our state has a rapidly aging population. According to the Department of Business, Economic Development, and Tourism, almost one in five residents is now at age 65 or older and more than one-third of all households include at least one person age 65 or older.[4] The elderly population is expected to continue increasing at a much faster rate than the overall population until 2030, when all baby boomers will be over 65.

Accordingly, we support the enactment of paid family leave and urge you to adopt this resolution to advance discussion about establishing family leave for our state's working families.

Mahalo,

Nate Hix
Director of Policy and Advocacy

[3] https://www.journals.uchicago.edu/doi/abs/10.1086/703138
[4] https://files.hawaii.gov/dbedt/economic/reports/Elderly_Population_in_Hawaii-Housing_Dec2021.pdf

TESTIMONY IN SUPPORT OF SCR145/SR117, REQUESTING THE SENATE STANDING COMMITTEE ON LABOR AND TECHNOLOGY AND HOUSE OF REPRESENTATIVES STANDING COMMITTEE ON LABOR TO CONVENE A LEGISLATIVE WORKING GROUP TO DEVELOP RECOMMENDATIONS FOR ESTABLISHING AND IMPLEMENTING A PAID FAMILY AND MEDICAL LEAVE PROGRAM FOR THE STATE.

SENATE COMMITTEE ON LABOR & TECHNOLOGY
MARCH 24, 2025

Aloha Chair Aquino, Vice Chair Lee, and Members of the Labor & Technology Committee:

The Democratic Party of Hawai'i **SUPPORTS** SCR145/SR117. Pursuant to the platform of the Democratic Party of Hawai'i, the Party supports policies to reduce income inequality and promote economic mobility.

Hawaii's existing leave policies provide unpaid leave and fail to cover a large portion of the workforce, making it financially challenging for many employees to take necessary time off. With the increasing expenses of living and healthcare, unpaid leave can exacerbate financial difficulties, turning a short-term crisis into prolonged economic insecurity. Many working households face the difficult decision of either maintaining their employment or attending to a child, an ill family member, or their own health issues. A legislative working group composed of stakeholders from sectors of Hawaii's society that would be impacted by the creation of a paid leave program will allow for a comprehensive and inclusive approach to developing a paid family and medical leave program. By involving representatives from labor organizations, businesses, community groups, and other relevant sectors, the working group can ensure that diverse perspectives and needs are considered. This working group will be instrumental in providing recommendations for a program that benefits all of Hawai'i's workers and families, fostering a healthier, more equitable, and resilient community.

Mahalo nui loa for the opportunity to testify in Support of SCR145/SR117. Should you have any questions or require further information, please contact the Democratic Party of Hawai'i at legislation@hawaiidemocrats.org.

March 24, 2025

Members of the Senate Committee on Labor and Technology:

Chair Henry J.C. Aquino
Vice Chair Chris Lee
Sen. Les Ihara, Jr.
Sen. Sharon Y. Moriwaki
Sen. Kurt Fevella

Re: SCR145/SR117 Relating to DLIR; DHRD; LRB; Legislative Working Group; Labor; Paid Family and Medical Leave; Report

Dear Chair Aquino, Vice Chair Lee, and Members of the Senate Committee on Labor and Technology:

The Hawai'i State Coalition Against Domestic Violence (HSCADV) addresses the social, political, and economic impacts of domestic violence on individuals, families, and communities. We are a statewide partnership of domestic violence programs and shelters.

On behalf of HSCADV and our 25 member programs statewide, I respectfully submit testimony in **strong support** of SCR145/SR117, which requests a working group to continue the discussion around paid family leave. This year's bills have been deferred, but the need for stronger programs to protect our working families and survivors of gender-based crimes continues to grow. The economic success of our state is linked to the well-being of our workforce, and similar programs in other states demonstrate that paid family leave benefits businesses and workers.

Paid Family and Medical Leave is not only beneficial for Hawai'i's caregivers and families but also to survivors of domestic violence, sexual assault, and stalking (all forms of gender-based violence) who need to take time off to receive victim services, make court appearances, seek medical services, or relocate themselves and family. Rhode Island, Connecticut, Oregon, Colorado, Minnesota, and Maine currently include safe leave in their paid family leave laws.

Survivors who have already faced immense trauma should not be forced to choose between personal and family physical safety or financial stability. **Survivors and their loved ones in Hawai'i need paid safe leave to manage their safety, care for their families, and remain in the workforce.**

HAWAI'I STATE COALITION AGAINST DOMESTIC VIOLENCE

Maintaining economic independence is critical to survivors' immediate, intermediate, and long-term safety and ability to recover from trauma. However, many survivors struggle to remain connected to the workforce as they face numerous challenges in obtaining and maintaining employment as a consequence of the abuse or violence.

When survivors can take paid time away from work to heal, recover, and make themselves and their families safe, it promises to strengthen survivors' ties to the workforce and allow them to meet critical needs in the wake of violence. Gender-based violence presents a concern for public health and safety, as well as for the economy, and victimization has serious repercussions for workers.

- More than half of survivors of all types of violence report difficulty with work or school as a result of victimization.[1]
- Survivors and their loved ones miss over 6.7 million work days yearly.[2]
- A 2022 national survey of victims of all types of violence found that one in six violence survivors reported losing a job or being demoted when they needed time off from work due to victimization.[3]
- An overwhelming 83% of survivors of domestic violence report an abusive partner has disrupted their ability to work; of those, more than half have lost their jobs because of abuse.[4]

By creating pathways to remain in the workforce and adequately support survivors of violence, Hawai'is economy benefits from a reduction in lost productivity and retains talented and innovative workers.

Thank you for the opportunity to testify on this important matter.

Sincerely,
Angelina Mercado, Executive Director

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[1] Alliance for Safety and Justice, "Crime Survivors Speak: National Survey Of Victims' Views On Safety and Justice" (September 2022), https://allianceforsafetyandjustice.org/wp-content/uploads/2022/09/Alliance-for-Safety-and-Justice-Crime-Survivors-Speak-September-2022.pdf.

[2] Alliance for Safety and Justice and Crime Survivors for Safety and Justice, "Lost Work, Pay, and Safety: Victims of Violence Urgently Need Safe Leave" (April 2024), https://allianceforsafetyandjustice.org/wp-content/uploads/2024/04/LostWorkLostPayLostSafety.pdf.

[3] Alliance for Safety and Justice, "Crime Survivors Speak: National Survey Of Victims' Views On Safety and Justice" (September 2022), https://allianceforsafetyandjustice.org/wp-content/uploads/2022/09/Alliance-for-Safety-and-Justice-Crime-Survivors-Speak-September-2022.pdf.

[4] Cynthia Hess & Alona Del Rosario, "Dreams Deferred: A Survey on the Impact of Intimate Partner Violence on Survivors' Education, Careers, and Economic Security" 9, Institute for Women's Policy Research (2018), https://iwpr.org/wp-content/uploads/2020/09/C475_IWPR-Report-Dreams-Deferred.pdf.

Senate Labor and Technology Committee
Sen. Aquino, Chair
Sen. Lee, Vice Chair

March 24, 2025, at 3:00 P.M.

RE: SCR145/SR117, Requesting the House and Senate Labor Standing Committees to convene a working group for establishing a Paid Family and Medical Leave Program

Aloha Chair Aquino, Vice Chair Lee, and members of the Committee:

Society of Human Resource Management – Hawaii ("SHRM Hawaii") respectfully offers comments on Senate Concurrent Resolution 145 and Senate Resolution 117:

SCR145 and SR117 request the Senate and House Standing Committees on Labor to convene a working group to develop recommendations for establishing a paid family and medical leave program for the State. The working group would include over a dozen members, including two representatives from organizations representing the interests of businesses with fewer than fifty employees. It would also provide that the working group utilize independent consultants and administrative facilitators to assist in the performance of its duties.

Paid family and medical leave is a complex and far-reaching issue, as evidenced by the range of perspectives shared during hearings this legislative session. Testimony has included both support and opposition, reflecting the diverse impacts on employers and employees alike. To ensure the issue is addressed in a balanced and effective manner, a variety of perspectives must be included.

Accordingly, SHRM Hawaii respectfully requests the following:

1. Add, on page 6, a subsection (15), as follows:

   "(15) A representative from the Society of Human Resource Management – Hawaii, to be invited by the chairperson of the working group;"

2. That, if and when the working group is convened, it engages independent consultants with expertise in human resource management.

The Society for Human Resource Management ("SHRM") is an international organization whose mission is to create workplaces where both employees and businesses thrive. SHRM traces its origin back to the founding of the American Society for Personnel Administration (ASPA) in 1948. Currently its membership number is almost 340,000 spanning 180 countries and touches the lives of more than 362 million workers and their families globally.

SHRM Hawaii is an affiliate of SHRM whose membership consists of almost 900 human resource professionals throughout the state of Hawaii. As such, it is uniquely positioned to provide a voice for both the employee and the employer concerns, including those of both large and smaller employers, thereby providing a key perspective in any discussion regarding implementing paid family leave in the state.

We look forward to contributing positively to the development of sound public policy and continuing to serve as a resource to the legislature on matters related to labor and employment laws.

Mahalo for the opportunity to provide testimony,

Erin Kogen and Rosanne M. Nolan
Co-chairs, SHRM Legislative Affairs Committee

SR-117
Submitted on: 3/20/2025 3:19:56 PM
Testimony for LBT on 3/24/2025 3:00:00 PM

Submitted By	Organization	Testifier Position	Testify
Mike Golojuch, Sr.	Individual	Support	Written Testimony Only

Comments:

I support SCR145. Please pass this resolution.

3/21/25

Paid Family Leave

Our names are Sara and Daniel Medeiros. We live on the island of Hawaii and are retired. We are in STRONG SUPPORT of Paid Family Leave which establishes a family and medical leave insurance program for working family caregivers.

Our island's aging population is growing and growing. Outside caregiving services to allow care in the home while family works is unaffordable, and the number of appropriate daycare and residential homes for elderly is very limited.

While my father/father in-law was very ill, my sister/sister in-law took unpaid time off to take care of him as he was dying. Luckily she was able to go back to her job upon his death. Needless to say, it was very difficult. She sacrificed a year toward retirement credits, promotion, sick leave and other benefits.

Family Caregivers are the backbone of Hawaii's long term care system. This proposed paid leave would allow working Family Caregivers, such as my sister/sister in-law to care for loved ones without sacrificing their job and income. Please support these unsung heroes by passing Paid Family Leave. They all deserve, and quite intimately so, our support.

Mahalo,

Sara and Daniel Medeiros

Kailua Kona, HI 96740

Senate Committee On Labor and Technology
Testimony on Senate Resolution 145/SR 117
Relating to Family Leave Working Group

Aloha Chair Aquino and Members of the Committee:

My name is Deborah M. Oyakawa, and I was a caregiver for my mother who had dementia. I am in STRONG SUPPORT of SCR 145/SR 117. The resolution establishes a working group to recommend family leave insurance program that can help working caregivers with paid time off to care for their loved ones at home.

Due to the stress of being a caregiver, my focus and energy level were taxed and I was not performing well at work. I had to reduce my hours significantly. To supplement my income, I tapped into my retirement plan and eventually drained the funds. I am now in my sixties with no retirement money to help support me.

There are many family caregivers who find themselves in similar situations. They sacrifice their own financial security to provide countless hours of care that range from bathing, preparing meals and escorting loved ones for medical visits. They lovingly perform these daily tasks so that their family member can remain in their homes and age in place. In addition, family caregivers often pay out of their own pockets for needed health care supplies and additional assistance. Like me, they have to draw down from their personal and retirement savings. They shouldn't have to choose between their own livelihood or take care their families. Please continue the efforts to support these unsung heroes by passing SCR 145/SR 117.

Mahalo for the opportunity to testify!

Deborah M. Oyakawa
Waikoloa, HI 96738
Email: deboyakawa@gmail.com

Testimony on Senate Bill No. 145/SR 117
RELATING TO WORKING GROUP FOR PAID FAMILY LEAVE
MONDAY, March 24, 2025 at 3:00 pm
Conference Room 224 & Videoconference
State Capitol
415 South Beretania Street

Chair Aquino and Members of the Committee:

My name is Lynnette Sakamoto, and I am a former caregiver. I am in STRONG SUPPORT of SCR 145/SR 117 which establishes a working group to work on a family and medical leave insurance program for working family caregivers.

From 2001 to 2014 I took care of both my parents. After my mom passed, I took care of my dad for 4 more years, a total of 17 years. While the physical and mental aspects of caregiving took its toll on me while I was caregiving, the financial toll is an ongoing challenge. I retired early from my primary job with the airlines which resulted in my retirement income being reduced, and I had to quit my secondary job in real estate because it was impossible to be on top of that while facing the daily challenges of caregiving.

The high cost of hiring caregivers to relieve me prevented us from using them as often as needed, and I'm amazed that I survived all those years of caregiving. I now watch as my cousins and friends struggle as I did as they care for their loved ones. Unfortunately, they, too, will experience future financial hardships because of the sacrifices they made for their loved ones.

Family caregivers are the backbone of Hawaii's long term care system. They provide countless hours of care that range from bathing, preparing meals, and escorting loved ones for medical visits. Many are juggling their family responsibilities while working to pay for their household expenses to keep a roof over their heads. Some are the sandwich generation caring for both aging kupuna and younger keiki in school. A proposed paid leave would allow working family caregivers to care for their loved ones without sacrificing their jobs and future retirement income. Please pass SCR 145/ SR 117 to work on a program for Hawaii families.

Mahalo for the opportunity to testify.

Lynnette Sakamoto
Kailua, HI

NOTICE OF HEARING
Monday, March 24, 2025

SCR 145/SR 117 - RELATING TO WORKING GROUP FOR PAID FAMILY LEAVE

Aloha Chair Aquino,Vice Chair Lee and members of the Committee on Labor and Technology. My name is Carol Wakayama and I wish to submit testimony in favor of S.C.R 145/ S.R. 117.

Volunteer family caregivers come forward to provide help to those they love. Although associated costs - to provide help - can range from hundreds to thousands of dollars, family caregivers currently provide this care without any compensation or tax credits. Family caregivers provide help such as preparing meals, providing hygiene and transportation. It could also be something relatively simple like reading to or talking story with their loved ones.

SCR 145/SR 117 establishes a working group for a paid family leave program to help working families who are working while providing caregiving for their loved ones. If passed, the working group could help recommend a program that would assist family caregivers to provide care/help to those they love without losing their jobs or paychecks.

I humbly request that SCR 145/SR 117 be considered for passage. Thank you.

Carol Wakayama
1011 Prospect Street #804
Honolulu, HI 96822
ckwakayama@gmail.com

SR-117
Submitted on: 3/21/2025 10:35:26 AM
Testimony for LBT on 3/24/2025 3:00:00 PM

Submitted By	Organization	Testifier Position	Testify
Angela Serota	Individual	Support	Written Testimony Only

Comments:

Aloha Chair Aquino and Members of the Committee,

My name is Angela Serota. I am a former caregiver and currently work with several family caregivers. I am in STRONG SUPPORT of SCR 145/SR 117. Family caregivers are an essential part of Hawaii's long term care system. For many families, providing care at home is the only option available. Too often, this service means 24 hour responsibility for a loved one's needs while working outside the home and caring for dependent children. Developing a paid family leave policy and program would allow working family carefivers to continue this necessary support without sacrificing their jobs and income. Please help support them in this vital and difficult role.

Mahalo for hearing my testimony.

Angela Serota from Kilauea, Kauai

SR-117
Submitted on: 3/21/2025 2:48:13 PM
Testimony for LBT on 3/24/2025 3:00:00 PM

Submitted By	Organization	Testifier Position	Testify
Sherrie Galdeira	Individual	Support	Written Testimony Only

Comments:

Aloha Chair Aquino, Vice Chair Lee, and Committee Members,

I **strongly support** SCR 145/SR 117, which request a working group to continue the discussion around paid family leave. This year's bills have been deferred, but the need for stronger programs to protect our working families continues to grow. The economic success of our state is linked to the well-being of our workforce, and similar programs in other states demonstrate that paid family leave benefits businesses and workers. Please support these resolutions!

Mahalo!

Hearing Date: Tuesday, March 25, 2025, 9:30 AM, Room 309

To: Committee on Labor
Rep. Jackson D. Sayama, Chair
Rep. Mike Lee, Vice Chair

Re: **HCR 179/HR 175**

Aloha Chair Aquino, Vice Chair Lee, and Committee Members,

My name is Jean Evans, and I am in **strong support of HCR 179/HR 175,** both of which request a working group to continue the discussion around paid family leave. This year's bills have been deferred, but the need for stronger programs to protect our working families continues to grow. The economic success of our state is linked to the well-being of our workforce, and similar programs in other states demonstrate that paid family leave benefits businesses and workers. Please support these resolutions!

Mahalo for your consideration.

Jean Evans

Jean Evans

To: House Committee on Consumer Protections and Commerce
Hearing: February 12, 2025, 2:00 p.m., Rm.329
Re: SUPPORT of SCR145 SR117 Relating to Paid Family Leave

Dear LBT Chair Aquino, Vice Chair Lee, and Committee Members,

Thank you for considering this SCR and this testimony in **support of SCR 145 and its companion bill SR117** which would create a working group to make recommendation for an insurance plan to allow workers to receive paid family and medical leave.

The United States remains the only industrialized nation in the world without paid family leave. By establishing paid family leave, Hawai`i would join the states of California, Colorado, Connecticut, D.C., Delaware, Maine, Maryland, Massachusetts, Minnesota, New Hampshire, New Jersey, New York, Oregon, Rhode Island, Vermont, Washington, and Wisconsin who have paid family leave.

The Federal Family Leave and Medical Leave Act was passed in 1993 and provides leave but no wage replacement. For many lower income workers, it is economically impossible to take sufficient time off for the birth of a baby or to care for a family member. This burden falls heavily on women who are more likely to be family care givers and heads of single parent households.

Please vote to create this working group..

Sincerely,

Amy Monk

Legislative Volunteer, Indivisible Hawaii

We're a grassroots movement of thousands of local Indivisible groups with a mission to elect progressive leaders, rebuild our democracy, and defeat the Trump agenda. In Hawai'i, we have ten groups across four islands, representing over a thousand pro-democracy citizens.

SR-117
Submitted on: 3/22/2025 7:55:16 PM
Testimony for LBT on 3/24/2025 3:00:00 PM

Submitted By	Organization	Testifier Position	Testify
Star Kemfort	Individual	Support	Written Testimony Only

Comments:

Aloha Chair Aquino, Vice Chair Lee, and Committee Members

It is with great concern that since Paid Family and Medical Leave was not passed that two resolutions will allow a working group to support future efforts with passing PFML program for the state of Hawai‘i. I Star Kemfort a parent and individual of the workforce in the state of Hawai‘i support these two resolutions SCR145/SR117. The two resolutions SCR145 and SR117 will provide further efforts necessary to ultimately pass Paid Family and Medical Leave (PFML) a benefit for all working families in the state of Hawai‘i. The potential of what PFML can provide to support families during uncertain times is crucial for the well-being of everyone within the workforce. The longevity of the workforce within our state needs more consistent benefits, and with extra support in those efforts, the result of Paid Family and Medical Leave being passed is of high priority and important. Please support these resolution efforts.

Mahalo!

SR-117
Submitted on: 3/22/2025 4:15:57 PM
Testimony for LBT on 3/24/2025 3:00:00 PM

Submitted By	Organization	Testifier Position	Testify
Caroline Kunitake	Individual	Support	Written Testimony Only

Comments:

Aloha Chair Aquino, Vice Chair Lee, and Committee Members,

I **strongly support** SCR 145/SR 117, which request a working group to continue the discussion around paid family leave. This year's bills have been deferred, but the need for stronger programs to protect our working families continues to grow. The economic success of our state is linked to the well-being of our workforce, and similar programs in other states demonstrate that paid family leave benefits businesses and workers. Please support these resolutions!

Mahalo!

SR-117
Submitted on: 3/22/2025 2:44:38 PM
Testimony for LBT on 3/24/2025 3:00:00 PM

Submitted By	Organization	Testifier Position	Testify
Elizabeth Hansen	Individual	Support	Written Testimony Only

Comments:

Aloha Chair Aquino, Vice Chair Lee, and Committee Members,

I **strongly support**SCR 145/SR 117, which request a working group to continue the discussion around paid family leave. This year's bills have been deferred, but the need for stronger programs to protect our working families continues to grow. The economic success of our state is linked to the well-being of our workforce, and similar programs in other states demonstrate that paid family leave benefits businesses and workers. Please support these resolutions!

Mahalo!

SR-117
Submitted on: 3/22/2025 2:38:41 PM
Testimony for LBT on 3/24/2025 3:00:00 PM

Submitted By	Organization	Testifier Position	Testify
Terri Yoshinaga	Individual	Support	Written Testimony Only

Comments:

I support these bill.

SR-117
Submitted on: 3/22/2025 2:33:54 PM
Testimony for LBT on 3/24/2025 3:00:00 PM

Submitted By	Organization	Testifier Position	Testify
J. Kehau Lucas	Individual	Support	Written Testimony Only

Comments:

Aloha Chair Aquino, Vice Chair Lee, and Committee Members,

I am writing in strong support of SCR 145/SR 117, which call for a working group to continue discussions on paid family leave. While this year's bills have been deferred, the need for stronger protections for our working families remains urgent. A thriving economy depends on the well-being of its workforce, and evidence from other states shows that paid family leave benefits both businesses and employees. I urge you to support these resolutions to keep the conversation moving forward.

Mahalo for your time and consideration.

Aloha ʻāina,

J. Kēhau Lucas

SR-117
Submitted on: 3/22/2025 2:19:14 PM
Testimony for LBT on 3/24/2025 3:00:00 PM

Submitted By	Organization	Testifier Position	Testify
Marcia A Armstrong	Individual	Support	Written Testimony Only

Comments:

I **strongly support**SCR 145/SR 117, which request a working group to continue the discussion around paid family leave. This year's bills have been deferred, but the need for stronger programs to protect our working families continues to grow. The economic success of our state is linked to the well-being of our workforce, and similar programs in other states demonstrate that paid family leave benefits businesses and workers. Please support these resolutions!

Mahalo!

SENATE COMMITTEE ON LABOR AND TECHNOLOGY
Senator Henry J.C. Aquino, Chair
Senator Chris Lee, Vice Chair

NOTICE OF HEARING
Tuesday, March 24, 2025: 3:00pm.

RE: SCR145/SR1I7 REQUESTING THE CONVENING OF A LEGISLATIVE WORKING GROUP

Aloha Chair Aquino, Vice Chair Lee, and Members of the Committee: My name is Linda Dorset, and I am in STRONG SUPPORT of SCR145/SR1I7. which convenes a legislative working group for a paid family and medical leave program for the state. Caregivers need a family leave policy that would support working caregivers who need some paid time off to care for a loved one at home. Family caregivers are the backbone of Hawaii's long term care system. They provide countless hours of care that range from bathing, preparing meals and escorting loved ones for medical visits. They lovingly perform these daily tasks so that the family member can remain in the home and age in place; but they sacrifice income, job security, and savings. Family caregivers often pay as much as $7,200/Year out of their own pockets for needed supplies such as incontinent supplies, medications, and additional in-home assistance. It is estimated that there are 154,000 Caregivers giving144 Million Care Hours/Year which amounts to $2.6 Billion of Unpaid Labor/Year. Many must also balance work and caregiving or leave the workforce altogether. With Hawaii's high cost of living, few can afford to quit their jobs. They shouldn't have to choose between their own financial security and caring for a loved one.

Please support SCR145/SR1I7. Caregivers deserve this help. We know probably all of us will be needing this help. Mahalo for the opportunity to testify!

Linda Dorset
Wailuku, Maui

SR-117
Submitted on: 3/22/2025 7:52:12 AM
Testimony for LBT on 3/24/2025 3:00:00 PM

Submitted By	Organization	Testifier Position	Testify
Ashley Stone-Mason	Individual	Support	Written Testimony Only

Comments:

Aloha e Chair Aquino, Vice Chair Lee, and Committee Members,

My name is Ashley Stone-Mason, I am a single, working mother of a young child and I have been a proud Hawai‘i community member since 2015. I am writing in strong support of House Concurrent Resolution 179 and House Resolution 175, which seek to establish a working group to implement a Paid Family and Medical Leave (PFML) program in Hawai‘i.

Investing in our keiki’s future begins with ensuring parents and caregivers have the time and financial security to care for them. Scientific research and real-world data from states with existing PFML programs show clear and measurable benefits for children’s health, development, and overall well-being. If implemented in Hawai‘i, PFML would provide critical benefits in the following ways:

1. Improved Infant and Maternal Health

- **States with PFML programs have seen a 5% reduction in infant mortality rates, including a 33% decrease in deaths related to respiratory diseases (National Bureau of Economic Research, 2021).**
- **Paid parental leave leads to higher breastfeeding rates, which in turn improves immunity, brain development, and long-term health outcomes for infants.**
- **Parents with access to paid leave are more likely to attend well-baby checkups and vaccinations, reducing preventable illnesses among our keiki.**

2. Strengthening Parent-Child Bonds

- **Research confirms that longer parental leave improves early childhood development, as newborns thrive on stability, care, and bonding.**
- **In states with PFML, fathers take parental leave at higher rates, promoting gender equity in caregiving and strengthening children’s emotional well-being.**

- **Infants whose parents can stay home longer experience less stress, better sleep patterns, and healthier brain development.**

3. Economic Stability for Families = Better Outcomes for Keiki

- **Hawai‘i has one of the highest costs of living in the nation, making unpaid leave financially devastating for many working families.**
- **Without PFML, many parents—especially those in hospitality, retail, and service industries—are forced to return to work within weeks of childbirth, leading to higher rates of postpartum depression and stress.**
- **Paid leave reduces reliance on public assistance programs, ensuring greater financial security for families raising young children.**

4. Long-Term Educational and Behavioral Benefits

- **Research links paid parental leave to improved cognitive and behavioral development in early childhood.**
- **Children whose parents had access to paid leave show higher school readiness, lower rates of ADHD, and better emotional regulation.**

A Policy That Aligns with Hawai‘i’s Values

Hawai‘i’s culture is rooted in ‘ohana—family comes first. Our keiki deserve the strongest possible start in life, and their parents deserve the time and resources to care for them without the fear of lost wages or job insecurity. By passing HCR 179 and HR 175, Hawai‘i has the opportunity to create a PFML program that uplifts families, strengthens communities, and ensures the long-term health and well-being of our youngest residents—thereby supporting our entire state for generations to come.

I urge you to support these resolutions and take action to establish Paid Family and Medical Leave in Hawai‘i—for our keiki, for our families, and for the future of our state.

Mahalo for your time and consideration.

Ashley Stone-Mason
Wailuku, Hawai‘i

SR-117
Submitted on: 3/21/2025 9:28:03 PM
Testimony for LBT on 3/24/2025 3:00:00 PM

Submitted By	Organization	Testifier Position	Testify
pamela anderson	Individual	Support	Written Testimony Only

Comments:

Aloha Chair Aquino, Vice Chair Lee, and Committee Members,

I **strongly support** SCR 145/SR 117, which request a working group to continue the discussion around paid family leave. This year's bills have been deferred, but the need for stronger programs to protect our working families continues to grow. The economic success of our state is linked to the well-being of our workforce, and similar programs in other states demonstrate that paid family leave benefits businesses and workers. Please support these resolutions!

Mahalo!

SR-117
Submitted on: 3/21/2025 5:10:59 PM
Testimony for LBT on 3/24/2025 3:00:00 PM

Submitted By	Organization	Testifier Position	Testify
Nanea Lo	Individual	Support	Written Testimony Only

Comments:

Hello Chair Sayama, Vice Chair Lee, and Committee Members,

I strongly support HCR 179/HR 175, which request a working group to continue the discussion around paid family leave. This year's bills have been deferred, but the need for stronger programs to protect our working families continues to grow. The economic success of our state is linked to the well-being of our workforce, and similar programs in other states demonstrate that paid family leave benefits businesses and workers. Please support these resolutions.

me ke aloha ʻāina,
Nanea Lo
Mōʻiliʻili, HI 96826
Sierra Club of Hawaiʻi Executive Committee Member
Board Member, Hawaiʻi Workers Center
Kanaka Maoli/Lineal Descendant of the Hawaiian Kingdom

SR-117
Submitted on: 3/21/2025 4:30:57 PM
Testimony for LBT on 3/24/2025 3:00:00 PM

Submitted By	Organization	Testifier Position	Testify
Kathryn Braun	Individual	Support	Written Testimony Only

Comments:

Aloha Chair Aquino, Vice Chair Lee, and Committee Members,

I **strongly support** SCR 145/SR 117, which request a working group to continue the discussion around paid family leave. This year's bills have been deferred, but the need for stronger programs to protect our working families continues to grow. The economic success of our state is linked to the well-being of our workforce, and similar programs in other states demonstrate that paid family leave benefits businesses and workers. Please support these resolutions!

Mahalo!

SR-117
Submitted on: 3/21/2025 4:14:32 PM
Testimony for LBT on 3/24/2025 3:00:00 PM

Submitted By	Organization	Testifier Position	Testify
Rachel Ebert	Individual	Support	Written Testimony Only

Comments:

Aloha Chair Aquino, Vice Chair Lee, and Committee Members,

I **strongly support** SCR 145/SR 117, which request a working group to continue the discussion around paid family leave. This year's bills have been deferred, but the need for stronger programs to protect our working families continues to grow. As a maternal mental health professional, I know firsthand how important it is to have support for families and time together postpartum. The economic success of our state is linked to the well-being of our workforce, and similar programs in other states demonstrate that paid family leave benefits businesses and workers and saves money! . Please support these resolutions!

Mahalo!

SR-117
Submitted on: 3/21/2025 3:43:01 PM
Testimony for LBT on 3/24/2025 3:00:00 PM

Submitted By	Organization	Testifier Position	Testify
K.M	Individual	Support	Written Testimony Only

Comments:

Aloha Chair Aquino, Vice Chair Lee, and Committee Members,

I **strongly support** SCR 145/SR 117, which request a working group to continue the discussion around paid family leave. This year's bills have been deferred, but the need for stronger programs to protect our working families continues to grow. The economic success of our state is linked to the well-being of our workforce, and similar programs in other states demonstrate that paid family leave benefits businesses and workers. Please support these resolutions!

Mahalo!

K. M.

SR-117
Submitted on: 3/21/2025 3:27:23 PM
Testimony for LBT on 3/24/2025 3:00:00 PM

Submitted By	Organization	Testifier Position	Testify
D. Dianne Bowen-Coleman	Individual	Support	Written Testimony Only

Comments:

Aloha Chair Aquino, Vice Chair Lee, and Committee Members,

I **strongly support** SCR 145/SR 117, which request a working group to continue the discussion around paid family leave. This year's bills have been deferred, but the need for stronger programs to protect our working families continues to grow. The economic success of our state is linked to the well-being of our workforce, and similar programs in other states demonstrate that paid family leave benefits businesses and workers. Please support these resolutions!

Mahalo!

SR-117
Submitted on: 3/21/2025 3:26:47 PM
Testimony for LBT on 3/24/2025 3:00:00 PM

Submitted By	Organization	Testifier Position	Testify
Dan Gardner	Individual	Support	Written Testimony Only

Comments:

Chair Aquino and members of the Labor and Technology Committee.

My wife Deborah and I are both in strong favor of a paid family and medical leave program in Hawaii to support our working family caregivers. Family caregivers are the mainstay of Hawaii's long term care system. They provide countless hours of loving care ranging from bathing and preparing meals to escorting loved ones for medical visits. Many are juggling their family responsibilities while working to pay for household expenses and keep a roof over their heads. Some are caring for both aging kupuna and younger keiki in school. This proposed paid family and medical leave program would allow working family caregivers to continue caring for their loved ones without sacrificing their job and income. Please support these unsung heroes who are very deserving of our support. Thank you

SR-117
Submitted on: 3/21/2025 3:25:55 PM
Testimony for LBT on 3/24/2025 3:00:00 PM

Submitted By	Organization	Testifier Position	Testify
Nikos Leverenz	Individual	Support	Written Testimony Only

Comments:

Chair Aquino, Vice Chair Lee, and LBT Committee Members:

I am writing in support of SCR 145/SR 117, which requests a working group to continue the discussion around paid family leave.

The need for policies that lessen burdens on working families continues to grow with increased costs of living, relatively low wages, and lack of time to attend to family needs.

The vitality of our state's economy is directly linked to the well-being of our workforce. Similar paid leave programs in other states demonstrate that paid family leave benefits businesses and workers.

Mahalo for the opportunity to provide testimony.

SR-117
Submitted on: 3/21/2025 3:22:18 PM
Testimony for LBT on 3/24/2025 3:00:00 PM

Submitted By	Organization	Testifier Position	Testify
Renee Hall	Individual	Support	Written Testimony Only

Comments:

Testimony in Support of SCR145 / SR117

I strongly support this resolution to develop a paid family and medical leave program in Hawai‘i. Our working families deserve the time and resources to care for loved ones without sacrificing financial stability. Please pass this important measure.

Mahalo,

Renee Hall Dacanay

SR-117
Submitted on: 3/21/2025 3:05:39 PM
Testimony for LBT on 3/24/2025 3:00:00 PM

Submitted By	Organization	Testifier Position	Testify
Ka'ale'a Kyrstin Hanawahine	Individual	Support	Written Testimony Only

Comments:

Aloha Chair Aquino, Vice Chair Lee, and Committee Members,

My name is Kaʻaleʻa Hanawahine, and I **strongly support** SCR 145/SR 117, which request a working group to continue the discussion around paid family leave. This year's bills have been deferred, but the need for stronger programs to protect our working families continues to grow. The economic success of our state is linked to the well-being of our workforce, and similar programs in other states demonstrate that paid family leave benefits businesses and workers. Please support these resolutions!

Mahalo!

SR-117
Submitted on: 3/21/2025 3:11:54 PM
Testimony for LBT on 3/24/2025 3:00:00 PM

Submitted By	Organization	Testifier Position	Testify
Barbara J. Service	Individual	Support	Written Testimony Only

Comments:

Please approve the convening of a legislative working group to study the establishment and implementation of a Paid Family Leave program. It is unfortunate that Hawaii has not yet convened a working group, much less established a program much less or even convened a working group to "study" the feasibility of such a program 84% of Americans approve Paid Family Leave; advocates have been working diligently on this matter for years. It's time!

Mahalo for the opportunity to testify.

Barbara J. Service MSW

Child Welfare Supervisor (ret.)

Passionate Kupuna advocate

SR-117
Submitted on: 3/23/2025 10:48:12 AM
Testimony for LBT on 3/24/2025 3:00:00 PM

Submitted By	Organization	Testifier Position	Testify
Younghee Overly	Individual	Support	Written Testimony Only

Comments:

Thank you for hearing SCR 145/SR 117, which request a working group to continue the discussion around paid family leave. This year's bills have been deferred, but the need for stronger programs to support our working families continues to grow. The economic success of our state depends on the well-being and retainment of our workforce. Our businesses depend on it. Please pass these resolutions.

SR-117
Submitted on: 3/23/2025 12:43:52 PM
Testimony for LBT on 3/24/2025 3:00:00 PM

Submitted By	Organization	Testifier Position	Testify
Leilani Kailiawa	Individual	Support	Written Testimony Only

Comments:

Aloha Chair Aquino, Vice Chair Lee, and Committee Members,

I **strongly support** SCR 145/SR 117, which requests a working group to continue the discussion around paid family leave. This year's bills have been deferred, but the need for stronger programs to protect our working families continues to grow. I have shared my personal testimony on zoom this legislative 2025 and 2024 about the need for paid family leave. It could have benefited our family, if it was available.

The economic success of our state is linked to the well-being of our workforce, and similar programs in other states demonstrate that paid family leave benefits businesses and workers. Please support these resolutions!

Mahalo!

Leilani Kailawa

LATE

SR-117
Submitted on: 3/23/2025 3:02:19 PM
Testimony for LBT on 3/24/2025 3:00:00 PM

Submitted By	Organization	Testifier Position	Testify
Sai Peng Tomchak	Individual	Support	Written Testimony Only

Comments:

Chair Aquino, and Members of the Committee:

My name is Sai Peng Tomchak and a caregiver of my mother-in-law. I strongly support Bill **SCR 145/SR 117**, which convenes a legislative working group for a paid family and medical leave program for the state.

Having been closely working with the human resource department at work for many years, I have seen many hard working staff members having to give up their jobs in order to take care of their loved ones. My husband and I are joint caregivers of my mother-in law. We are lucky that we can work together to take care of mom. However, even with both of us helping each other, we still struggle to find enough time off from work when mom needs extensive care in hospitals or at home. It is hard to imagine the challenges that many caretakers have to overcome when they take on these responsibilities all on their own! When employees give up their jobs in order to take care of their loved o inful financial realities. For their employers, they have to go through cos recruiting processes to hire their replacements.

LATE

I respectfully ask you to vote for this bill. The Hawaii caregivers are desperately in need of your support!

Mahalo,

Sai Peng Tomchak

LATE

JOSH GREEN, M.D.
GOVERNOR OF Hawaii
KE KIAʻĀINA O KA MOKUʻĀINA ʻO HAWAIʻI

KENNETH FINK, MD, MGA, MPH
DIRECTOR OF HEALTH
KA LUNA Holocene

CAROLINE CADIRAO
DIRECTOR
Executive Office on Aging

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STATE OF HAWAII
DEPARTMENT OF HEALTH
KA ʻOIHANA OLAKINO
EXECUTIVE OFFICE ON AGING
NO. 1 CAPITOL DISTRICT
250 SOUTH HOTEL STREET, SUITE 406
HONOLULU, HAWAII 96813-2831

Testimony in SUPPORT of HCR179/HR175

EQUESTING THE SENATE STANDING COMMITTEE ON LABOR AND TECHNOLOGY AND HOUSE OF REPRESENTATIVES STANDING COMMITTEE ON LABOR TO CONVENE A LEGISLATIVE WORKING GROUP TO DEVELOP RECOMMENDATIONS FOR ESTABLISHING AND IMPLEMENTING A PAID FAMILY AND MEDICAL LEAVE PROGRAM FOR THE STATE

COMMITTEE ON LABOR
EP. JACKSON D. SAYAMA, CHAIR
REP. MIKE LEE, VICE CHAIR

Testimony of Caroline Cadirao
Director, Executive Office on Aging
Attached Agency to the Department of Health

Hearing: Tuesday, March 25, 2025, 9:30 a.m.., Conference Room 309

EOA Position: The Executive Office on Aging (EOA), an attached agency to the Department of Health (DOH) **supports SCR145/SR117**.

Purpose and Justification: This measure requests the Senate Standing Committee on Labor and Technology and the House of Representatives Standing Committee on Labor to convene a legislative working group to develop recommendations for establishing and implementing a paid family and medical leave program for the State.

According to the U.S. Bureau of Labor Statistics most working people in the United States do not have paid family leave through their jobs. Even unpaid leave under the federal

Family and Medical Leave Act is inaccessible for 69 percent of Hawai‘i residents. Most workers don’t qualify or can’t afford to take unpaid leave.

Between 2020 and 2030 the population of those age sixty-five and over is expected to increase significantly by 22.5%. As Hawai‘i’s aging population continues to rise many caregivers struggle to balance full or part-time work with caring for their loved one. A paid family leave program would provide a work/life balance for caregivers.

Paid family leave benefits employers as well. Workers with family leave are more likely to return to work after their leave is over. Studies have shown that paid family leave increases worker productivity and retention rates. Thirteen states and the District of Columbia have passed family leave laws. States with family leave have seen significant health, social, and economic benefits. Implementing a state paid family and medical leave program benefits businesses and workers.

Recommendation: EOA supports this resolution to develop recommendations that would help to establish and implement a paid family and medical leave program for the state.

Thank you for the opportunity to testify.

LATE

SR-117
Submitted on: 3/24/2025 6:22:22 AM
Testimony for LBT on 3/24/2025 3:00:00 PM

Submitted By	Organization	Testifier Position	Testify
Kristy Arias	Individual	Support	Written Testimony Only

Comments:

Aloha! I'm saddened by the paid family leave bill died this legislative session. My testimony today is to help SC145 get a group to support this important need!! That we may continue to provide work force development, to help business owners understand the benefits for paid family leave to their employees and that the payments to have coverage for their workers are minimal. Thank you!

LATE

SR-117
Submitted on: 3/23/2025 11:14:32 PM
Testimony for LBT on 3/24/2025 3:00:00 PM

Submitted By	Organization	Testifier Position	Testify
Cheryl Ho	Individual	Support	Written Testimony Only

Comments:

Aloha Chair Aquino, Vice Chair Lee, and Committee Members,

I offer my strong support for SR117/SCR145:

Last year, I was assisting a friend from church, to arrange for and travel to the continent, for a critically-needed surgery. It was expected that she would need 2 weeks for the trip, including travel, actual surgery, hospital recuperation, and travel back to Honolulu.

This friend is a single parent with shared legal custody of an 11-year old son. Grandparents in this case are either deceased, or living overseas.

The boy‘s mother works night shift in a care facility, and needs to sleep during the day (except on certain weekend days). Leading up to the trip, it became a huge, conflict-ridden issue of how the son would be cared for. She knew that if she had to take time off to care for her son, she would lose up to two weeks of pay.

Two (2) weeks is a long time to expect anyone to take leave without pay, to care for a child. If PAID FAMILY LEAVE is enacted, children who depend on parents for their physical, emotional, and social health will be assured of that care. Their caregiving parent will be able to take leave from work without the worry and financial stress of loss of income.

Research has shown that family leave programs can be established in a manner that is affordable for small businesses and our state.

I strongly urge you to CONVENE A LEGISLATIVE WORKING GROUP TO DEVELOP RECOMMENDATIONS FOR ESTABLISHING AND IMPLEMENTING A PAID FAMILY AND MEDICAL LEAVE PROGRAM FOR THE STATE. to begin the administrative processes that will bring Paid Family Leave into a reality.

MAHALO FOR HEEDING MY TESTIMONY!!

Cheryl O. Ho, Nu‘uanu-
Retired Social Worker

LATE

SR-117
Submitted on: 3/23/2025 10:57:52 PM
Testimony for LBT on 3/24/2025 3:00:00 PM

Submitted By	Organization	Testifier Position	Testify
Joell Edwards	Testifying for Wainiha Country Market Inc	Support	Remotely Via Zoom

Comments:

Aloha Chair Aquino, Vice Chair Lee, and Committee Members,

I **strongly support** SCR 145/SR 117, which request a working group to continue the discussion around paid family leave. This year's bills have been deferred, but the need for stronger programs to protect our working families continues to grow. The economic success of our state is linked to the well-being of our workforce, and similar programs in other states demonstrate that paid family leave benefits businesses and workers. Please support these resolutions!

Mahalo!

LATE

SR-117
Submitted on: 3/23/2025 10:07:33 PM
Testimony for LBT on 3/24/2025 3:00:00 PM

Submitted By	Organization	Testifier Position	Testify
Chloe Pua'ena Vierra-Villanueva	Individual	Support	Written Testimony Only

Comments:

Aloha Chair Aquino, Vice Chair Lee, and Committee Members,

I strongly support SCR 145/SR 117, which request a working group to continue the discussion around paid family leave. This year's bills have been deferred, but the need for stronger programs to protect our working families continues to grow. The economic success of our state is linked to the well-being of our workforce, and similar programs in other states demonstrate that paid family leave benefits businesses and workers. Please support these resolutions!

Mahalo,

Pua‘ena

(‘Ohana Leadership Council)

LATE

March 23, 2025

Subject: Support for SCR 145/SR117

Chair Aquino and Members of the Committee:

I am writing today in **STRONG SUPPORT of SCR 145/SR117 which convenes a legislative working group for a paid family and medical leave program for the state.**

It is important that the working group develop recommendations on a paid family leave policy and program that supports working family caregivers to better balance their job and family responsibilities, reducing their stress and allowing them to better support their loved ones.

The new 2024 State of ALICE in Hawaii report showed that 15% of all households in Hawaii currently face financial difficulty with the financial costs of caregiving for someone other than a child. Family caregivers are the backbone of Hawaii's long term care system. They provide countless hours of care that range from bathing, preparing meals and escorting loved ones for medical visits. Many are juggling family responsibilities while working to pay household expenses and keep a roof over their heads. Some are the sandwich generation caring for both aging kupuna and younger keiki in school.

Developing a paid family leave policy and program would allow working family caregivers to care for their loved without sacrificing their job and income. They all deserve our support.

Mahalo for the opportunity to testify on this important issue and for your action to support ALICE families.

Michelle Bartell
President & CEO
Aloha United Way

auw.org
auw211.org
200 N Vineyard Blvd Suite 700
Honolulu, HI 96817
(808) 536-1951
Fax: (808) 543-2222

LATE

To: Hawaii State Senate Committee on Labor and Technology

Hearing Date/Time: Monday March 24, 2025, 3:00pm

Place: Hawaii State Capitol, CR 224 & Videoconference

Re: Judith Ann Armstrong supports SCR145 to Establish and Implement a paid Family and Medical Leave Program for the State

Dear Chair Senator Henry J.C. Aquino, Vice Chair Senator Chris Lee and members of the Labor and Technology Committee

I, Judith Ann Armstrong, support SCR 145/SR 117, which request a working group to continue the discussion around paid family leave. This year's bills have been deferred, but the need for stronger programs to protect our working families continues to grow. The economic success of our state is linked to the well-being of our workforce, and similar programs in other states demonstrate that paid family leave benefits businesses and workers. Please support these resolutions!

Thank you for this opportunity to testify in support of SCR145.

Sincerely,

Judith Ann Armstrong

LATE

SR-117
Submitted on: 3/23/2025 7:38:25 PM
Testimony for LBT on 3/24/2025 3:00:00 PM

Submitted By	Organization	Testifier Position	Testify
Jeanne Ohta	Individual	Support	Written Testimony Only

Comments:

I strongly support SCR 145 and SR 117 which requests a working group to continue discussions on paid family leave. Paid Family Leave is essential for our working families. The economic success of our state is linked to the well-being of our workforce, and similar programs in other states demonstrate that paid family leave benefits businesses and workers. Please pass these resolutions.

LATE

SR-117
Submitted on: 3/23/2025 3:37:07 PM
Testimony for LBT on 3/24/2025 3:00:00 PM

Submitted By	Organization	Testifier Position	Testify
Nancy Rustad	Testifying for AAUW Hawaii	Support	Written Testimony Only

Comments:

Aloha Chair Aquino, Vice Chair Lee, and Committee Members,

I **strongly support**SCR 145/SR 117, which request a working group to continue the discussion around paid family leave. This year's bills have been deferred, but the need for stronger programs to protect our working families continues to grow. The economic success of our state is linked to the well-being of our workforce, and similar programs in other states demonstrate that paid family leave benefits businesses and workers. Please support these resolutions!

Mahalo!

LATE

SR-117
Submitted on: 3/24/2025 7:54:17 AM
Testimony for LBT on 3/24/2025 3:00:00 PM

Submitted By	Organization	Testifier Position	Testify
Annette Taeko Mente	Individual	Support	Written Testimony Only

Comments:

Dear Chair & Committee Members,

Please support this critical legisation needed for Hawaii's working families.

LATE

SR-117
Submitted on: 3/24/2025 9:49:33 AM
Testimony for LBT on 3/24/2025 3:00:00 PM

Submitted By	Organization	Testifier Position	Testify
Michael Golojuch, Jr. (he/him)	Testifying for Pride at Work – Hawai‘i	Support	Written Testimony Only

Comments:

Aloha Senators,

Pride at Work – Hawai‘i is an official chapter of *Pride at Work* which is a national nonprofit organization that represents LGBTQIA+ union members and their allies. We are an officially recognized constituency group of the AFL-CIO that organizes mutual support between the organized Labor Movement and the LGBTQIA+ Community to further social and economic justice.

Pride at Work – Hawai‘i fully supports Senate Concurrent Resolution 145.

We ask that you support this needed resolution.

Mahalo,

Michael Golojuch, Jr. (he/him)
President
Pride at Work – Hawai‘i

LATE

SR-117
Submitted on: 3/24/2025 11:05:23 AM
Testimony for LBT on 3/24/2025 3:00:00 PM

Submitted By	Organization	Testifier Position	Testify
Erin Vierra-Villanueva	Individual	Support	Written Testimony Only

Comments:

Aloha Chair Aquino, Vice Chair Lee, and Committee Members,

I **strongly support** SCR 145/SR 117, which request a working group to continue the discussion around paid family leave. This year's bills have been deferred, but the need for stronger programs to protect our working families continues to grow. The economic success of our state is linked to the well-being of our workforce, and similar programs in other states demonstrate that paid family leave benefits businesses and workers. Please support these resolutions!

Mahalo!

LATE

SR-117
Submitted on: 3/24/2025 11:55:36 AM
Testimony for LBT on 3/24/2025 3:00:00 PM

Submitted By	Organization	Testifier Position	Testify
Deanna Espinas	Individual	Support	Written Testimony Only

Comments:

In strong support.