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STATE OF HAWAIʻI | KA MOKUʻĀINA O HAWAIʻI
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KA ʻOIHANA HOʻOMŌHALA LIMAHANA
235 S. BERETANIA STREET
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Statement of
BRENNA H. HASHIMOTO
Director, Department of Human Resources Development

Before the
HOUSE COMMITTEE ON LABOR
Tuesday, March 25, 2025
9:30 AM
State Capitol, Conference Room 309

In consideration of
HR 175/ HCR 179, 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 Sayama, Vice Chair Lee, and the members of the committee.

The Department of Human Resources Development (HRD) offers the following comments for HR 175/ HCR 179 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.

HRD appreciates the intent of this resolution and respectfully requests the following amendment to composition of the working group:

> (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.

HAWAII STATE COMMISSION
ON THE STATUS OF WOMEN

March 23, 2025

Position: Support of HR175/HCR179

To: Representative Jackson D. Sayama, Chair
Representative Mike Lee, Vice Chair
Members of the House Committee on Labor

From: Llasmin Chaine, LSW, Executive Director, Hawai'i State Commission on the Status of Women

Re: Testimony in Support of HR175/HCR179, Requesting LBT and LAB Convene a Legislative Working Group to Develop Recommendations for Establishing and Implementing a Paid Family and Medical Leave Program for the State

Hearing: Tuesday, March 25, 2025, 9:30 a.m.
Conference Room 309, 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 HR175/HCR179.

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 improve 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.:**

- **HR175**:
  - 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 AARP 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

- **HCR179**:
  - 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 AARP 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 HR175/HCR179**. Thank you for this opportunity to submit testimony and comments.

Hawai‘i State Lesbian, Gay, Bisexual, Transgender, Queer Plus Commission

Advocating for the Hawai‘i LGBTQIA+ Community

Mailing Address: LGBTQ+ Commission, c/o The Department of Human Services, P.O. Box 339, Honolulu, Hawai‘i 96809-0339

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March 23, 2025

House’s Committee on Labor
Hawai‘i State Capitol
415 South Beretania Street
Honolulu, HI 96813

Hearing: Tuesday, March 25, 2025

RE: **Strong Support for House Concurrent Resolution 179 with Requested Amendment**

Aloha Chair Sayama, Vice Chair Lee, and committee members,

I am writing in strong support of House Concurrent Resolution 107 on behalf of the Hawai‘i State Lesbian, Gay, Bisexual, Transgender, Queer Plus (LGBTQ+) Commission, which was established by the 2022 Hawai‘i State Legislature with the following purpose:

> “…to improve the State's interface with members of the lesbian, gay, bisexual, transgender, queer, plus community; identify the short- and long-range needs of its members; and ensure that there is an effective means of researching, planning, and advocating for the equity of this population in all aspects of state government.”

The Hawai‘i State LGBTQ+ Commission strongly supports **House Concurrent Resolution 179** (HCR 179), 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.

A robust and inclusive paid family and medical leave program is essential for ensuring that all workers—regardless of gender identity, sexual orientation, or family structure—have the ability to care for themselves and their loved ones without risking their livelihoods. Across the nation, we have seen that paid leave policies promote healthier families, reduce financial insecurity, and contribute to stronger, more equitable communities. Hawai‘i must take bold steps to guarantee that no worker is forced to choose between their health and economic security.

LGBTQIA+ Families and the Critical Need for Inclusive Paid Leave

For LGBTQIA+ families in particular, a comprehensive paid family and medical leave program is vital. Many LGBTQIA+ individuals rely on chosen families, including extended networks of support, to provide care in times of illness or need. Without explicit recognition of diverse family structures, LGBTQIA+ workers often find themselves excluded from traditional leave policies.

Establishing a working group to develop recommendations ensures that the resulting program reflects the lived realities of all families in Hawai‘i.

Request for Amendment

To that end, the Hawai‘i State LGBTQ+ Commission respectfully requests an **amendment to HCR 179** to include a representative from the Commission on the proposed legislative working group. The inclusion of a Commission representative will ensure that the voices and unique concerns of LGBTQIA+, māhū, and non-binary communities are incorporated into the policy development process. Without intentional inclusion, marginalized communities risk being overlooked in critical policy decisions.

Proposed Amendment:

Add language to include:

- A representative from the Hawai‘i State LGBTQ+ Commission as a member of the legislative working group.

Ensuring diverse representation on the working group will provide a more comprehensive and equitable framework for implementing a paid family and medical leave program that truly serves all of Hawai‘i’s workers and families.

Should you or any member of your staff have any questions regarding this testimony you can reach the Hawai‘i State LGBTQ+ Commission at hawaiistatelgbtqpluscommission@gmail.com.

Mahalo for the opportunity to testify in strong support of HCR 179. We urge the committee to advance this resolution with the recommended amendment to ensure that Hawai‘i moves forward with an inclusive and effective paid family and medical leave program.

Michael Golojuch, Jr. (he/him)
Vice Chair
Hawai‘i State LGBTQ+ Commission

JOSH GREEN, M.D.
GOVERNOR OF Hawaii
KE KIAʻĀINA O KA MOKUʻĀINA ʻO HAWAIʻI

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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.

JOSH GREEN, M.D.
GOVERNOR

SYLVIA LUKE
LIEUTENANT GOVERNOR

JADE T. BUTAY
DIRECTOR

WILLIAM G. KUNSTMAN
DEPUTY DIRECTOR

STATE OF HAWAI'I
KA MOKU'ĀINA O HAWAI'I
DEPARTMENT OF LABOR AND INDUSTRIAL RELATIONS
KA 'OIHANA PONO LIMAHANA

March 25, 2025

To: The Honorable Jackson D. Sayama, Chair
The Honorable Mike Lee, Vice Chair, and
Members of the House Committee on Labor

Date: Tuesday, March 25, 2025
Time: 9:30 a.m.
Place: Conference Room 309, State Capitol

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

Re: H.C.R. 179 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
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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.

EXAMINATION OF A NEED FOR LEGISLATIVE ACTION

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** H.B. NO.

HOUSE OF REPRESENTATIVES
SIXTH LEGISLATURE, 19 71
STATE OF HAWAII

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;

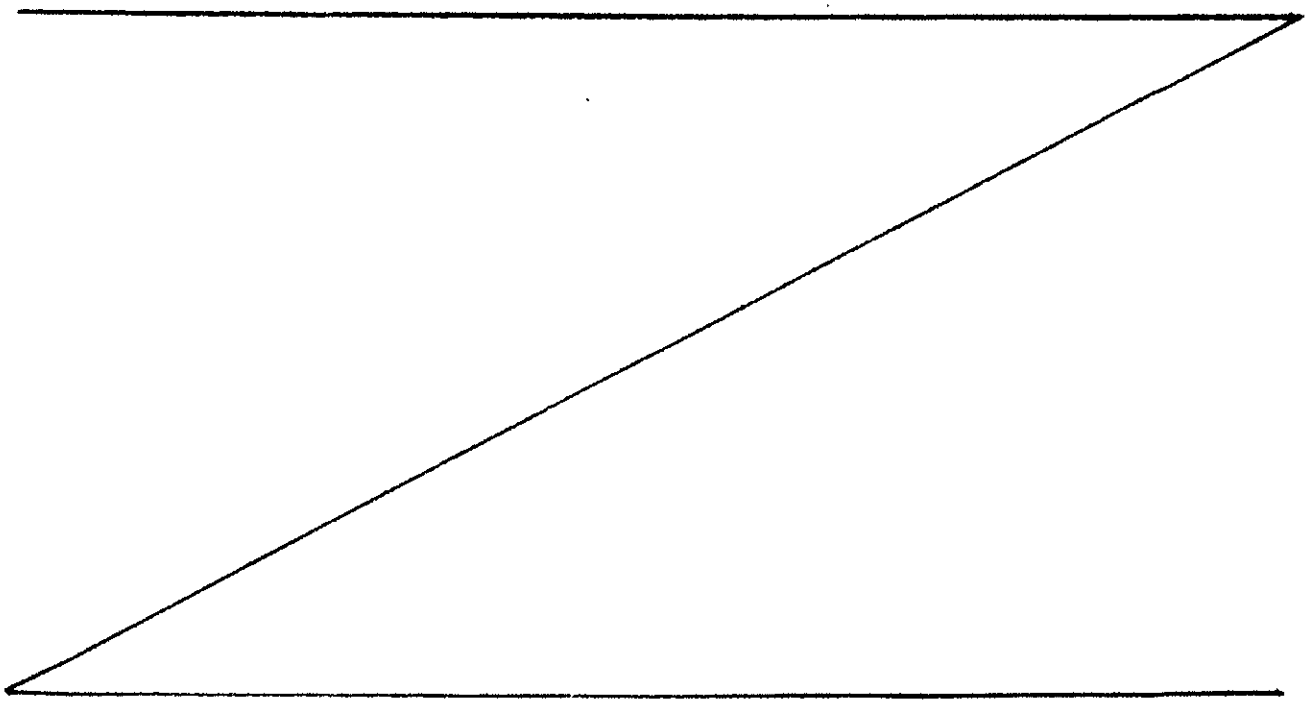
(B) Intensive medical care while hospitalized;

(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.

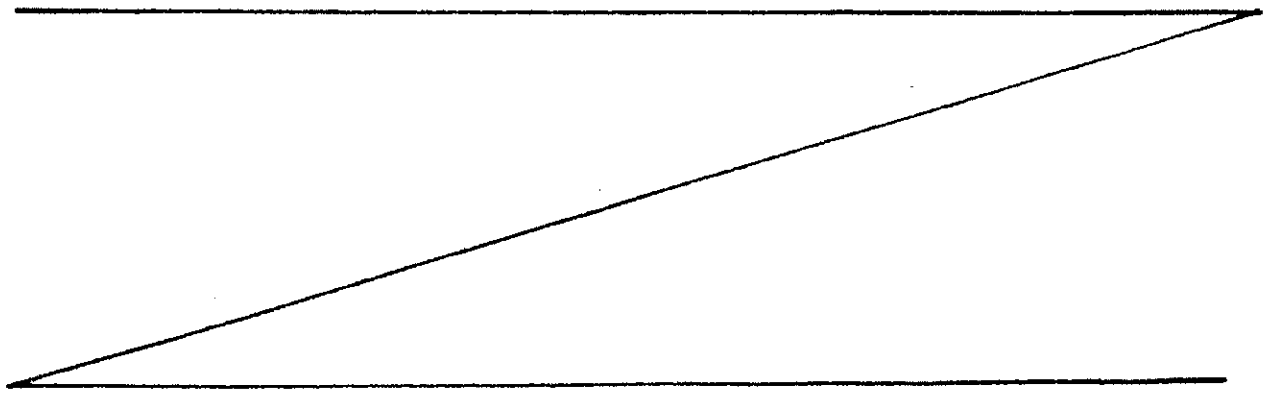
Sec. -21 Adjustment of employer-sponsored plans. Where employees subject to the coverage of this chapter are included in the coverage provisions of an employer-sponsored prepaid health care plan covering similar employees employed outside the State

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.

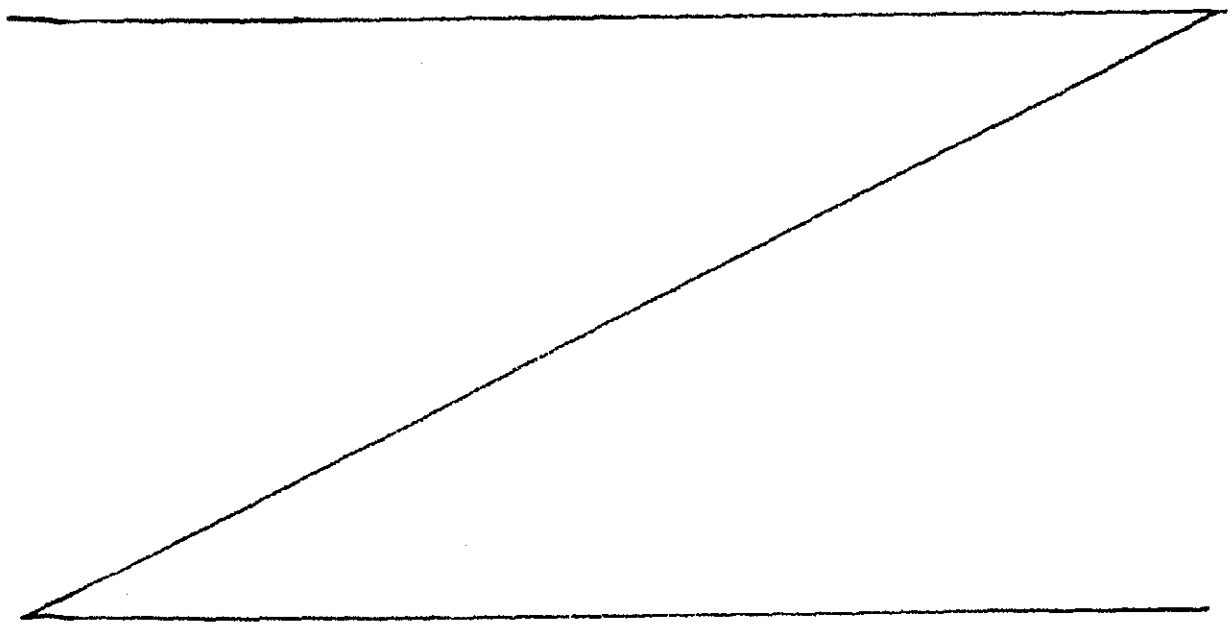
The director may round off the amounts specified in this chapter for the purpose of eliminating payments from the premium supplementation and continuation fund in other than even dollar amounts or other purposes.

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

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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

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Testimony in SUPPORT of H.C.R. 179 & H.R. 175

Representative Jackson Sayama, Chair
Representative Mike Lee, Vice Chair
Senate Committee on Labor and Technology
March 25th, 2025, at 9:30 a.m. Room Number: 309

The Office of Wellness and Resilience (OWR) in the Governor's Office **SUPPORTS** resolutions H.C.R. 179 and H.R. 175.

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.

H.C.R. 179 and H.R. 175 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
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LEGISLATIVE REFERENCE BUREAU
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Written Comments

HCR179/HR175

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 House Committee on Labor

Tuesday, March 25, 2025, 9:30 a.m.
Conference Room 309

Chair Sayama and Members of the Committee:

Good morning, Chair Sayama 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 H.C.R. No. 179 and H.R. No. 175, 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.

PAID FAMILY LEAVE PROGRAM IMPACT STUDY

IN ACCORDANCE WITH ACT 109, SESSION LAWS OF HAWAII 2018

Prepared for:

Legislative Reference Bureau, State of Hawaii

November 13, 2019

Revised December 5, 2019

Spring℠
AN ALERA GROUP COMPANY

REVISION NOTE

This revised version of the *Paid Family Leave Program Impact Study* includes revisions requested by the Legislative Reference Bureau after the delivery of the final product.

This revision includes the following changes from the version originally submitted to the Legislature on November 13, 2019:

(1) Cost projections were amended to reflect a sixty percent load for public sector employee benefits;

(2) Additional information was added to reflect temporary disability insurance (TDI) leave benefits in other states that allow employees to care for their own serious health condition; and

(3) Other technical changes were made for the purposes of clarity and style.

Charlotte A. Carter-Yamauchi
Director

December 2019

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Acronyms Defined

AWBA	Average Weekly Benefit Amount
AWW	Average Weekly Wage
CFRA	California Family Rights Act
CRADLE	U.S. Child Rearing and Development Leave Empowerment Act
CUIC	California Unemployment Insurance Code
DBL	New York Disability Benefits Law
DCD	Disability Compensation Division of the Hawaii Department of Labor and Industrial Relations
DLIR	Hawaii Department of Labor and Industrial Relations
DOES	District of Columbia Department of Employment Services
DOL	U.S. Department of Labor
EDD	California Employment Development Department
EEOC	U.S. Equal Employment Opportunity Commission
EOA	Hawaii Executive Office of Aging
EOLWD	Massachusetts Executive Office of Labor and Workforce Development
ERISA	U.S. Employee Retirement Income Security Act
ETS	Hawaii Office of Enterprise Technology Services
FAMILY	U.S. Family and Medical Insurance Leave Act
FAQ	Frequently Asked Questions
FLA	New Jersey Family Leave Act

FLI	New Jersey Family Leave Insurance
FMLA	U.S. Family and Medical Leave Act
HFLL	Hawaii Family Leave Law
ICD	International Classification of Disease
IT	Information Technology
LWD	New Jersey Department of Labor and Workforce Development
MDG	Medical Duration Guidelines
NAM	National Arbitration and Mediation
NYSIF	New York State Insurance Fund
OPFL	District of Columbia Office of Paid Family Leave
PFL	Paid Family Leave
PFLAC	District of Columbia Paid Family Leave Advisory Committee
PFML	Paid Family and Medical Leave
PHC	Hawaii Prepaid Health Care
PTO	Paid Time Off
QA	Quality Assurance
RR	Replacement Ratio
SAFE	New Jersey Security and Financial Empowerment Act
SAWW	State Average Weekly Wage
SDI	California State Disability Insurance

SFTP	Secure File Transfer Protocol
TAT	Turnaround Time
TCI	Rhode Island Temporary Caregiver Insurance
TDI	Temporary Disability Insurance
TPA	Third Party Administrator
UI	Unemployment Insurance
VP	Voluntary Plan
WC	Workers' Compensation
WMW	Weekly Minimum Wage
1099-MISC	Miscellaneous Income

Glossary

Administrative Cost Funding Rate: A calculation within this report that is the result of dividing the State Administrative Costs divided by Taxable Wage Base.

Benefit Duration: The average length of time that benefits are expected to be paid to an employee, as specified by the insurance contract or plan design.

Benefit Adjustment Factor: Factors used in the model to adjust for paid family leave incidence rates due to benefit schedule variations under different state models.

Claim Frequency (Incidence Rate): A measure of the percentage of insureds (eligible claimants) that will make claims against the paid leave program.

Claims Cost: Cost associated with paid family leave claims only before addition of administrative costs.

Covered Family Members: The specified family members that are covered under a paid family leave policy (e.g., an employee's child or spouse, siblings, grandparents, or individuals that are the equivalent of a familial relationship).

Community Rating: A rating structure under which all employees pay the same funding or premium rates regardless of their risk profile including demographic differences, industry, size and experience.

Contribution Rate: The percentage of wages an employee and/or an employer will pay into a paid family or paid medical leave program, to fund the program. May also be referred to as the funding rate.

Eligible Employers: Employers that meet the requirements to be considered eligible and therefore insured or covered by a plan.

Eligible Employees: Employees that meet the requirements to be considered eligible and therefore insured or covered by a plan.

Exigency Leave: The type of leave used to help employees manage family affairs when their family members are called to or on covered active duty.

Eligible Labor Force: People in the labor force who are eligible to receive paid family leave benefits.

Employer Mandate: Require employers to provide coverage through self-insurance or approved private coverage at the employer's expense, with or without employee contributions.

Eligibility: One or more requirements that must be fulfilled in order to be insured or covered by insured or self-insured plans.

Fully Insured: A program in which the employer pays a premium to a commercial insurance carrier in return for coverage.

Indicative Claim(s) Funding Rate: A calculation within this report that is the result of dividing Modeled Claims Cost by the Taxable Wage Base.

Indicative Funding Rate: A calculation within this report that is the result of adding the Indicative Claims Funding Rate and the Administrative Cost Funding Rate.

Labor Force: The number of individuals who either are employed or are seeking employment.

Loss Ratio: The portion of funding contributions or insurance premium use to cover claims.

Long Term Disability (LTD): A benefit plan that replaces a portion (e.g., 50%, 60% or 66%) of an employee's income when that income is lost due to an extended illness and/or injury.

Paid Family Leave (PFL): Program that provides paid time off to an employee who needs to care for a family member for a variety of reasons such as bonding with a new child or caring for a family member with a serious health condition. Leave programs differ by state and program characteristics vary such as benefit payment amounts, length of leave, covered events and funding structures.

Paid Family and Medical Leave (PFML): Program that provides paid time off to an employee who needs to care for a family member or due to the employee's own medical condition. PFML laws have been enacted in states without temporary disability insurance (TDI) or paid family leave (PFL) leave laws already in place and the characteristics of each law vary across jurisdictions.

Wage Replacement Ratio: The percentage of an individual's wage that is replaced while on a paid leave.

Risk: Uncertainty as to the outcome of an event when two or more possibilities exist.

Risk Adjustment: Under community rating, a mechanism where insurance carriers with better than average actual or expected claims experience pay into the risk pool while insurance carriers with higher than average expected, or actual claims experience get paid from the pool.

Short Term Disability (STD): Type of insurance that pays income replacement benefit (usually 60% to 80%) for total disability after a brief waiting period (typically one to seven days).

Social Insurance: Require employees and/or employers to submit payroll contributions into a dedicated fund. The amount of this payment (contribution rate) is set by the state, risk and resources are pooled together, and benefits are generally administered by the government, with private plan options possibly allowed following state approval.

Taxable Wage Base: The maximum amount of earned income on which employees must pay paid family leave contributions.

Temporary Disability Insurance (TDI): Statutory insurance to provide payments for lost wages because an injury/illness prevents the employee from doing their usual job while recovering.

Executive Summary

This report was prepared by Spring Consulting Group, an Alera Group Company, LLC (Spring) as requested by the Legislative Reference Bureau (the Bureau), and pursuant to Act 109, Session Laws of Hawaii 2018. Act 109 directed the Bureau to conduct an analysis to understand the impacts of the establishment of a paid family leave program on industry, consumers, employees, employers and caregivers.

The Bureau conducted a Request for Proposal (RFP) process to identify an objective and unbiased contractor to conduct the study. As the selected contractor, Spring analyzed the following aspects:

- Paid family leave background, evolution and summary of current state;
- Comparative analysis of the seven state paid leave models in place at the time of request;
- Hawaii-based cost breakdowns for each of the seven state-specific models; and
- Options for compliance and enforcement of a proposed paid family leave program.

If Hawaii decides to move forward in establishing a PFL program, several pertinent policy aspects will need to be determined by lawmakers. Although each are described separately below and within this report, they should be considered as a whole and interrelated.

Plan Structure

- Plan model (e.g., social insurance, social insurance with opt-outs, social insurance alongside regulated and private options, employer mandate)
- Rating method (e.g., community rating with or without risk adjustment if private insurance is allowed, or individual employer and carrier rate determination)
- Plan design including but not limited to:
  - Benefit amount and wage replacement ratio – progressive or not, percentage of salary replaced, and any minimum or maximum benefit
  - Length of leave (including maximum weeks) for bonding and family care
  - Employer eligibility (e.g., public employers, employer size, self-employed)
  - Employee eligibility (e.g., minimum time worked, minimum earnings achieved)
  - Qualifying events
  - Covered relationships
  - Job protection
  - Interaction with the State's Temporary Disability Insurance (TDI) program

Funding

- Taxable wage base for funding (e.g., Hawaii TDI wage base, social security wage base, other)
- Contributions to funding (e.g., employee, employer, employee and employer)

- Updated costs, particularly as indicative funding rates in this report could change as additional and updated state by state experience can be obtained

Administration

- Administrative structure (e.g., administering agency, level of staffing, information technology system used, data reporting)
- Claims management (e.g., claim application and submission methods, eligibility, claim payment timing, interaction with TDI and other employee benefits)
- Ongoing monitoring (e.g., employer opt-out application, compliance review, annual actuarial funding review)

Implementation Timeline

- Rollout sufficient to gain industry and employer support
- Framework to educate and prepare the community
- Protocol for contributions and pre-funding

A. Paid Family Leave Background, Evolution & Summary of Current State

Most workers will experience a time they need to be away from their job for a medical or family need. For some, it may be to bond with a new baby. For others, it may be to care for a parent or child with a serious illness, or even their own medical condition. As less than a fourth of United States workers have paid family leave programs available to them, and only slightly more (34% to 39%) have access to short- or long-term disability coverage, the momentum for both federal and state legislation continues to increase.

In 1993, the United States passed the Family and Medical Leave Act (FMLA) to provide a means for employees to balance work and family responsibilities by taking unpaid leave for certain reasons. Since its passage, numerous states (including Hawaii) have enacted laws to expand unpaid leave protection, either by loosening the eligibility requirements or increasing the amount of leave. Beginning in 2004, states with temporary disability insurance (TDI) laws started adding paid family leave (PFL) to their programs. PFL programs go beyond the medical coverage under TDI to provide paid time off for employees caring for family members, either to bond with a new child or to care for a family member with a serious health condition or who needs medical attention. Some states also cover activities related to the military deployment of a family member.

Although paid leave initiatives have been introduced at the federal level to include these and similar aspects, none of them have passed. As shown in Exhibit i, seven states had enacted their own paid family and medical leave laws at the time of the Bureau's request, four of which had TDI

programs in place before adding PFL. Since that time, two more states have passed paid leave laws, but are outside the scope of this analysis.

Exhibit i

States With Paid Family Leave Laws			
	In Place At Time of Bureau's Request	**Passed After Bureau's Request (Out of Scope of Analysis)**	**TDI In Place Before Adding PFL**
California	✓		✓
Connecticut		✓	
District of Columbia	✓		
Massachusetts	✓		
New Jersey	✓		✓
New York	✓		✓
Oregon		✓	
Rhode Island	✓		✓
Washington	✓		

For the seven states of focus, the most common model is that of social insurance where employers can opt-out to private plans and either administer the plan themselves or partner with an insurance carrier or third-party administrator (TPA) on a fully insured or self-insured basis. The scope of coverage provided by each state varies significantly, from the eligibility requirements, to the qualifying reasons for leave, waiting periods, leave durations, benefit levels, benefit calculations, and whether there is job protection. Furthermore, the definitions of what is covered and how, and the mechanics of calculating benefit payment can be cumbersome.

Employers and industry professionals have voiced concern over these differences and points of confusion as they not only make it challenging for employers to communicate and educate their employees, but also to understand and determine how paid leave laws coordinate with other benefit plans (e.g., sick leave, disability, workers' compensation). The issue is heightened for employers that have employees in more than one state, as they may have multiple paid leave laws to interpret.

As such, regulation that is clear, administration that is straightforward and education that is comprehensive are essential to a state's success and core to the intention of paid leave laws being designed to support workers. Running paid family/medical leave concurrently with unpaid FMLA leave, considering a simplified benefit formula, aligning the definition of salary with that of disability or workers' compensation (WC), and avoiding Employee Retirement Income Security Act (ERISA) status are also advised.

Advocating for return to work within the law, providing gender neutral covered relationships and leave lengths, excluding job protection (as it is accounted for elsewhere) and sunsetting existing unpaid leave laws (to start fresh with any new law) are thought to provide clarity and decrease confusion. Allowing for at least two, but ideally three years, to implement a new program is suggested. This allows appropriate time so parameters can be clearly defined, and administration and funding requirements can be thoroughly devised.

B. Comparative Analysis of Seven State Plan Leave Models

1. State Structures

As mentioned above, of the seven states of focus, the most common structure is that of social insurance. This structure requires workers and/or their employers to submit payroll contributions into a dedicated fund. When a worker qualifies for leave, they receive partial wage replacement. Rates are set by the state, risk and resources are pooled together, and benefits are generally administered by the government.

Two of the seven states (District of Columbia and Rhode Island) operate social insurance models through an exclusive state fund. Four states (California, Massachusetts, New Jersey and Washington) allow employers to opt-out of the state-administered plan and cover their employees with limited private options that may be fully insured or self-insured. One state (New York) offers highly regulated and private options where employers may elect to offer benefits through a state insurance fund, private insurance or self-insurance, all of which are subject to community rating (where all employers and/or their employees pay the same rate) but include a risk adjusting mechanism to maintain private insurer equity.

Exhibit ii

Paid Family Leave by State Structure			
State	**Social Insurance Through an Exclusive State Fund**	**Social Insurance with an Opt-Out: Limited Private Options**	**Social Insurance Alongside Regulated and Private Options**
California		✓	
District of Columbia	✓		
Massachusetts		✓	
New Jersey		✓	
New York			✓
Rhode Island	✓		
Washington		✓	

Alternatives to social insurance include an employer mandate and a non-contributory program, neither of which are in place for the states of focus of this report.

2. Scope of Coverage

The scope of paid leave coverage afforded by each of the seven states varies considerably. Examples include different eligibility, qualifying events, covered relationships, job protection, benefit amounts, lengths of leave, claim submission methods, claim payment timing, funding and contribution requirements.

Employers required to comply with the law range from all employers to those with more than fifty employees. Employee eligibility for benefits may include an earnings requirement, hours worked minimum, or both.

All seven states provide family leave to bond with a new child or to care for a family member with a serious health condition as qualifying events. Four states (District of Columbia, Massachusetts, New York and Washington) include care for a covered service member, while one state (New Jersey) provides coverage for victims of domestic or sexual violence. Three of the seven states (District of Columbia, Massachusetts and Washington) provide leave for an employee's own serious health condition, as they do not have TDI laws in place to cover that aspect.

For covered relationships, the federal FMLA provides for employees to take leave to care for a child, parent, or spouse. State paid leave laws encompass this set of relationships and may extend coverage to employees taking leave to care for grandparents, grandchildren, siblings, or for one state, any individual with whom the employee has the equivalent of a family relationship.

While four of the seven states (Massachusetts, New York, Rhode Island and Washington) provide job protection ensuring employees are returned to the same or similar position when they return to work, three of the states (California, District of Columbia and New Jersey) only provide a monetary benefit and otherwise defer to concurrency with other federal or state programs.

The benefit formula that determines employee payment while on PFL varies significantly by jurisdiction. Four states (California, District of Columbia, Massachusetts and Washington) calculate it based on a progressive benefit structure and state average wage whereby employees with a lower average wage receive a higher benefit percentage. Three states (New Jersey, New York and Rhode Island) provide a flat percentage of average weekly wage. Annual benefit maximums can limit the wage replacement employees receive, especially those earning a higher average weekly wage. Four states (California, New York, Rhode Island and Washington) provide minimum benefit amounts, while three states (District of Columbia, Massachusetts and New Jersey) are silent on this aspect.

Like benefit amounts, the length of family leave allotted varies greatly, from as low as four weeks to as high as twenty-six weeks. The first few states to implement PFL programs had the shortest leave allotments, which have since increased for California and New Jersey. While some states have a standard maximum leave duration that applies to all covered leave reasons, others specify maximum durations based on the specific reason leave is being requested.

3. Gender Equity

Although the specifics of existing paid leave programs vary by jurisdiction, they aim to provide employees with wage replacement while taking time off for a variety of family or medical reasons. These programs are thought to help retain valuable employees who need help balancing work and family, reduce employer costs for when time is being taken, and contribute to U.S. economic growth. In addition to childcare, these laws allow workers to provide care for elderly parents without having to sacrifice their livelihoods.

Both the reasons for leave and definitions of covered family member continue to broaden under PFL laws, and as a result encourage leave taking to be less specific to gender and more focused on caregiving relationships. Historical and recent PFL data points to more leave being taken by males, particularly for bonding but somewhat for family care. Both research studies and data trends also suggest that longstanding cultural norms about gender, work and household responsibilities are starting to break down.

While this will take time to fully understand, the impact of PFL programs on workforce participation is thought to be positive, though their influence on hiring and pay practices is inconclusive to date. In the meantime, protections by the Equal Employment Opportunity Commission (EEOC) and community rating under social insurance models serve to mitigate hiring, pay and overall gender discrimination risk.

4. Ease of Making Applications or Claims

When employees do need to make a claim for PFL benefits, the process for submitting an application is primarily online, with traditional options of mail, fax or at a service center supported. The four states with PFL programs that are in operation (California, New Jersey, New York and Rhode Island) promote online as being a quicker method for the claimant, but at the same time provide instructions for print, mail and fax if that is preferred. The three newer states to offer PFL (District of Columbia, Massachusetts and Washington) are still developing their processes.

5. Speed of Benefit Payments

After an employee's eligibility has been confirmed, three states (California, Massachusetts and Washington) issue payment within fourteen days. One jurisdiction (District of Columbia) commits to payment within ten days of an eligibility determination. One state (New Jersey) issues funds two days after a claim is approved. Another state (Rhode Island) commits to a three to four-week turnaround time for payments, after receipt of an approved application. This can be faster if a state specific debit card is used, for example within twenty-four hours.

6. Financial Sustainability

When it comes to PFL funding, four states (California, New Jersey, New York and Rhode Island) rely solely on employee contributions, while two states (Massachusetts and Washington) gather a combination of both employer and employee payments and one jurisdiction (District of Columbia) is funded entirely by employers. In most cases, employers can subsidize employee contributions by paying some or all of the required premium. Contribution requirements are based on either the state or federal taxable wage bases or the state average weekly wage, with the wage base and contribution rates varying broadly across states.

7. Administration

Of the seven states that have implemented or are in the process of developing their paid leave systems, three states (California, District of Columbia and Washington) have organized them as part of their state employment agencies, and three states (Massachusetts, New Jersey and Rhode Island) have structured them through their labor departments. One state (New York) administers its program in coordination with WC through its state WC Board and corresponding state insurance fund.

Within each administrative agency, specific sections have been established to manage and oversee PFL, either in conjunction with or separate from TDI. Particular units or areas of responsibility that may exist within PFL administration programs include tax/premium contribution collection, customer service, claims administration, audit and fraud detection, appeals, medical, private plan oversight, and overall program support, which may include or be separate for information technology (IT), training and education and outreach. In addition, finance and actuarial functions vary by type of model.

For the four states (California, Massachusetts, New Jersey and Washington) that allow employers to opt-out of the state to private plans, the administrative body also oversees the application for exemption process and provides ongoing governance to ensure employers remain compliant. One

state (New York) only provides governance as it is up to the private insurance market and the state fund to administer claims, albeit through a highly regulated mechanism.

8. Data Collection Capabilities

To support claims administration, states collect employer and employee data through employer reporting via online portals or secured file feeds. Data collected generally includes employer identifying information, employee identifying information, employee counts, wages and contribution data, with specific fields and forms differing across states.

9. Compliance Monitoring Capabilities

While states approach compliance differently, and the newer states are still finalizing their processes, there is a broad theme of reviewing PFL claims against other sources or databases within the state purview, other benefits an employee may be eligible for, validity of diagnoses as deemed by a clinical resource or against industry specific guidelines and enforcing penalties when fraud is detected.

C. Hawaii-based Cost Breakdowns for Each of the Seven Models

1. Model Overview

Spring developed an actuarial impact model that utilizes actual PFL claim and other industry data to project claim incidence rates, number of weeks benefit (i.e., duration), average benefit payments, expected costs and funding rates under existing state models and Hawaii's current TDI structure. Bonding and family care claims were developed separately due to differences in various claim characteristics, specifically incidence rates, maximum benefit period and benefit amounts. The model overlays Hawaii specific labor force characteristics on California, District of Columbia, Massachusetts, New Jersey, New York, Rhode Island and Washington PFL models over a five-year time horizon. In addition, the Hawaii TDI model is reviewed. Various benefit maximum period and fixed and progressive wage replacement ratios are also considered.

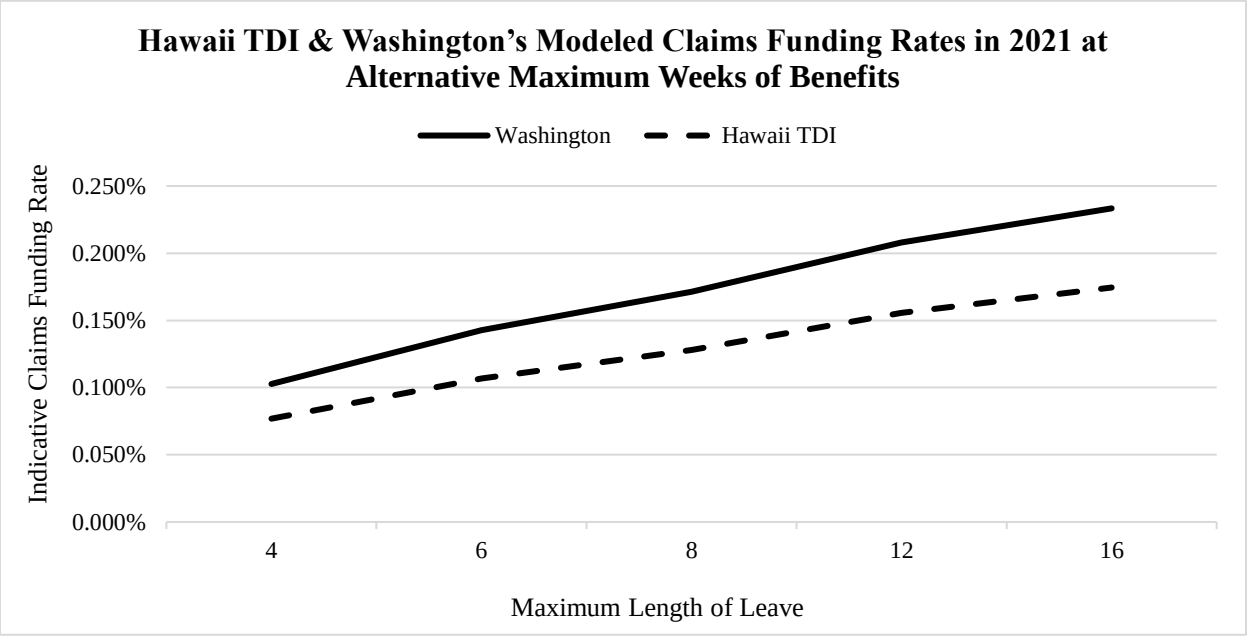
To account for variability, Spring's internal simulation model produces a reasonable range of claims cost and indicative claims funding rate projections by considering expected variations in both incidence rates and average weeks of benefit.

2. Projected Impacts by State

The primary driver of differences between state modeled indicative claims funding rates is the maximum number of weeks of benefit under each state model. The impact of maximum weeks of

benefit is illustrated in Exhibit iii for Hawaii TDI and Washington. The other state projections of modeled indicative claims funding rates fall within these lines.

Exhibit iii



The remaining differences in modeled indicative claims funding rates are mostly explained by average weekly benefit amount variances which are impacted by wage replacement ratios and maximum benefits.

Washington has the highest wage replacement ratio which results in the highest average weekly benefit. New Jersey and the District of Columbia also have high wage replacement ratios resulting in high average weekly benefits. Rhode Island and California fall in the middle of the average weekly benefit projections with moderate wage replacement ratios. Massachusetts follows next due to a lower maximum on the benefit formula. Hawaii TDI and New York's average weekly benefit formula results in the lowest average weekly benefit due to lower wage replacement ratios and maximums.

The indicative claims funding rates (or claims cost divided by taxable wage base) is highly impacted by the denominator (or taxable wage base) of the formula. Exhibit iv summarizes the average weekly benefit amount (AWBA) and indicative claims funding rate by state model assuming a common 8-week maximum benefit for bonding and family care leaves. The highest indicative claims funding rates are for the Washington and New York models, although New York has the lowest modeled average weekly benefit amount. This is driven by the low taxable wage cap in New York in comparison to other states. The District of Columbia also has an inconsistent

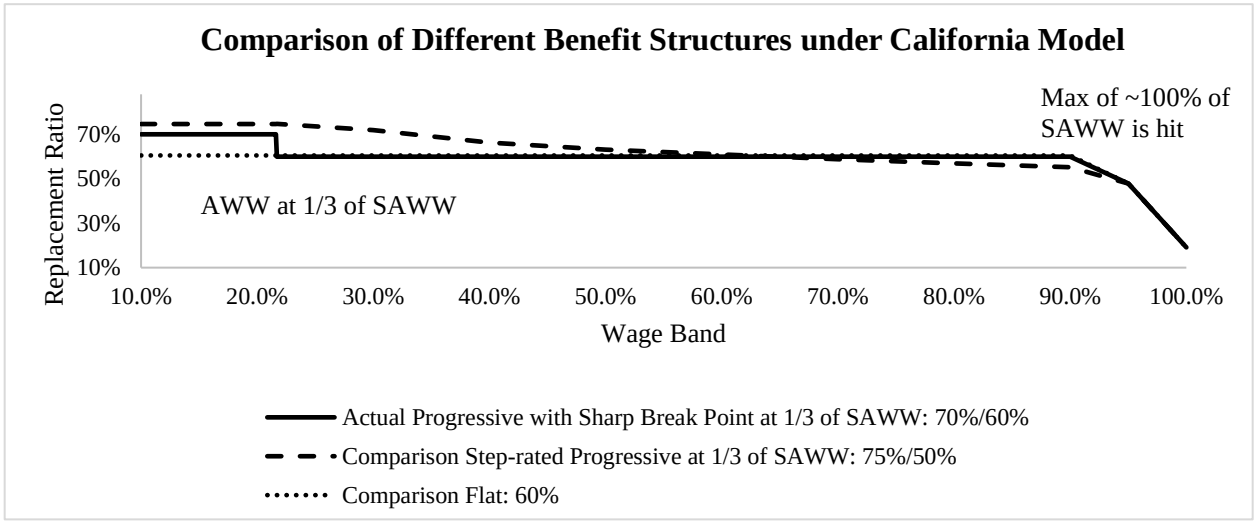
relationship because the taxable wage base is not capped. The lowest indicative claims funding rates are for the Massachusetts and Hawaii TDI models.

Exhibit iv

Hawaii Modeled Average Weekly Benefit Amount and Claims Cost by State Model with 8-Week Maximum Benefit in 2021		
State Model	**Hawaii Modeled AWBA**	**Modeled Indicative Claims Funding Rate with 8-Week Maximum Benefit**
California	$557	0.144%
District of Columbia	$630	0.140%
Massachusetts	$550	0.134%
New Jersey	$651	0.159%
New York	$523	0.160%
Rhode Island	$599	0.140%
Washington	$691	0.171%
Hawaii TDI	$525	0.128%

Fixed and progressive wage replacement ratios are considered by using the State of California model as an example with other states discussed later in the report. As illustrated in Exhibit v, California's progressive benefit model results in a sharp decrease in benefit amount for people that go over the 1/3 of state average weekly wage (SAWW) threshold. Step-rated progressive models, by comparison, further benefit lower paid employees without significantly decreasing the benefits for highly paid employees. A flat benefit structure that includes a maximum is still progressive as wage replacement ratios drop once the maximum benefit is hit.

Exhibit v



PFL eligibility, including minimum salary and weeks worked as well as requirements to include or exclude public sector employees and self-employed workers, though important to total costs, impact both the costs and the taxable wage base denominator. Therefore, eligibility rules do not affect the indicative claims funding rate. Hawaii will want to closely review eligibility rules for both cost and administrative ease.

Lastly, to arrive at the total indicative funding rate charged to employers we add administrative costs for each state model to the indicative claims funding rate based on Hawaii labor force specifics. Claims funding rates are assumed to be equal for both the social insurance and governance only models below as community rating is assumed in both approaches.

Exhibit vi below includes ongoing annual costs of $2.624 million for a social insurance model exclusively through the state and the ongoing annual costs of $1.103 million for a governance only model. Columns 3 and 4 below divide the ongoing state administrative charges by the taxable wage base in column 2 to determine the administrative cost funding rates.

Estimated administrative cost funding rates for the social insurance model in column 3 are added to the indicative claims funding rates in column 5 to determine indicative funding rates for the social insurance model, in column 6 of the chart.

Carrier premium rates, in addition to claim costs, include other costs such as administrative costs, state assessments, profits and taxes. Carrier premium rates in column 7 of the chart includes carrier fees equal to 15% of carrier premium rates to cover costs other than claim costs. This 15% fee also covers any state administration charges for governance only as developed in the fourth column of the chart. The math for column 7 carrier premium rates is column 5 carrier funding rates divided by 85% (= 100% – 15% other costs.)

As shown below in Exhibit vi, total funding costs would be higher for employers in an employer mandate model, as carriers would likely add higher administrative expenses.

Exhibit vi

Ongoing Administrative Cost and Indicative Funding Rate by State Model in 2021						
State Model	**Taxable Wage Base ($M)**	**Ongoing State Administrative Charge Rates**		**Claims Funding Rate in Hawaii**	**Total Indicative Funding Rate**	
		Social Insurance Model ($2.624M)	**Governance Only Model ($1.103M)**		**Hawaii State Fund***	**Carrier Premium Rates****
(1)	**(2)**	**(3)**	**(4)**	**(5)**	**(6)**	**(7)**
California	$21,413	0.012%	0.005%	0.144%	0.156%	0.170%
District of Columbia	$29,021	0.009%	0.004%	0.138%	0.147%	0.163%
Massachusetts	$21,759	0.012%	0.005%	0.162%	0.174%	0.191%
New Jersey	$31,213	0.008%	0.004%	0.193%	0.201%	0.227%
New York	$17,497	0.015%	0.006%	0.193%	0.208%	0.228%
Rhode Island	$19,499	0.013%	0.006%	0.084%	0.098%	0.099%
Washington	$28,023	0.009%	0.004%	0.208%	0.217%	0.245%
Hawaii TDI	$22,876	0.011%	0.005%	0.107%	0.118%	0.126%
* Sum of ongoing administrative cost percentage under social insurance model and claims cost percentage						
** Claims cost % divided by loss ratio of 85%						

3. Consideration of Employer Size

Although state-based data was not obtained by employer size for this study, a recent formal carrier and TPA market survey suggests that larger employers have higher PFL incidence/loss ratios than smaller employers. Large employers typically have more robust leave management programs and proactively work to integrate disability, WC, FMLA, paid and unpaid leave, and sick leave benefits for their employees. They typically want to give their employees full replacement benefits, and they strive to provide high awareness about paid leave benefits, compared to their smaller employer counterparts.

For smaller employers, PFL incidence/loss ratios tend to be lower. They often make their own arrangements when employees take time off, or do not have the infrastructure to follow through a more formal or even state-run process. This leads to small employers subsidizing large employer usage, if all size employers contribute to the funding pool. Conversely, as some administrative costs do not increase by employer size, insurers providing PFL coverage incur higher administrative costs as a percentage of premium for smaller employers relative to larger employers. These higher administrative costs for smaller employers as a percent of premiums should in part or in whole offset their lower expected claim costs.

4. Impact to Employees & Costs of Compliance

The impact of these patterns on employees is largely dependent on the path their employers take (e.g., state model, private plan opt-out) within the model (e.g., social insurance, employer mandate) that is made available to them. When employee contributions are required, and employers opt out, employers typically have the choice to deduct the contributions from an employee's paycheck or pay them on the employee's behalf. In the latter case, employees receive PFL, but at their employers' expense and/or as integrated with a broader employee benefit package.

With regard to the cost of compliance related to other mandates, PFL programs require a certain level of governance that is outlined in the staffing description and costs in section D.3. of the Executive Summary. Outside of administering claims, this entails reviewing and processing appeals, where an established process (usually with two levels of appeal) should be followed by which claimants (or their employers) can exercise their right to appeal benefit denials. It also includes detecting fraud and abuse, where processes, procedural rules and resources are not only highly valued, but important to assure the public that PFL benefits are fair and equitable. Governance also involves outreach and education, which is essential to achieving a well-understood and appropriately accessed PFL program.

D. Options for Compliance & Enforcement of a Proposed Paid Family Leave Program

1. Functional Requirements

Governance includes the hiring of appropriate management staff to direct policies, determine internal process and administer an office for PFL.

Claims administration staff would administer the bonding and family care claims that flow through to the state. This starts with the initial reporting of a claim, then moves to determining eligibility. Once a claimant has met the eligibility requirements, administrators confirm that the reason leave is being requested is valid. From there, a decision to either approve or deny a claim is based on the application submitted and the administrator's review of eligibility and the leave event. Wage data is used to calculate a claimant's leave benefit and coordination with other benefits considered. Appropriate payments are then dispersed through either paper checks mailed to claimants, debit cards loaded with funds at regular intervals, or direct deposits into existing accounts.

Support staff would aid with claim audits, quality assurance, fraud detection, appeals and training, and also monitor tax/premium contribution collection and review private plan applications. IT staff would manage the system platforms used and provide data, analytic and reporting support as needed.

2. Administering Department

As a new state seeking to enact a paid leave system, Hawaii will need to choose or create a vehicle and structure for administration. The state must do so in accordance with the type of model (social insurance, employer mandate) it establishes for PFL and consider the structure it already has in place for TDI, which is an employer mandated program.

Under a social insurance model, either exclusively through the state or through allowance of private plan opt outs, the infrastructure for PFL will require all the functional and structural areas described above and thus, a new agency created, such as an office for PFL. Under a social insurance model that is highly regulated and reliant on private markets or an insurance fund, or under an employer mandate, Hawaii's role would be limited to governance and could likely be accomplished through adding staff to an existing agency, such as the Disability Compensation Division (DCD) of the Hawaii Department of Labor and Industrial Relations (DLIR).

States that had TDI before adding PFL have been successful in expanding their long-standing TDI programs under a social insurance model. Hawaii is unique in being the only state to operate TDI as a pure employer mandate. To date, none of the states have taken the employer mandate approach for PFL.

Some states have built on their existing Unemployment Insurance (UI) programs to deliver TDI/PFL however, this is not recommended due to the philosophical differences between UI benefits intended for workers when they separate from their jobs, and TDI and PFL benefits intended to facilitate return to work and require medical documentation and vocational review.

States that more recently passed PFL laws are starting to collaborate with state insurance departments, insurance carriers and TPAs that have a wealth of knowledge and experience handling disability, FMLA, and paid and unpaid family leave benefit programs. Having private insurers and TPAs provide and administer PFL benefits is thought to reduce the financial and administrative burden on government agencies and leverages expertise, systems and staff that is already available. It also provides employers with a way to manage a number of leave and benefits in one consolidated platform, thereby increasing ease of use and compliance.

3. Staffing & Information Technology

We have estimated staff count by role and commented on the IT infrastructure that will need to be developed for (1) a social insurance model exclusively through the state; (2) a social insurance model that allows private plan opt outs and (3) a governance only role that would be applicable to a social insurance model that is highly regulated and reliant on private markets or an insurance fund, or an employer mandate.

For illustrative and conservative purposes, the estimated staff counts for a full year of claims assumes the California model of eligibility and benefit terms as (1) 22.5 people to support a social insurance model exclusively through the state; (2) 22 people for a social insurance model that allows private plan opt outs and (3) 7.5 people to play a governance only role. These figures could be higher or lower depending on the state model considered and/or the eligibility requirements involved.

Although a detailed analysis of existing DLIR IT would need to be conducted to state for sure, Spring is of the opinion that Hawaii would not need to build their own solution to administer a PFL program. Instead, Spring believes the necessary IT infrastructure could be achieved by Hawaii utilizing comprehensive software that is already available in the marketplace to manage disability, FMLA, paid and unpaid leaves. This software could be identified through an RFP process. The selected system could interface with the State's UI system and others within the DLIR. The costs of the system are anticipated to consist of annual ongoing fees for technology lease/maintenance and initial one-time or implementation fees that would account for development, testing, custom programming, data feeds and training.

4. Projected Costs for a PFL System in Hawaii

These staff counts and IT infrastructure translate into financial terms of (1) $1.1 million start-up and $2.624 million ongoing to support a social insurance model exclusively through the state; (2) $1.1 million start-up and $2.618 million ongoing for a social insurance model that allows private plan opt outs and (3) $660,000 start-up and $1.103 million ongoing to play a governance only role.

I. Introduction

A. Background

Spring Consulting Group, an Alera Group Company, LLC (Spring) was engaged as an unbiased and objective contractor by the Legislative Reference Bureau (the Bureau) to conduct a study to identify potential impacts of establishing a paid family leave program in the State of Hawaii. This request was pursuant to Act 109, Session Laws of Hawaii 2018, that was signed into law on July 5, 2018. The Act requires the Bureau to conduct a sunrise analysis to understand the impact of the establishment of a paid family leave program on industry, consumers, employees, employers, and caregivers.[1]

B. Scope

Act 109 requires that this study examine the following concepts:

1. Comparative analysis of other state paid leave models, including a review of current temporary disability insurance usage and other state temporary disability insurance models, including:
   - **1.1.** Scope of coverage
   - **1.2.** Gender equity
   - **1.3.** Ease of making applications or claims
   - **1.4.** Speed of benefit payments
   - **1.5.** Financial sustainability
   - **1.6.** Administration
   - **1.7.** Data collection capabilities
   - **1.8.** Compliance monitoring capabilities
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
3. Examination of options for compliance and enforcement of the proposed paid family leave program with recommendations for additional staffing and support for the Hawaii Department of Labor and Industrial Relations to effectuate a program.[2]

C. Methodology

During the three-month period that was prescribed for the study, Spring reviewed existing literature and studies regarding paid family leave trends and usage and assessed available state specific and industry related data, including but not limited to the State of California Employment Development Department, New Jersey Department of Labor and Workforce Development, New York State Paid Family Leave Department, Rhode Island Department of Labor and Training, the

Department of Labor, Bureau of Labor Statistics, U.S. Census Bureau, the Integrated Benefits Institute and private insurance carrier or third-party administrator (TPA) data. Spring interviewed representatives from the Hawaii Department of Labor & Industrial Relations, as well as California, New Jersey, Massachusetts, Rhode Island, and Washington state paid family leave agencies. Spring gathered perspectives from employers that have experienced paid family leave programs, as well as from insurance carriers and TPAs that administer them.

In addition, Spring developed an actuarial impact model that utilizes actual paid family leave (PFL) claim and other industry data to project claim incidence rates, number of weeks of benefit (i.e., duration), average benefit payments, expected costs and funding rates under existing state models and also under Hawaii's current temporary disability insurance (TDI) structure. Bonding and family care claims were developed separately due to differences in various claim characteristics, specifically incidence rates and duration. To account for variability, Spring also used internal simulation software to produce a reasonable range of claims cost and funding rate projections by considering expected variations in both incidence rates and durations. The accuracy and reliability of the PFL projections depend upon assumptions described in Appendix A of this report entitled "Development of Estimated Model Parameters" found on page 89. The estimates can be characterized as actuarial central estimates. Each estimate represents an expected value over a range of reasonably possible outcomes; they do not reflect all conceivable extreme events where the contribution of such events to an expected value is not reliably predictable. The estimates are not defined by a precise statistical measure (i.e., mean, median, mode, etc.), but are selected from multiple indications produced by a variety of generally accepted actuarial methods that are intended to respond to various drivers of ultimate claim liabilities. It is also important to note that this analysis and the projections presented should be understood as estimates at one point in time and are subject to future change.

In performing this analysis, data and other information collected through available existing PFL programs and other industry sources as referenced throughout was relied upon. Spring has not audited or verified this data and other information. If the underlying data or information is inaccurate or incomplete, the results of our analysis may likewise be inaccurate or incomplete. In that event, the results of our analysis may not be suitable for the intended purpose. Historical claim and exposure data have been used in estimating expected results for the 2020 through 2024 projection period. Changes in any portion of the information or assumptions upon which Spring's estimates are based will require a reevaluation of the results of this report and possibly a revision of these estimates.

D. Organization of the Report

Beyond the Acronyms, Glossary, and Executive Summary, this report is organized to examine the major areas set forth in the Act.

Section I introduces the premise of the report, including the background, scope and methodology.

Section II discusses the concept of PFL, how it has evolved and what existing models of PFL have to offer in California, the District of Columbia (Washington, D.C.), Massachusetts, New Jersey, New York, Rhode Island and Washington.

Section III considers the impacts of adopting similar methods of PFL programs in Hawaii by overlaying Hawaii specific characteristics on specific state program scenarios over a 5-year time horizon and with various benefit period and fixed and progressive wage replacement ratios.

Section IV outlines how PFL programs are administered and discusses methods for building effective processes to ensure compliance of a paid leave program.

Section V presents key findings discovered through the analysis and resulting observations and conclusions.

Section VI includes further detail as appendices.

II. Comparative Analysis of Existing Models

A. Paid Family Leave Context & Evolution

1. Policy & Coverage

Family leave policies are designed to support workers when they need to take time off for themselves or family members. For some, it may be to bond with a new baby. For others, it may be to care for a parent or child with a serious illness, or even their own medical condition or diagnoses. Given these parameters, it is likely that most workers will experience a time when they need to be away from their jobs for a medical or family need. When this occurs, 17% of United States workers have paid family leave programs available, 39% have access to short-term disability coverage, and 34% to long-term disability.[3]

2. Federal Legislation

In 1993, the United States Congress passed the Family Medical and Leave Act (FMLA) to provide a means for employees to balance work and family responsibilities by taking unpaid leave for certain reasons. It was predicated on concerns for the needs of the American workforce and the development of high-performance organizations. This federal act recognized that children and elderly people are increasingly dependent on family members that work, and workers need reassurance that they will not be asked to choose between their jobs and families when the need to care for them arises.[4]

The FMLA allows eligible employees to take up to 12 work weeks of unpaid, job-protected leave during a 12-month period to care for a new child, care for a seriously ill family member, or recover from a serious illness. It was amended in 2008 and again in 2009 to include military caregiver and qualifying exigency leave for up to 26 weeks, and to recognize the non-traditional work hours of airline flight crewmembers and flight attendants. The FMLA requires employers to maintain benefits during an employee's leave, including continuing group health coverage, and reinstate the employee to the same or an equivalent position upon their return from leave.[5]

The FMLA covers both public and private-sector employers who employ 50 or more employees for at least 20 workweeks in the previous or current calendar year. To be eligible, employees must have worked for the employer for 1,250 hours during the 12 months prior to the start of leave (cumulatively and considering breaks in service over 7 years) and work at a location where the employer has 50 or more employees within 75 miles.[6] An estimated 68.2% of U.S. workers are covered by the FMLA, while 31.8% are not. Further, almost half of employees with an unmet need for time off report they cannot afford to take leave.[7]

3. State Structures

Numerous states[i] have enacted state family and medical leave laws that provide additional benefits to employees beyond the federal FMLA, usually in the form of less stringent eligibility requirements or an additional amount of leave. A lesser but expanding number have enacted state leave laws that afford pay during employee leave. The state programs vary in that they may mandate pay for medical leave, for family leave, or for both family and medical leave.

Five states – California, Hawaii, New Jersey, New York, Rhode Island – and Puerto Rico granted access to paid medical leave through TDI programs. Generally, to qualify for leave under a TDI program, an employee must be unable to work due to a serious medical condition or disability.

Four of the five beforementioned states – California, New Jersey, New York and Rhode Island – added PFL to their TDI programs. Paid family leave provides paid leave for employees who may need time off for reasons besides their own medical condition, such as the need to care for ill family members or to bond with a new child. Three additional jurisdictions - Massachusetts, the District of Columbia, and Washington – have developed paid leave programs that provide both family and medical leave (PFML) benefits, as they do not have TDI programs in place.

Of the seven states that have enacted paid family and medical leave programs, the most common structure is that of social insurance. Social insurance defines by statute that workers and/or their employers submit payroll contributions into a dedicated fund. Under this model, when a worker qualifies for leave, they receive partial wage replacement. Rates for employee and employer contributions are set by the state, as well as the wage replacement ratio. Risk and resources are pooled together.

Under this social insurance structure, the District of Columbia and Rhode Island operate through an exclusive state fund, where claimants access benefits solely through the state. California, Massachusetts, New Jersey, and Washington allow employers to opt-out of the state-administered plan and cover their employees with limited private options. Employers in these states may opt out of the state program by applying for an exemption and provide benefits through a fully insured program or by self-insuring. New York is unique in that it offers highly regulated and private options wherein employers may elect to offer benefits through the State Insurance Fund, private insurance or self-insurance, with the private insurance option including a risk adjustment mechanism.

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[i] California, Colorado, Connecticut, District of Columbia, Hawaii, Illinois, Indiana, Iowa, Kentucky, Louisiana, Maine, Maryland, Massachusetts, Minnesota, Montana, Nebraska, New Hampshire, New Jersey, New York, North Carolina, Ohio, Oklahoma, Oregon, Rhode Island, Tennessee, Vermont, Washington, and Wisconsin.

Exhibit 1

Paid Family Leave by State Structure			
State	**Social Insurance Through an Exclusive State Fund**	**Social Insurance with an Opt-Out: Limited Private Options**	**Social Insurance Alongside Regulated and Private Options**
California		✓	
District of Columbia	✓		
Massachusetts		✓	
New Jersey		✓	
New York			✓
Rhode Island	✓		
Washington		✓	

An alternative structure to social insurance is that of an employer mandate. Under this model a state requires employers to provide coverage through self-insurance or state approved private insurance coverage. Employers may elect to cover either the full cost of the program or collect contributions and share the cost of the program with employees, up to permitted levels set by each state. This model is not in effect for any PFL programs in the states this report focuses on. It is, however, in place in Hawaii, not only for its TDI program, but also for its Prepaid Health Care (PHC) program. Under this model, employers (and their insurance or service provider partners) rather than the government or related representatives administer the benefit. There is no common rate setting or transfer of government funds to offset costs as employers are expected to finance the paid leave themselves.

In addition to social insurance and employer mandate program structures, a noncontributory option exists. Under this model financial benefits are still afforded through a government program, but it is financed through general funds instead of premium contributions by workers and/or employers. This structure is not in place for paid medical or family leave in the U.S. and is a less common approach than social insurance in other countries.

4. Pending Initiatives

There are an additional number of states in the regulatory phases of offering paid leave[ii] and several more[iii] that have introduced legislation. Further, there is political, commercial and individual momentum for broader legislation. Eighty-four percent of Americans across Democratic, Independent

[ii] Connecticut and Oregon.
[iii] Colorado, Hawaii, Iowa, Illinois, Maine, Minnesota, North Carolina, Nebraska, New Hampshire, Oklahoma, Pennsylvania, Tennessee and Vermont

and Republican parties support a national paid family and medical leave policy that would cover all working individuals.[8]

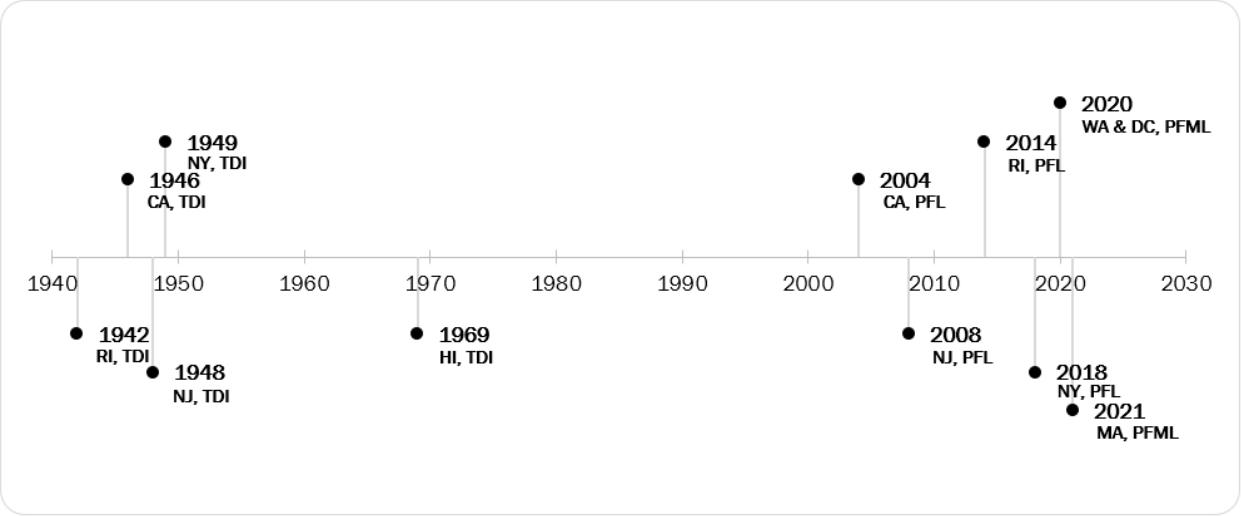
Many initiatives have been proposed at the federal level with the biggest differences concerning structure, funding, and breadth of coverage. The WorkFlex in the 21st Century Act, for example, would amend the Employment Retirement Income Security Act (ERISA) by allowing employers to opt out of other applicable state and local benefit laws in exchange for a minimum threshold of paid leave (ranging from 12 to 20 days depending on the size of the employer and tenure of the employee) and flexible work options (at least one of a biweekly work program, compressed work schedule, telework, job-sharing, flexible or predictable schedule).[9] The Family and Medical Insurance Leave (FAMILY) Act would establish an Office of Paid Family and Medical Leave within the Social Security Administration and be funded by a payroll tax. It would provide employees with two-thirds of their wages, up to a $4,000 monthly cap, for up to 60 workdays, or 12 workweeks, in a year to address their own serious health condition, including pregnancy or childbirth; to deal with the serious health condition of a family member; to care for a new child; and for certain military caregiving and leave purposes.[10] The Economic Security for New Parents Act and Child Rearing and Development Leave Empowerment (CRADLE) Act would provide more of a parental leave coverage, be financed by a portion of Social Security and would allow both natural and adoptive parents to receive up to three months of paid leave benefits in exchange for postponing the activation of their retirement benefits for up to six months.[11,12]

B. Current State Program Models

1. Specific States of Focus

Considering this momentum and the scope of Act 109, the jurisdictions of focus for this analysis include California, the District of Columbia, Massachusetts, New Jersey, New York, Rhode Island, and Washington. Of these, Rhode Island was the first to create a TDI program in 1942. As shown in Exhibit 2, this trend grew as California implemented a TDI program in 1946, New Jersey in 1948 and New York in 1949. Hawaii was the last state to establish TDI twenty years later in 1969. After thirty years, in 2004, California became the first state to add PFL to its TDI program. New Jersey followed suit by implementing PFL in 2008, Rhode Island in 2014, and New York in 2018. The District of Columbia and Washington passed new paid leave laws in 2017 that will go into effect in 2020, while Massachusetts law passed in 2018 and will go into effect in 2021.

Exhibit 2



2. Paid Medical Leave Development

In examining these models, it is important to point out that disability or TDI programs are solely focused on medical conditions for the employee, and more specifically, medical conditions classified as a disabling illness or injury, either physical or mental, and including pregnancy, that prevent an employee from performing regular and customary work. The coverage is non-occupational in nature, and therefore does not consider conditions that are thought to be caused by the person's job. Benefits are typically subject to a (7-day) waiting period, can last from 26 to 52 weeks (with 26 weeks being most common), and pay between 50% and 66 2/3% wage replacement subject to minimum and maximum weekly amounts.

3. Paid Family Leave Expansion

PFL programs go beyond medical coverage to provide paid time off for employees caring for family members. In particular, leave is available for covered employees to bond with a new child or to care for a family member with a serious health condition or who needs medical attention. Some states also cover activities related to the military deployment of a family member. Benefits may or may not be subject to a waiting period, can last from 4 weeks to 26 weeks, and pay between 50% and 90% wage replacement subject to minimum and maximum weekly amounts.

Of the states this report focuses on, four had TDI programs in place before adding PFL. Three did not have TDI programs in place, so instead included employee medical leave for an employee's own serious health condition in the PFL laws, which are often referenced as PFML as summarized in Exhibit 3.

Exhibit 3

State Paid Medical and Paid Family Leave by Leave Law Type			
State	**Paid Medical Leave through TDI**	**Paid Family Leave through PFL**	**Paid Family and Medical Leave through PFML**
California	✓	✓	
District of Columbia			✓
Massachusetts			✓
New Jersey	✓	✓	
New York	✓	✓	
Rhode Island	✓	✓	
Washington			✓

C. Scope of Coverage Afforded

The paragraphs below compare and contrast the scope of PFL coverage afforded by the seven jurisdictions. The parameters related to child bonding and care for a family member will be most important to Hawaii, and are the focus of our report, as the State already has a TDI program (and in effect medical leave for own serious health condition) in place.

1. State Summaries

i. California

In California, employees looking to take PFL must earn at least $300 in wages during a base period, work for a private or public employer and take leave for a qualifying reason. Qualifying reasons include parents taking leave for bonding following the birth, adoption, or placement of a child for foster care or for employees to take time to care for a family member with a serious health condition. Beginning January 1, 2021, leave will also be available for a qualifying military exigency due to the overseas deployment of an employee's family member. Paid leave for an employee's own serious health condition is covered under California State Disability Insurance (SDI) and employees must meet the same eligibility requirements.

While California PFL provides a monetary benefit, job protection is not provided through PFL but may be available under FMLA or the California Family Rights Act (CFRA) that run concurrently. The weekly benefit for PFL is 60% to 70% of an employee's income, depending on their quarterly income in the base period of 5 to 18 months prior to the claim start date and may range between $50 and $1,252 in 2019. If an employee's highest quarterly earnings are between $929 and $5,385.37, the benefit is about 70%, while if the highest quarterly earnings are greater than $5,385.37, the benefit is about 60% of earnings. Employees who earn between $300 and $928.99 receive a minimum benefit of $50. The benefit cap is adjusted annually by a statutory formula.

Employees who qualify for leave may take up to 6 weeks of leave in a 12-month period, which will expand to 8 weeks on July 1, 2020. For bonding leave, employees must take at least 2 weeks at a time, unless employers grant a request for a shorter duration. To care for a family member with a serious health condition, intermittent leave is available an hour at a time, or the shortest period used by the payroll system. Employers may require employees to take up to 2 weeks of accrued, but unused, vacation time before the employee's initial receipt of benefits. Employers are required to maintain group health plan coverage, though employees must continue to make premium payments.[13]

ii. District of Columbia

The District of Columbia passed a PFML law in April of 2017, with benefits becoming payable on July 1, 2020. The law applies to all employers who pay unemployment insurance on behalf of employees. Unique to D.C., and perhaps due to some of the nature of work in the jurisdiction, employees are covered if at least 50% of their work time is spent in D.C., for an eligible D.C. based employer. Alternatively, if employees do not meet this threshold, they are covered if a substantial amount of work time is at the D.C. site of an eligible employer and not more than 50% of work is in another jurisdiction.

The law only provides a monetary benefit and does not include job protection. However, leave may run concurrently with FMLA and D.C. FMLA. During leave, employees receive a benefit based on their average weekly wage (AWW) relative to the D.C. minimum wage. If employees have an AWW less than or equal to 150% of the D.C. minimum wage multiplied by 40, benefits are 90% of an employee's AWW. If an employee has an AWW that is greater than 150% of the D.C. minimum wage multiplied by 40, benefits are 90% of an employee's AWW plus 50% of the amount the employee's AWW exceeds 150% of the minimum wage multiplied by 40. The maximum weekly benefit in the first year of the program is $1,000.

Employees can take up to eight weeks as parents to bond with a new child, six weeks to care for a family member with a serious health condition, and up to 2 weeks for an employee's own serious health condition. Employees taking leave must satisfy a 7 consecutive day waiting period per year, regardless of the number of qualifying events. Up to 16 weeks of leave are available per year, which must be taken in at least full day periods. Employees earning long term disability payments, unemployment, or self-employment income are not eligible to receive benefits at the same time.[14] The ability for an employee to use employer-provided paid leave benefits (e.g., vacation time, sick time) while taking paid family leave is determined by the employer's policies.[15] An employee's health insurance must be maintained during leave, under the same conditions that apply while an employee is regularly at work.[16]

iii. Massachusetts

While Massachusetts PFML is not available until January 2021, it will require all employers to provide this benefit to W-2 employees including full-time, part-time, seasonal, and temporary employees, union employees, and 1099-MISC contractors if they make up more than 50% of an employer's total workforce. Employees may apply for leave if they are parents taking leave to bond with a child within 12 months of the child's birth, adoption, or foster care placement, to care for a family member with a serious health condition, to care for a family member who is a covered servicemember, for a qualifying exigency due to a family member's call to active duty, or for one's own medical condition.

In addition to a monetary benefit, Massachusetts PFML provides job protection and ensures employees are restored to the employee's previous or an equivalent position upon return from leave. An employee's weekly benefit is calculated by taking 80% of the employee's AWW that is less than 50% of the state average weekly wage (SAWW) ($1,383 in 2019), plus 50% of the employee's AWW greater than the SAWW, up to a maximum of 64% of the SAWW ($850 in 2019 per the regulation). The benefit cap is adjusted annually based on statewide average weekly wages.

Subject to a 7 consecutive day waiting period, employees may take up to 12 weeks of leave for family leave for bonding, a military exigency, or to care for a family member. 20 weeks is available for medical leave, and 26 weeks for family leave to care for a covered servicemember. As a combined total, 26 weeks may be taken at a maximum within a 52-week period. Leave to care for a family member or for a covered service member or medical leave may be taken intermittently, if medically necessary. Intermittent leave is available for bonding, if an employer agrees to it, and for leave for a qualifying military exigency. Employees may elect to use accrued paid time off offered by the employer rather than receiving PFL benefits, as long as they meet employer notice requirements and certification processes to use the leave.[17] While an employee is on leave, health benefits must be continued by the employer, as if the employee had been at work, with employees continuing to make their own contributions.[18]

iv. New Jersey

New Jersey family leave insurance (FLI) covers employers with 30 or more employees. For employees to be eligible, they must have worked 20 weeks earning at least $172 weekly or have earned a combined total of $8,600 in the first four quarters (the base year). New Jersey FLI can be taken to bond with a new child or care for a family member. As of February 2019, FLI includes leave taken under the New Jersey SAFE Leave Act which provides protected time off for employees if they themselves or their family members have been victims of domestic or sexual violence (which applies to employers with 25 or more employees).[19] Paid leave for an employee's own serious health condition is covered under New Jersey TDI in accordance with TDI eligibility requirements.

While New Jersey FLI provides a monetary benefit, job protection is not provided, but may be available under FMLA or the New Jersey Family Leave Act (FLA) which run concurrently when a claimant meets all eligibility requirements. Employees will receive 66 2/3% of their AWW, up to 53% of the SAWW, which in 2019 is set at $650. No longer subject to a waiting period (this was removed effective July 1, 2019), benefits apply for up to a maximum of 6 weeks or up to 20 days for leave related to domestic assault/sexual violence. Effective July 1, 2020, the maximum entitlement will increase to 12 weeks and wage replacement will increase up to 85% of an employee's base weekly wage, maxing out at 70% of the SAWW. Intermittent leave can be taken in as few increments as days to care for a family member, while employees taking leave for bonding can take intermittent leave in weeks only. Advance notice is required when leave is foreseeable and if proper notice is not given, an employee's leave entitlement may be reduced by 14 days.[20]

In relation to other leaves, employees cannot simultaneously use paid family leave and disability benefits or unemployment compensation.[21] Prior to February 2019, employers could require employees use up to 2 weeks of accrued time before taking FLI, which would then be reduced by up to 14 days. New regulations now enable employees to elect the use of employer provided paid time off which does not reduce an employee's leave entitlement. Employers must continue health benefits for employees on leave.[22]

v. New York

New York employees are eligible for PFL if they work for eligible employers and are either full time employees who have worked 20 or more hours per week for 26 consecutive weeks with the same employer or part-time employees who have worked less than 20 hours per week for 175 days with the same employer. Eligible employers include all private employers with 1 or more employees on each of at least 30 consecutive or non-consecutive days in any calendar year. Public employers and self-employed individuals are not automatically included under the law but may voluntarily opt-in to the program.

New York PFL provides job-protected leave for employees who need time away from work to bond with a new child, to care for a family member with a serious health condition or to assist loved ones when a spouse, domestic partner, child or parent is on active service or has been notified of an impending call to duty in a foreign country. Paid leave for an employee's own serious health condition is covered under New York Disability Benefits Law (DBL) in accordance with DBL eligibility requirements. The PFL leave allotment and benefit amount is not subject to a waiting period and increases annually from 10 weeks at 55% of an employee's AWW in 2019 up to a maximum weekly benefit of $746.61, to 10 weeks at 60% in 2020, and to 12 weeks at 67% in 2021.

The shortest leave increments available (including for intermittent time) is one day. Combined with New York DBL, the maximum length of leave cannot exceed 26 weeks in a 52-week period.

Employers cannot require employees to use paid time off while on PFL and must continue health insurance on the same terms as if the employee had continued to work.[23]

vi. Rhode Island

Rhode Island employees are eligible for paid family leave through temporary caregiver insurance (TCI) when they have worked for an eligible employer and have been paid at least $12,600 in base period wages. Employees that have not earned that amount may be eligible if they earn $2,100 in one base period quarter, total base period wages are at least 1.5 times the highest quarter earnings, and base period taxable wages are at least $4,200. Eligible employers include all private employers in Rhode Island, however public employers may elect to have certain classes of employees participate in the program. Self-employed individuals are not able to opt-in to the program. Leave is available under Rhode Island TCI for employees needing time to bond with a new child within the first 12 months of parenting, or to care for a family member with a serious health condition. Paid leave for an employee's own serious health condition is covered under Rhode Island TDI in accordance with TDI eligibility requirements.

Rhode Island TCI provides job protection in that employees must be offered a comparable position with equivalent seniority, status, employment benefits, pay and other terms and conditions as the job they were in before taking leave. When a qualified healthcare provider indicates an employee cannot work for at least 7 consecutive days, leave for bonding or to care for a family member can be taken for up to 4 weeks. Not subject to a waiting period, employees receive a weekly benefit of 4.62% of wages paid during the highest quarter of their base period which amounts to approximately 60% of weekly wages up to $867 per week, plus dependent benefits up to $1,170.[24] The benefit cap is adjusted annually based on statewide average weekly wages. Any leave taken for TCI reduces leave available for Temporary Disability Insurance or TDI. Employees cannot use TCI and TDI at the same time, however employees may use paid salary, sick or vacation pay while on TCI.[25] Employers are also required to maintain health insurance coverage for employees on leave.

vii. Washington

Washington PFML payroll deductions began January 1, 2019 and reporting began July 1, 2019; however benefits will not be available to employees until January 1, 2020. The law applies to all employers, except for federal employers, and includes out of state employers with Washington based employees. To be eligible for benefits, employees must have worked at least 820 hours in the qualifying period, which is the first 4 of the last 5 completed calendar quarters, or the last 4 completed calendar quarters beginning the day the employee takes leave. Under the law, Washington employees can take leave to bond with a new child within 12 months of the birth or placement,

to care for a family member with a serious health condition, for activities related to the deployment of a family member, or for medical leave for an employee's own serious health condition.

Washington PFML provides job protection if the employer has 50 or more employees, the employee has worked for the employer for at least 12 months, and the employee has worked at least 1,250 hours in the last 12 months. The weekly benefit is based on annual earnings in relation to the SAWW. If an employee earns less than or equal to 50% of the SAWW, the benefit is 90% of the employee's AWW, rounded down to the nearest dollar. Alternatively, if an employee earns more than 50% of the SAWW, the benefit is the sum of 90% of the employee's AWW up to 50% of the SAWW, plus 50% of employee's AWW that is over 50% of the SAWW. Weekly benefits will be capped at $1,000.

Claimants must meet a 7 consecutive day waiting period before accessing leave, which may last up to 12 weeks in the 52-week benefit period. Leave can be extended by 2 weeks when it is a result of pregnancy complications, and by 4 weeks when an employee uses a combination of family and medical leave. If an employee experiences a serious health condition with pregnancy and takes a combination of family and medical leave, the total leave duration can be up to 18 weeks (16 weeks of combined leave plus 2-week extension for pregnancy complications). A waiting period is not required for bonding leave and only one waiting period must be met per year, regardless of the number of qualifying events. Leave must be taken in at least 8-hour increments. When leave is foreseeable, employees must give their employer a 30-day notice before leave begins.

Washington PFML runs concurrent with FMLA and is in addition to any leave for sickness or temporary disability due to pregnancy or childbirth. Any week in which the employee is eligible to receive federal or state unemployment compensation, industrial insurance, or disability insurance, the employee is disqualified from receiving family or medical leave benefits.[26] Employees can choose to supplement or substitute PFML benefits for accrued time off, such as sick leave or vacation time. Employers must maintain any existing health benefits for employees on leave for the duration of the approved leave.[27]

2. Employer & Employee Eligibility

Employers required to comply with PFL laws differ across the relevant states, ranging from all employers to those with more than 50 employees. Employee eligibility for benefits is more detailed, usually involving an earnings requirement or a certain amount of time worked for an employer.

Exhibit 4

State	Employer Eligibility as of October 2019	Employee Eligibility as of October 2019
California (CA)	▪ All private employers ▪ Public entities electing to participate	▪ Earned $300 in wages in CA subject to insurance tax in the base period
District of Columbia (D.C.)	▪ All private employers that are required to pay unemployment insurance, except for those exempt from taxes in D.C. by federal law or treaty ▪ Self-employed individuals can voluntarily opt-in	▪ 50% of work occurs in D.C. ▪ Employed when applying for benefits
Massachusetts (MA)	▪ All employers with covered MA employees and 1099-MISC contractors if more than 50% of the employer's workforce ▪ Public employers and self-employed individuals can voluntarily opt-in	▪ Work is localized in MA, or work is not localized in any state, but operations are based in MA, or operations are not based in any state, but the employee resides in MA ▪ 15 weeks or more of earnings and earned at least $4,700 in the last 12 months ▪ Former employees not separated for more than 26 weeks
New Jersey (NJ)	▪ Employers with 30 or more employees covered under New Jersey Unemployment Compensation Law, including state and government employment *Note: Before June 30, 2019, the program applied to employers with 50 or more employees*	▪ Worked 20 calendar weeks in the base year; and ▪ Earned $172 or more per week; or ▪ Earned $8,600 or more in the base year *Note: When the program was implemented in 2009, the earning requirement was $143 per week or $7,200 during the base year. The requirement has generally increased each year*
New York (NY)	▪ Private employers with 1 or more employees on each of at least 30 consecutive or non-	▪ Full time employees who worked 20+ hours per week for 26 weeks

	consecutive days in any calendar year ▪ Public employers and self-employed individuals can voluntarily opt in	▪ Part time employees who worked less than 20 hours per week for 175 days
Rhode Island (RI)	▪ All RI private employers ▪ Governmental entities may elect to have certain classes of employees participate ▪ Self-employed individuals are not eligible to opt in	▪ Paid at least $12,600 in the base period; or earned at least $2,100 in one base period quarter; and ▪ Total base period taxable wages are at least 1.5x the highest quarter earnings; and ▪ Base period taxable wages are at least $4,200
Washington (WA)	▪ All WA employers, except for Federal employers ▪ Out of state employers with WA employees ▪ Federally recognized tribes and self-employed individuals can voluntarily opt in	▪ Work 820+ hours in a qualifying period ▪ All or most of the work performed is in WA

3. Qualifying Events

Each state that provides PFL affords employees family leave to bond with a new child, or family leave to care for a family member with a serious health condition. The District of Columbia, Massachusetts, New York, and Washington provide a leave allotment for military members to address issues before they are deployed (qualifying military exigency[iv]). Massachusetts extends the amount of time employees can take to care for a family member who is a covered service member. New Jersey is unique in that it provides leave for employees to care for themselves or a family member who was a victim of domestic or sexual violence. Medical leave for an employee's own serious health condition is included for the District of Columbia, Massachusetts, and Washington, as they do not also have a statutory disability law.

[iv] Definitions differ by state, but qualifying military exigencies may include the need to attend military events, childcare related activities, making financial or legal arrangements, attending counseling or other parental activities.

Exhibit 5

State	Qualifying Events as of October 2019
California	▪ Family leave for bonding due to the birth, adoption or foster care placement of a new child ▪ Family leave to care for a family member's serious health condition ▪ Beginning 1/1/2020, leave is available for qualifying military exigencies
District of Columbia	▪ Family leave for bonding due to the birth, adoption or foster care placement of a new child ▪ Family leave to care for a family member's serious health condition ▪ Family leave due to a qualifying military exigency ▪ Medical leave to care for one's own serious health condition
Massachusetts	▪ Family leave for bonding due to the birth, adoption or foster care placement of a new child ▪ Family leave to care for a family member's serious health condition ▪ Family leave to care for a family member who is a covered servicemember ▪ Family leave due to a qualifying military exigency ▪ Medical leave to care for one's own serious health condition
New Jersey	▪ Family leave for bonding due to the birth, adoption or foster care placement of a new child ▪ Family leave to care for a family member's serious health condition ▪ Family leave to care for a family member seeking medical attention for, or recovering from, physical or psychological injuries due to domestic or sexual violence ▪ Medical leave to seek medical attention for, or recover from, physical or psychological injuries due to domestic or sexual violence *Note: Leave for domestic or sexual violence was added in February 2019, through the NJ SAFE Act*
New York	▪ Family leave for bonding due to the birth, adoption or foster care placement of a new child ▪ Family leave to care for a family member's serious health condition ▪ Family leave due to a qualifying military exigency
Rhode Island	▪ Family leave for bonding due to the birth, adoption or foster care placement of a new child ▪ Family leave to care for a family member's serious health condition
Washington	▪ Family leave for bonding due to the birth, adoption or foster care placement of a new child ▪ Family leave to care for a family member's serious health condition ▪ Family leave due to a qualifying military exigency ▪ Medical leave to care for one's own serious health condition

4. Covered Relationships

PFL programs often expand the definition of family member beyond that set originally by the federal law. The federal FMLA provides protections for employees to take leave to care for a child, parent, or spouse.[28] State laws encompass this set of relationships and may extend coverage to employees taking leave to care for grandparents, grandchildren, siblings, or in the case of New Jersey, any individual with whom the employee has the equivalent of a family relationship.

Exhibit 6

State	Covered Family Members as of October 2019
California	▪ Child (biological, adopted, or foster son or daughter, a legal ward, a son or daughter of a domestic partner, or the person to whom the employee stands in loco parentis) ▪ Parent (biological, foster, or adoptive parent, a parent-in-law, step-parent, a legal guardian, or other person who stood in loco parentis to the employee when the employee was a child) ▪ Spouse Domestic Partner ▪ Grandparent (parent of the employee's parent) ▪ Grandchild (child of the employee's child) ▪ Sibling (a person related to another person by blood, adoption, or affinity through a common legal or biological parent) *Note: Family member definition expanded in 2014 to include parent-in-law, grandparent, grandchild and sibling*
District of Columbia	▪ Child (biological, adopted or foster son or daughter, a stepson or stepdaughter, a legal ward, a son or daughter of a domestic partner, or a person to whom an eligible individual stands in loco parentis) ▪ Parent (biological, foster, or adoptive parent, a parent-in-law, a step-parent, a legal guardian, or other person who stood in loco parentis to an eligible individual when the eligible individual was a child) ▪ Parent-in-Law ▪ Spouse ▪ Registered Domestic Partner ▪ Grandparent ▪ Sibling
Massachusetts	▪ Child (biological, adopted or foster child, a stepchild or legal ward, a child to whom the covered individual stood in loco parentis, or a person to whom the covered individual stood in loco parentis when the person was a minor child)

State	Covered Family Members as of October 2019
	▪ Parent (biological, adoptive, step- or foster mother or father of the covered individual) ▪ Parent-In-Law or Parent of Domestic Partner ▪ Spouse ▪ Domestic Partner ▪ Grandchild ▪ Grandparent (parent of the covered individual's parent) ▪ Sibling (biological, adoptive, stepbrother or stepsister of a covered individual)
New Jersey	▪ Child (biological, adopted, foster child, or resource family child, stepchild, legal ward, or child of a parent including a child who becomes the child of a parent pursuant to a valid written agreement between the parent and gestational carrier) ▪ Parent (biological, adoptive, foster parent, resource family parent, step-parent, parent-in-law or legal guardian, having a parent-child relationship with a child as defined by law, or having sole or joint legal or physical custody, care, guardianship, or visitation with a child, or who became the parent of the child pursuant to a valid written agreement between the parent and a gestational carrier) ▪ Spouse ▪ Domestic Partner ▪ Civil Union Partner ▪ Grandchild ▪ Grandparent ▪ Sibling ▪ Any other individual whom the employee shows to have a close association with the employee which is the equivalent of a family relationship *Note: Family member definition expanded in 2019 to include sibling, grandparent, grandchild, parent in law, any other individual related by blood to the employee, and any other individual whom the employee shows to have a close association with the employee which is the equivalent of a family relationship*
New York	▪ Child (biological, adopted, foster son or daughter, stepson or stepdaughter, legal ward, son or daughter of a domestic partner, or the person to whom the employee stands in loco parentis) ▪ Parent (biological, foster, adoptive parent, parent-in-law, stepparent, legal guardian, or another person who stood in loco parentis to the employee when the employee was a child)

State	Covered Family Members as of October 2019
	▪ Spouse ▪ Domestic Partner ▪ Grandchild (child of the employee's child) ▪ Grandparent (parent of the employee's parent)
Rhode Island	▪ Child (biological, adopted, or foster son or daughter, a stepson or stepdaughter, a legal ward, a son or daughter of a domestic partner, a son or daughter of an employee who stands in loco parentis to that child) ▪ Parent (biological, foster, adoptive parent, stepparent, legal guardian, or another person who stands in loco parentis to the employee or the employee's spouse or domestic partner when he/she was a child) ▪ Parent-In-Law (parent of the employee's spouse or domestic partner) ▪ Spouse (party in common law marriage, a party in a marriage conducted and recognized by another state or country, or in a marriage) ▪ Domestic Partner ▪ Grandparent (parent of the employee's parent)
Washington	▪ Child (biological, adopted, or foster child, a stepchild, or a child to whom the employee stands in loco parentis, is a legal guardian, or is a de facto parent, regardless of age or dependency status) ▪ Parent (biological, adoptive, de facto, or foster parent, stepparent, or legal guardian of an employee or the employee's spouse, or an individual who stood in loco parentis to an employee when the employee was a child) ▪ Spouse (husband or wife, or state registered domestic partner) ▪ Grandchild (child of the employee's child) ▪ Grandparent (parent of the employee's parent) ▪ Sibling

5. Job Protection

While some state leave programs do provide protections ensuring employees are returned to the same or similar position when they return to work, other states, such as California, only provide a monetary benefit and not a leave entitlement. In these cases, job protection is only provided if the leave runs concurrently with another federal or state program providing leave such as the FMLA.

Exhibit 7

State	Job Protection Provided as of October 2019
California	▪ No
District of Columbia	▪ No
Massachusetts	▪ Yes
New Jersey	▪ No
New York	▪ Yes
Rhode Island	▪ Yes, upon returning to work, employees must be offered a comparable position with equivalent seniority, status, employment benefits, pay and other terms and conditions as the job they were in before taking leave
Washington	▪ Yes, if the employer has 50 or more employees, the employee has worked for the employer for at least 12 months, and the employee has worked at least 1,250 hours in the last 12 months

6. Benefit Amount

The wage replacement formula for benefits an employee can receive while on leave varies significantly by jurisdiction. California, the District of Columbia, Massachusetts, and Washington all have calculations based on a progressive benefit structure, whereby employees with a lower average wage receive a higher benefit percentage. In comparison, New Jersey, New York and Rhode Island provide a straightforward flat percentage wage replacement ranging from 55% to 67%. Annual benefit maximums further limit the wage replacement rate employees can receive, especially those earning a higher average weekly wage. Currently, California has the highest maximum weekly benefit an employee can earn, at $1,252, which is about twice the $650 weekly New Jersey maximum. California, New York, Rhode Island and Washington provide minimum benefit amounts, while the District of Columbia, Massachusetts, and New Jersey do not state minimums.

Exhibit 8

State	Benefit Amount as of October 2019
California	▪ 60% of an employee's weekly earnings for employees who earn 1/3 or more of the state average quarterly earnings ▪ 70% of an employee's weekly earnings for employees who earn less than 1/3 of the state average quarterly wage ▪ Maximum benefit of $1,252 per week ▪ Minimum benefit of $50 per week

State	Benefit Amount as of October 2019
	Note: In 2004, the first year of the program, the maximum weekly benefit was $728 and has generally increased annually. The benefit amount also increased to 60% -70% in 2018, from the original benefit of 55%
District of Columbia	▪ For employees with AWW less than or equal to 150% of the D.C. minimum wage multiplied by 40, the benefit amount is 90% of an employee's AWW ▪ For employees with AWW greater than 150% of the D.C. minimum wage multiplied by 40, the benefit amount is 90% of an employee's AWW plus 50% of the amount the employee's AWW exceeds 150% of the minimum wage multiplied by 40 ▪ Maximum benefit of $1,000 per week recalculated annually to increase relative to the annual average increase in the Consumer Price Index for All Urban Consumers in the Washington-Baltimore Metropolitan area ▪ No stated minimum
Massachusetts	▪ 80% of an employee's AWW that is equal to or less than 50% of the SAWW; plus ▪ 50% of an employee's AWW that is greater than 50% of the SAWW ▪ Maximum benefit of $850 in 2019 recalculated annually to be 64% of the SAWW ▪ No stated minimum
New Jersey	▪ 66 2/3% of an employee's AWW ▪ Maximum benefit of $650 per week recalculated annually based on the SAWW ▪ No stated minimum ▪ Beginning 7/1/2020, employees can receive up to 85% of an employee's AWW, up to 70% of the SAWW *Note: In 2009, the first year the program was in place. the maximum weekly benefit was $546 and has increased annually*
New York	▪ 55% of an employee's AWW in 2019 ▪ Maximum benefit of $746.41 in 2019 which is 55% of the current SAWW ▪ Minimum benefit is the lesser of $100 and employee's full weekly wages ▪ Benefit increases to 60% in 2020 and 67% in 2021 are required by NY PFL regulations *Note: In 2018, the first year the program was in place, the weekly benefit was 50% of AWW up to $652.96 (50% of SAWW)*

State	Benefit Amount as of October 2019
Rhode Island	▪ 4.62% of an employee's total highest quarter wages in the base period which amounts to approximately 60% ▪ Maximum benefit of $867 per week, plus dependent allowance up to $1,170 ($10 per dependent or 7% of weekly benefit rate per dependent, up to 5 dependents), based on the SAWW ▪ Minimum benefit of $98 per week, based on state minimum wage *Note: In 2014, the first year the program was in place, the maximum weekly benefit was $752, and the minimum benefit was $74, which has increased annually*
Washington	▪ For an employee who earns less than or equal to 50% of the SAWW, the benefit is 90% of the employee's AWW ▪ If an employee earns more than 50% of the SAWW, the benefit is the sum of 90% of their AWW up to 50% of the SAWW, plus 50% of the employee's AWW that is greater than 50% of the SAWW ▪ Maximum benefit of $1,000 per week recalculated annually to be 90% of the SAWW ▪ Minimum benefit is the lesser of $100 and employee's full weekly wages

7. Length of Leave

Like benefit amounts, the length of leave allotted by each PFL law varies greatly. As the first few states to implement PFL programs, California, New Jersey, and Rhode Island historically had the shortest leave allotments. However, both California and New Jersey ruled to increase leave durations in 2020 to 8 and 12-week maximums, respectively. Most states indicate leave allotment by type of leave. Some states, such as the District of Columbia, Massachusetts and Washington, set maximums that combine all leave types. Massachusetts is by far the most generous state in terms of leave length, offering 26 weeks of combined leave, while Rhode Island provides the least generous family leave allotment of only 4 weeks.

Exhibit 9

State	Maximum Length of Leave as of October 2019
California	▪ 6 weeks total for parental leave for bonding and for family leave to care for a family member *Note: Increases to 8 weeks effective 7/1/2020; Provides 52 weeks for employee's own serious health condition through TDI law*
District of Columbia	▪ 8 weeks for parental leave for bonding ▪ 6 weeks for family leave to care for a family member with a serious health condition ▪ 2 weeks for medical leave ▪ 16 weeks total if all qualifying events occur within 52-week period
Massachusetts	▪ 12 weeks for family leave for bonding, care for a family member with a serious health condition, or for a military exigency ▪ 20 weeks for medical leave ▪ 26 weeks for family leave to care for a family member who is a covered service member ▪ 26 weeks combined maximum within a 52-week period
New Jersey	▪ 6 weeks total for parental leave for bonding and for family leave to care for a family member with a serious health condition ▪ 20 days total for family leave to care for a family member, or medical leave for one's self, seeking medical attention for, or recovering from, physical or psychological injuries due to domestic or sexual violence *Note: Leave entitlement for bonding and to care for a family member increases to 12 weeks effective 7/1/2020; Provides 26 weeks for employee's own serious health condition through TDI law*
New York	▪ 10 weeks total for parental leave for bonding, for family leave to care for a family member with a serious health condition, and for family leave due to a qualifying exigency ▪ Increases to 12 weeks effective 1/1/2021 *Note: Maximum leave length initially allotted in 2018 was 8 weeks and increased to 10 weeks effective 1/1/19; Provides 26 weeks for employee's own serious health condition through TDI law*
Rhode Island	▪ 4 weeks total for parental leave for bonding and for family leave to care for a family member with a serious health condition *Note: Provides 30 weeks for employee's own serious health condition through TDI law*
Washington	▪ 12 weeks total for parental leave for bonding, for family leave to care for a family member with a serious health condition, for family leave due to a qualifying exigency, and for medical leave to care for one's own serious health condition ▪ Additional 2 weeks available when leave is a result of pregnancy complications ▪ 16 weeks when a combination of family and medical leave is used ▪ 18 weeks when a combination of family and medical leave is used, and leave is a result of pregnancy complications

D. Gender Equity Considerations

Although the specifics vary by jurisdiction, PFL programs aim to provide employees with wage replacement while taking time off for a variety of family or medical reasons. Both the reasons for leave and definitions of covered family member continue to broaden under PFL laws, making leave taking less specific to gender and more focused on caregiving relationships.

According to the Department of Labor (DOL), the most common reason for taking FMLA leave is for one's own serious health condition (55%), followed by bonding (21%), family care (18%), other qualifying reasons (2%) or other non-qualifying or unknown reasons (4%).[29] Under states with PFL programs, bonding is more frequent and longer in duration than in states without PFL laws. In addition, bonding leave for men is more than twice as high and 44% longer in states with PFL laws than states without PFL laws.[30] California has seen a shift in more leaves being taken by men, with the number of male bonding claims almost quadrupling since program inception and the number of male family care claims more than doubling from 2005 to 2018.[31,32,33,34] Rhode Island has seen a similar trend with an increasing number of males filing TCI claims,[35] and New York's female to male claim filing ratio seems to be heading in the same direction.[36]

1. Workforce Participation

Family friendly policies such as PFL are thought to help retain valuable employees who need help balancing work and family,[37] reduce employer costs for when time is being taken, and contribute to U.S. economic growth.[38] In addition to childcare, these laws allow workers to provide care for elderly parents without having to sacrifice their livelihoods.[39]

Studies point to paid leave policies increasing the likelihood that women will enter the labor force,[40] stay in the labor force, and have less of a need for public assistance.[41] This is especially the case when the paid leave entitlement is around three months.[42] Women are more likely to work later into their pregnancies, and more likely to return to work after a child's birth.[43] One study shows that implementing PFL polices decreases female separations by 1.5% as a result of access to job-protected leave, and therefore increases female attachment to the labor force.[44] Further, female labor force participation increases when fathers take more paternity leave.[45]

2. Hiring & Pay Practices

When it comes to hiring practices, the limited research that exists is both inconclusive and contradictory. A few studies point to PFL policies raising the education and skill requirements in job postings,[46] slightly reducing employment rates for younger women,[47] and increasing the perceived cost of hiring women compared to men.[48] At the same time, others conclude that desirability of an

applicant is based on perceived commitment to the job, not the fact that leave had been taken[49] and that PFL policies also slightly reduce employment rates for younger men.[50]

From a pay perspective, a few available studies report encouraging results. Sixty-nine percent of women who returned to the same employer after the birth of their first child experienced no changes in pay, skill level, or hours.[51] Further, female labor force wages are thought to increase when fathers take more paternity leave, with one study suggesting that fathers taking paternity leave increases the ability of mothers to engage in paid work, with a positive effect on both female labor force participation and wages.[52]

These and other emerging findings point to paternity leave and broader caregiving having the potential to change longstanding cultural norms about gender, work and household responsibilities.[53] In addition, the Equal Employment Opportunity Commission (EEOC) affords protections against discrimination and actively investigates employer practices that are thought to be unequal. Lastly, but very importantly, social insurance models as utilized by the states that have passed PFL laws mitigate hiring and discrimination risks for those more likely to take advantage of PFL. Under these models, community rating or flat rates over the entire state risk pool result in all employers equally sharing in the cost of providing PFL coverage to their employee populations.

E. Ease of Making Applications or Claims

The process of submitting a claim is primarily online, with some states also offering more traditional methods. Specifically, California, the District of Columbia, New Jersey, Rhode Island, and Washington all allow applications online. New York only requires submission of an application via mail, but online submission may be available through an administrator. While the District of Columbia and Washington's processes are still under development, so far applications may only be submitted via online portal, with no mail or fax option. The process in Massachusetts is still being determined.

Exhibit 10

State	Ease of Making Applications or Claims as of October 2019
California	▪ Apply by completing the Claim for Paid Family Leave Benefits Form online, by mail or at a service center ▪ Bonding claims must include documentation showing relationship to the child (e.g., birth certificate, adoptive placement agreement, foster care placement record) ▪ Caregiving claims must include a medical certification from the treating physician and the care recipient's signature
District of Columbia	▪ Employee will file a claim using the Office of Paid Family Leave online portal

State	Ease of Making Applications or Claims as of October 2019
	Note: Process is under development at the time of writing
Massachusetts	*Note: Process is under development at the time of writing*
New Jersey	▪ Apply by filing a claim online, by mail, or by fax ▪ Employees must create an account on the Department of Labor and Workforce Development (LWD) website and either start the application online or print the application to be mailed or faxed ▪ Included in the application are forms for the treating physician to complete, which can also be completed online, mail or fax by the physician ▪ Online applications are processed quicker than those sent by mail or fax
New York	▪ Employees can request the forms from their employer or insurance carrier, or download online, which may include a Request for Paid Family Leave, a Release of Personal Health Information Under the Paid Family Leave Law (for family leave), a Health Care Provider Certification (for family leave), Bonding Certification (for bonding leave), or a Military Qualifying Event Form (for military family support leave) ▪ Forms must be completed by the employee, the employer, the family member to whom care is being provided (if applicable), and the health care provider ▪ The completed packet can be mailed or faxed to the insurance carrier
Rhode Island	▪ Claimants can apply online, download a paper application, or call to have a paper application mailed ▪ Employees are responsible for completing the application and for requesting and submitting the medical form, completed by the treating physician ▪ Completed forms can be submitted online, by mail or fax
Washington	▪ Claimant will create an account, complete application and upload documentation as proof of the qualifying event ▪ Documentation may include a certification of serious health condition form, active duty orders, birth certificate, or placement-related court documents *Note: Process is under development at the time of writing*

F. Speed of Benefit Payments

After states have confirmed an employee's eligibility, payment is issued within 14 days, except for in the District of Columbia, New Jersey and Rhode Island. Payments in the District of Columbia must be issued within 10 days of an eligibility determination. New Jersey issues funds 2 days after a claim is approved. Rhode Island commits to a 3 to 4 week turn-around-time for payments, after receipt of an approved application. This can be faster if a state specific debit card is used.

Exhibit 11

State	Speed of Benefit Payments as of October 2019
California	▪ Initial benefit paid within 24 hours for payment issued on the Employment Development Department (EDD) Debit Card or 7 to 10 days for checks by mail from the determination of eligibility, which will be decided within 14 days of receipt of a complete claim
District of Columbia	▪ Initial benefit paid within 10 business days of the determination of eligibility, which is issued 10 business days following the receipt of claim ▪ Benefit paid biweekly after the initial payment
Massachusetts	▪ Initial benefit paid within 14 days of eligibility determination
New Jersey	▪ A debit card will be sent to the claimant before the application is processed, but funds will not be loaded until 2 business days after the application is approved
New York	▪ Initial benefit paid or denied within 18 calendar days of receipt of completed request, or the first day of leave, whichever is later ▪ Benefits paid biweekly after the initial payment
Rhode Island	▪ Initial benefit paid within 3 to 4 weeks of receipt of a valid application
Washington	▪ Initial benefit paid within 14 days of the application, when a claim is approved ▪ Benefit paid biweekly after the initial payment

G. Financial Sustainability of Models

1. Funding Method

All state programs, except for the District of Columbia, are funded through some degree of employee payroll deductions. California, New Jersey, New York and Rhode Island are solely funded by employee contributions, while Massachusetts and Washington are funded through a combination of both employer and employee payments. The District of Columbia is the only jurisdiction funded entirely by employers to date. These payments are considered mandatory for covered

employers and employees. However, and in most cases, employers can subsidize employee contributions by paying some or all of the required premium.

Exhibit 12

State	Funding Method as of October 2019
California	▪ Employee payroll deductions
District of Columbia	▪ Employer payroll tax
Massachusetts	▪ Employee and Employer contributions *Note: Employers with less than 25 employees are not required to contribute employer portion of premium*
New Jersey	▪ Employee payroll deduction
New York	▪ Employee payroll deduction
Rhode Island	▪ Employee payroll deduction
Washington	▪ Employee and Employer contributions *Note: Employers with less than 50 employees are not required to contribute employer portion of premium*

2. Contribution Rates

Contribution requirements are based on either the state or federal taxable wage bases or the state average weekly wage. The taxable wage base and contribution rates vary broadly across states.

Exhibit 13

State	Contribution Rates as of October 2019
California	▪ 1.0% of wages up to taxable wage base of $118,371 for TDI and PFL *Note: In 2004, the first year the program was in place, the contribution rate was 1.18% of a $68,829 taxable wage base*
District of Columbia	▪ 0.62% of total wages (not subject to a cap) for PFL
Massachusetts	▪ 0.75% of federal social security base limit of $132,900 for PFML ▪ 0.62% medical leave contribution, of which employer pays at least 60% (0.372%) and employee pays up to 40% (0.248%) ▪ 0.13% family leave contribution, of which the employee pays the entire share
New Jersey	▪ 0.08% of wages up to taxable wage base of $34,400 for FLI *Note: In 2009, the first year the program was in place, the contribution rate was 0.09% of a $28,900 taxable wage base*
New York	▪ 0.153% of employee's AWW, up to SAWW of $1,357.11 for PFL

State	Contribution Rates as of October 2019
	Note: The contribution rate in 2018 was 0.126% of weekly wage
Rhode Island	▪ 1.1% of wages up to taxable wage base of $71,000 for TDI and TCI *Note: In 2014, the first year the program was in place, the contribution rate was 1.2% of a $62,700 taxable wage base*
Washington	▪ 0.4% of wages up to taxable wage base of $132,900 for PFML ▪ 1/3 is family leave premium, 2/3 is medical leave premium ▪ Employers are required to pay at least 1/3 of total premiums and may withhold up to 2/3 from employees, but can elect to cover a higher share

H. Data Collection Capabilities

States collect employer and employee data through employer reporting via online portals or secured file feeds. Data collected generally includes employer information, such as identification numbers and business names, employee identifying information like social security number and name, employee counts, wages and contribution data. Specific fields and forms differ across states.

Exhibit 14

State	Data Collection Capabilities as of October 2019
California	▪ All employers are required to submit employment tax returns, wage reports and payroll tax deposits to the EDD ▪ Beginning 1/1/2019, this is required to be submitted online
District of Columbia	▪ Quarterly wage reports and tax payments are submitted via online portal (same portal used for unemployment insurance)
Massachusetts	▪ Employers must report wages paid, payment for contract services rendered and workforce information via the MassTaxConnect online portal
New Jersey	▪ Employee quarterly earnings ▪ Employer's quarterly report to include monthly payroll counts (number of full-time, part-time employees) and quarterly contributions report ▪ Reporting can be done online or by secure file transfer protocol (SFTP)
New York	▪ Employers are responsible for reporting employee contributions on Form W2
Rhode Island	▪ Employers are responsible for deducting TDI tax and submitting contributions to the Employer Tax Unit quarterly

State	Data Collection Capabilities as of October 2019
	▪ Employers must provide employee wage and employment reports when requested by TDI following the receipt of an employee's claim
Washington	▪ Employers will create accounts or log into the SecureAccess Washington (SAW) website to submit reports ▪ Reports must include business identification information, total premiums collected from employees, employee identifying information and quarterly wages and time worked

I. Compliance Monitoring

While states approach compliance differently, there is a broad theme of reviewing claims against other sources and enforcing penalties when fraud is detected. As the District of Columbia, Massachusetts, and Washington are still in the "rulemaking" phase, processes may not yet be final.

Exhibit 15

State	Compliance Monitoring as of October 2019
California	▪ SDI monitors claim payments, actively investigates suspicious activity, and seeks repayment and conviction through prosecution ▪ EDD issues guidance to employers and physicians on fraud prevention methods and may seek confirmation of information from these sources ▪ Fraud is punishable by prison time and/or a fine up to $20,000
District of Columbia	*Note: Process is under development at the time of writing*
Massachusetts	▪ Employer penalties for failing to provide required notifications to employees will be $50 per employee on the first violation and $300 per employee for subsequent violations *Note: Process is under development at the time of writing*
New Jersey	▪ State verifies claims and reviewed diagnosis (ICD) codes and the care recipient's estimated date of recovery to determine if the claim is consistent with the normal anticipated duration ▪ Employers are asked to notify the New Jersey Division of Temporary Disability and Family Leave Insurance immediately upon discovery of incorrectly reported information
New York	▪ The state requires the employer to confirm data submitted with claims by employees such as hours worked and wages earned ▪ Issues with compliance and fraud are handled by the insurance carrier

State	Compliance Monitoring as of October 2019
Rhode Island	▪ Registered nurses review claims when they exceed medical duration guidelines (MDG) and is referred to the Claims Management Unit ▪ TDI can require individuals to be examined by an impartial qualified healthcare provider to determine eligibility and continued disability ▪ TDI has an internal program to determine if someone has received TDI benefits during a period when they were working and is in constant contact with the Workers' Compensation Court, insurance carriers, and the Unemployment Insurance Division to determine if someone has received TDI benefit to which they are not entitled
Washington	▪ Data will be cross checked against state databases *Note: Process is under development at the time of writing*

III. Projected Impacts of Adopting Similar Models in Hawaii

A. Employee Leave in Hawaii

1. Population & Labor Force Demographics

With a population of approximately 1.42 million people, Hawaii has both similarities and differences to the other states of focus that are considered in our projections and modeling.[54] Similar to California and Washington, Hawaii features an equal mix of males and females in both the population and workforce.[55,56] Hawaii has the second highest birth rate,[57] and the lowest mortality rate among the states examined for purposes of this study.[58] The average household size is larger than the other states,[59] and a smaller proportion of workers are age 64 and over.[60] The average wage in Hawaii is lower than most states, [61] likely driven by the large portion of employment by firms with less than 100 employees. Additionally, Hawaii unemployment rates are similar to most states.[62]

Exhibit 16

Demographic Comparison for States of Focus				
State	**Female / Male Gender Mix**	**Birth Rate per 1,000 Population**	**Age-Adjusted Death Rate per 100,000 Population**	**Average Household Size**
California	50.3 / 49.7	11.93	614.8	2.96
District of Columbia	52.6 / 47.4	13.78	753.0	2.28
Massachusetts	51.5 / 48.5	10.31	672.2	2.53
New Jersey	51.1 / 48.9	11.24	666.7	2.74
New York	51.4 / 48.6	11.57	640.4	2.63
Rhode Island	51.4 / 48.6	10.04	704.3	2.46
Washington	50.0 / 50.0	11.82	677.4	2.55
Hawaii	49.9 / 50.1	12.27	582.8	3.02

Exhibit 17

Demographic Comparison for States of Focus				
State	**Workers Age 64 and Over**	**Average Weekly Wage**	**Population Percent from Firms with <100 Employees**	**2018 Unemployment Rate**
California	5.8%	$1,405	58.6%	4.2%
District of Columbia	5.5%	$1,849	48.1%	5.6%
Massachusetts	7.1%	$964	62.8%	2.6%
New Jersey	6.5%	$1,606	54.4%	3.4%
New York	6.8%	$1,415	56.8%	4.2%
Rhode Island	6.9%	$1,696	52.8%	4.1%
Washington	6.1%	$1,082	61.6%	4.1%
Hawaii	4.9%	$1,390	57.2%	4.4%

2. Existing Leave Programs

In addition to federal FMLA that all states are subject to, Hawaii has a state TDI program, as well as a state family leave law, a prepaid healthcare law and a caregiver program in place. Although we did not contact nor evaluate these programs, they are described below as there are times when more than one program might apply to an employee leave event.

i. Hawaii Temporary Disability Insurance

Hawaii TDI provides employees with up to 26 weeks of leave when they are unable to work due to a non-occupational injury or sickness. To be eligible for leave, the employee must have at least 14 weeks of Hawaii employment, during which they were paid for 20 hours or more per week. This work requirement does not need to be met consecutively and does not need to be with only one employer. Eligible claimants must also have earned at least $400 in the 52 weeks preceding the first day of disability and must be in current employment. Eligible employees receive 58% of their AWW, up to the maximum weekly benefit amount ($632 in 2019). If an employee's AWW is less than $26, the weekly benefit amount is equal to the employee's AWW up to $14,[63] with a minimum of $1.[64] Hawaii TDI only provides a monetary benefit and does not ensure a claimant's job is protected.

As TDI is run under an employer mandate model, Hawaii does not require employer or employee contributions to a state fund. Employers are responsible for providing coverage but may elect to take a deduction up to 0.5% of an employee's weekly wage, up to 0.5% of the maximum weekly

wage base or $5.44 per week in 2019. Employers must cover at least 50% of plan costs, plus any additional costs not chargeable to the employee. It is up to employers to choose whether to purchase an insured plan through an authorized carrier or to offer a self-insured plan approved by the Disability Compensation Division of the Hawaii Department of Labor and Industrial Relations (DCD). Claimants must meet a 7-day waiting period before benefits are eligible to begin on the 8th consecutive day of disability. Employees have up to 90 days from the date of disability to file a claim before being at risk to lose part or all of the benefit payments. Employees who disagree with a determination can submit appeals to the DCD or the Department of Labor and Industrial Relations (DLIR) District office within 20 calendar days of the claim notice.[65] Claim and benefit processes may differ by employer or insurance carrier but must at least meet the minimum conditions of the law.

ii. Hawaii Family Leave Law

Under the Hawaii Family Leave Law (HFLL) an employee may be eligible for up to 4 weeks of unpaid family leave each calendar year for the birth or adoption of a child, or to care for a child, spouse, reciprocal beneficiary, or parent with a serious health condition. HFLL is considered an expansion of the FMLA as there are no restrictions for eligibility based on hours worked. Therefore, part time, seasonal or freelance workers may be covered, as long as they work for a company with 100 or more employees and have at least 6 months of consecutive employment. As in other states, for an employee to take leave to care for a child, there is no limitation on the age of the child, but the child must be an employee's biological, adopted, or foster son or daughter of an employee; stepchild; or legal ward. A parent is defined as a biological, foster, adoptive parent; a parent-in-law; a stepparent; a legal guardian; a grandparent; or a grandparent-in-law.[66] An employee may substitute up to ten days per year of their accrued paid leave (i.e., vacation or sick leave) for any part of HFLL, however, when an employer has a self-insured TDI plan using the company's sick leave policy, only the amount in excess of the statutorily required minimum (e.g., fifteen days) can be applied. If an employee qualifies for both HFLL and FMLA, both leave periods will run concurrently.[67]

iii. Hawaii Prepaid Health Care Act

Hawaii's Prepaid Health Care Act (PHCA) is an employer mandate to improve health care coverage. It sets a minimum standard of health care benefits for workers by requiring employers to offer coverage to employees working at least 20 hours per week for four or more consecutive weeks. For eligible employees, it offers protection against the high cost of medical and hospital care that

comes into play for nonwork-related illness or injury. Unless an applicable collective bargaining agreement specifies differently, employers contribute at least one-half of the premium for the coverage and employees contribute the balance, through payroll deductions, up to a maximum of 1.5 percent of the employee's wages.[68]

iv. Hawaii Kupuna Caregivers Act

Hawaii also has a caregiver program in place through the Kupuna Caregivers Act (Act 102, Session Laws of Hawaii 2017). The goal of the program is to help caregivers stay in the workforce while still assisting loved ones. It strives to provide a stipend of up to $70 per day, pending availability of appropriated funds, for people who work at least 30 hours per week while also caring for an elderly family member that is 60 years of age or older. It can be used for a variety of aspects to help the caregiver meet responsibilities without having to sacrifice work, such as adult day care costs, home health care workers, home aids, meal deliveries, transportation or cleaning services.[69]

3. Claimant Characteristics

When considering potential claimant characteristics for Hawaii, it is important to reflect upon the PFL data available for the four states that have currently operational programs in place.

i. California PFL Data

Since the inception of California's PFL program in 2004, there has been an increasing trend of bonding and family care claims for both males and females, but a shift in more leaves being taken by men. For example, and as shown in Exhibit 18, the female/male ratio for paid claims has decreased significantly from 4.14 to 1.66, suggesting that the proportion of men taking leave has increased significantly since the program started.

Exhibit 18

Actual California PFL Claims by Gender [70,71]								
Claim Year	**Filed Claims**			**Paid Claims**			**Approved Claims Percentage**	
	Female	**Male**	**Ratio**	**Female**	**Male**	**Ratio**	**Female**	**Male**
2005	125,480	30,609	4.10	119,948	28,994	4.14	96%	95%
2006	131,775	34,243	3.85	125,363	32,239	3.89	95%	94%
2007	142,748	40,417	3.53	135,892	38,081	3.57	95%	94%
2008	153,020	46,871	3.26	145,899	44,345	3.29	95%	95%
2009	142,732	44,995	3.17	136,090	42,596	3.19	95%	95%
2010	146,856	53,789	2.73	139,905	51,055	2.74	95%	95%
2011	148,024	57,516	2.57	141,063	54,638	2.58	95%	95%
2012	150,807	62,966	2.40	144,933	60,423	2.40	96%	96%
2013	151,211	65,748	2.30	141,860	61,620	2.30	94%	94%
2014	163,045	75,234	2.17	153,968	71,030	2.17	94%	94%
2015	161,638	75,895	2.13	153,022	71,851	2.13	95%	95%
2016	170,111	86,378	1.97	160,156	81,370	1.97	94%	94%
2017	168,539	90,880	1.85	158,799	85,767	1.85	94%	94%
2018	177,368	106,446	1.67	168,338	101,298	1.66	95%	95%

Reviewing the same period broken out by bonding and family care claims in Exhibit 19, the data indicates a growing utilization of bonding by fathers. While the number of female bonding claims increased by 34% since inception, the number of male bonding claims almost quadrupled (376%) since the inception of the program. The female/male ratio for bonding claims witnesses a trend towards equality in most recent years.

A similar trend can also be found in family care claims. Both female and male family care claims have more than doubled from 2005 to 2018. The female/male ratio, however, decreases at a lower rate.

Exhibit 19

Actual California PFL Paid Claims by Claim Type and Gender [72,73]						
Claim Year	**Bonding Claims**			**Family Care Claims**		
	Female	**Male**	**Ratio**	**Female**	**Male**	**Ratio**
2005	108,453	23,991	4.52	11,495	5,003	2.30
2006	114,039	27,250	4.18	11,324	4,989	2.27
2007	123,855	32,772	3.78	12,037	5,309	2.27
2008	133,245	38,582	3.45	12,654	5,763	2.20
2009	125,011	37,569	3.33	11,079	5,027	2.20
2010	126,514	45,097	2.81	13,391	5,957	2.25
2011	126,922	48,165	2.64	14,141	6,473	2.18
2012	129,189	53,058	2.43	15,743	7,365	2.14
2013	127,022	54,690	2.32	14,839	6,930	2.14
2014	137,405	63,260	2.17	16,563	7,770	2.13
2015	136,364	64,045	2.13	16,658	7,806	2.13
2016	141,243	72,220	1.96	18,912	9,150	2.07
2017	140,149	77,040	1.82	18,650	8,728	2.14
2018	145,137	90,186	1.61	23,201	11,112	2.09

ii. New Jersey FLI Data

New Jersey differs from California, New York and Rhode Island in that the proportion of males taking leaves is much less although it has also increased over time. The driver of this difference is not explained in the underlying data shown in Exhibit 20.

Exhibit 20

Actual New Jersey FLI Claims by Gender [74]								
Claim Year	**Total Claims (Eligible and Ineligible)**			**Eligible Claims**			**Eligible Claim Percentage**	
	Female	**Male**	**Ratio**	**Female**	**Male**	**Ratio**	**Female**	**Male**
2014	29,188	5,508	5.30	25,396	4,454	5.70	87%	81%
2015	29,424	5,511	5.34	25,092	4,345	5.77	85%	79%
2016	29,488	5,822	5.06	24,972	4,570	5.46	85%	78%
2017	31,343	6,829	4.59	26,067	5,003	5.21	83%	73%

Exhibit 21

Actual New Jersey FLI Eligible Claims by Claims Type and Gender [75]						
Claim Year	**Bonding Claims**			**Family Care Claims**		
	Female	**Male**	**Ratio**	**Female**	**Male**	**Ratio**
2014	21,806	3,227	6.76	3,590	1,227	2.93
2015	21,841	3,259	6.70	3,251	1,086	2.99
2016	21,647	3,540	6.11	3,325	1,030	3.23
2017	22,681	3,889	5.83	3,386	1,114	3.04

New Jersey's data, however, is helpful in examining claimant characteristics by different age groups. According to Exhibit 22, nearly 2/3 of bonding claims are for people age 25 to 34 years while nearly 1/3 is for people age 35 to 44. For family care claims, nearly 2/3 are for people age 45 and over, and less than 1/4 is for people 35 to 44. Age composition is quite stable over the span of four years.

Exhibit 22

Actual New Jersey FLI Eligible Claims by Claims Type and Age Group [76]								
Age Group	**Bonding Claims**				**Family Care Claims**			
	2014	**2015**	**2016**	**2017**	**2014**	**2015**	**2016**	**2017**
Under 25	5%	5%	4%	4%	1%	1%	1%	1%
25-34	64%	64%	64%	63%	13%	12%	12%	12%
35-44	30%	31%	31%	32%	24%	23%	23%	22%
45-54	1%	1%	1%	1%	30%	31%	30%	29%
55-64	0%	0%	0%	0%	25%	26%	27%	28%
Over 65	0%	0%	0%	0%	7%	7%	7%	8%

iii. New York PFL Data

New York data is only available for one year as the program was launched in 2018. As shown in Exhibit 23, although both bonding and family care claims are higher for women than men, these rates are similar to recent data from California and Rhode Island. Additionally, in New York's first year of 2018, the highest number of bonding claims are filed by people age 34 while the highest number of family care claims are filed by people age 56.[77]

Exhibit 23

Actual New York PFL Approved Claims by Claims Type and Gender [78]						
Claim Year	**Bonding Claims**			**Family Care Claims**		
	Female	**Male**	**Ratio**	**Female**	**Male**	**Ratio**
2018	59,000	26,600	2.22	27,400	10,900	2.51

Exhibit 24 shows PFL claims by wage band in New York. 18% of claims are made by people with annual wages over $100,000 while accounting for only 10% of the eligible labor force.[79]

Exhibit 24

Actual New York PFL Claims by Wage Band [80]		
Wage Band	**Number of Claims**	**Percentage of Total Claims**
<20K	6,800	5%
20-40K	32,900	26%
40-60K	32,000	25%
60-80K	22,500	18%
80-100K	12,400	10%
100-120K	7,500	6%
120-140K	4,900	4%
140-160K	3,500	3%
160-180K	2,000	2%
180-200K	1,500	1%
>200K	2,000	2%
Total	**128,000**	**100%**

iv. Rhode Island TCI Data

In Rhode Island, as in California and New York, an increasing number of males are filing TCI claims. Also notable, as illustrated in Exhibit 25, is the decreasing overall approval rate for claims filed since the establishment of Rhode Island's TCI program. In 2018, less than half of the claims filed by males were approved while 60% of those filed by females were approved.

This could be driven by the fact that the term for non-approved claims changed since 2017 to "pending claims" from "denied claims" to be more accurate as most non-approved claims are pending due to lack of documentation. On a TCI bonding claim, for instance, the claimant must provide proof of the parent-child relationship for the claim to be approved.

Exhibit 25

Actual Rhode Island TCI Claims by Gender[81]								
Claim Year	**Filed Claims**			**Approved Claims**			**Approved Claims Percentage**	
	Female	**Male**	**Ratio**	**Female**	**Male**	**Ratio**	**Female**	**Male**
2014	3,408	1,701	2.00	2,685	1,185	2.27	79%	70%
2015	4,693	3,016	1.56	3,278	1,663	1.97	70%	55%
2016	5,777	4,160	1.39	3,789	2,093	1.81	66%	50%
2017	6,399	4,754	1.35	3,910	2,314	1.69	61%	49%
2018	6,893	5,386	1.28	4,149	2,607	1.59	60%	48%

Like California PFL data, and as shown in Exhibit 26, the ratio of female/male bonding claims decreases over time while the female/male family care ratio is more stable since 2015. For bonding, 1.5 women take leaves for every man while for family care, 2.2 women take leaves for every man.

Exhibit 26

Actual Rhode Island TCI Paid Claims by Claims Type and Gender [82]						
Claim Year	**Bonding Claims**			**Family Care Claims**		
	Female	**Male**	**Ratio**	**Female**	**Male**	**Ratio**
2014	1,946	901	2.16	739	284	2.60
2015	2,500	1,303	1.92	778	360	2.16
2016	2,965	1,719	1.72	824	374	2.20
2017	3,035	1,933	1.57	875	381	2.30
2018	3,206	2,184	1.47	943	423	2.23

B. Impact Model Overview

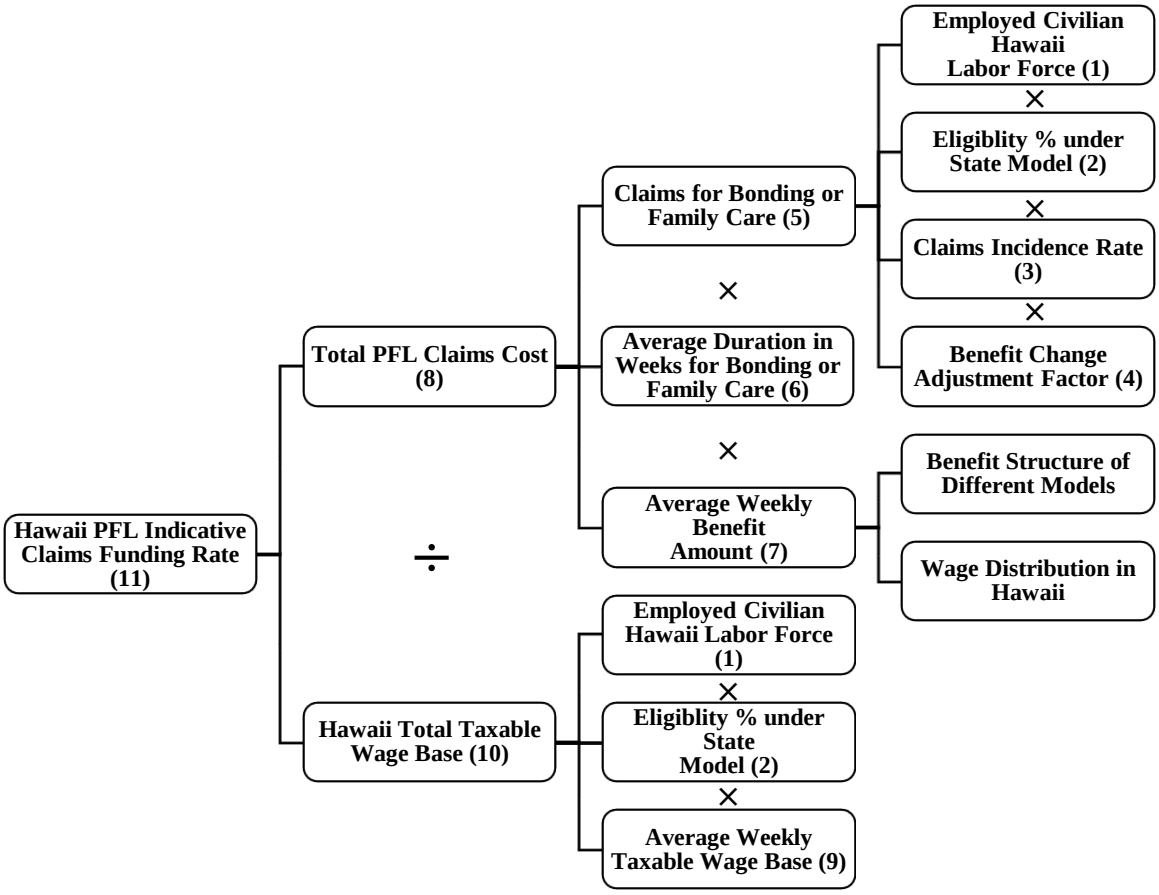
1. Model Structure

The actuarial model developed for this report is based on key assumptions, technical components and a range of variables. It projects the cost for implementing a PFL program in Hawaii from 2020 to 2024 under different state models (including the Hawaii TDI model) and alternative maximum benefit periods as well as flat and progressive benefit structures.

The basis of the claims cost model and therefore the calculation of total claims cost for the PFL program is equal to the product of claims frequency (or incidence rate), number of weeks of benefit (or duration), and average weekly benefit amount. The indicative claims funding rate is then calculated as this total claim cost divided by the estimated taxable wage base, as illustrated in Exhibit

27. The additional costs for administering the program are discussed in section C.3 beginning on page 61.

Exhibit 27



i. Claims Frequency (Incidence)

Expected incidence rates are modeled separately for bonding and family care utilizing the actual PFL incidence rates reported by California, New Jersey, New York and Rhode Island. Adjustments are made for Hawaii demographic differences, Hawaii wage differences, state benefit variations and eligibility differences where appropriate.

Incidence rates are developed by dividing actual PFL claims by eligible employees in the labor force. Eligible employees in the labor force are determined by multiplying the percentage of the labor force eligible for each state model by the total Hawaii labor force.

ii. Number of Weeks of Benefit Received (Duration)

Duration is projected separately for bonding and family care claim types. This is calculated based on actual state PFL data. The durations are extrapolated under high maximum week alternatives based on a combination of available data, industry norms and benchmarks.

iii. Average Weekly Benefit Amount

Average Weekly Benefit Amount (AWBA) is the final aspect used to determine total claim cost under each model. This is calculated by applying Hawaii wage distribution data to state benefit rules.

iv. Average Taxable Wage Base

Estimated annual taxable wage base for funding the state models is calculated using Hawaii wage distribution data based on estimated eligible workers under the state models and the maximum wage subject to funding the program costs.

2. Sample Calculation of Hawaii PFL Total Claims Cost

Exhibit 28 demonstrates our methodology by providing a sample calculation of the projected 2021 results for Hawaii under the California modeled structure. We illustrate 2021 as that is the earliest year Hawaii could potentially implement a program (even though 2022 or 2023 is more likely).

Exhibit 28

Projected Hawaii PFL Claims Cost for 2021 Under California Model			
Components	**Bond-ing**	**Family Care**	**Total**
Employed Civilian Hawaii Labor Force (1)	672,132	672,132	672,132
Eligibility % under California Model (2)	65.2%	65.2%	65.2%
Claims Incidence Rate (3)	1.50%	0.39%	1.89%
Benefit Change Adjustment Factor (4)	107.1%	119.7%	109.7%
Claims (5) = (1) x (2) x (3) x (4)	**7,052**	**2,049**	**9,101**
Average Duration in Weeks (6)	6.6	4.3	6.1
Average Weekly Benefit Amount (AWBA) (7)	$557	$557	$557
Total PFL Claims Cost in $M: (8) = (5) x (6) x (7) / $1M	**$25.9**	**$4.9**	**$30.9**
Average Weekly Taxable Wage Base (9)			**$940**
Total Taxable Wage Base in $M: (10) = (1) x (2) x (9) x 52 / $1M			**$21,413**
Hawaii PFL Indicative Claims Funding Rate (11) = (8) / (10)			**0.144%**

Further description of the above components is reflected in Exhibit 29.

Exhibit 29

Claims Funding Calculation Component Descriptions
▪ Employed Civilian Hawaii Labor Force: Projected 2021 employed civilian labor force in Hawaii based on data from the Bureau of Labor Statistics (BLS) ▪ Eligibility: Percentage of eligible Hawaii labor force under the state specific models (California in the above example). This considers state program eligibility requirements and actual labor force participation (as available) ▪ Claims Incidence Rate: Eligible claims for bonding and family care for the eligible Hawaii labor force. This rate also considers a baseline benefit level of 60% wage replacement, a 7-day waiting period and no job protection ("baseline benefits") ▪ Benefit Adjustment Factor: An adjustment is made for expected change in incidence due to the richness of program benefit levels relative to the baseline benefits ▪ Claims: Estimates the approved paid claims for bonding and family care in Hawaii under the selected state model ▪ Average Duration in Weeks: Estimates average duration in weeks for bonding and family care in Hawaii, accounting for the maximum benefit duration of the state program ▪ Average Weekly Benefit Amount: Estimates the average weekly benefit payout amount for Hawaii by using Hawaii's wage distribution based on the estimated eligible workers under the state model ▪ Total PFL Program Claims Cost: Total program claim costs associated with the state model ▪ Average Weekly Taxable Wage Base: Estimates the average wage base for the state model using Hawaii's wage distribution based on estimated eligible workers under the state model and the maximum wage subject to funding the program costs ▪ Total Annual Taxable Wage Base: Total taxable wage base for Hawaii under the state model ▪ Hawaii PFL Indicative Claims Funding Rate: Claims for the Hawaii PFL program as a percentage of the total annual taxable wage base

3. Simulation Model: Assumptions, Variability in Key Impact Model Parameters & Results

The model simulated a reasonable range of claims cost rate outcomes. This was done by first modeling expected variations in both incidence rates and duration of weekly benefits paid (in weeks). Actual PFL data for California, Rhode Island, New Jersey and New York was utilized in combination with actuarial judgment to estimate variations in these two components for determining claims cost. The development of these ranges is detailed in Appendix A beginning on page 89. By simulating this estimated variability, a range of estimated claim cost rates (low, central, high) was established based on 10,000 independent trials of simulation results. These ranges are illustrated for each state model in section B.5 found on page 50. It is expected that the low- and high-end points will occur much less frequently than the central estimate, although estimating actual incidence rates is inherently uncertain and it is possible for actual PFL claim rates in Hawaii to occur outside

of the modeled ranges for any given state model implemented. Appendix C, beginning on page 133, provides a comprehensive technical overview of the simulation model.

4. Hawaii PFL Modeled Results & Discussion

The following tables (Exhibits 30 to 36) summarize the mean expected model results for 2021. These results reflect expected Hawaii PFL performance under each of the eight different state models. The full results over the 2020 through 2024 projection period can be found in Appendix B.

Exhibit 30

2021 Projected Eligible Hawaii Labor Force and Paid Claims by State Model			
State Model	**Eligible Labor Force**	**Bonding Claims**	**Family Care Claims**
California	438,043	7,052	2,049
District of Columbia	485,350	8,315	2,204
Massachusetts	408,740	6,825	1,809
New Jersey	544,116	9,706	2,875
New York	431,262	6,808	1,978
Rhode Island	381,901	5,854	1,628
Washington	497,486	9,020	2,299
Hawaii TDI	485,729	7,227	1,879

i. 2021 Projected Number of Eligible Claimants (Labor Force)

California and New Jersey claim projections reflect actual PFL program participation based on historical claim level data, since this data was available. All other state projections reflect estimated participation based on state program eligibility requirements. Massachusetts, New York, and Rhode Island eligible claimant levels are lower because self-employed and public workers are not eligible. New Jersey does not exclude public employees therefore claims projections are higher; Washington only excludes federal employees.

ii. 2021 Projected Number of Eligible Claims

In addition to eligibility differences, the projected number of eligible claims also reflect benefit level differences for each state model. New Jersey and Washington have the richest benefit in terms of maximum weekly benefit and wage replacement ratio and therefore we are projecting claims to be higher relative to other states. Rhode Island and Hawaii TDI have the least generous benefit formula terms which lead to lower claims in comparison to the other states. New Jersey family care claims are higher than the other states due to the removal of the waiting period and the more generous replacement ratio.

iii. 2021 Denied Claims Activity

Denial claim rates vary widely across the states that make denial data available (i.e., California, New Jersey and Rhode Island). For both California and New Jersey, denial rates for family care are significantly higher than for bonding. Recent bonding denial rates are a low of 4.2% (as a percent of total filed claims) for California, 13.5% for New Jersey and a high of 44.8% for Rhode Island. Recent family care denial rates are approximately 13.0% for California, 28.0% for New Jersey and a high of 43.7% for Rhode Island.

In Rhode Island, reasons for denial of benefits include no certification, insufficient earnings in the base period, and receipt of unemployment or workers' compensation (WC) benefits.[83] Interviews we held with various other state agencies indicated the top reasons to be late notice by the employee, not meeting the eligibility requirements and failure to complete the application.

Our denial projections assume all other states having a 12% denial rate for bonding and a 25% denial rate for family care based on the weighted average experience of these three states. The high denied rate in Rhode Island, illustrated in Exhibit 31, includes pending claims. Most pending claims are due to lack of documentation and can be approved and paid once the documentation is received. Therefore, a lesser weight is given to Rhode Island's denied rate in determining a denied rate for other states.

Exhibit 31

Projected Filed, Denied, and Paid Bonding Claims by State Model in 2021*				
State Model	**Filed**	**Denied Rate**	**Denied**	**Paid**
California	7,363	4.2%	311	7,052
District of Columbia	9,449	12.0%	1,134	8,315
Massachusetts	7,755	12.0%	931	6,824
New Jersey	11,225	13.5%	1,519	9,706
New York	7,736	12.0%	928	6,808
Rhode Island	10,608	44.8%	4,755	5,853
Washington	10,250	12.0%	1,230	9,020
Hawaii TDI	8,212	12.0%	985	7,227
* Numbers may not add up due to rounding				

Exhibit 32

Projected Filed, Denied, and Paid Family Care Claims by State Model in 2021*				
State Model	**Filed**	**Denied Rate**	**Denied**	**Paid**
California	2,355	13.0%	306	2,049
District of Columbia	2,939	25.0%	735	2,204
Massachusetts	2,412	25.0%	603	1,809
New Jersey	3,992	28.0%	1,117	2,875
New York	2,638	25.0%	660	1,979
Rhode Island	2,889	43.7%	1,261	1,628
Washington	3,065	25.0%	766	2,299
Hawaii TDI	2,505	25.0%	626	1,879
* Numbers may not add up due to rounding				

Exhibit 33

Projected Filed, Denied, and Paid Total Bonding and Family Care Claims by State Model in 2021*				
State Model	**Filed**	**Denied Rate**	**Denied**	**Paid**
California	9,718	6.3%	617	9,101
District of Columbia	12,388	15.1%	1,869	10,519
Massachusetts	10,167	15.1%	1,534	8,633
New Jersey	15,217	17.3%	2,636	12,581
New York	10,374	15.3%	1,588	8,786
Rhode Island	13,497	44.6%	6,016	7,481
Washington	13,315	15.0%	1,996	11,319
Hawaii TDI	10,717	15.0%	1,612	9,105
* Numbers may not add up due to rounding				

iv. 2021 Projection of Average Number of Benefit Weeks & Total Number of Benefit Weeks (Duration)

The projected total number of benefit weeks are calculated as the product of average claim duration and eligible claims from Exhibit 30. Rhode Island has the lowest average number of benefit weeks for both bonding and family care due to the 4-week maximum in place. California has an 8-week maximum for bonding and family care while the District of Columbia has an 8-week maximum for bonding and a 6-week maximum for family care. All remaining states have a 12-week maximum for both bonding and family care. Hawaii TDI results assume a 6-week maximum.

Exhibit 34

Projected Average and Total Number of Benefit Weeks for Bonding and Family Care by State Model in 2021				
State Model	**Average Number of Weeks for Bonding**	**Average Number of Weeks for Family Care**	**Total Number of Weeks for Bonding**	**Total Number of Weeks for Family Care**
California	6.6	4.3	46,542	8,811
District of Columbia	6.6	4.0	54,881	8,817
Massachusetts	8.2	4.5	55,976	8,141
New Jersey	8.2	4.5	79,609	12,935
New York	8.2	4.5	55,838	8,902
Rhode Island	3.8	3.2	22,244	5,209
Washington	8.2	4.5	73,979	10,346
Hawaii TDI	5.4	4.0	39,025	7,516

v. 2021 Projection of Maximum, Weekly Benefit Amount, Average Weekly Benefit Amount & Total Benefit per Claimant

Washington has the highest wage replacement which results in the highest average weekly benefit. New Jersey and the District of Columbia also have high wage replacement ratios resulting in high average weekly benefits. Rhode Island and California fall in the middle of the average weekly benefit projections with moderate wage replacement ratios. Massachusetts follows next due to a lower maximum on the benefit formula. Hawaii TDI and New York's average weekly benefit formula results in the lowest average weekly benefit due to lower replacement ratios and maximums.

As a result, California's maximum weekly benefit amount is the highest at 100% of SAWW, followed by Washington at 90% of SAWW. Rhode Island is somewhere in the middle at 85% of SAWW, while Massachusetts is the lowest at 64% of SAWW.

The average total benefit per claimant is calculated as the average duration from Exhibit 34 multiplied by the average weekly benefit amount. Rhode Island's 4-week maximum benefit leads this to be the lowest average total benefit per claimant. Washington's average is the highest as a result of having a 12-week maximum and providing the second highest average weekly benefit compared to other state models. The next highest is New Jersey, also with a 12-week maximum and the second most generous wage replacement formula.

Exhibit 35

Projected Maximum Weekly Benefit Amount, Average Weekly Benefit Amount, and Total Benefit per Claimant by State Model in 2021			
State Model	**Modeled Maximum Weekly Benefit Amount**	**Modeled Average Weekly Benefit Amount**	**Total Benefit per Claimant**
California	$1,158	$557	$3,391
District of Columbia	$1,000	$630	$3,815
Massachusetts	$741	$550	$4,084
New Jersey	$811	$651	$4,788
New York	$776	$523	$3,852
Rhode Island	$984	$599	$2,196
Washington	$1,042	$691	$5,150
Hawaii TDI	$813	$525	$2,685

vi. 2021 Projection of Total Annual PFL Claims Cost in Dollars & as a Percentage of Taxable Wage Base for Hawaii

Total annual PFL claims cost are equal to the product of projected eligible claim count, duration, and average weekly benefit amount. These values are illustrated in Exhibit 36. Rhode Island's total annual program costs in dollars and as a percent of taxable wage base is the lowest and is driven by a combination of having the lowest percentage of eligible workers and the lowest maximum weeks of benefit compared to the other states. Hawaii TDI is the second lowest, mostly due to the 6-week maximum assumption. The highest cost state models are New Jersey and Washington. New York is more towards the low end in terms of total program cost, but at the higher end as a percentage of taxable wage base due to a lower cap on taxable wage base.

Exhibit 36

Projected Annual Hawaii PFL Program Claims Cost, Covered Wages and Total Claims Cost as Percentage of Total Wages by State Model in 2021			
State Model	**Total Annual Hawaii PFL Program Claims Cost ($Millions)**	**Total Annual Hawaii Taxable Wages ($Millions)**	**Total Claims Cost (as Percentage of Total Wages in Hawaii)**
California	$30.9	$21,413	0.144%
District of Columbia	$40.1	$29,021	0.138%
Massachusetts	$35.3	$21,759	0.162%
New Jersey	$60.2	$31,213	0.193%
New York	$33.8	$17,497	0.193%
Rhode Island	$16.4	$19,499	0.084%
Washington	$58.3	$28,023	0.208%
Hawaii TDI	$25.9	$24,198	0.107%

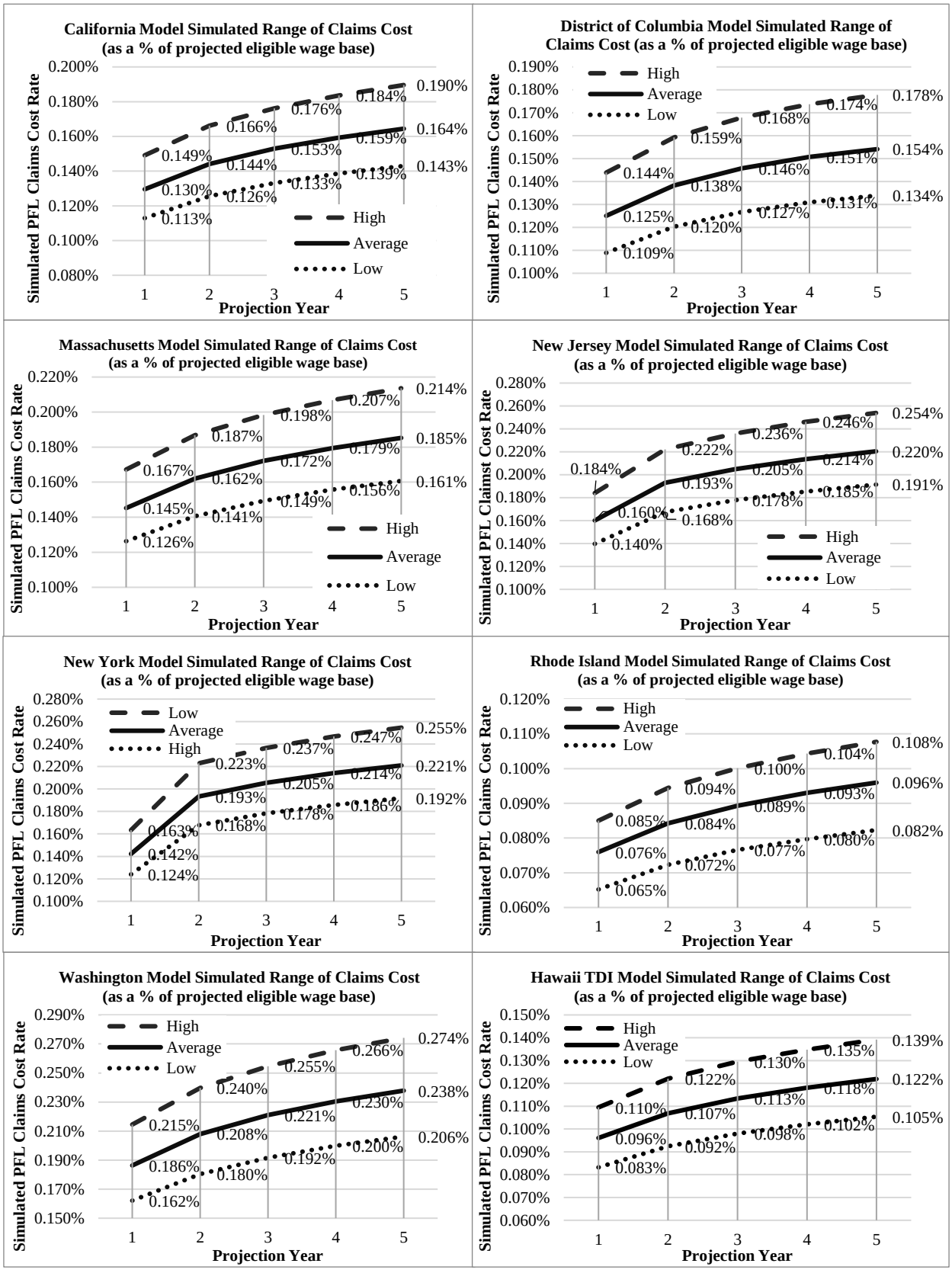
5. Sensitivity Tested Model Components & the Indicated Range of Results

The simulation considers variation in both incidence rates and number of weeks of benefit payout. We estimated a reasonable range of claims cost outcomes around the modeled projections. There is considerable variation between actual PFL state incidence rates even after adjusting for differences in state eligibility, demographic differences, and benefit level differences that impact the incidence rates. Viewing this simulated range of results allowed us to understand the sensitivity of the modeled incidence rates and number of weeks of benefit payout have to the overall claims cost results for Hawaii's prospective PFL program under each of the state models. This range of projected total claims cost (as a percentage of total taxable wage base in Hawaii) in comparison to modeled average estimates is shown for each state model below. The following charts graphically present the range of claims cost percentages by state for the 2020 to 2024 projection period. The low end represents the 5th percentile of simulated claims cost outcomes and the high end represents the 95th percentile of simulated claims cost outcomes.

The year-over-year increases in the simulated claims cost rates shown in Exhibit 37 reflect modeled incidence rate trends. The development of these trends is shown in Appendix A.5 and A.6 for bonding and family leave, on pages 103 and 104, respectively. These trends account for the expected participation growth of a newly implemented program in Hawaii over the first five projection years and is expected to flatten out over time. Further, the year-over-year increases from 2020 (Year 1) to 2021 (Year 2) reflect any benefit level changes in each of the states' benefit formulas. These benefit level adjustments impact both modeled incidence rates and average weekly benefit calculation and are also further detailed in the Appendix. The distance between the low and high lines in each graph is proportionally the same for the 5 projection years with minor differences due to rounding and the random nature of the simulation model results.

Indicative funding rates should be updated prior to implementation in Hawaii to reflect any drafted legislation and updated state experience.

Exhibit 37


California Model Simulated Range of Claims Cost (as a % of projected eligible wage base)
Simulated PFL Claims Cost Rate
Projection Year
High
Average
Low
District of Columbia Model Simulated Range of Claims Cost (as a % of projected eligible wage base)
Massachusetts Model Simulated Range of Claims Cost (as a % of projected eligible wage base)
New Jersey Model Simulated Range of Claims Cost (as a % of projected eligible wage base)
New York Model Simulated Range of Claims Cost (as a % of projected eligible wage base)
Rhode Island Model Simulated Range of Claims Cost (as a % of projected eligible wage base)
Washington Model Simulated Range of Claims Cost (as a % of projected eligible wage base)
Hawaii TDI Model Simulated Range of Claims Cost (as a % of projected eligible wage base)

C. Alternative Structure Analyses

1. Maximum Week Options

As outlined previously, the projected maximum weekly benefit under the current state programs are as follows:

Exhibit 38

Maximum Duration in Weeks by Leave Type and Projection Year				
State Model	**Bonding Leave**		**Family Leave**	
	2020	**2021-2024**	**2020**	**2021-2024**
California	8	8	8	8
District of Columbia	8	8	6	6
Massachusetts	12	12	12	12
New Jersey	6 *	12	6	12
New York	10	12	10	12
Rhode Island	4	4	4	4
Washington	12	12	12	12
Hawaii TDI	6	6	6	6
*New Jersey maximum duration increases to 12 weeks effective 7/1/2020				

By varying the maximum weekly benefit amounts in the model, certain results outlined previously will change. As such, we assess the impact of the following maximum week of benefit alternative scenarios under each of the state models:

- Four (4) Weeks
- Six (6) Weeks
- Eight (8) Weeks
- Twelve (12) Weeks
- Sixteen (16) Weeks

For the purpose of this alternative maximum leave duration analysis we illustrate the 2021 projections. The relative state model relationships are not expected to vary significantly for the other projection years.

Exhibit 39

Projected Average Duration of Bonding and Family Care Leave (in weeks) in 2021					
Leave Type	**Maximum Duration**				
	4	**6**	**8**	**12**	**16**
Bonding Leave	3.8	5.4	6.6	8.2	9.3
Family Care Leave	3.2	4.0	4.3	4.5	4.6

Exhibit 40

Projected Average Combined Bonding and Family Care Number of Weeks Compensated by State Model in 2021					
State Model	**Maximum Duration**				
	4	**6**	**8**	**12**	**16**
California	3.7	5.1	6.1	7.4	8.3
District of Columbia	3.7	5.1	6.1	7.4	8.3
Massachusetts	3.7	5.1	6.1	7.4	8.3
New Jersey	3.7	5.1	6.1	7.4	8.2
New York	3.7	5.1	6.1	7.4	8.3
Rhode Island	3.7	5.1	6.1	7.4	8.3
Washington	3.7	5.1	6.1	7.5	8.4
Hawaii TDI	3.7	5.1	6.1	7.4	8.3

Exhibit 41

Projected Total Combined Bonding and Family Care Number of Weeks Compensated by State Model in 2021					
State Model	**Maximum Duration**				
	4	**6**	**8**	**12**	**16**
California	33,354	46,277	55,354	67,061	75,134
District of Columbia	38,652	53,720	64,359	78,121	87,616
Massachusetts	31,723	44,090	52,822	64,117	71,909
New Jersey	46,081	63,911	76,420	92,544	103,663
New York	32,200	44,676	53,439	64,740	72,535
Rhode Island	27,453	38,121	45,634	55,337	62,029
Washington	41,632	57,902	69,416	84,325	94,613
Hawaii TDI	33,475	46,541	55,777	67,730	75,977

Exhibit 42 shows the projected total benefit paid per claimant. This takes the projected average weekly benefit from Exhibit 35, on page 49, for 2021 multiplied by the expected duration under each of the alternative maximum weekly durations. The highest total benefits per claimant are

under the New Jersey and Washington models, whereas the lowest are under the New York and Hawaii TDI models.

Exhibit 42

Projected Average Total Benefit per Claimant by State Model in 2021					
State Model	**Maximum Duration**				
	4	**6**	**8**	**12**	**16**
California	$2,043	$2,835	$3,391	$4,108	$4,602
District of Columbia	$2,315	$3,218	$3,855	$4,679	$5,248
Massachusetts	$2,021	$2,809	$3,365	$4,084	$4,581
New Jersey	$2,384	$3,306	$3,954	$4,788	$5,363
New York	$1,916	$2,658	$3,179	$3,852	$4,316
Rhode Island	$2,196	$3,050	$3,651	$4,427	$4,962
Washington	$2,543	$3,536	$4,239	$5,150	$5,778
Hawaii TDI	$1,931	$2,685	$3,218	$3,907	$4,383

Exhibit 43 shows the total benefit payment costs. This is the projected total benefit per claimant in Exhibit 42 multiplied by the expected total number of eligible claims from Exhibit 30 on page 45. The highest gross benefit payments are under the New Jersey and Washington models, whereas the lowest are under the New York and Rhode Island models. Rhode Island model generates the lowest gross benefit payments due to stricter eligibility requirements.

Exhibit 43

Projected Gross Benefit Payments (in Millions) by State Model in 2021					
State Model	**Maximum Duration**				
	4	**6**	**8**	**12**	**16**
California	$18.6	$25.8	$30.9	$37.4	$41.9
District of Columbia	$24.4	$33.8	$40.6	$49.2	$55.2
Massachusetts	$17.4	$24.2	$29.1	$35.3	$39.5
New Jersey	$30.0	$41.6	$49.7	$60.2	$67.5
New York	$16.8	$23.4	$27.9	$33.8	$37.9
Rhode Island	$16.4	$22.8	$27.3	$33.1	$37.1
Washington	$28.8	$40.0	$48.0	$58.3	$65.4
Hawaii TDI	$17.6	$24.4	$29.3	$35.6	$39.9

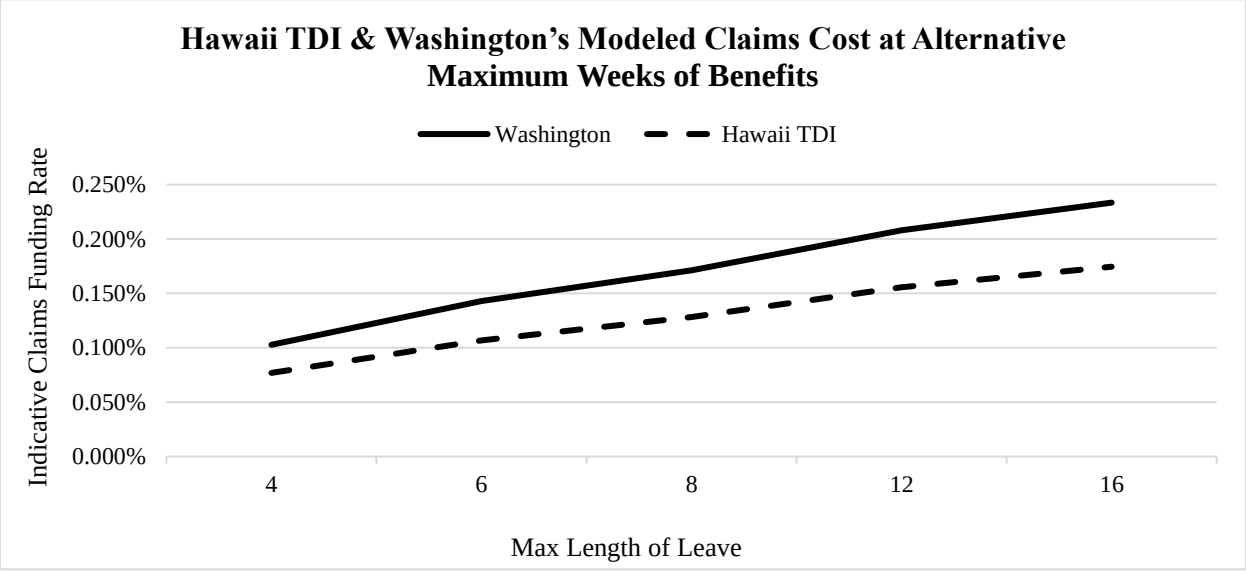
Exhibit 44 shows the total projected claims cost for 2021 as a percent of total taxable wage base. This takes the projected total benefits in Exhibit 43 divided by the taxable wage base in Exhibit 36.

Exhibit 44

Projected Claims Cost Funding Level by State Model in 2021					
State Model	**Maximum Duration**				
	4	**6**	**8**	**12**	**16**
California	0.09%	0.12%	0.14%	0.17%	0.20%
District of Columbia	0.08%	0.12%	0.14%	0.17%	0.19%
Massachusetts	0.08%	0.11%	0.13%	0.16%	0.18%
New Jersey	0.10%	0.13%	0.16%	0.19%	0.22%
New York	0.10%	0.13%	0.16%	0.19%	0.22%
Rhode Island	0.08%	0.12%	0.14%	0.17%	0.19%
Washington	0.10%	0.14%	0.17%	0.21%	0.23%
Hawaii TDI	0.08%	0.11%	0.13%	0.16%	0.17%

The primary driver of differences between state modeled claims cost funding levels is the maximum number of weeks of benefit under each state program. A graphical depiction of the range of state modeled indicative claims funding rates at each alternative maximum weeks of benefit is illustrated in Exhibit 45 of Hawaii TDI's and Washington's modeled indicative claims funding rates. The other state projections of modeled claims cost fall within these lines.

Exhibit 45



The remaining differences in modeled claims cost is mostly explained by modeled AWBA differences.

Washington has the highest modeled AWBA and claims cost. Hawaii TDI has the second lowest AWBA and the lowest claims cost. New York is an outlier since it has the lowest modeled AWBA and the second highest modeled claims cost. This is driven by the low taxable wage base cap in New York in comparison to the other states. The District of Columbia also has an inconsistent relationship, and this is because they do not have a taxable wage base cap.

Exhibit 46

Hawaii Modeled Average Weekly Benefit Amount and Claims Funding Rates by State Model in 2021 with 8-Week Maximum Benefit		
State Model	**Hawaii Modeled AWBA**	**Modeled Indicative Claims Funding Rates with 8-Week Maximum Benefit**
California	$557	0.144%
District of Columbia	$630	0.140%
Massachusetts	$550	0.134%
New Jersey	$651	0.159%
New York	$523	0.160%
Rhode Island	$599	0.140%
Washington	$691	0.171%
Hawaii TDI	$525	0.128%

Washington has the highest wage replacement which results in the highest average weekly benefit. New Jersey and District of Columbia also have high wage replacement ratios resulting in high average weekly benefits. Rhode Island and California fall in the middle of average weekly benefit projections with moderate wage replacement ratios. Massachusetts follows next due to a lower maximum on the benefit formula. Hawaii TDI and New York's average weekly benefit formula results in the lowest due to lower wage replacement ratios and maximums.

2. Benefit Structure Differentials (Flat vs. Progressive)

We illustrate two progressive benefit structures and one flat benefit structure. For California, the first progressive benefit structure (current structure) decreases the wage replacement ratio at a certain wage level and applies it to the total wages, which in effect creates a sharp break point for the benefit amount received instead of a gradual change in benefit. The other alternative progressive benefit structure is step-rated, whereby the first $x dollars of wages applies a higher replacement ratio and then the excess applies the lower replacement ratio. This step-rated feature creates a more gradual benefit amount change.

For the remaining states, we illustrate two progressive benefit structures that are both step-rated, one with 1/3 of SAWW as the break point, and the other with ½ of SAWW as the break point. For each state, these alternative structures are developed to illustrate the same expected average benefit

with each alternative structure. Exhibit 47 illustrate this concept with a visualization of wage replacement ratio variations for people in different wage band. Our analysis also assumes the program maximum and minimum would remain unchanged. More detailed calculations for each state model is listed in Appendix D, beginning on page 134.

The results show that step-rated progressive models benefit the lower paid employees compared to flat-rated model, without significant decreasing the benefits on more highly paid employees. The sharp break-point progressive model used by California will create a sharp decrease in replacement ratio for people going over the threshold. Comparing the two step-rated models with different thresholds (1/3 SAWW vs. 1/2 SAWW), placing a lower threshold will benefit the lowest paid employees more (population below 20% wage band in most states) while placing a higher threshold will strike a smoother transition for the population below the 50% wage band.

Exhibit 47

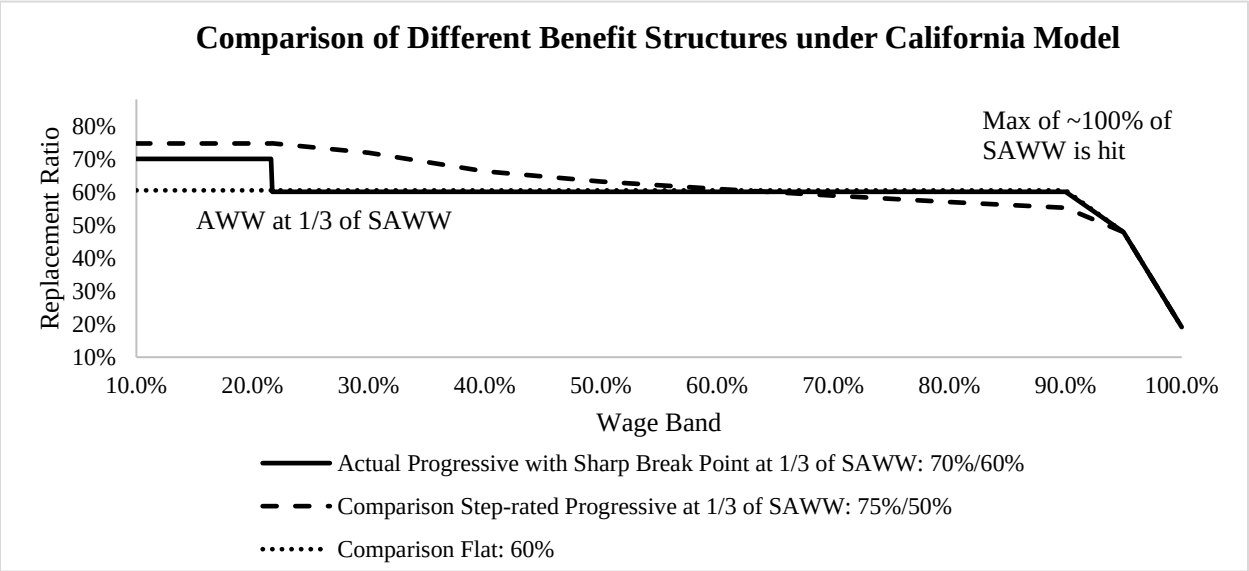


Exhibit 48

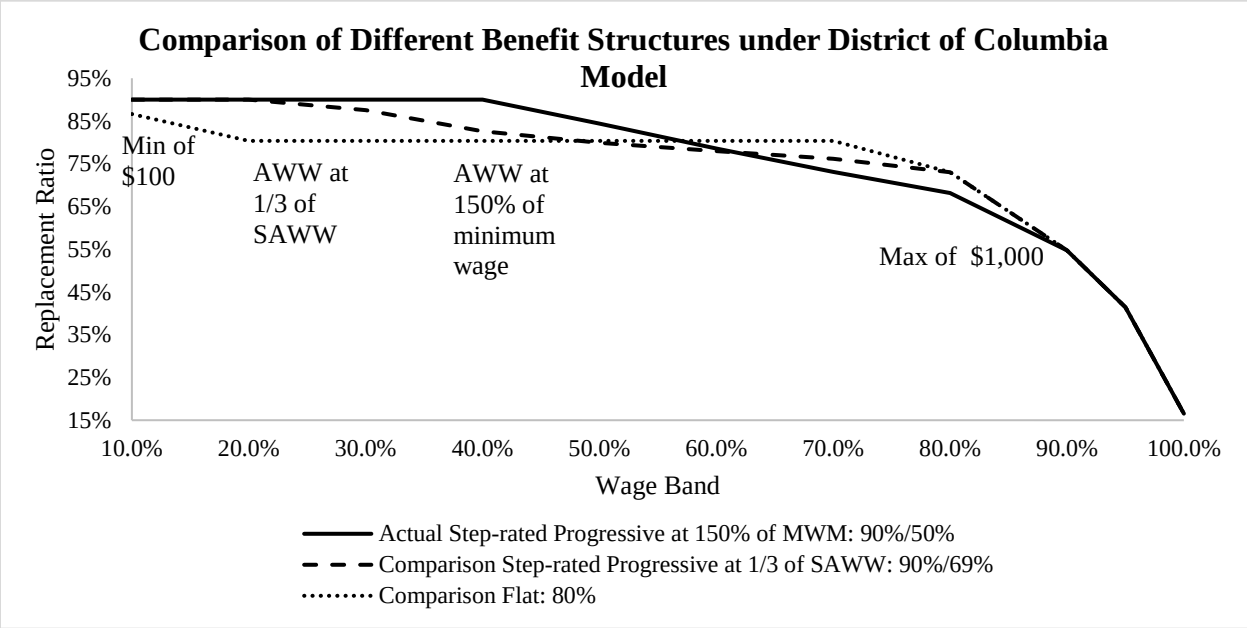
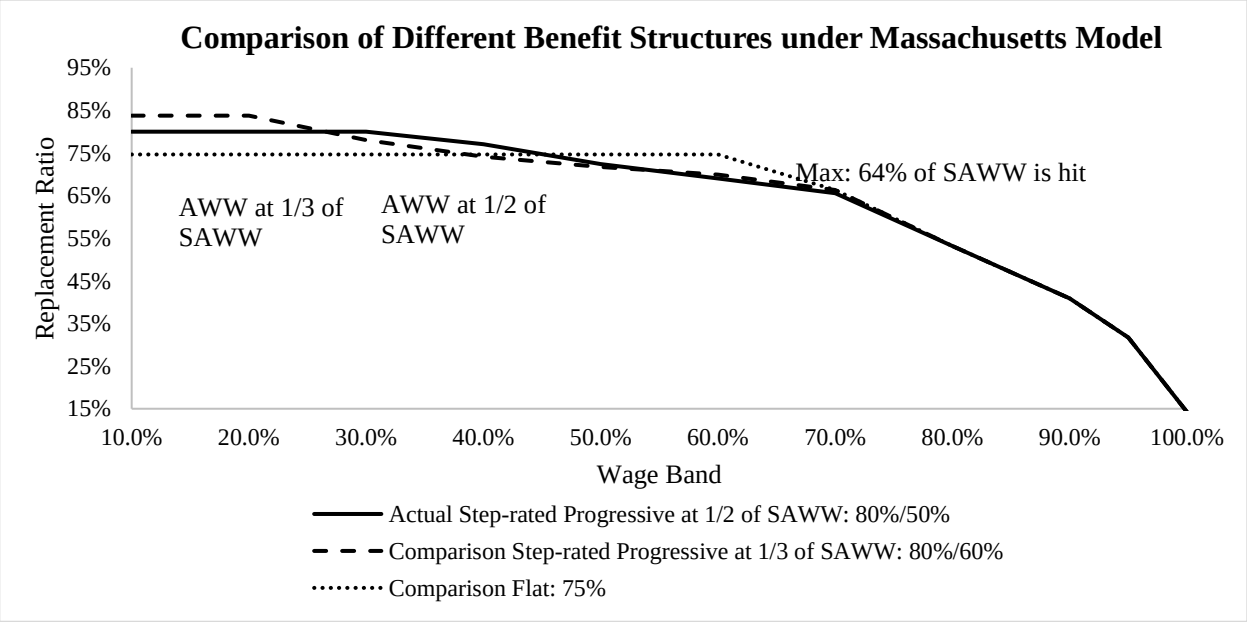


Exhibit 49



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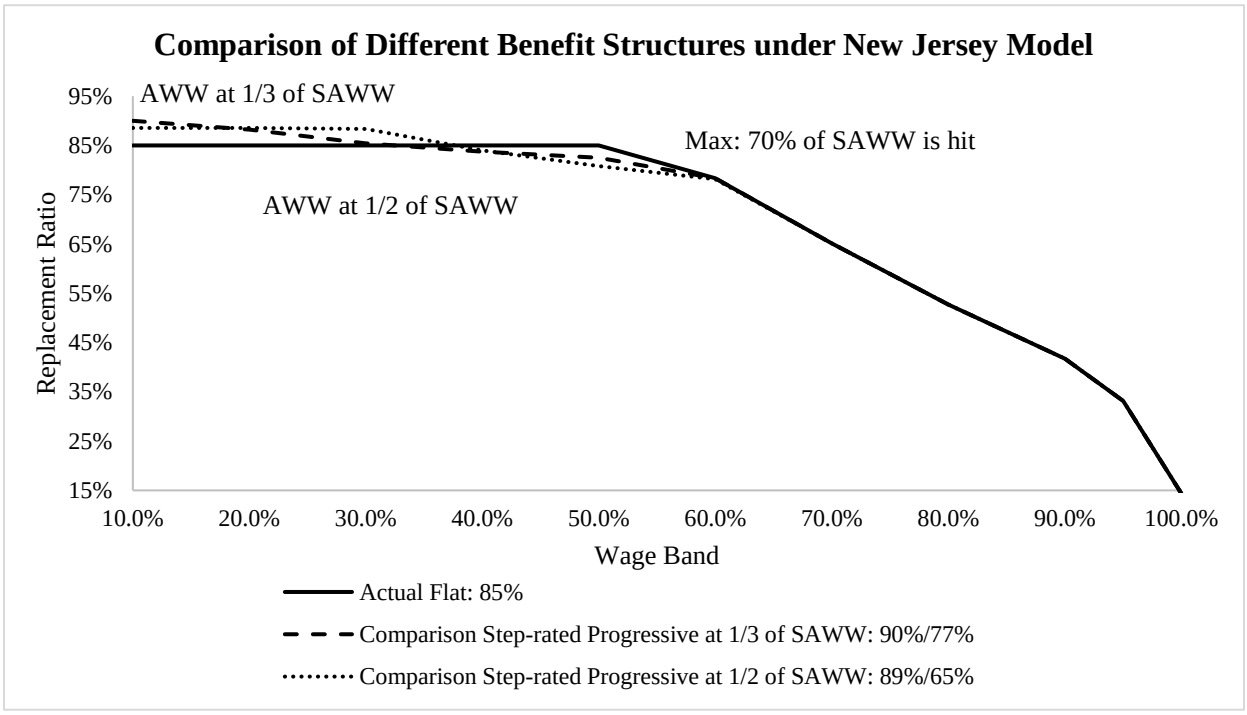


Exhibit 51

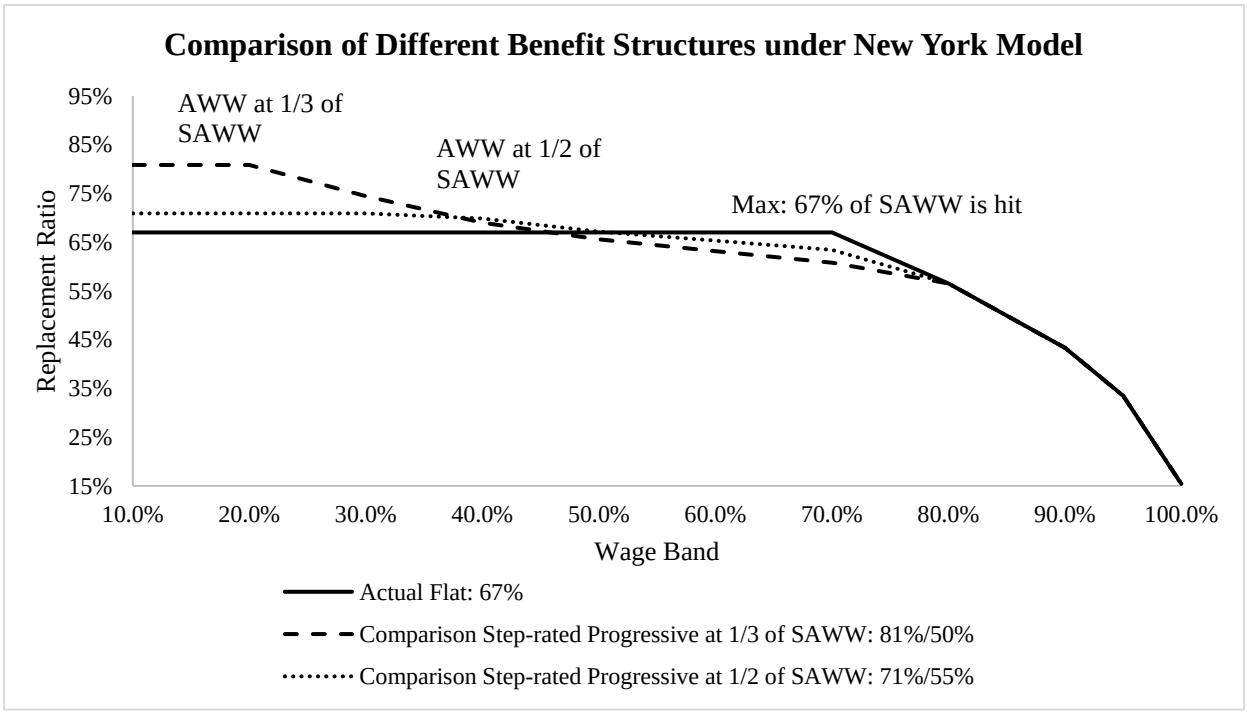


Exhibit 52

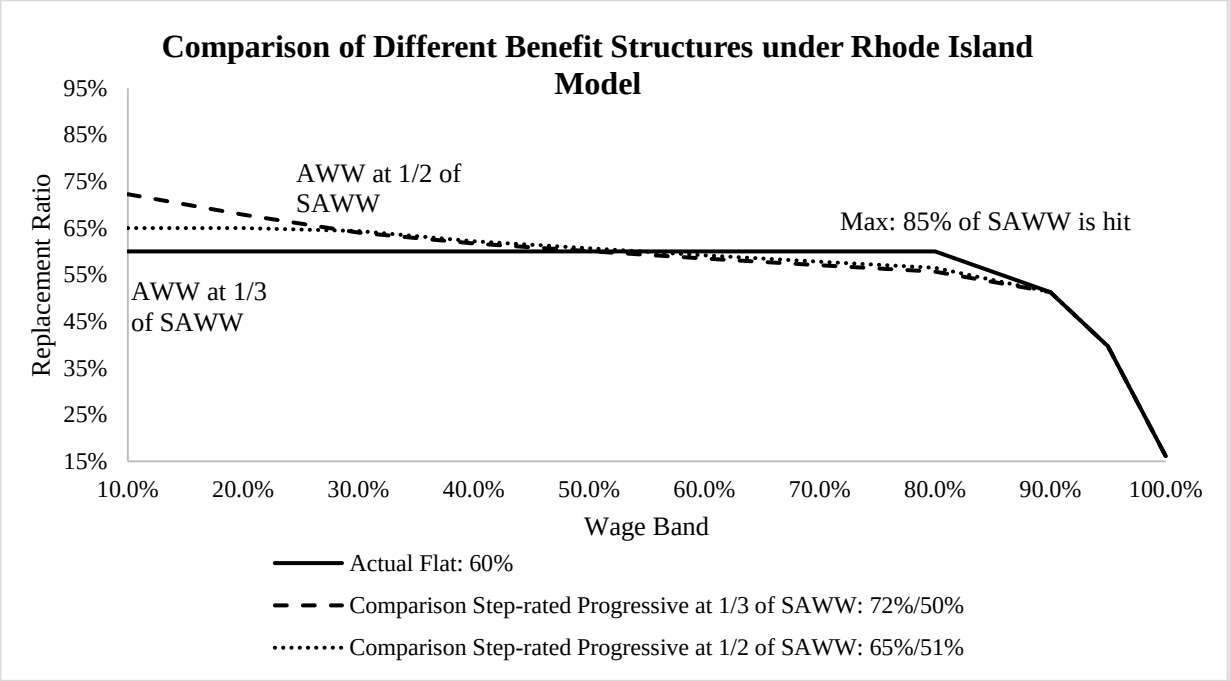


Exhibit 53

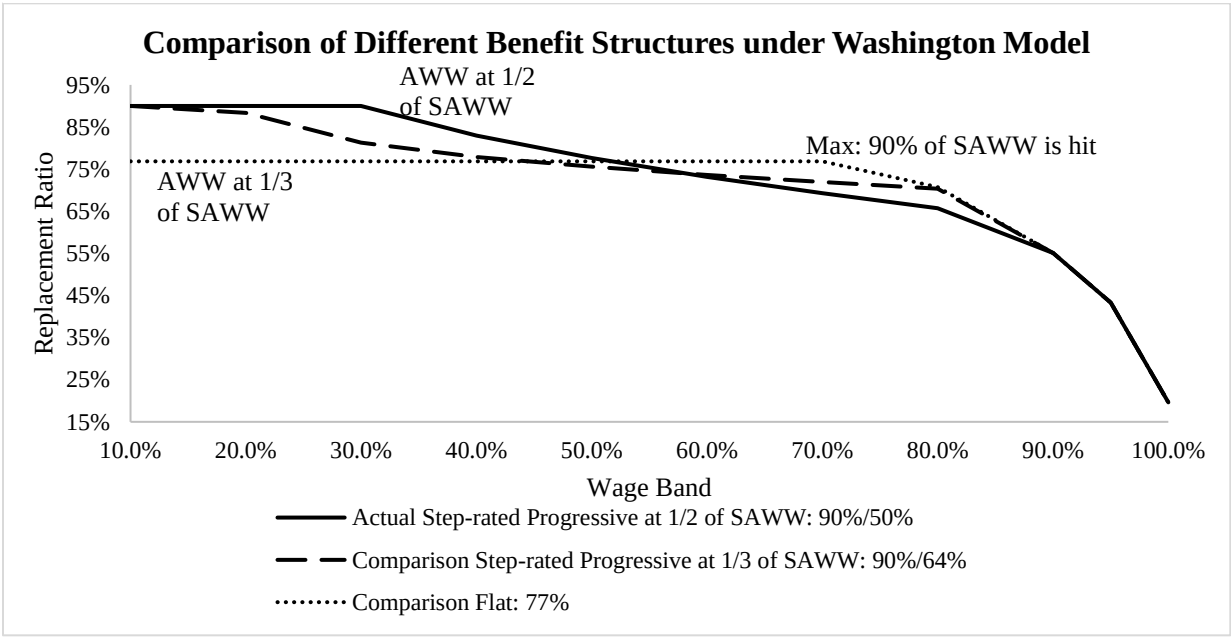
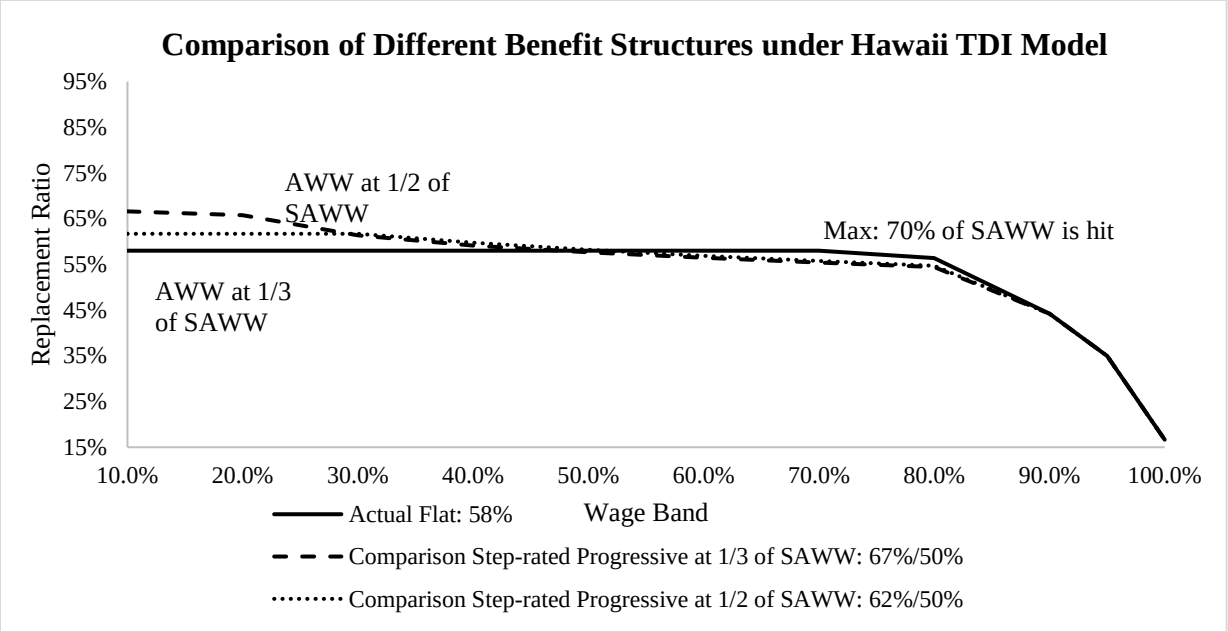


Exhibit 54



3. Administrative & Funding Rates by State Structure Type

The modeling illustrated above is based on a social insurance model whereby contributions cover the costs of claims. Therefore, the model assumes rates are set by Hawaii using community rating techniques; they do not vary by claims experience; all employees/employers are treated similarly and are not subject to cost variations based on age, gender, geographic location or any other demographic factor. They are pooled across the entire state workforce allowing the higher costs of people needing to take leave to be offset by those that do not take it.

In a social insurance model where employers can opt out to private plans, there is a risk of employers selecting against the community rate. Employers with "good" risk may opt out and leave the state with "bad" risk. As private plan opt outs in California and New Jersey are relatively low at 3% to 4%, we assume 3% of employers will opt out which should not significantly impact the community rated experience.

Under a social insurance model that is highly regulated with private options where employers may elect to offer benefits through a state insurance fund, private insurance or self-insurance (like New York), or an employer mandate model, contributions may vary to reflect each employers' risk profile. Parameters can be set around how much an employee can contribute (such as how Hawaii TDI limits an employee's contribution to not exceed 0.5% of the weekly wage). Insurer rates can be community rated and subject to a risk adjustment mechanism where insurance carriers with better than average claims experience pay into the risk pool while insurance carriers with higher

than average claims experience get paid from the pool. An alternative is to develop a risk score based on the mix of lives covered by each carrier and the risk pool charges or pays each carrier dependent upon relative risk scores; however, this more complex approach has not been done in the paid leave market.

Regardless, insurance carriers need to incorporate marketing costs (including broker commissions), claim adjudication, premium taxes and administrative costs as well as profit margins in their premium rates. Based on our recent survey of 12 carriers and TPAs, 15% of premium is likely needed to cover non-claim costs including state administrative charges for governance. Though the administrative expense ratio will vary by employer size with the expense ratio higher for smaller employers, this perhaps can be offset by lower expected claim loss ratios for smaller employers thereby maintaining the same community rate for employers of all sizes.

In order to arrive at total funding costs for Hawaii to consider, below we combine the claim, administrative or carrier charges together for each of two following models to develop indicative costs for the state scenarios previously presented.

- State fund: claim funding plus state administrative cost
- Carrier premium: claim funding grossed up to cover expenses or claims divided by (1 – 15%)

Exhibit 55 (third and fourth columns) develops the ongoing state administrative cost charges to administer the state fund as a percentage of the taxable wage base and alternatively the cost of governance only for a private model which can also cover opt-outs from a social insurance model allowing private plans. The cost of a governance only model is less than half the cost of administering a state fund.

The last two columns of Exhibit 55 show indicative total funding costs for claims plus administration state model for 2021. The indicative Hawaii state fund cost rates is simply the sum of claims cost rates and state pool administrative charge rates. Carrier premium rates reflect the claim cost rates grossed up for carrier administrative charges equal to 15% of premium.

Exhibit 55

Ongoing Administrative Cost and Indicative Funding Rate in 2021 by State Model						
State Model	**Taxable Wage Base ($M)**	**Ongoing State Administrative Charges**		**Total Claims Cost % of Total Wages in Hawaii**	**Indicative Funding Rate**	
		Social Insurance Model ($2.624M)	**Governance Only Model ($1.103M)**		**Hawaii State Fund***	**Carrier Premium Rates****
California	$21,413	0.012%	0.005%	0.144%	0.156%	0.170%
District of Columbia	$29,021	0.009%	0.004%	0.138%	0.147%	0.163%
Massachusetts	$21,759	0.012%	0.005%	0.162%	0.174%	0.191%
New Jersey	$31,213	0.008%	0.004%	0.193%	0.201%	0.227%
New York	$17,497	0.015%	0.006%	0.193%	0.208%	0.228%
Rhode Island	$19,499	0.013%	0.006%	0.084%	0.098%	0.099%
Washington	$28,023	0.009%	0.004%	0.208%	0.217%	0.245%
Hawaii TDI	$22,876	0.011%	0.005%	0.107%	0.118%	0.126%
* Sum of ongoing administrative cost percentage under social insurance model and claims cost percentage						
** Claims cost percentage divided by a loss ratio of 85%						

Carrier premium rates are projected to be 1% to 13% higher than funding rates for the state fund. Under a social insurance model with private plan opt-outs, Hawaii may choose to follow other states and not allow employee contributions to exceed those that would be charged for the state fund.

D. Additional Cost Breakdowns

1. Size of Employer.

Although state-based employer size data was not readily available for this study,[v] a recent formal carrier and TPA market survey[84] suggests that larger employers have higher PFL incidence/loss ratios than smaller employers. Large employers typically have more robust leave management programs and proactively work to integrate disability, WC, FMLA, paid and unpaid leave, and sick

[v] State PFL data is not published or generally released by employer size. Obtaining it would be subject to a formal request for information process that only some states will entertain and typically takes longer than the time allotted for this study.

leave benefits for their employees. They typically want to give their employees full replacement benefits, and they strive to provide high awareness about paid leave benefits, compared to their smaller employer counterparts.

For smaller employers, PFL incidence/loss ratios tend to be lower. They often make their own arrangements when employees take time off, or don't have the infrastructure to follow through a more formal or even state-run process. This leads to small employers subsidizing large employer usage, if all size employers contribute to the funding pool. Insurers providing PFL coverage will incur higher administrative costs as a percentage of premium for smaller employers relative to larger employers. The higher administrative costs for smaller employers as a percent of premiums should in part or in whole offset their lower expected claim costs. The same could be said for certain industries (e.g., healthcare), that tend to utilize paid leave and absence benefits more than other industries.

2. Impacts to Employees

The impacts of these patterns on employees is largely dependent on the path their employer takes within the model that is made available to them. When employee contributions are required, and employers opt out, they typically have the choice to deduct them from an employee's paycheck or pay them on the employee's behalf. In the latter case, employees receive PFL, but at their employers' expense.

3. Cost of Compliance Related to Other Mandates

With regard to the cost of compliance related to other mandates, PFL programs require a level of governance that is outlined in the next section of the report. Outside of administering claims, this entails reviewing and processing appeals, detecting fraud and abuse and supporting outreach and education. Industry experts suggest that state departments should work closely with their department of insurance counterparts, and not assume that Unemployment Insurance (UI) is the model to follow. PFL should dovetail with statutory disability leave and considered as part of a broader employee benefit offering, not just in one silo. A simplified benefit formula and coordination with disability and FMLA is thought to decrease confusion and increase awareness,[85] which is ultimately the goal of implementing a PFL program in the first place.

IV. Compliance & Enforcement Options

A. Functional Requirements

In order to effectively support a paid leave program, a number of operational and educational activities are required. All leave programs begin with the reporting of a leave, then flow through to determining eligibility, approval or denial, and for approved claims, ensuring that payment is made. Protocols for appeals, as well as detecting fraud and abuse should be in place. A strategy and implementation plan for outreach and education are also critical.

1. Operational Activities

i. Considering Applications

For initial leave intake to be successful, the administrator should be able to efficiently collect all the necessary and initial claim information from the employee.[86] While the trend for intake methods is becoming increasingly more web or online-based, states also offer mail and fax options.

Exhibit 56

State	Claim Submission Methods as of October 2019
California[87]	▪ Online ▪ Mail
District of Columbia[88]	▪ Online *Note: Process is under development at the time of writing*
Massachusetts[89]	▪ Online *Note: Process is under development at the time of writing*
New Jersey[90]	▪ Online ▪ Mail ▪ Fax
New York[91]	▪ Varies by plan administrator/carrier
Rhode Island[92]	▪ Online ▪ Mail
Washington[93]	▪ Online *Note: Process is under development at the time of writing*

ii. Determining Eligibility

Applications must be reviewed to confirm employees meet the eligibility requirements established under the leave law, which may include an employee's earnings, hours worked during an established time period, or both. California and Rhode Island base eligibility on earnings. New York

and Washington determine eligibility based on time worked. Massachusetts and New Jersey base eligibility on both earnings and time worked, whereas the District of Columbia only looks to see if a claimant was employed with an eligible employer at the time of application and that 50% of work occurred in the district.

To confirm if a claimant meets the eligibility requirements, states look to access available data. Data collected for UI typically includes quarterly wage information for employees that can be utilized to verify eligibility based on earnings and, in some cases, may also include work hours. Alternative sources may include previous year state and federal individual tax filings. Additionally, fees might be required to access and use state or federal data.[94]

iii. Verifying Qualifying Events

Beyond confirming a claimant has met the eligibility requirements, administrators must confirm that the reason leave is being requested is valid. If an employee is requesting leave due to the birth or placement of a new child, a birth certificate, hospital discharge, declaration of paternity, or an adoption or foster placement record is enough to validate leave for bonding. This can be further verified through state birth records.

Leave claims to care for family members require certification from the treating medical provider of the family member receiving care. This verification includes accepted medical coding terminology as well as the expected duration of the care needed. Verification techniques can be built into software applications. Clarification questions may be posed to physicians or providers. In some cases, such as in Rhode Island, medical reviews are conducted by clinicians. All states reserve the ability to request an exam from an independent medical examiner to validate the medical necessity for leave.[95] Confirming an employee's relationship to the individual receiving care is more difficult. Employees, care recipients, and treating providers are typically asked to attest to the covered relationship within the claim form. California, New Jersey, and Rhode Island do not require proof of the relationship, except for bonding. The degree of scrutiny applied to claims must balance the goal of providing benefits promptly and within established timelines with the goal of managing the risk of relying on incomplete or potentially false information.

iv. Approving or Denying the Request

A decision to either approve or deny a claim is based on the application submitted and the administrator's review of eligibility and the leave event.[96] If employees are deemed eligible and the qualifying leave reason is validated, administrators will approve and pay a claim. If a claim is denied, employees will be notified and given the opportunity to appeal the decision. Eligibility decisions are generally communicated to claimants through letters mailed to the individual, however states may provide online resources to check on the status of a claim. For example, New Jersey has an

online portal that provides basic claim information including claim and payment status.[97] States typically mandate the time period in which a claim decision must be made as a performance standard. The expected turnaround times (TAT) for each state are listed in Exhibit 57.

Exhibit 57

State	Benefit Determination TAT Performance Standards as of October 2019
California[98]	▪ 14 days from receipt of a completed claim
District of Columbia[99]	▪ 10 business days from receipt of a completed claim
Massachusetts[100]	▪ 14 days from receipt of a completed claim
New Jersey[101]	▪ Not stated; applications are processed in the order received
New York[102]	▪ 18 days from the latter of receipt of a completed claim or the first day of leave
Rhode Island[103]	▪ 3 to 4 weeks from the receipt of a valid application
Washington[104]	▪ 14 days from receipt of a clean claim

v. Calculating Amount of Benefit

Similar to determining eligibility, wage data is needed to calculate a claimant's leave benefit. This data may be collected from employees and verified through state or federal data resources or reports provided by employers.

New Jersey, for example, previously required employer statements and based benefits on the average weekly wage immediately preceding the claim. It is now calculated based on employer earnings reports submitted to the state from previous quarters. The state may still reach out to employers to request additional data if information supplied with the claim is insufficient.[105]

The time period used to calculate an employee's benefit may differ from what is used to confirm eligibility. For instance, the District of Columbia bases eligibility on the 52 weeks immediately preceding the leave, while the benefit is calculated on a wage base established by the highest 4 out of 5 quarters immediately preceding the leave.

Exhibit 58

State	Benefit Base Methods as of October 2019
California[106]	▪ The weekly benefit amount is based on the highest quarter of earnings in the base period ▪ The base period is 12 months, divided into 4 consecutive quarters, and includes wages subject to the SDI tax paid about 5 to 18 months preceding the start of leave (defined as the first 4 of the prior 5 quarters before the quarter in which a claim is filed)
District of Columbia[107]	▪ AWW equals the total wages in covered employment earned during the highest 4 out of 5 quarters immediately preceding a qualifying event divided by 52
Massachusetts[108]	▪ AWW is calculated using earnings from the base period ▪ Base period is the last 4 completed calendar quarters immediately preceding the start date of a qualified period of paid family or medical leave ▪ A completed calendar quarter is one for which an employment and wage detail report has been or should have filed
New Jersey[109]	▪ AWW is calculated by dividing base year (first 4 of the last 5 completed quarters) earnings by the number of base weeks ▪ A base week is any week in which an employee earned at least $172
New York[110]	▪ AWW is calculated as the average of the employee's last 8 weeks of wages ▪ Wages will be the greater of either the last 8 weeks including the week leave began *or* the last eight weeks worked excluding the week leave began
Rhode Island[111]	▪ Weekly benefit rate is 4.62% of wages paid in the highest quarter of the employee's base period ▪ The base period is the first 4 of the last 5 completed calendar quarters before the start date of leave
Washington[112]	▪ Weekly benefit is prorated by the percentage of hours on leave compared to the number of hours provided as the typical workweek hours ▪ AWW is calculated by dividing the employee's total wages during the 2 quarters of the employee's qualifying period in which total wages were highest by 26, rounded to the next lower multiple of one dollar ▪ Qualifying period is the first 4 of the last 5 completed calendar quarters or, if eligibility is not established, the last 4 completed calendar quarters immediately preceding the application for leave

vi. Coordinating with Other Benefits

Generally, employees who are receiving benefits under a PFL program are not eligible to receive payments under other state or federal programs, such as disability, unemployment or WC. Unpaid state and federal leaves and in some cases employer specific leaves may run concurrently to the paid leave, if leave reasons and eligibility criteria overlap. Furthermore, employers may be able to supplement employee's benefits with other benefits (e.g., paid time off (PTO), disability) up to a certain percentage of the employee's wage.[113]

Exhibit 59

State	Benefit Coordination as of October 2019
California[114]	▪ If entitled to FMLA and CFRA, PFL must be taken concurrently ▪ Employers can require the use of up to 2 weeks of earned but unused vacation time prior to the initial receipt of benefits (sick leave cannot be used) ▪ Employers can provide additional benefits while employees are receiving PFL payments to "top up" the plan to 100% of an employee's normal weekly wage
District of Columbia[115]	▪ Not eligible for PFL benefits if receiving long term disability payments ▪ Not eligible for PFL benefits if receiving unemployment compensation ▪ Not eligible for PFL benefits if earning self-employment income
Massachusetts[116]	▪ Runs concurrently to leave taken under applicable state and federal leave laws including MA Parental Leave Act and FMLA when leave is for a qualified reason under those acts
New Jersey[117]	▪ Employees may elect to use PTO in addition to FLI benefits without reducing the employee's entitlement to FLI
New York[118]	▪ Employees may elect to use paid time off while on PFL, but employers cannot require they do so ▪ Employees cannot collect disability and PFL benefits at the same time ▪ Employees cannot collect PFL while collecting WC for a total disability, however employees on a reduced earnings schedule may be eligible
Rhode Island[119]	▪ Employee must be fully released from a TDI claim before applying for TCI
Washington[120]	▪ Leave runs concurrent with FMLA ▪ Leave is in addition to any leave for sickness or temporary disability due to pregnancy or childbirth ▪ Not eligible to receive PFL while also receiving federal or state unemployment compensation, industrial insurance, or disability insurance

vii. Processing & Dispersing Payments

States issue payments through either paper checks mailed to claimants, debit cards loaded with funds at regular intervals, or direct deposits into existing accounts. States are progressively moving

away from issuing paper checks in favor of debit cards and direct deposit to claimants' banks. Debit cards, combined with claimant notification, allow states to pay benefits for various programs such as PFL, disability or unemployment. Cards are reloaded at established intervals during the benefit entitlement period. To issue debit cards, states must partner with banking and financial institutions.

viii. Reviewing & Processing Appeals

Each state has an established process by which claimants can exercise their right to appeal benefit denials. In most states, two levels of administrative appeals exist before cases are sent through the state and federal court systems. Not only are employees able to appeal decisions, but their employers may also be given the right to submit an appeal. In California, New Jersey, and Rhode Island, the process for PFL is identical to the process for unemployment insurance.[121]

Employees are given instructions on how to appeal a decision when a claim is denied. This includes a timeframe in which the appeal must be submitted. The time provided varies among states and is, for example, 7 days in New Jersey, and 30 days in California. Appeals must typically be made in writing, but online options are also available.[122,123]

Exhibit 60

State	Appeal Process as of October 2019
California[124]	▪ When a claim is denied, claimants receive an appeal form with the denial notice that must be submitted within 30 days of the mailing date of the decision notice ▪ The EDD will evaluate the claim and notify the employee of the results or issue payment on the claim ▪ If the EDD cannot issue payment, the appeal will be sent to the California Unemployment Insurance Appeals Board local Office of Appeals, who will mail the claimant a notification with a hearing date ▪ The hearing will be evaluated by an Impartial Administrative Law Judge
District of Columbia[125]	▪ Appeals are sent to the Office of Administrative Hearings
Massachusetts[126]	▪ Appeals are made to the department within 10 days of receipt of the notice of determination ▪ When making an appeal, the claimant may request a hearing or agree to a disposition without a hearing or submit evidence without appearing at a hearing ▪ A final decision will be issued by the department within 30 days of the hearing

State	Appeal Process as of October 2019
	▪ Further appeals may be filed as complaints in the district courts for the county where the individual resides or was last employed within 30 days of the receipt of the final decision
New Jersey[127]	▪ Submit appeal online or in writing to the Division of Temporary Disability Insurance ▪ Reviewed by an appeals examiner who will decide how to proceed based on the provided information ▪ If the issue can be resolved without a hearing, the claimant will receive a call from a division representative ▪ Appeals not easily resolved will be sent to the appeal tribunal and claimants will receive a notice in the mail to register for an administrative telephone hearing ▪ A decision from the tribunal will be mailed to the claimant with additional step to take if the claimant is not satisfied with the decision
New York[128]	▪ When a leave request is denied, the carrier must provide the reason for denial and information about requesting arbitration ▪ The denial will be reviewed by an Arbitrator (independent, third party who will make a final and binding determination) based on information submitted by the employee and carrier ▪ The state- approved administrator of all arbitrations in New York State Paid Family Leave claim disputes is National Arbitration and Mediation (NAM)
Rhode Island[129,130]	▪ Submit a written appeal request to the TCI Appeals Coordinator ▪ The claim will be assigned to a Referee at the Board of Review who will schedule a hearing with the employee ▪ The referee will render a decision ▪ If the claimant does not agree with the decision, an appeal may be made to the Board of Review for final review
Washington[131]	▪ An appeal may be filed with the commissioner of appeals within 30 days of decision notification ▪ The commissioner will assign an administrative law judge to conduct a hearing and issue a proper order upon notice of an appeal

ix. Detecting Fraud & Abuse

PFL program administration must include processes, procedural rules and resources to protect against fraud and abuse, identify potential occurrences and prosecute offenders. Strong anti-fraud measures assure that the public perceives that PFL benefits are fairly and equitably made only to

those who are entitled to them. The monetary values of taxes and contributions and of benefit payments make sound financial controls essential.

California has, over time, implemented a comprehensive fraud prevention and detection program that offers valuable examples to leave administrators in other states.[132] As documented in the EDD's annual report, PFL is a benefit of high value which can lead to attempts to defraud the system for personal gain. Examples of these activities include 1) employers may not fully pay required taxes; 2) claimants may claim or continue to claim benefits while working; 3) imposters may falsely use identities of workers to obtain benefits; 4) physicians or providers may certify medical conditions inappropriately; and 5) forged documents may be submitted.[133]

The EDD in California administers fraud prevention and detection programs for UI, SDI and PFL programs. Prevention activities include customer education and attestation of understanding about the illegality of submitting false information (e.g. so-called fraud notices on claim documents), reviews of physician and provider licenses, verification of medical information (potentially including independent medical examinations), and cross matching of data.[134] Private insurance carriers who administer disability and/or PFL benefits have procedures that are equally robust. These procedures are employed in combination with external auditors who verify that practices follow stated norms and report findings and suggestions for improvement. Finally, sound practices require that once suspected or identified, possible fraud must be fully investigated up to and including arrests and prosecution.

States with private plan options oversee similar activities. Employers are required to formally apply to the states for approval to offer private plans. Approvals are dependent on adherence to state specifications for coverage including the requirement that coverage provisions be at least as good as those offered by the state plan. Some states require a common administrator for temporary disability and family leave (California, New York and New Jersey) and others allow a split between private and state plans (Massachusetts and Washington State). Once plans have been implemented, employers are subject to oversight of their plans by the states. This can take multiple forms, including required state reporting and onsite audits.

Exhibit 61

State	Administration Options	Private Plan Requirements as of October 2019
California	▪ Employers may apply to opt-out of state plan for temporary disability and paid family leave in favor of a Voluntary Plan (VP)	▪ Majority of employees must approve opting out of state plan ▪ Plan must provide all benefits of SDI and one benefit that is better; cannot cost employees more than SDI

State	Administration Options	Private Plan Requirements as of October 2019
		▪ If approved, employer must post security deposit with the state to guarantee all obligations are met ▪ Employers must adhere to prescribed benefit determination procedures and submit required reports to state ▪ Annual onsite compliance reviews required by California Unemployment Insurance Code (CUIC) and conducted by EDD. Formal audit report delivered within 90 days with requirement to address any corrective actions.[135]
District of Columbia	▪ District administered plan only	▪ Insured or self-insured private plans are not allowed
Massachusetts	▪ Private plan option (insured or self-insured) allowed for either temporary disability or family leave or both	▪ Benefits must be equal or greater than those provided by state PFML ▪ Self-insurers must post bond ▪ Must adhere to state requirements for coverage and provide job protection ▪ Application for private plan online; decision promised in 1-2 business days ▪ Appeals allowed ▪ Oversight responsibilities under development[136]
New Jersey[137]	▪ Private plan option (insured or self-insured) allowed; must be for both temporary disability and family leave allowed	▪ Private plan must at least equal the provisions of the state plan ▪ Insurance carriers approved to offer PFL are posted to website ▪ Private Plan Claims Manual available ▪ Semi-annual/annual reports required by employers for statistical purposes (claims submitted, accepted, amounts paid) and annual yearly summary including earned premium and administrative costs

State	Administration Options	Private Plan Requirements as of October 2019
		▪ As of May 2019, New Jersey no longer requires employee election of a private plan and employers no longer need to contribute to the TDI trust fund
New York[138,139]	▪ No state plan option ▪ Coverage provided by private insured or self-insured plans or New York State Insurance Fund (NYSIF) ▪ Same administrator required for temporary disability and family leave	▪ PFL coverage falls under NY procedures for insured and self-insured private plans; filing process and model language included ▪ List of insurance carriers offering PFL posted on website ▪ Insurance company exams generally conducted on-site every 24-36 months by Department of Financial Services followed by written report
Rhode Island	▪ State administered plan only	▪ Insured or self-insured private plans are not allowed
Washington[140]	▪ Private plan option (insured or self-insured) allowed for either temporary disability or family leave or both	▪ Plan provisions must meet or exceed state plan and be offered to all employees ▪ Employers submit application for private plan to state with fee of $250; re-application with fee is required for each of first 3 years. If application denied, may be appealed; employees covered by state until approved ▪ To assure portability of coverage when employees change jobs, employers must report wages and hours worked by employee quarterly when operating their own plans ▪ State oversight responsibilities under development

2. Outreach & Education

A robust and continuous education and outreach program is essential to a well-understood and valued PFL program. Hawaii is in a unique position to benefit from the experiences of states with existing or planned programs, including the most mature programs in California, New Jersey, New York and Rhode Island and programs under development in the District of Columbia, Washington and Massachusetts. Each of the seven states can provide valuable insights or lessons learned about

addressing the unique attributes of a state's employers and working population, and best practices can be extracted from their experiences.

The identification of customers and constituents and their roles and responsibilities in a PFL program is the essential first step in developing a plan for education and outreach activities.

Exhibit 62

Customer/Constituent	Roles and Responsibilities
Employer	▪ Collect payroll taxes or contributions to fund PFL ▪ Guide employees to the state in accordance with state laws and/or self-administer or use an insurance carrier or TPA if opt out to a private plan ▪ Advocate for PFL and source of information for employees
Employee	▪ The recipient of PFL benefits ▪ Employees must understand their coverage, how their plan is funded and details about claim filing and administration
Physicians/Providers	▪ Provide documentation of medical condition for personal or care giver leave
Participating Stakeholders	▪ Vendors and suppliers that provide software and other services necessary to administer PFL ▪ Includes payroll and tax vendors and resources, legal resources, insurance brokers, carriers and TPA's
Additional Stakeholders	▪ Resources who can assist in "getting the word out" about benefits for workers caring for ill or elderly family members ▪ Includes private and public medical and residential care facilities, social service agencies and, clinics, hospitals, assisted living and nursing homes

Education and outreach information should be disseminated through effective and efficient communication channels. The timing of the plan's deliverables should respect the goals of building awareness and support detailed content based on a "need to know" basis. For example, the premium or tax collection process precedes the payment of benefits, requiring that employers be placed near the front end of the communication timeline. Employees, on the other hand, benefit from paid leave information closer to when they are either anticipating a leave or accessing benefits.

California and the District of Columbia represent examples of education and outreach programs from two different perspectives. California has the oldest PFL program in the nation, while the District of Columbia program is being developed with benefits beginning in 2020. Massachusetts and Washington are likewise under development. New York and New Jersey, with long-established

plans and administrative structures, do not have readily available information regarding formal education and outreach plans, and a Rhode Island historical perspective is informative as noted below.

Exhibit 63

State	Education and Outreach Methods as of October 2019
California	▪ California has been providing PFL since 2004 and the state's experience illustrates the need for continuous education. The workforce changes over time and gaps in consumers' understanding are revealed. Current outreach activities are as follows:[141] ☐ The legislature authorized $6.2 million over a three-year period, 2014-2017, to support education and outreach activities ☐ The state identified family care leave as an area needing emphasis, thus the Education and Outreach Unit within the Disability Insurance Branch was created to accomplish these tasks ☐ The unit utilized a consultant to implement a statewide media outreach campaign titled "Moments Matter."[142] This campaign consisted of digital and print advertisements and publications, ethnically focused to reach the diverse multicultural populations of California[143] ☐ A PFL microsite was launched: ☐ The campaign included radio ads focusing on bonding and caregiving leave, media briefings and television and radio interviews and outreach events to constituents. Videos promoting PFL program created and posted to the website ☐ The EDD and PFL advocates meet quarterly to exchange information and promote further outreach goals[144]
District of Columbia	▪ Public education and awareness campaigns are required by D.C.'s paid leave law[145] ▪ Collecting premium taxes from employers to fund the program necessitates that they be a priority audience for detailed education about their responsibilities and required actions. Major 2019 activities as reported by the District include: ☐ Launched a public website as the information hub for engaging with the public: https://dcpaidfamilyleave.dc.gov. Constituents will find electronic newsletters, the employer webinar series, collateral such as one-page fact sheets, an employer tool kit, and frequently asked questions (FAQ's). The state reports that informational videos are particularly effective in communicating complex information[146]

State	Education and Outreach Methods as of October 2019
	☐ The District is actively engaged in a range of community outreach activities including Information Sessions for members of the business community, Town Hall Forums directed to employers, and a series of Business Walks by which staff of the Office of Paid Family Leave (OPFL) distribute printed collateral to smaller business owners, inform them of the website and answer questions ☐ The District uses multiple channels of communication—printed mailers, social media, television and radio newscasts as part of an advertising campaign currently emphasizing employers. ☐ The District plans to install The Paid Family Leave Advisory Committee (PFLAC), an informal body used to solicit input and feedback regarding PFL issues and to provide another avenue for sharing information with the public[147]
Massachusetts	▪ Massachusetts is in the early stages of developing their program and the state's website, www.mass.gov, links the user to PFML information for employers and workers with updated postings as the implementation plan proceeds[148.] ▪ The site contains detailed information about employer contributions, timelines, fact sheets and guides for employers about their new responsibilities regarding contributions to the state. The site also contains an online application for opting out of the state plan in favor of a private plans, self-insured or through a carrier and a tool for employers to calculate their contributions[149] ▪ The state has built a feedback tool into the site which asks the user if their question has been answered; responses can be used to formulate additional content
New Jersey	▪ The New Jersey website, https://myleavebenefits.nj.gov, is the hub for information and allows for online claim submission and the ability to access information about individual claims[150]
New York	▪ The state has a dedicated website, https://www.paidfamilyleave.ny.gov, which provides a program overview, FAQ's, employer resources and updated information[151] ▪ Employers who provide private insurance for DBL and PFL are the source of information for workers along with their carriers and administrators
Rhode Island	▪ Rhode Island implemented PFL in six months ▪ The state has a PFL dedicated website: www.ripaidleave.net

State	Education and Outreach Methods as of October 2019
	▪ After the first year of PFL administration, the University of Rhode Island, partnering with the RI Department of Labor and Training, conducted a program assessment and surveys with PFL-eligible employees. Survey results showed only 50% of eligible individuals were aware of the state's TCI program, thus targeted marketing, outreach and education were recommended[152] ▪ Rhode Island received funding from the U.S. DOL to launch its education and outreach campaign [153]
Washington	▪ Washington's program is under development. As the first program in the U.S. not built on an existing disability program, the statute allocated funding for outreach. Since the bill was passed in 2017, $1.5 million has been spent. The campaign has been built by 6 full time staff and a communication strategy firm[154] ▪ The state's communication plan employs a variety of outreach tools, including a website, www.paidleave.wa.gov, where program details are posted, employer toolkits, webinars, emails, business ads, ethnic print, digital ads (videos, social media), radio, paystub inserts, and earned media (new coverage)[155]

In our research and interviews with various state agencies there were multiple mentions of necessary or particularly effective tools which may be considered best practices regardless of the type of model applied.

Exhibit 64

Education and Outreach Best Practices
▪ A successful PFL program relies on a well-orchestrated and continuous education and outreach plan tailored to the state's business community and its employees. Over-communication is impossible. Regular feedback mechanisms identify gaps and improve content and message delivery ▪ A dedicated website serves as a communication hub where information is posted, stored and easily accessed ▪ Webinars and informational videos are effective and well-received tools for conveying complex information ▪ A wide variety of communication channels, tailored to the state, constitute an effective education program, including digital, print, radio, television and in-person informational forums; multiple language capabilities are required.

- Advisory committees can serve as a formal means for information exchange between constituents and the state department administering and/or overseeing PFL. These discussions provide information to guide implementation and administration, identify barriers and misunderstandings and build support and trust
- Well-staffed customer service contact centers are beneficial to responding to questions about all aspects of a PFL program and are essential to quality claim administration

B. Administering Department

1. Specific States of Focus

States that have already implemented PFL systems or are in the process of developing them have built their programs through their employment security agencies, who also administer Unemployment Insurance (California, District of Columbia, Washington), or through their labor departments (Massachusetts, New Jersey, Rhode Island). The exception is New York who administers its program in coordination with WC through its New York State Workers' Compensation Board and the NYSIF that provides WC, TDI and PFL.

Exhibit 65

State	Administrative Agency	Responsible for PFL
California[156]	Employment Development Department (EDD)	Disability Insurance Branch (Central Office Division, Field Office Division)
District of Columbia[157]	Department of Employment Services (DOES)	Office of Paid Family Leave (OPFL)
Massachusetts	Executive Office of Labor and Workforce Development (EOLWD)	Department of Family and Medical Leave
New Jersey	Department of Labor and Workforce Development	Division of Temporary Disability and Family Leave Insurance
New York[158]	Workers' Compensation Board	Department of Financial Services
Rhode Island	Department of Labor and Training	Temporary Disability, Caregiver Insurance Section
Washington	Employment Security Department	Office of Paid Family and Medical Leave

Some of the states (California, New Jersey, Massachusetts, Washington) allow employers to opt out of the state option to private plans whereby the administrative body also oversees the application for exemption process and provides ongoing governance to ensure employers remain compliant. Of the four states that provide this option, two of them (Massachusetts and Washington) allow employers to split the opt-out to allow medical leave only, family only or both medical and family leave. One state (New York) only provides governance as it is up to the private insurance market and the NYSIF to administer claims, albeit through a highly regulated mechanism.

Within each administrative agency, and as relevant to the above-mentioned structures and associated claim volumes, specific sections have been established to manage and oversee PFL, either in conjunction with or separate from TDI. Particular units or areas of responsibility that may exist within PFL administration programs include tax/premium contribution collection, customer service, claims administration, audit and fraud detection, appeals, medical, private plan oversight, and overall program support, which may include or be separate for information technology (IT), training and education and outreach. In addition, finance and actuarial functions vary by type of model.

Access to state services is most commonly provided online where claims are filed and supportive information can be found; through call centers where inquiries from claimants, employers and medical providers are addressed; or in person where customers can visit offices to submit or pick up a claim form, ask questions or provide additional documentation for their claim.

IT systems aid in determining PFL eligibility, adjudicating PFL claims, and ensuring that PFL benefit payments are calculated accurately and dispersed timely. Efficiencies should be built between PFL and UI systems for eligibility data, coordination of benefits, and to minimize redundant reporting, but are otherwise recommended to be separate and distinct. Ideally, the same system should be used to manage TDI and PFL (or stand alone for PFML) and the system should be specific to the requirements of leave management. Many of the established states use custom built systems to manage claims, while some of the newer states are in the process of seeking more modernized and absence specific systems.

2. Hawaii Department of Labor & Industrial Relations

Although Hawaii does not have a PFL law in place, it does have its long-standing TDI program, enacted in 1969, which is administered by the DLIR. Conversations held with the DLIR indicate that it is responsible for oversight and management of the DCD in their administration of TDI, as well as WC and PHC. The DCD does not conduct day to day claim management for these coverages. The major activities performed within these groups are centered on appeals, hearings, cost review, vocational rehabilitation review, compliance and program support. For WC, most employers purchase insurance from carriers authorized to transact business in Hawaii, and some are approved to be self-insured. The TDI program is employer mandated and is provided through insured or self-insured vehicles (there is no state fund).

Similar to other states, Hawaii services have been shifting to primarily online delivery, although there are satellite offices in the counties of Kauai, Maui and Hawaii that provide in-person customer support. Information technology has been evolving with centralization of systems and initiatives to automate disability processes. The state is also in the process of developing a proprietary system to be used for WC.

3. Anticipated Support & Potential Approach

As a new state seeking to enact a paid leave system, Hawaii will need to choose or create a vehicle and structure for administration. The state must do so in accordance with the type of model (social insurance, employer mandate) it establishes for PFL and considering the structure it already has in place for TDI.

Under a social insurance model, either exclusively through the state (District of Columbia, Rhode Island) or through allowance of private plan opt outs (California, Massachusetts, New Jersey, Washington), the infrastructure for PFL will require all of the functional and structural areas described above and thus, a new agency created, such as an office for PFL. Under a social insurance model that is highly regulated and reliant on private markets or an insurance fund (New York), Hawaii's role would be limited to governance and could likely be accomplished through adding staff to an existing agency, such as the DCD.

Other states have been successful in expanding their long-standing TDI programs for PFL; however, Hawaii is unique in being the only state to deliver TDI as a pure employer mandate. To date, none of the states have taken the employer mandate approach for PFL. Although, there are concerns that gender inequity could result from such an approach, the effects could be mitigated through appropriate risk sharing mechanisms, and the EEOC provides protections against discrimination.

Some states have built on their existing UI programs, however, this is not recommended due to the philosophical differences between UI benefits being intended for workers when they separate from their jobs and TDI and PFL benefits intended to facilitate return to work. PFL departments are starting to collaborate with state insurance departments, insurance carriers and TPAs that have claims, customer service and administrative staff and experience handling disability, FMLA, and paid and unpaid family leave benefit programs.[159] Having private insurers and TPAs provide and administer PFL benefits is thought to reduce the financial and administrative burden on government agencies; leverage expertise, systems and staff that is already available; and provide employers with a way to manage a number of leave and benefits in one consolidated platform, thereby increasing ease of use and compliance.[160]

C. Staffing & Information Technology

As it is not yet known which model the state will choose, we have estimated staff count by role and commented on the IT infrastructure that will need to be developed for (1) a social insurance model exclusively through the state; (2) a social insurance model that allows private plan opt outs and (3) a governance only role that would be applicable to a social insurance model that is highly regulated and reliant on private markets or an insurance fund or an employer mandate.

1. Recommended Roles & Headcount

The roles that will be needed to effectively manage a paid leave program in Hawaii can be organized into several categories. Program management staff would run an office for PFL by directing policy, determining processes, facilitating education and outreach and the like. Claims administration staff would administer the bonding and family care claims that will flow through to the state. Support staff would aid the claims staff in terms of audit, quality assurance, fraud detection, appeals and training, and would also monitor tax/premium contribution collection and review private plan applications. IT staff would manage the system platforms used and provide data, analytic and reporting support as needed. According to discussion with Hawaii's Office of Enterprise Technology Services (ETS), all would be supported by ETS from a shared services perspective.

The number of recommended staff in each category, according to individual roles are summarized below. The figures are shown by model type and are based on the first full year of claims. For illustrative and conservative purposes, they are based on Hawaii assuming the California model of eligibility and benefit terms.

Exhibit 66

	Social Insurance Model through an Exclusive State Fund	Social Insurance Model with Private Plan Opt-Outs	Governance Only Role
Program Management Staff			
Director	1	1	1
Office Manager	1	1	1
Policy Developer	1	1	1
Education and Outreach Manager	1	1	1
Administrative Support	1	1	1
Claims Administration Staff			
Senior Claim Specialists	3	2	--
Claim Specialists	2	2	--
Intake/Customer Service Representatives	2	1	--
Manager	1	1	--
Supervisor	1	1	--
Clinical/Vocational Rehabilitation Specialist	0.5	0.5	--
Program Support Staff			
Audit/QA and Fraud	2	2	--
Appeals	1	0.5	--
Training Specialist	1	1	--
Tax/Premium Contribution Collection	1	1	1

	Social Insurance Model through an Exclusive State Fund	Social Insurance Model with Private Plan Opt-Outs	Governance Only Role
Private Plan Review	--	2	--
IT Staff			
System Integration Administrator	1	1	--
System Analyst and Coordinator	1	1	1
Data, Analytics and Reporting Specialist	0.5	0.5	0.5
System Team Support	0.5	0.5	--
Total Estimated Staff Count	22.5	22	7.5

2. IT Infrastructure Development

In addition to the carriers and TPAs that are already actively involved in the leave administration market, there are a number of software platforms that have been built to specifically manage disability, FMLA, paid and unpaid leaves. They are based on leave management business rules that link to federal, state and local regulatory guidelines, include comprehensive workflow to guide the process from intake to eligibility, all the way through to claim determination and correspondence generation. They match incoming documents to claims, trigger automated tasks for consistent action, and include audit trails and change history to facilitate audits and fraud inquiries. They are user-friendly and prepared to manage multiple leaves on a concurrent basis, and interface with other systems to share data as appropriate.

As a result, and although a detailed analysis of current Hawaii DLIR IT infrastructure would need to be conducted to be sure, Spring is of the opinion that Hawaii would not need to build their own PFL system solution from the ground up. Instead, a request for proposal process could be conducted to select from a cadre of existing systems that are already prepared to manage PFL in an efficient and effective manner. The selected system could interface with the UI system and possibly others within the DLIR, and the costs would consist of annual ongoing fees for technology lease/maintenance and initial one-time or implementation fees that would account for development, testing, custom programming, data feeds and training.

D. Projected Start-Up Costs

The staffing numbers and IT infrastructure for each of the three options have been translated into financial terms and estimated costs below. Start-up costs have been separated to the extent possible, and ongoing costs categorized accordingly. A more detailed accounting can be found in the Appendix.

Exhibit 67

	Social Insurance Model through an Exclusive State Fund	Social Insurance Model with Private Plan Opt-Outs	Governance Only Role
Start-Up Costs			
Staffing with 60% Benefits Load and 5% Property & Equipment Load	Note: Program Management Staff to be Phased In	Note: Program Management Staff to be Phased In	Note: Program Management Staff to be Phased In
IT Software Implementation	$0.400M	$0.400M	--
Marketing Strategy & Materials	$0.100M	$0.100M	$0.60M
External Legal	$0.100M	$0.100M	$0.100M
External Consultants & Actuaries	$0.500M	$0.500M	$0.500M
Sub-Total Start-Up Costs	$1.100M	$1.100M	$0.660M
Ongoing Costs			
Staffing with 60% Benefits Load and 5% Property & Equipment Load	$2.240M	$2.235M	$0.953M
IT Software	$0.175M	$0.175M	--
Tools and Training	$0.009M	$0.008M	--
External Legal	$0.050M	$0.050M	$0.050M
External Consultants & Actuaries	$0.150M	$0.150M	$0.100M
Sub-Total Ongoing Costs	$2.624M	$2.618M	$1.103M

V. Observations & Conclusions

A. Perspective on Existing Models

Without a federal law in place, the momentum for states to pass their own paid leave laws is increasing. For the states that have enacted laws, the most common model is that of social insurance where employers can opt-out to private plans and either administer the plan themselves or partner with an insurance carrier or TPA on a fully insured or self-insured basis to do so.

The scope of coverage provided by each state law varies significantly, from the eligibility requirements, to the qualifying reasons for leave, waiting periods, leave durations, benefit levels, benefit calculations, and whether there is job protection. Furthermore, the definitions of what is covered and how, and the mechanics of calculating benefit payment can be cumbersome.

Employers and industry professionals have voiced concern over these differences and points of confusion as they not only make it challenging for employers to communicate and educate their employees, but also to understand and determine how paid leave laws coordinate with other benefit plans (e.g., sick leave, disability, WC) that employers offer. The issue is heightened for employers that have employees in more than one state, as they may have not only one paid leave law, but multiple paid leave laws to interpret.

As such, regulation that is clear, administration that is straightforward, and education that is comprehensive are essential to a state's success and core to the intention of paid leave laws being designed to support workers. Striving for consistency with other state benefits and mandates, particularly ensuring they dovetail with statutory disability and considering paid leave as part of a broader benefit offering, will decrease confusion and increase awareness of all parties involved.

B. Modeling Conclusions

In terms of the analysis that was conducted to consider the impacts of adopting the paid leave models of seven states, there are a range of costs and funding levels to consider, as well as rating structure to determine.

The primary driver of differences between state modeled claims cost funding levels is the maximum number of weeks of benefit under each state program. The remaining differences in modeled claims cost is mostly explained by average weekly benefit amount differences which is impacted by wage replacement ratios and maximum benefits.

Although the body of the report describes various cost and funding measures and illustrates several options for Hawaii to consider, all point to the Washington, New York and New Jersey models resulting in the highest indicative claim funding rates (projected claim costs divided by projected

taxable wage base) to Hawaii, though New York has the second lowest average weekly benefit amount. This is driven by the low taxable wage base in New York in comparison to the other states. Also, although the District of Columbia has a relatively high average weekly benefit amount, the funding rate is relatively low because they do not cap the taxable wage base. The District of Columbia, Massachusetts and Hawaii TDI models result in the lowest funding rates to Hawaii. California falls in the middle of the range.

C. Industry Insights

Hawaii is in a unique position as it already has a TDI law in place which could be expanded upon as other states have done, however it is carried out through an employer mandate, which none of the states have done. The closest model to an employer mandate is New York, which Hawaii could implement, likely without creating a state fund and instead allowing private plan opt-outs and lifting the TDI restriction that carriers or TPAs need to have an on-island presence to administer claims. Whichever model Hawaii chooses, there will be a certain number of staff that will need to be added to the existing state infrastructure and an office for PFL established.

For new states seeking to enact a paid leave system, industry professionals offer the following advice, some of which is thought to encourage gender equity and even increase state to state equity:

- Preserve the statutory requirement that disability benefits for an employee's own medical condition provide for 26 weeks of leave, which is the standard period of privately insured short-term disability policies, and that family leave be limited to a shorter period of time up to the 12 weeks that is afforded under FMLA. Cap the total benefit with a combined maximum entitlement of 26 weeks that can be taken in one year[161]
- Legislation should clearly state that paid family/medical leave run concurrently with unpaid FMLA leave so that leaves are not "stacked" and employees don't end up with double or more the amount of leave contemplated by the statutes.[162] Consider a simplified benefit formula, align the definition of salary with that of disability or WC, avoid ERISA status, advocate for return to work, provide gender neutral covered relationships and leave lengths, exclude job protection (as it is accounted for elsewhere) and sunset unpaid leave laws (to start fresh with the new law)[163]
- Include the opportunity for employers to opt-out to private plans in the regulations and allow both fully insured and self-insured options for employers to choose from.[164] Within these parameters, set minimum standards but allow employers and insurers the flexibility to design and offer coverage that provides equal or richer benefits than any designated state benefits
- Allow for adequate timing to implement a new program, which is felt to be at least two years but ideally two to three years, starting with the point at which legislation is developed so that parameters can be clearly-defined and administration requirements well thought out, and a thorough job can be done to estimate cost[165]

- Leverage industry experts (e.g., insurance carriers, TPAs, brokers and consultants) in all steps of the paid leave law development process, as they have been managing both paid and unpaid leave for years and can provide valuable insight into industry and market best practices. Invite industry to comment on draft regulations, provide input on process and administrative nuances. Hire people with industry experience into state departments as applicable, and work closely with department of insurance counterparts to ensure effective coordination[166]

If Hawaii decides to move forward in establishing a PFL program, several pertinent policy aspects will need to be determined by lawmakers. Although each are described below and separately within this report, they should be considered as a whole and interrelated.

Plan Structure

- Plan model (e.g., social insurance, social insurance with opt-outs, social insurance alongside regulated and private options, employer mandate)
- Rating method (e.g., community rating with or without risk adjustment if private insurance is allowed, or individual employer and carrier rate determination)
- Plan design including but not limited to:
  - Benefit amount including wage replacement ratio – progressive or not, percentage of salary replaced, and any minimum or maximum benefit
  - Length of leave (including maximum weeks) for bonding and family care
  - Employer eligibility (e.g., public employers, employer size, self-employed)
  - Employee eligibility (e.g., minimum time worked, or minimum earnings achieved)
  - Qualifying events
  - Covered relationships
  - Job protection
  - Interaction with the State's TDI program

Funding

- Taxable wage base for funding (e.g., Hawaii TDI wage base, social security wage base or other)
- Contributions to funding (e.g., employee, employer, employee and employer contributions)
- Updated costs, particularly as indicative funding rates in this report could change as additional and updated state by state experience can be obtained

Administration

- Administration structure (e.g., administering agency, level of staffing, information technology system used, data reporting)
- Claims management (e.g., claim application and submission methods, eligibility, claim payment timing, interaction with TDI and other employee benefits)

- Ongoing monitoring (e.g., employer opt-out application, compliance review, annual actuarial funding review)

Implementation Timeline

- Rollout sufficient to gain industry and employer support
- Framework to educate and prepare the community
- Protocol for contributions and pre-funding

VI. Appendices

A. Development of Estimated Model Parameters

This section provides extensive detail on the development of each of the estimated model parameters with appropriate narrative and technical support. Each of these model parameters is used to estimate the various 5-year projections presented in Appendix B. The impact of historical benefit changes prior to the projection period were reviewed to project the results.

1. Hawaii Labor Force

Exhibit 68 shows the employed labor force in Hawaii from 2015 to 2024 based on an annualized growth rate of 0.5%.[167]

Exhibit 68

Historical and Projected Hawaii Employee Labor Force		
Year	**Employed Labor Force[168]**	**Note**
2015	649,950	Actual
2016	662,800	Actual
2017	667,000	Actual
2018	662,150	Actual
2019	665,461	Projection Year 0
2020	668,788	Projection Year 1
2021	672,132	Projection Year 2
2022	675,493	Projection Year 3
2023	678,870	Projection Year 4
2024	682,264	Projection Year 5

2. Eligibility

Eligibility is the percentage of total labor force that receives PFL benefits and is used in our analyses in two ways. First, state eligibility for existing state programs was utilized to bring the state specific incidence rate data to a common level to model an appropriate baseline projection for Hawaii's modeled PFL incidence rate. Then Hawaii eligibility factors were utilized to adjust Hawaii's projected labor force for total eligible claimants (i.e., eligible labor force) in Hawaii under each state model. These eligibility factors reflect the various state eligibility requirements identified previously. Differences between the actual state eligibility factors and the determined Hawaii factors arise due to differences in state wage distributions, mix of public and private sector employment, self-employment and others discussed below.

Exhibit 69

Eligibility Adjustments as a Percentage of Employee Labor Force		
State Model	**State Eligibility Factor**	**Hawaii Eligibility Factor**
California	70.00%	65.20%
District of Columbia	NA	72.20%
Massachusetts	NA	60.80%
New Jersey	80.00%	81.00%
New York	67.90%	64.20%
Rhode Island	62.70%	56.80%
Washington	NA	74.00%
Hawaii TDI	72.30%	72.30%

For California and New Jersey, the state data eligibility percentages are developed based on actual data in recent published state PFL performance reports.[169,170] This accounts for actual program participation in addition to the state eligibility requirements in place.

For the remaining states and Hawaii TDI, state eligibility percentages are developed based on state wage survey data and state model eligibility requirements.[171]

3. Benefit Level Adjustments

Benefit level differences between state models have an impact on actual claim activity. As the wage replacement ratio increases a higher incidence rate is expected. Further, decreasing the waiting period and increasing job protection both have the effect of increasing incidence rates (and vice versa).

Historical period benefit level factors are developed and applied to California, New Jersey, Rhode Island and New York claim data to bring actual observed claim incidence rates to a consistent baseline level (60% replacement, a 7-day waiting period and no job protection) to model an appropriate baseline projection for Hawaii's modeled PFL incidence rate. Exhibits 70 and 71 detail the differences from the developed baseline for each of the state models and corresponding impacts. The subsequent pages discuss the development of the benefit adjustments.

Exhibit 70

Baseline Adjustments		
State Model	**Waiting Period**	**Job Protection**
Baseline	7-day waiting period	No job protection
California	2018 adjustment for elimination of waiting period: 4% for bonding and 14% for family care	None
District of Columbia	None	None
Massachusetts	None	2021 adjustment of 1% for offering job protection
New Jersey	None	2020 adjustment of 1% for offering anti-retaliatory rule
New York	2018 adjustment for no waiting period: 4% for bonding and 14% for family care	2018 adjustment of 1% for offering job protection
Rhode Island	2014 adjustment for no elimination period: 2% for bonding and 7% for family care	2014 adjustment of 1% for offering job protection
Washington	2020 adjustment of 4% for no waiting period for bonding	None
Hawaii TDI	None	None

Exhibit 71

Baseline Adjustments		
State Model	**Benefits**	**Definition of Family Members**
Baseline	60% replacement ratio subject to 100% of SAWW with no minimum	Child, spouse, parent, domestic partner
California	(1) 2004 adjustment of -1% for 55% replacement ratio and $50 minimum benefit; (2) 2018 adjustment of 3% for replacement ratio of 70%/60% based on 1/3 of SAWW	2014 adjustment of 2% based on expanded definition for family members
District of Columbia	2020 adjustment of 14% for replacement ratio of 90%/50% based on minimum wage subject to $1,000 maximum benefit	2020 adjustment of 2% based on expanded definition for family members
Massachusetts	2021 adjustment of 10% for replacement ratio of 80%/50% based on 50% of SAWW subject to 64% of SAWW maximum benefit	2021 adjustment of 2% based on expanded definition for family members

Baseline Adjustments		
New Jersey	2020 adjustment of 13% for replacement ratio of 85% subject to 70% of SAWW maximum	2020 adjustment of 4% based on expanded definition for family members (most liberal definition)
New York	(1) 2018 adjustment of -3% for replacement ratio of 50% subject to 50% of SAWW maximum; (2) 2019 adjustment of -2% for replacement ratio of 55% subject to 55% of SAWW maximum; (3) 2020 adjustment of -1% for replacement ratio of 60% subject to 60% of SAWW maximum	2018 adjustment of 2% based on expanded definition for family members
Rhode Island	2014 adjustment of -1% for 60% replacement ratio subject to a minimum based on state minimum wage and maximum (around 85% of SAWW)	2014 adjustment of 2% based on expanded definition for family members
Washington	2020 adjustment of 16% for replacement ratio of 90%/50% based on 50% of SAWW, subject to 90% of SAWW maximum	2020 adjustment of 2% based on expanded definition for family members
Hawaii TDI	2020 adjustment of -1% for 58% replacement ratio subject to 70.18% of SAWW maximum	No adjustment assuming Hawaii PFL program uses the baseline definition under TDI model

i. Elimination of Waiting Period Adjustment Description

Historical elimination of waiting period adjustments are developed using the indicated increase shown from 2017 to 2018 for California's claim rates (as a percentage of the California labor force). The resulting adjustments to the incidence rate are 4.0% for bonding and 14% for family care. Rhode Island factors were modeled at 2.0% for bonding and 7% for family care claim as the maximum duration is only 4 weeks.

ii. Job Protection Adjustment Description

The model includes a 1.0% increase in incidence rates when job protection is included in the leave laws. This is developed from survey data by multiplying the 4.6% of all employees who reported needing leave for a qualified family and medical reason but not taking it, and 17% of those not taking leave due to the fear of losing a job.[172]

iii. Expansion of the Definition of Covered Family Members Description

Family leave rates are modeled based on the observed 2% trend in California's family leave incidence rate associated with the 2014 definition change, wherein the definition of family member was expanded from a child, spouse, parent, and domestic partner, to include parent-in-law, grandparent, grandchild, and sibling.[173]

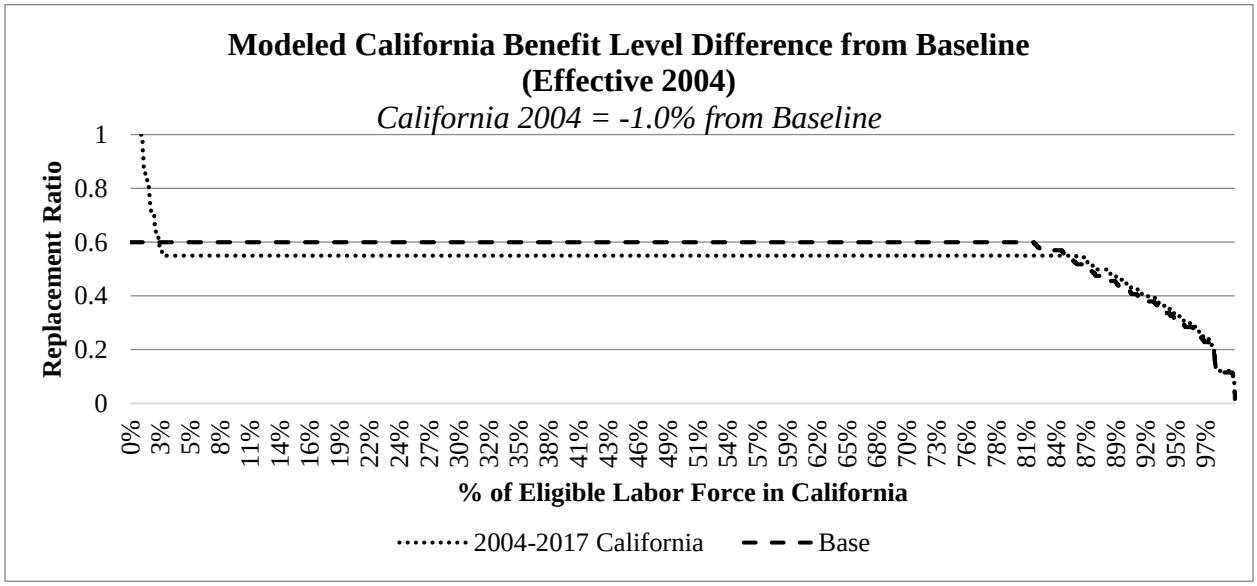
iv. Benefit Change Adjustment Descriptions

Changes in benefit levels from baseline were used to model the impact on both the bonding and family care incidence rates. As the wage replacement ratio and/or program maximum benefit increase a higher incidence rate is expected and vice versa. An insurer's group short term disability rate filing[174] with an effective date of January 1, 2019 was used to model these impacts for each state model. These modeled differences from baseline are summarized by state below.

a. California

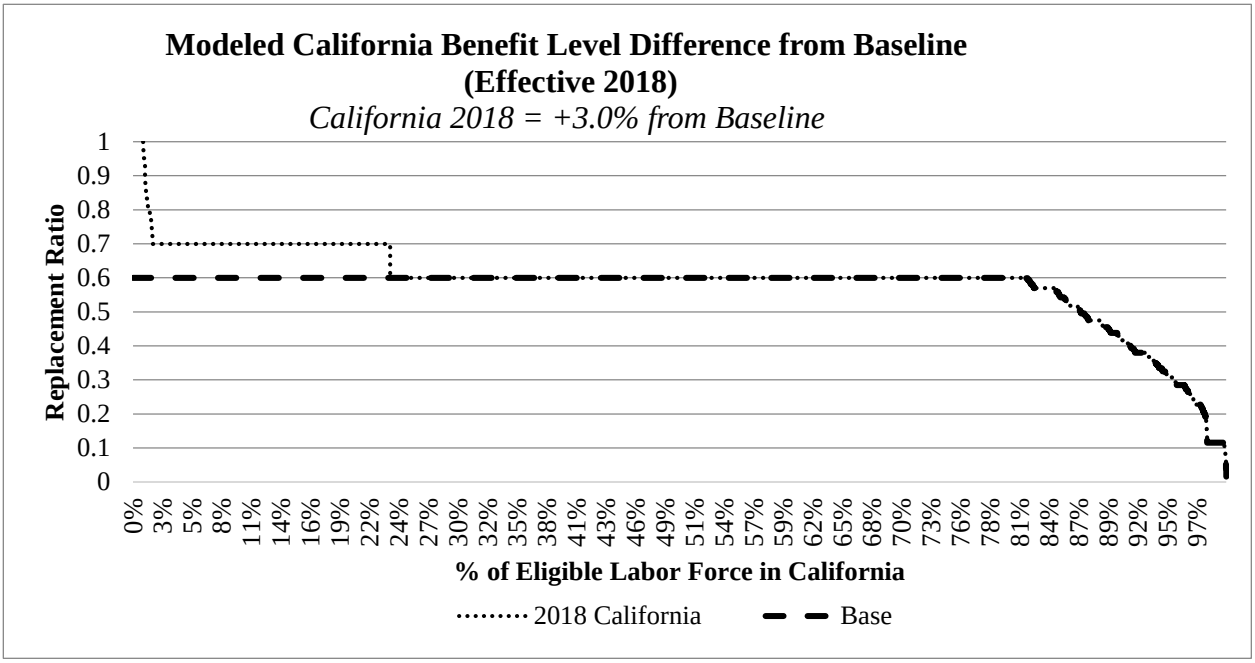
The impact of California's 2004 and 2018 benefit adjustment from the established baseline is developed utilizing the incidence rate adjustments of -1% and 3% respectively. The estimate is based on a combination of industry disability rate filing replacement ratio factors, relative benefit level differences (wage replacement ratio and program minimum and maximum benefit), and eligible labor force data. Benefit level differences from baseline and the eligible labor force percentage impacted are illustrated in Exhibit 72.

Exhibit 72



The dashed baseline 60% wage replacement ratio is up to a maximum benefit of 100% of SAWW. Thus, for highly paid employees, the wage replacement ratio decreases at the maximum benefit level. The dotted California line is similar but demonstrates a 55% wage replacement ratio and recognizes the $50 California minimum benefit. Thus, for lower paid employees, the California plan is above the baseline plan indicating a richer benefit, while for most employees the California line is below the baseline due to a 55% wage replacement ratio compared to the baseline 60% ratio. Finally, for highly paid employees, the benefit is capped at the same maximum. The California plan is actuarially determined to be worth 1% less than the baseline. Similarly, the California plan, as revised in 2018 in Exhibit 73, is determined to be worth 3% more than the baseline.

Exhibit 73

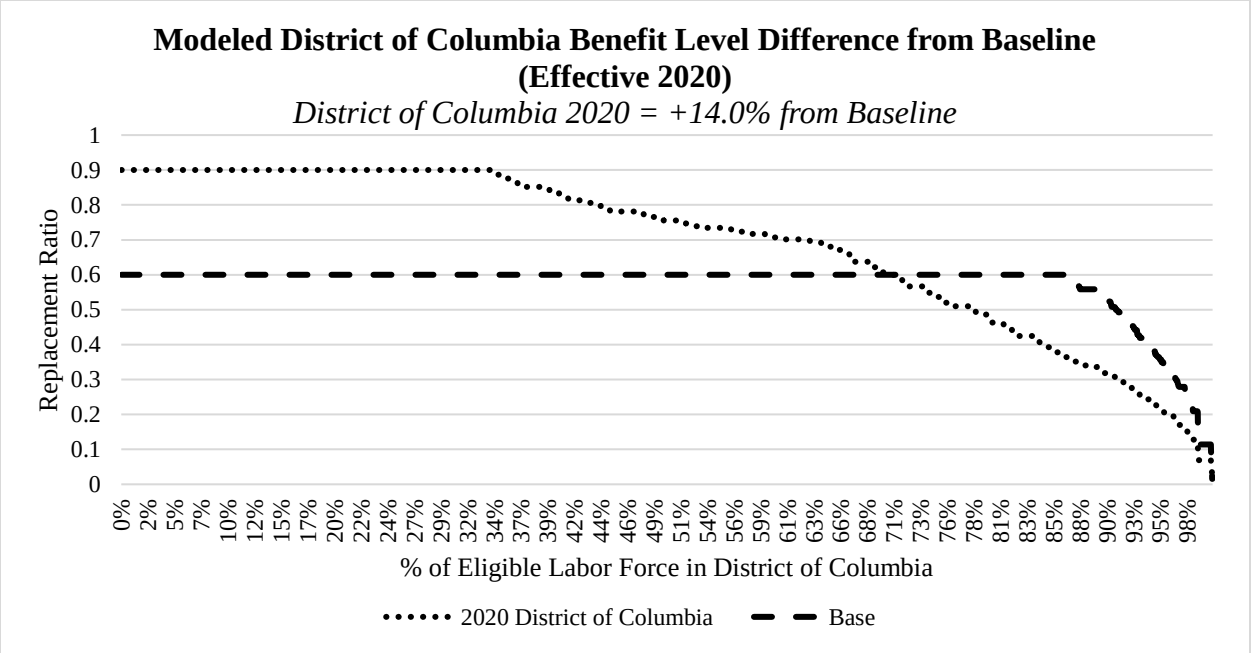


b. District of Columbia

The impact of District of Columbia's 2020 benefit level adjustment from the established baseline is developed utilizing the incidence rates adjustment of +14%. The dashed baseline 60% wage replacement ratio is up to a maximum benefit of 100% of SAWW. Thus, for highly paid employees, the wage replacement ratio decreases at the maximum benefit level. The dotted District of Columbia line demonstrates a progressive structure with a 90% replacement ratio for wages up to 150% of minimum wage and 50% of wages above 150% of minimum wage, subject to a maximum of $1,000. Thus, for lower paid employees, District of Columbia's plan is well above the baseline plan indicating a much richer benefit. This difference from baseline begins to taper off at the 33rd percentile of wage earners and drops below baseline at approximately the 70th percentile of wage earners. This is attributable to a combination of the reduction in contribution rate and then the

capped maximum benefit. The District of Columbia plan is actuarially determined to be worth 14% more than the baseline.

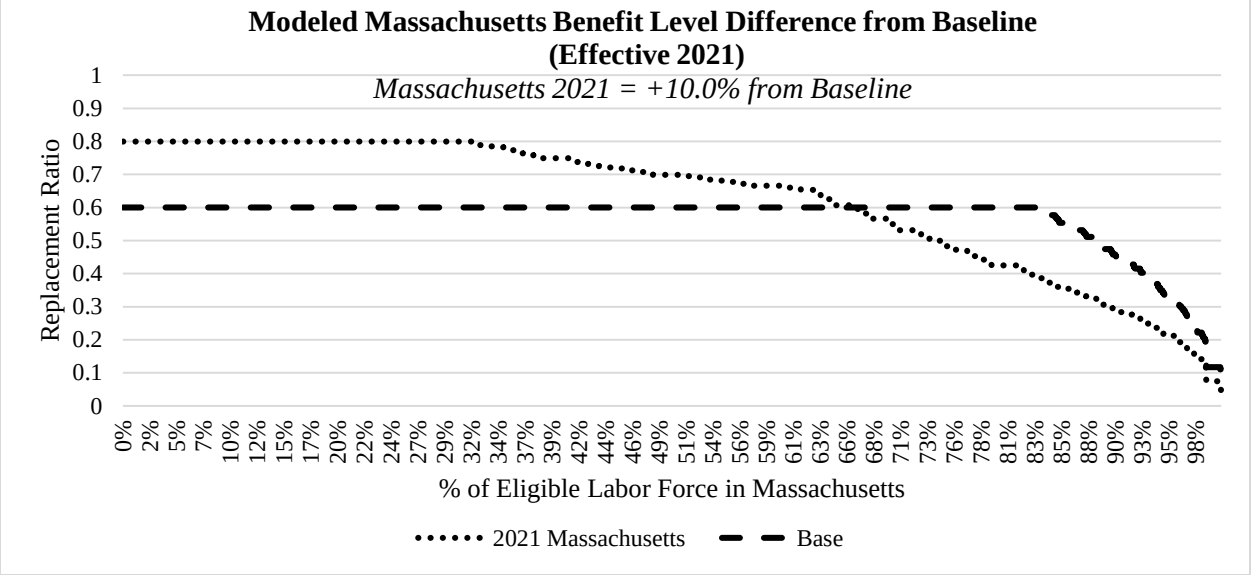
Exhibit 74



c. Massachusetts

The impact of Massachusetts's 2021 benefit level adjustment from the established baseline is developed utilizing the incidence rates adjustment of +10%. The dashed baseline 60% wage replacement ratio is up to a maximum benefit of 100% of SAWW. Thus, for highly paid employees, the wage replacement ratio decreases at the maximum benefit level. The dotted Massachusetts line demonstrates a progressive benefit structure with an 80% replacement ratio for wages up to 1/2 of SAWW and 50% of wages above 1/2 of SAWW, subject to a maximum of 64% of SAWW. Thus, for lower paid employees, Massachusetts's plan is well above the baseline plan indicating a much richer benefit. This difference from baseline begins to taper off at the 30th percentile of wage earners and drops below baseline at approximately the 65th percentile of wage earners. This is attributable to a combination of the reduced contribution rate and the capped maximum benefit. The Massachusetts plan is actuarially determined to be worth 10% more than the baseline.

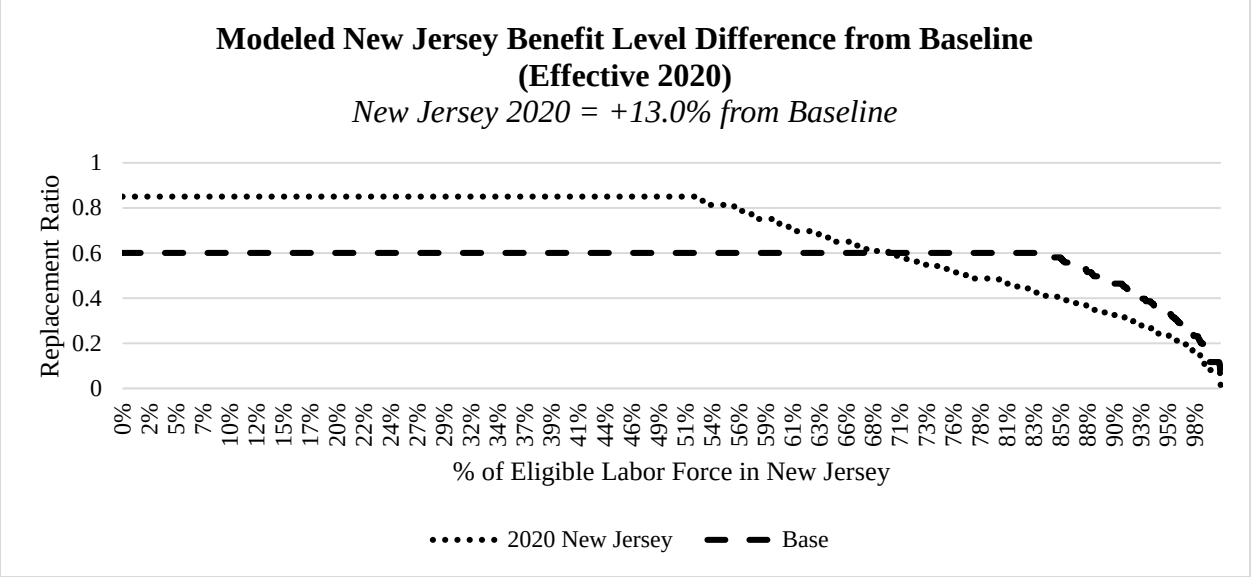
Exhibit 75



d. New Jersey

The impact of New Jersey's 2020 benefit level adjustment from the established baseline is developed utilizing the incidence rates adjustment of +13%. The dashed baseline 60% wage replacement ratio is up to a maximum benefit of 100% of SAWW. Thus, for highly paid employees, the wage replacement ratio decreases at the maximum benefit level. The dotted New Jersey line demonstrates a fixed benefit structure with an 85% replacement ratio for wages, subject to a maximum of 70% of SAWW. Thus, for lower paid employees, New Jersey's plan is well above the baseline plan indicating a much richer benefit. This difference from baseline begins to taper off at the 50th percentile of wage earners and drops below baseline at approximately the 70th percentile of wage earners. This is attributable to the capped maximum benefit. The New Jersey plan is actuarially determined to be worth 13% more than the baseline.

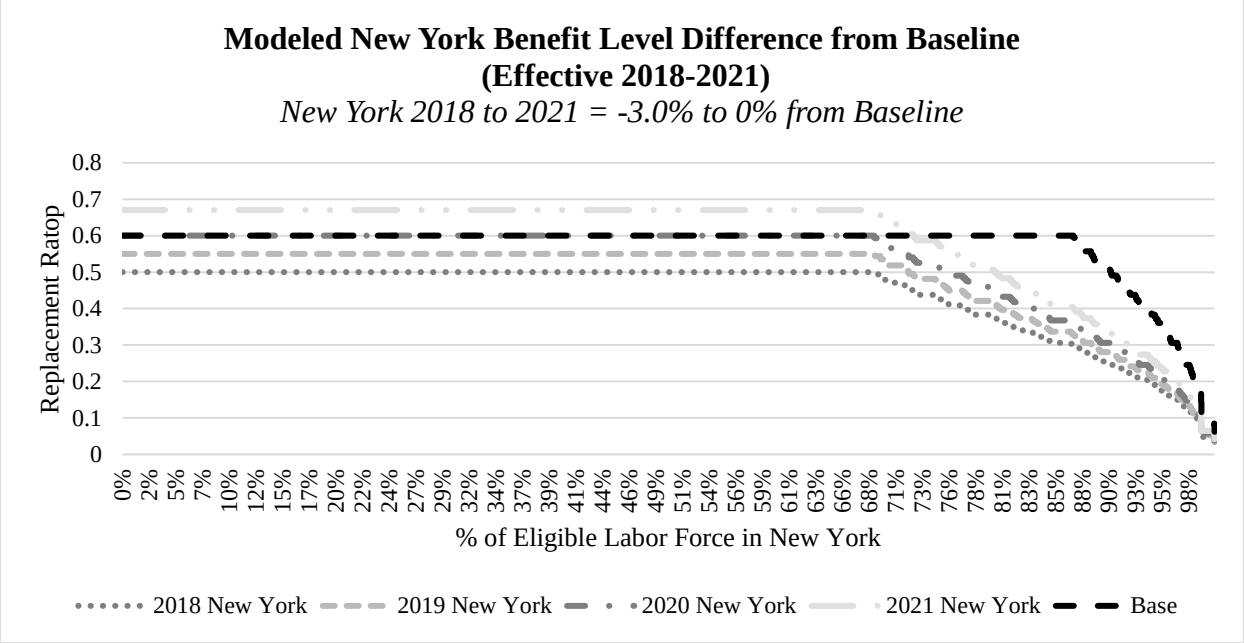
Exhibit 76



e. New York

The impact of New York's 2018, 2019, 2020 and 2021 benefit level adjustments from the established baseline are developed utilizing the incidence rates adjustment of -3%, -2%, -1%, and 0% respectively. The dashed baseline 60% wage replacement ratio is up to a maximum benefit of 100% of SAWW. Thus, for highly paid employees, the wage replacement ratio decreases at the maximum benefit level. The dotted New York line for 2018 demonstrates a fixed benefit structure with an 50% wage replacement ratio, subject to a maximum of 50% of SAWW. The dotted New York lines for the subsequent 3 years also represent a fixed rate structure but with increases in both the replacement ratio for wages and subject maximum to 55%, 60% and 67%, respectively. The 2018 through 2020 benefits are at or below baseline for all wage earners. Starting with the 2021 benefit level adjustment at 67%, roughly 2/3 of the population are above the baseline plan indicating a richer benefit for lower wage earners. This difference from baseline begins to taper off at the 67th percentile of wage earners and drops below baseline at approximately the 73rd percentile of wage earners. This is attributable to the capped maximum benefit. The New York plan is actuarially determined to be worth 3%, 2%, 1%, and 0% less than the baseline for 2018, 2019, 2020 and 2021, respectively.

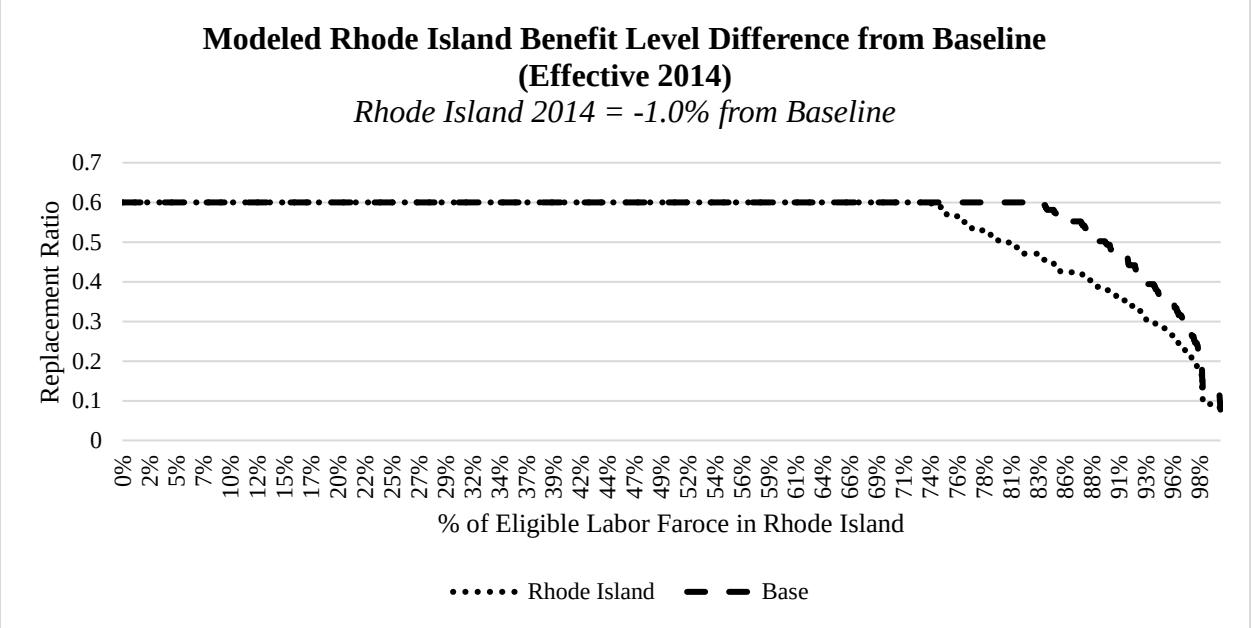
Exhibit 77



f. Rhode Island

The impact of Rhode Island's 2014 benefit level adjustment from the established baseline is developed utilizing the incidence rates adjustment of -1%. The dashed baseline 60% wage replacement ratio is up to a maximum benefit of 100% of SAWW. Thus, for highly paid employees, the wage replacement ratio decreases at the maximum benefit level. The dotted Rhode Island line demonstrates a fixed benefit structure with an 60% wage replacement ratio, subject to a maximum of 85% of SAWW. Thus, for lower paid employees, Rhode Island's plan is equal to the baseline plan indicating no difference in benefit. These zero differences from baseline change at the 75th percentile of wage earners and starts decreasing from baseline. This is attributable to the capped maximum benefit. The Rhode Island plan is actuarially determined to be worth 1% less than the baseline.

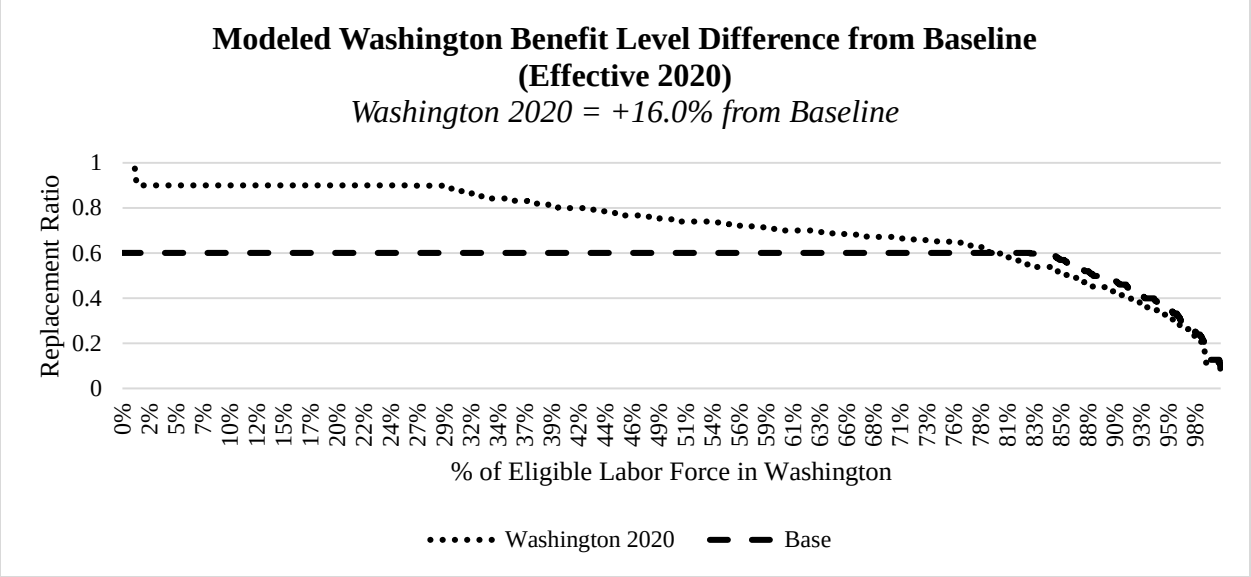
Exhibit 78



g. Washington

The impact of Washington's 2020 benefit level adjustment from the established baseline is developed utilizing the incidence rates adjustment of +16%. The dashed baseline 60% wage replacement ratio is up to a maximum benefit of 100% of SAWW. Thus, for highly paid employees, the wage replacement ratio decreases at the maximum benefit level. The dotted Washington line demonstrates a progressive benefit structure with an 90% replacement ratio for wages up to 1/2 of SAWW and 50% of wages above 1/2 of SAWW, subject to a maximum of 90% of SAWW. There is also a minimum benefit of $100. Thus, for lower paid employees, the Washington plan is well above the baseline plan indicating a richer benefit. This difference from baseline begins to taper off at the 30th percentile of wage earners and drops below baseline at approximately the 80th percentile of wage earners. This is attributable to a combination of the reduced contribution rate and the capped maximum benefit. The Washington plan is actuarially determined to be worth 16% more than the baseline.

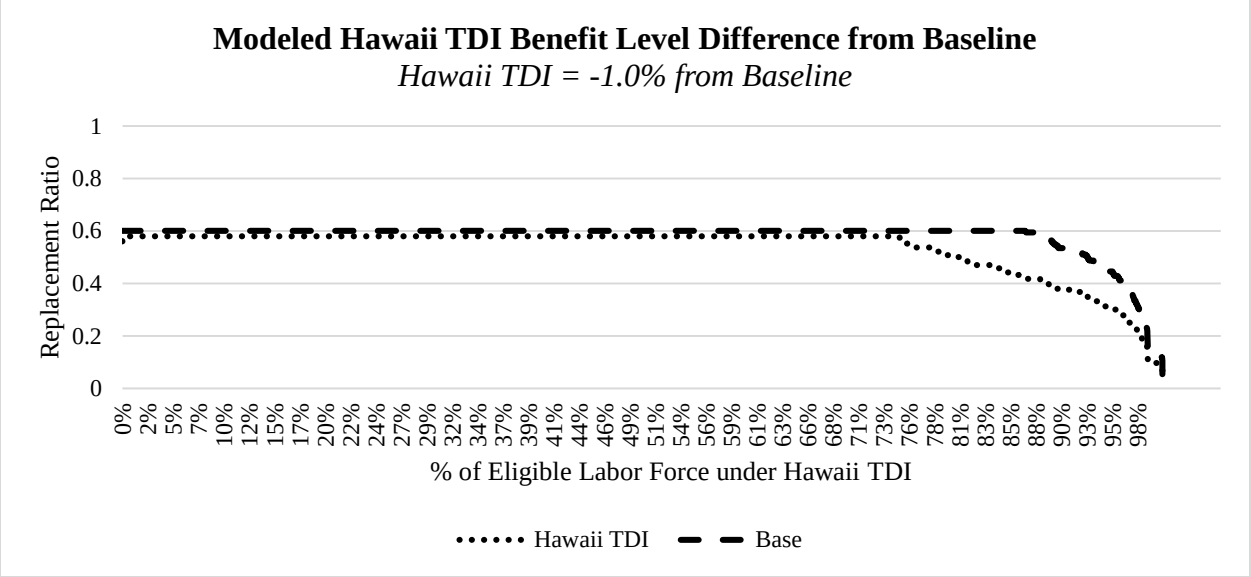
Exhibit 79



h. Hawaii TDI

The impact of Hawaii TDI benefit level adjustment from the established baseline is developed utilizing the incidence rates adjustment of -1%. The dashed baseline 60% wage replacement ratio is up to a maximum benefit of 100% of SAWW. Thus, for highly paid employees, the wage replacement ratio decreases at the maximum benefit level. The dotted Hawaii TDI line demonstrates a fixed benefit structure with an 58% wage replacement ratio, subject to a maximum of 70.1% (58% x 1.21) of SAWW. Thus, for lower paid employees, Hawaii TDI's model is less than the baseline for all wage earners. The Hawaii TDI adjustment is actuarially determined to be worth 1% less than the baseline.

Exhibit 8o



4. Demographic Adjustments

To model an appropriate baseline projection for Hawaii's expected PFL incidence rate using actual historical state PFL claim incidence rates, adjustments were needed to account for certain differences between states for demographics. Certain demographic characteristics are expected to drive a portion of the differences observed between states claims activity, along with the benefit level and eligibility differences previously discussed.

The model adjusts bonding incidence rates for demographic differences between states by comparing both birth rates differences from Hawaii and differences in female labor force in the prime birthing age band of 20-44 for Hawaii. The relative differences between Hawaii and each state were weighted to arrive at the selected adjustment factor to applied to the historical state incidence rate. More weight has given to the female labor force 20-44 differences.

Exhibit 81

Demographic Adjustment to Historical Bonding Incidence Rate				
State	**Year**	**Birth Rate per 1,000 Population*[175]**	**Female Labor Force Age 20-44 / Total[176]**	**Selected Adjustment Factor**
California	2017	11.93	24.7%	99.3%
California	2018	N/A	24.6%	99.3%
Hawaii	2016	12.64	23.5%	100% baseline
Hawaii	2017	12.27	23.7%	100% baseline
Hawaii	2018	N/A	24.3%	100% baseline
New Jersey	2016	11.48	22.5%	103.4%
New Jersey**	2017	11.24	23.7%	103.4%
New York	2018	N/A	25.1%	100.0%
Rhode Island	2017	10.04	26.3%	101.3%
Rhode Island	2018	N/A	24.4%	101.3%
* CDC's latest report is 2017 so 2018 birth rate is not available				
** New Jersey only has published PFL data up to 2017				

For family care, this adjustment considers the relative relationship of working females over the age of 44 relative to the total labor force in Hawaii. This is utilized because New Jersey data indicates two thirds of family care claims are submitted by females over age 44. The proportion is then compared to the state specific PFL claim data. The family care incidence rate is adjusted based on this relationship. The incidence rate for family leave in Hawaii is estimated to be approximately 8.1% higher than in California due to a higher proportion of females in Hawaii over 45 years of age in the labor force. California, New Jersey, Rhode Island and New York incidence adjustment factors for Hawaii demographic differences are summarized in Exhibit 82.

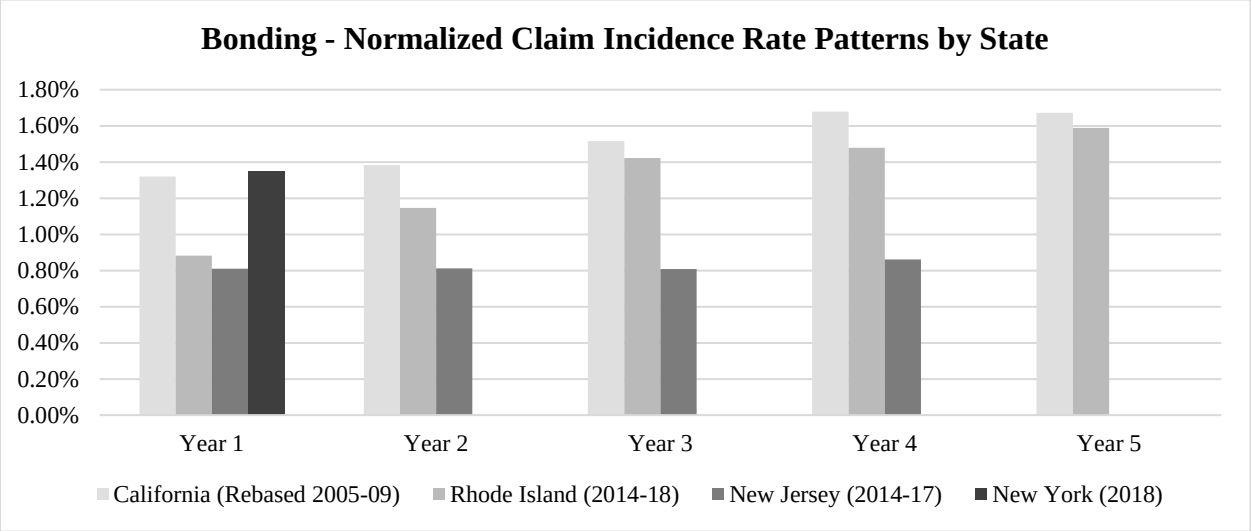
Exhibit 82

Demographic Adjustment to Historical Family Care Incidence Rate			
State	**Year**	**Female Labor Force Age 45+ / Total*[177]**	**Selected Adjustment Factor**
California	2017	19.4%	108.1%
California	2018	19.4%	108.1%
Hawaii	2016	22.0%	100% baseline
Hawaii	2017	22.6%	100% baseline
Hawaii	2018	22.7%	100% baseline
New Jersey	2016	22.4%	99.9%
New Jersey	2017	22.3%	99.9%
New York	2018	21.7%	102.3%
Rhode Island	2017	20.9%	103.0%
Rhode Island	2018	21.8%	103.0%
*New Jersey only has published PFL data up to 2017			

5. Bonding Incidence Rate

Bonding incidence rate is the number of paid bonding claims as a percentage of eligible labor force. The bonding incidence rate projections for Hawaii are developed by bringing historical claim level data to a common level for benefit and demographic differences as developed above. Exhibit 83 shows the resulting adjusted incidence rates for each of the existing PFL programs.

Exhibit 83



Projection year 2020 bonding incidence rate is based on weighting bonding incidence rates for states with current programs using the first year the program was in place (California, 1.32%, Rhode Island, 0.91% and NY-, 1.35%). This is adjusted to develop an annual trend of 1.2%. The trended rates for California, Rhode Island and New York are 1.35%, 0.97% and 1.15%, respectively. Weight is then applied in proportion to the square root of the current state labor force to arrive at the selection of a 1.33% bonding incidence rate for 2020. New Jersey incidence rates are excluded as an outlier.

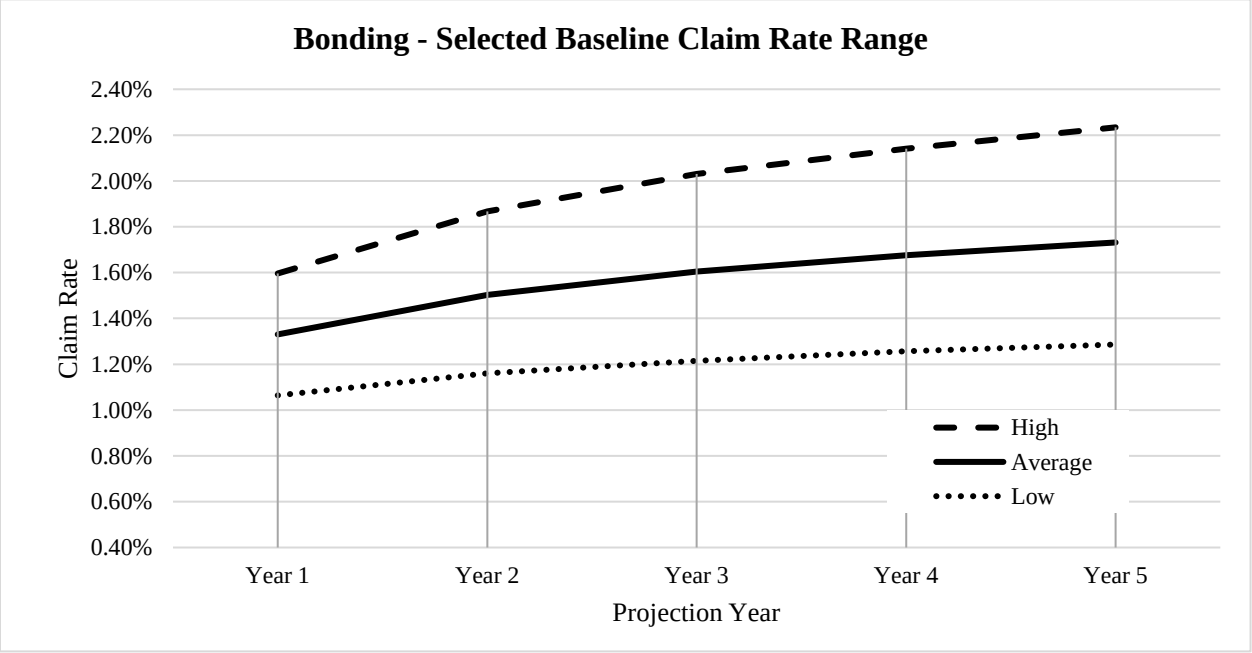
Next, trend increases are applied for the later projection years. The modeled 2021 through 2024 bonding incidence rate trends reflect the following fitted pattern for California incidence rates 2005 through 2009 using a natural log fit.

Exhibit 84

Modeled Year-to-Year Bonding Incidence Rate Trends					
	2020	**2021**	**2022**	**2023**	**2024**
Fitted California Trend	1.28%	1.45%	1.54%	1.61%	1.67%
Modeled Year-to-Year Trend	--	13.0%	6.7%	4.5%	3.3%

A low and high range of outcomes is selected based on the variability in the above state indications and actuarial judgment. The low, central and high figures represent a broad range of estimates based on observed PFL claims experience. Actual claim incidence rates could fall outside of this range. Exhibit 85 illustrates this range of selections against historical bonding incidence rates.

Exhibit 85

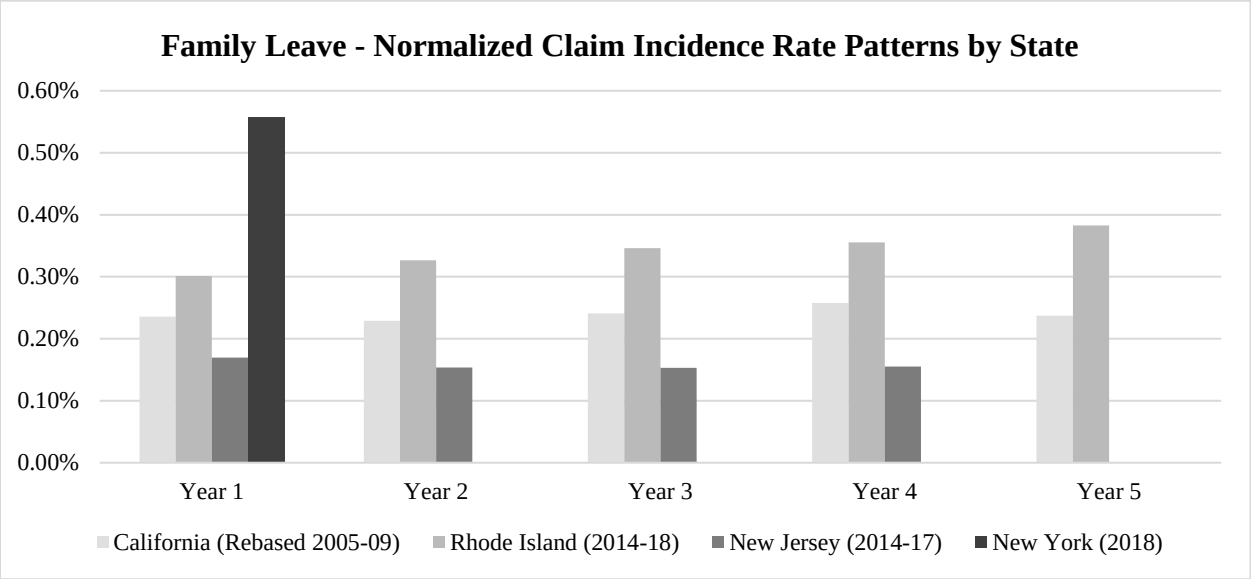


6. Family Leave Incidence Rate

The Hawaii family leave incidence rate is the number of PFL claims as a percentage of employed labor force. The selected bonding incidence rate projections are developed by bringing historical claim level data to a common level for benefit and demographic differences as noted above.

Exhibit 86 shows the resulting adjusted incidence rates for each of the existing PFL programs.

Exhibit 86



The family care incidence rate in projection year 2020 is based on a weighting of bonding incidence rate for California (rebased, 0.15%), Rhode Island (0.30%), and New York (0.57%) in the year the program was first implemented adjusted for an annual trend of 2.5%. The trended rates for California, Rhode Island and New York are 0.22%, 0.35% and 0.60%, respectively. Weight is then applied in proportion to the square root of the current state labor force to arrive at the selection of a 0.38% bonding incidence rate for 2020. NJ incidence rates are excluded as an outlier.

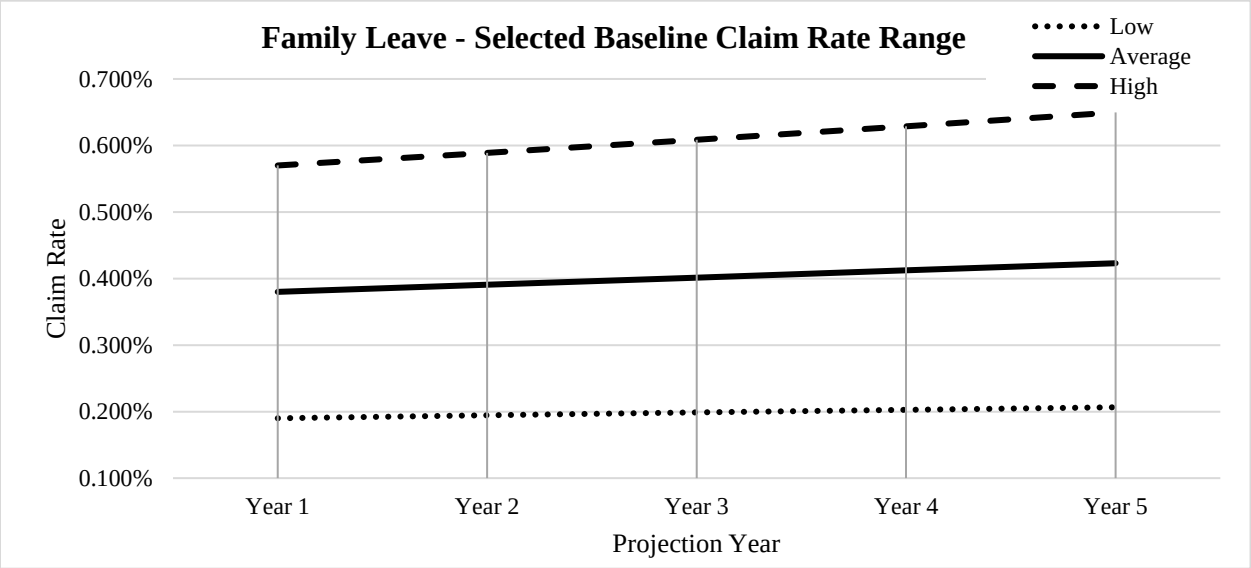
Next, trend increases are applied for the later projection years. The selected 2021 through 2024 family care incidence rate trends reflect the following fitted pattern for California incidence rates 2014 through 2018 using a linear fit.

Exhibit 87

Modeled Year-to-Year Family Care Incidence Rate Trends					
	2020	**2021**	**2022**	**2023**	**2024**
Fitted California Trend	0.21%	0.22%	0.22%	0.23%	0.24%
Change from Prior Year	--	2.8%	2.8%	2.7%	2.6%

A low and high range of outcomes is selected based on the variability in the above state indications and actuarial judgment. The low, central and high estimates represent a broad range of estimates based on observed PFL claims experience. Actual claim incidence rates could fall outside of this range. Exhibit 88 illustrates the range of selections against historical bonding incidence rates.

Exhibit 88



7. Claim Durations

Claim duration is the estimated average length of leave (in weeks) for bonding and family care claims. Duration is a function of the maximum benefit period. As the maximum benefit period increases, more people discontinue their leave. The rate of discontinuance is higher for family care than for bonding claims.

On average in Hawaii, 9.53 weeks are taken for bonding, whereas 4.27 weeks are taken to care for family members if there is no maximum benefit period.[178] As a result, increasing the maximum benefit period has a greater impact on bonding claims costs than on family care claim costs. Available data for PFL bonding versus family care claims is limited to only New Jersey and New York in 2018. These programs are subject to 6-week and 8-week maximum benefit periods, respectively.

Exhibit 89

Actual Duration by Claim Type (Number of Weeks)				
Year	**Bonding Claims**		**Family Leave Claims**	
	New Jersey	**New York**	**New Jersey**	**New York**
2014	5.4	N/A	4.0	N/A
2015	5.4	N/A	4.0	N/A
2016	5.4	N/A	4.0	N/A
2017	5.3	N/A	4.0	N/A
2018	5.4	6.6	4.0	4.2
Maximum	6.0	8.0	6.0	8.0

As actual PFL claim durations do not extend beyond these limits, an extrapolation approach is used to consider the expectation that the portion of leave takers decreases for each additional week of leave taken. Estimates for 4, 6, 8, 10, 12, 14 and 16 weeks are developed separately for bonding and family care with this consideration. The range of selected durations at different maximum benefit periods is illustrated below. This considers both the New Jersey and New York data points as well as the durations results stated above.

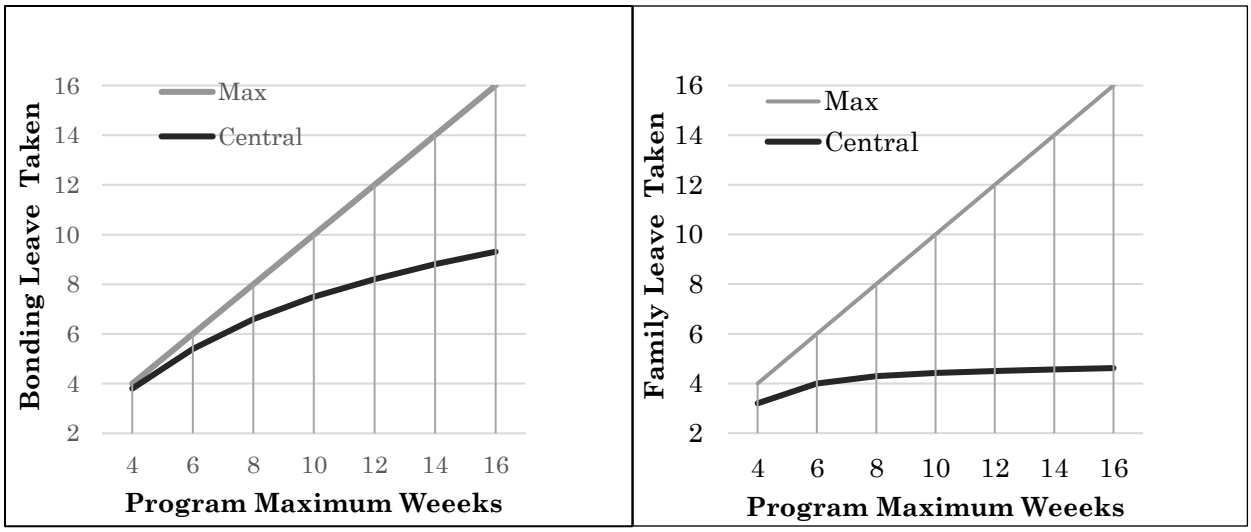
Exhibit 90

Central Estimate of Average Duration by Maximum Duration (Number of Weeks)		
Maximum Duration	**Bonding Claims**	**Family Leave Claims**
4	3.8	3.2
6	5.4	4.0
8	6.6	4.3
10	7.5	4.4
12	8.2	4.5
14	8.8	4.6
16	9.3	4.6

As shown in the below graphs, the difference between maximum duration and the modeled (central) duration increase with the increasing maximum duration, with selected average duration flattening much more quickly for family care.

Exhibit 91

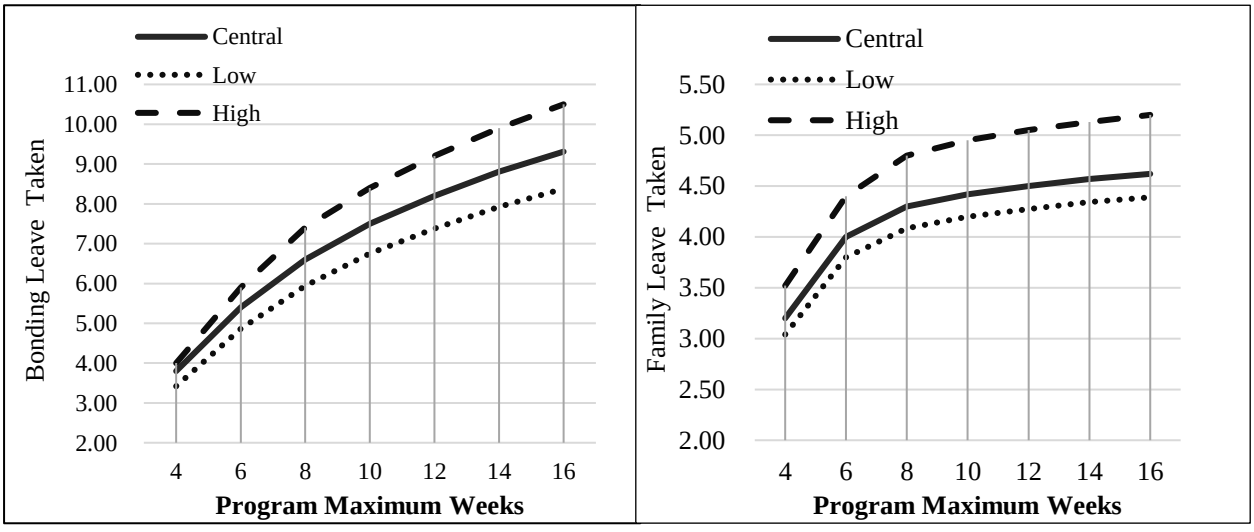
Central Expected Bonding and Family Care Claim Duration Compared to Maximum



As shown in the below graphs, the model ranges between the expected mode durations (Central line in chart) and the low and high dotted line. Each incremental increase in maximum weeks corresponds to an increase in the expected duration. Further each additional increase in program maximum weeks leads to a smaller and smaller increase expected weeks of benefit payments since the percentage of the eligible workforce receiving benefits decreases over time. The larger distance between the high and central estimates in comparison to the distance between the low and central estimates is driven by the uncertainty of actual experience at higher maximum durations. These ranges were arrived at using actuarial judgment with consideration of this theoretical basis.

Exhibit 92

Modeled Bonding and Family Care Claim Duration Range



8. Average Weekly Benefit Amount & Taxable Wage Base

The average weekly benefit amount and taxable wage base in Hawaii is the estimated average weekly benefit subject to the state modeled PFL benefit rules and eligibility requirements. Calculating the average weekly benefit amount consists of the following steps:

1) The weekly wage distribution is calculated based on the eligible Hawaii labor force under the state eligibility requirements. An annual wage growth trend of 2.5% and a labor growth trend of 0.5% is applied to each annual projection period.[179,180] Note the expected average weekly wage in our model for Hawaii is approximately 10% higher than the bureau of labor and statistics (BLS) indication suggests. Because of the application of each state's program benefit maximum, the possible overestimate of expected average weekly benefit amount and average weekly taxable wage base is significantly mitigated. Also, significant variations exist between states' calculations of average weekly benefit.
2) The state maximum contribution formula for the projection year is applied to the wage distribution in step 1 to calculate the distribution of wages subject to the contribution rate to fund PFL program costs. This includes application of the state maximum contribution. The average weekly taxable wage base is then calculated based on the distribution of these wage contributions.
3) The state benefit formula for the projection year is applied to the wage distribution in step 1 to calculate the distribution of weekly benefit payouts. This includes application of benefit formula minimums, maximums and wage replacement ratios. The average weekly benefit received is then calculated based on the distribution of these weekly benefit payouts.

The results and explanations of the projections under California's PFL model for the 2020 through 2024 projection period are shown in Exhibit 93 to 95. Subsequent tables show the results for the other state models.

i. California

The following table shows the average wage distribution and overall average wage for Hawaii of eligible labor force under the California model. The projections adjust Hawaii data for California eligibility requirements, labor force growth and wage growth for the five projection years. The average shown in the last row shows Hawaii's average weekly wage of eligible labor force under this model.

Exhibit 93

Average Weekly Wage Earned by Eligible Labor Force in Hawaii under the California Program[181]					
Wage Band	**Projection Year**				
	2020	**2021**	**2022**	**2023**	**2024**
10.0%	$117	$120	$123	$126	$129
20.0%	$271	$278	$285	$292	$299
30.0%	$424	$435	$446	$457	$468
40.0%	$571	$585	$600	$615	$630
50.0%	$707	$725	$743	$762	$781
60.0%	$851	$872	$894	$916	$939
70.0%	$1,051	$1,077	$1,104	$1,132	$1,160
80.0%	$1,339	$1,373	$1,407	$1,442	$1,478
90.0%	$1,785	$1,830	$1,876	$1,923	$1,971
95.0%	$2,361	$2,420	$2,480	$2,542	$2,606
100.0%	$5,909	$6,057	$6,208	$6,364	$6,523
Average	**$1,125**	**$1,153**	**$1,182**	**$1,212**	**$1,242**

The following table caps the prior table at the maximum taxable wage.

Exhibit 94

Average Taxable Wage Base by Eligible Labor Force in Hawaii under the California Program[182]					
Wage Band	**Projection Year**				
	2020	**2021**	**2022**	**2023**	**2024**
10.0%	$117	$120	$123	$126	$129
20.0%	$271	$278	$285	$292	$299
30.0%	$424	$435	$446	$457	$468
40.0%	$571	$585	$600	$615	$630
50.0%	$707	$725	$743	$762	$781
60.0%	$851	$872	$894	$916	$939
70.0%	$1,051	$1,077	$1,104	$1,132	$1,160
80.0%	$1,339	$1,373	$1,407	$1,442	$1,478
90.0%	$1,785	$1,830	$1,876	$1,923	$1,971
95.0%	$2,054	$2,106	$2,158	$2,212	$2,268
100.0%	$2,054	$2,106	$2,158	$2,212	$2,268
Average	**$917**	**$940**	**$964**	**$988**	**$1,012**

To develop the average weekly average benefit for a specific state, we overlay the benefit payout rules of that state to Hawaii's eligible wage distribution and calculate the distribution of average weekly benefit amount and the overall average. The benefit rule in California, for example, states that the average weekly benefit amount is 60% wage replacement for individuals who earn 1/3 or more of the state average quarterly wage and 70% wage replacement for individuals who earn less than 1/3 of the state average quarterly wage (it's also subject to a minimum of $50 and a maximum of 100% of SAWW).[183] The results are illustrated by percentile for informational purposes. For example, the $50 minimum is not illustrated as it falls below 10%.

Exhibit 95

Average Weekly Benefit Amount by Eligible Labor Force in Hawaii under the California Program					
Wage Band	**Projection Year**				
	2020	**2021**	**2022**	**2023**	**2024**
10.0%	$82	$84	$86	$88	$90
20.0%	$190	$195	$200	$204	$210
30.0%	$255	$261	$268	$274	$281
40.0%	$343	$351	$360	$369	$378
50.0%	$424	$435	$446	$457	$468
60.0%	$511	$523	$536	$550	$564
70.0%	$630	$646	$662	$679	$696
80.0%	$803	$824	$844	$865	$887
90.0%	$1,071	$1,098	$1,125	$1,154	$1,182
95.0%	$1,130	$1,158	$1,187	$1,217	$1,247
100.0%	$1,130	$1,158	$1,187	$1,217	$1,247
Average	**$544**	**$557**	**$571**	**$586**	**$600**

Further detail behind the sample calculations are as follows:

- For year 1 at 10% wage: average weekly wage at the 10% is $117 and is below 1/3 of state average wage of $377 (=$1,130/3). Therefore, the benefit will be 70% x $117 = $82.
- For year 1 at 40% wage: average weekly wage at the 40% is $571 and is greater than 1/3 of state average wage of $377 (=$1,130/3). Therefore, the benefit will be 60% x $571 = $343.
- For year 1 at 90% wage: average weekly wage at the 90% is $1,785. Therefore, the benefit will be 60% x $1,785 = $1,071.
- For year 1 at 95% wage: average weekly wage at the 95% is $2,361. This wage is capped at the maximum of $2,054 (=$1,130/0.55). Therefore, the benefit will be 60% x $2,054 = $1,438 but is capped at the state maximum of $1,130 (=100% x $1,130).

The same calculation process is applied to other states with results shown in the following exhibits.

ii. District of Columbia

Exhibit 96

Average Weekly Wage Earned by Eligible Labor Force in Hawaii under the District of Columbia Program					
Wage Band	**Projection Year**				
	2020	**2021**	**2022**	**2023**	**2024**
10.0%	$113	$115	$118	$121	$124
20.0%	$268	$274	$281	$288	$295
30.0%	$421	$432	$443	$454	$465
40.0%	$569	$583	$597	$612	$628
50.0%	$705	$723	$741	$760	$779
60.0%	$849	$870	$892	$914	$937
70.0%	$1,048	$1,075	$1,102	$1,129	$1,157
80.0%	$1,336	$1,370	$1,404	$1,439	$1,475
90.0%	$1,782	$1,827	$1,873	$1,920	$1,968
95.0%	$2,357	$2,416	$2,477	$2,539	$2,602
100.0%	$5,897	$6,044	$6,195	$6,350	$6,509
Average	**$1,122**	**$1,150**	**$1,179**	**$1,208**	**$1,238**

Exhibit 97

Average Taxable Wage Base by Eligible Labor Force in Hawaii under the District of Columbia Program					
Wage Band	**Projection Year**				
	2020	**2021**	**2022**	**2023**	**2024**
10.0%	$113	$115	$118	$121	$124
20.0%	$268	$274	$281	$288	$295
30.0%	$421	$432	$443	$454	$465
40.0%	$569	$583	$597	$612	$628
50.0%	$705	$723	$741	$760	$779
60.0%	$849	$870	$892	$914	$937
70.0%	$1,048	$1,075	$1,102	$1,129	$1,157
80.0%	$1,336	$1,370	$1,404	$1,439	$1,475
90.0%	$1,782	$1,827	$1,873	$1,920	$1,968
95.0%	$2,357	$2,416	$2,477	$2,539	$2,602
100.0%	$5,897	$6,044	$6,195	$6,350	$6,509
Average	**$1,122**	**$1,150**	**$1,179**	**$1,208**	**$1,238**

Exhibit 98

Average Weekly Benefit Amount by Eligible Labor Force in Hawaii under the District of Columbia Program					
Wage Band	**Projection Year**				
	2020	**2021**	**2022**	**2023**	**2024**
10.0%	$101	$104	$106	$109	$112
20.0%	$241	$247	$253	$259	$266
30.0%	$379	$389	$398	$408	$418
40.0%	$512	$525	$538	$551	$565
50.0%	$601	$616	$632	$647	$664
60.0%	$673	$690	$707	$725	$743
70.0%	$773	$792	$812	$832	$853
80.0%	$917	$940	$963	$987	$1,000
90.0%	$1,000	$1,000	$1,000	$1,000	$1,000
95.0%	$1,000	$1,000	$1,000	$1,000	$1,000
100.0%	$1,000	$1,000	$1,000	$1,000	$1,000
Average	**$620**	**$630**	**$641**	**$652**	**$662**

iii. Massachusetts

Exhibit 99

Average Weekly Wage Earned by Eligible Labor Force in Hawaii under the Massachusetts Program					
Wage Band	**Projection Year**				
	2020	**2021**	**2022**	**2023**	**2024**
10.0%	$196	$201	$206	$211	$216
20.0%	$359	$368	$378	$387	$397
30.0%	$491	$503	$516	$529	$542
40.0%	$626	$642	$658	$674	$691
50.0%	$756	$775	$795	$815	$835
60.0%	$890	$912	$935	$958	$982
70.0%	$1,090	$1,117	$1,145	$1,174	$1,203
80.0%	$1,359	$1,393	$1,428	$1,463	$1,500
90.0%	$1,769	$1,814	$1,859	$1,905	$1,953
95.0%	$2,281	$2,338	$2,397	$2,457	$2,518
100.0%	$5,072	$5,199	$5,329	$5,462	$5,599
Average	**$1,121**	**$1,149**	**$1,178**	**$1,208**	**$1,238**

Exhibit 100

Average Taxable Wage Base by Eligible Labor Force in Hawaii under the Massachusetts Program					
Wage Band	**Projection Year**				
	2020	**2021**	**2022**	**2023**	**2024**
10.0%	$196	$201	$206	$211	$216
20.0%	$359	$368	$378	$387	$397
30.0%	$491	$503	$516	$529	$542
40.0%	$626	$642	$658	$674	$691
50.0%	$756	$775	$795	$815	$835
60.0%	$890	$912	$935	$958	$982
70.0%	$1,090	$1,117	$1,145	$1,174	$1,203
80.0%	$1,359	$1,393	$1,428	$1,463	$1,500
90.0%	$1,769	$1,814	$1,859	$1,905	$1,953
95.0%	$2,281	$2,338	$2,397	$2,457	$2,518
100.0%	$2,620	$2,685	$2,752	$2,821	$2,892
Average	**$999**	**$1,024**	**$1,049**	**$1,076**	**$1,102**

Exhibit 101

Average Weekly Benefit Amount by Eligible Labor Force in Hawaii under the Massachusetts Program					
Wage Band	**Projection Year**				
	2020	**2021**	**2022**	**2023**	**2024**
10.0%	$157	$161	$165	$169	$173
20.0%	$288	$295	$302	$310	$317
30.0%	$393	$403	$413	$423	$434
40.0%	$483	$495	$507	$520	$533
50.0%	$548	$561	$575	$590	$605
60.0%	$614	$630	$645	$662	$678
70.0%	$715	$732	$751	$770	$789
80.0%	$723	$741	$760	$779	$798
90.0%	$723	$741	$760	$779	$798
95.0%	$723	$741	$760	$779	$798
100.0%	$723	$741	$760	$779	$798
Average	**$537**	**$550**	**$564**	**$578**	**$592**

iv. New Jersey

Exhibit 102

Average Weekly Wage Earned by Eligible Labor Force in Hawaii under the New Jersey Program					
Wage Band	**Projection Year**				
	2020	**2021**	**2022**	**2023**	**2024**
10.0%	$272	$279	$286	$293	$300
20.0%	$434	$445	$456	$468	$479
30.0%	$570	$584	$598	$613	$629
40.0%	$700	$718	$736	$754	$773
50.0%	$842	$863	$885	$907	$929
60.0%	$1,010	$1,035	$1,061	$1,087	$1,114
70.0%	$1,215	$1,245	$1,276	$1,308	$1,341
80.0%	$1,501	$1,538	$1,577	$1,616	$1,657
90.0%	$1,895	$1,942	$1,991	$2,040	$2,091
95.0%	$2,387	$2,447	$2,508	$2,571	$2,635
100.0%	$5,502	$5,639	$5,780	$5,925	$6,073
Average	**$1,238**	**$1,269**	**$1,301**	**$1,333**	**$1,367**

Exhibit 103

Average Taxable Wage Base by Eligible Labor Force in Hawaii under the New Jersey Program					
Wage Band	**Projection Year**				
	2020	**2021**	**2022**	**2023**	**2024**
10.0%	$272	$279	$286	$293	$300
20.0%	$434	$445	$456	$468	$479
30.0%	$570	$584	$598	$613	$629
40.0%	$700	$718	$736	$754	$773
50.0%	$842	$863	$885	$907	$929
60.0%	$1,010	$1,035	$1,061	$1,087	$1,114
70.0%	$1,215	$1,245	$1,276	$1,308	$1,341
80.0%	$1,501	$1,538	$1,577	$1,616	$1,657
90.0%	$1,895	$1,942	$1,991	$2,040	$2,091
95.0%	$2,325	$2,383	$2,443	$2,504	$2,566
100.0%	$2,325	$2,383	$2,443	$2,504	$2,566
Average	**$1,076**	**$1,103**	**$1,131**	**$1,159**	**$1,188**

Exhibit 104

Average Weekly Benefit Amount by Eligible Labor Force in Hawaii under the New Jersey Program					
Wage Band	**Projection Year**				
	2020	**2021**	**2022**	**2023**	**2024**
10.0%	$231	$237	$243	$249	$255
20.0%	$369	$378	$388	$397	$407
30.0%	$484	$496	$509	$521	$534
40.0%	$595	$610	$626	$641	$657
50.0%	$716	$734	$752	$771	$790
60.0%	$791	$811	$831	$852	$873
70.0%	$791	$811	$831	$852	$873
80.0%	$791	$811	$831	$852	$873
90.0%	$791	$811	$831	$852	$873
95.0%	$791	$811	$831	$852	$873
100.0%	$791	$811	$831	$852	$873
Average	**$635**	**$651**	**$667**	**$684**	**$701**

v. New York

Exhibit 105

Average Weekly Wage Earned by Eligible Labor Force in Hawaii under the New York Program					
Wage Band	**Projection Year**				
	2020	**2021**	**2022**	**2023**	**2024**
10.0%	$272	$279	$286	$293	$300
20.0%	$434	$445	$456	$468	$479
30.0%	$570	$584	$598	$613	$629
40.0%	$700	$718	$736	$754	$773
50.0%	$842	$863	$885	$907	$929
60.0%	$1,010	$1,035	$1,061	$1,087	$1,114
70.0%	$1,215	$1,245	$1,276	$1,308	$1,341
80.0%	$1,501	$1,538	$1,577	$1,616	$1,657
90.0%	$1,895	$1,942	$1,991	$2,040	$2,091
95.0%	$2,387	$2,447	$2,508	$2,571	$2,635
100.0%	$5,502	$5,639	$5,780	$5,925	$6,073
Average	**$1,238**	**$1,269**	**$1,301**	**$1,333**	**$1,367**

Exhibit 106

Average Taxable Wage Base by Eligible Labor Force in Hawaii under the New York Program					
Wage Band	**Projection Year**				
	2020	**2021**	**2022**	**2023**	**2024**
10.0%	$146	$150	$154	$157	$161
20.0%	$325	$333	$341	$350	$359
30.0%	$470	$482	$494	$506	$519
40.0%	$606	$621	$636	$652	$668
50.0%	$738	$756	$775	$794	$814
60.0%	$872	$894	$916	$939	$962
70.0%	$1,066	$1,093	$1,120	$1,148	$1,177
80.0%	$1,130	$1,158	$1,187	$1,217	$1,247
90.0%	$1,130	$1,158	$1,187	$1,217	$1,247
95.0%	$1,130	$1,158	$1,187	$1,217	$1,247
100.0%	$1,130	$1,158	$1,187	$1,217	$1,247
Average	**$761**	**$780**	**$800**	**$820**	**$840**

Exhibit 107

Average Weekly Benefit Amount by Eligible Labor Force in Hawaii under the New York Program					
Wage Band	**Projection Year**				
	2020	**2021**	**2022**	**2023**	**2024**
10.0%	$88	$100	$103	$105	$108
20.0%	$195	$223	$229	$234	$240
30.0%	$282	$323	$331	$339	$347
40.0%	$363	$416	$426	$437	$448
50.0%	$443	$507	$519	$532	$546
60.0%	$523	$599	$614	$629	$645
70.0%	$640	$732	$751	$769	$789
80.0%	$678	$776	$795	$815	$836
90.0%	$678	$776	$795	$815	$836
95.0%	$678	$776	$795	$815	$836
100.0%	$678	$776	$795	$815	$836
Average	**$457**	**$523**	**$536**	**$549**	**$563**

vi. Rhode Island

Exhibit 108

Average Weekly Wage Earned by Eligible Labor Force in Hawaii under the Rhode Island Program					
Wage Band	**Projection Year**				
	2020	**2021**	**2022**	**2023**	**2024**
10.0%	$328	$336	$344	$353	$362
20.0%	$465	$477	$489	$501	$513
30.0%	$592	$607	$622	$637	$653
40.0%	$708	$725	$744	$762	$781
50.0%	$823	$844	$865	$887	$909
60.0%	$977	$1,001	$1,026	$1,052	$1,078
70.0%	$1,181	$1,210	$1,240	$1,271	$1,303
80.0%	$1,458	$1,494	$1,532	$1,570	$1,609
90.0%	$1,873	$1,920	$1,968	$2,017	$2,067
95.0%	$2,421	$2,482	$2,544	$2,607	$2,672
100.0%	$5,958	$6,107	$6,260	$6,416	$6,577
Average	**$1,259**	**$1,291**	**$1,323**	**$1,356**	**$1,390**

Exhibit 109

Average Taxable Wage Base by Eligible Labor Force in Hawaii under the Rhode Island Program					
Wage Band	**Projection Year**				
	2020	**2021**	**2022**	**2023**	**2024**
10.0%	$197	$201	$206	$212	$217
20.0%	$279	$286	$293	$300	$308
30.0%	$355	$364	$373	$382	$392
40.0%	$425	$435	$446	$457	$469
50.0%	$494	$506	$519	$532	$545
60.0%	$586	$601	$616	$631	$647
70.0%	$708	$726	$744	$763	$782
80.0%	$875	$897	$919	$942	$966
90.0%	$960	$984	$1,009	$1,034	$1,060
95.0%	$960	$984	$1,009	$1,034	$1,060
100.0%	$960	$984	$1,009	$1,034	$1,060
Average	**$584**	**$599**	**$613**	**$629**	**$645**

Exhibit 110

Average Weekly Benefit Amount by Eligible Labor Force in Hawaii under the Rhode Island Program					
Wage Band	**Projection Year**				
	2020	**2021**	**2022**	**2023**	**2024**
10.0%	$328	$336	$344	$353	$362
20.0%	$465	$477	$489	$501	$513
30.0%	$592	$607	$622	$637	$653
40.0%	$708	$725	$744	$762	$781
50.0%	$823	$844	$865	$887	$909
60.0%	$977	$1,001	$1,026	$1,052	$1,078
70.0%	$1,181	$1,210	$1,240	$1,271	$1,303
80.0%	$1,458	$1,494	$1,532	$1,570	$1,609
90.0%	$1,524	$1,562	$1,602	$1,642	$1,683
95.0%	$1,524	$1,562	$1,602	$1,642	$1,683
100.0%	$1,524	$1,562	$1,602	$1,642	$1,683
Average	**$958**	**$982**	**$1,006**	**$1,032**	**$1,057**

vii. Washington

Exhibit 111

Average Weekly Wage Earned by Eligible Labor Force in Hawaii under the Washington Program					
Wage Band	**Projection Year**				
	2020	**2021**	**2022**	**2023**	**2024**
10.0%	$200	$205	$210	$215	$221
20.0%	$398	$408	$418	$428	$439
30.0%	$555	$569	$583	$597	$612
40.0%	$686	$703	$721	$739	$757
50.0%	$817	$837	$858	$879	$901
60.0%	$975	$999	$1,024	$1,050	$1,076
70.0%	$1,171	$1,201	$1,231	$1,261	$1,293
80.0%	$1,438	$1,474	$1,510	$1,548	$1,587
90.0%	$1,847	$1,893	$1,940	$1,989	$2,038
95.0%	$2,346	$2,405	$2,465	$2,527	$2,590
100.0%	$5,180	$5,309	$5,442	$5,578	$5,717
Average	**$1,185**	**$1,214**	**$1,245**	**$1,276**	**$1,308**

Exhibit 112

Average Taxable Wage Base by Eligible Labor Force in Hawaii under the Washington Program					
Wage Band	**Projection Year**				
	2020	**2021**	**2022**	**2023**	**2024**
10.0%	$200	$205	$210	$215	$221
20.0%	$398	$408	$418	$428	$439
30.0%	$555	$569	$583	$597	$612
40.0%	$686	$703	$721	$739	$757
50.0%	$817	$837	$858	$879	$901
60.0%	$975	$999	$1,024	$1,050	$1,076
70.0%	$1,171	$1,201	$1,231	$1,261	$1,293
80.0%	$1,438	$1,474	$1,510	$1,548	$1,587
90.0%	$1,847	$1,893	$1,940	$1,989	$2,038
95.0%	$2,346	$2,405	$2,465	$2,527	$2,590
100.0%	$2,620	$2,685	$2,752	$2,821	$2,892
Average	**$1,057**	**$1,083**	**$1,110**	**$1,138**	**$1,167**

Exhibit 113

Average Weekly Benefit Amount by Eligible Labor Force in Hawaii under the Washington Program					
Wage Band	**Projection Year**				
	2020	**2021**	**2022**	**2023**	**2024**
10.0%	$180	$184	$189	$194	$199
20.0%	$358	$367	$376	$386	$395
30.0%	$499	$512	$525	$538	$551
40.0%	$569	$583	$598	$613	$628
50.0%	$634	$650	$666	$683	$700
60.0%	$713	$731	$749	$768	$787
70.0%	$812	$832	$853	$874	$896
80.0%	$945	$968	$993	$1,017	$1,043
90.0%	$1,017	$1,042	$1,068	$1,095	$1,122
95.0%	$1,017	$1,042	$1,068	$1,095	$1,122
100.0%	$1,017	$1,042	$1,068	$1,095	$1,122
Average	**$674**	**$691**	**$709**	**$726**	**$744**

viii. Hawaii TDI

Exhibit 114

Average Weekly Wage Earned by Eligible Labor Force in Hawaii under the Hawaii TDI Program					
Wage Band	**Projection Year**				
	2020	**2021**	**2022**	**2023**	**2024**
10.0%	$200	$205	$210	$215	$220
20.0%	$392	$402	$412	$422	$433
30.0%	$545	$559	$573	$587	$602
40.0%	$679	$696	$713	$731	$749
50.0%	$807	$827	$847	$869	$890
60.0%	$960	$984	$1,009	$1,034	$1,060
70.0%	$1,153	$1,181	$1,211	$1,241	$1,272
80.0%	$1,406	$1,441	$1,477	$1,514	$1,552
90.0%	$1,793	$1,838	$1,883	$1,931	$1,979
95.0%	$2,266	$2,323	$2,381	$2,440	$2,501
100.0%	$4,763	$4,883	$5,005	$5,130	$5,258
Average	**$1,145**	**$1,173**	**$1,203**	**$1,233**	**$1,264**

Exhibit 115

Average Taxable Wage Base by Eligible Labor Force in Hawaii under the Hawaii TDI Program					
Wage Band	**Projection Year**				
	2020	**2021**	**2022**	**2023**	**2024**
10.0%	$116	$119	$122	$125	$128
20.0%	$227	$233	$239	$245	$251
30.0%	$316	$324	$332	$340	$349
40.0%	$394	$403	$413	$424	$434
50.0%	$468	$480	$492	$504	$516
60.0%	$557	$571	$585	$600	$615
70.0%	$668	$685	$702	$720	$738
80.0%	$793	$813	$833	$854	$875
90.0%	$793	$813	$833	$854	$875
95.0%	$793	$813	$833	$854	$875
100.0%	$793	$813	$833	$854	$875
Average	**$512**	**$525**	**$538**	**$552**	**$566**

Exhibit 116

Average Weekly Benefit Amount by Eligible Labor Force in Hawaii under the Hawaii TDI Program					
Wage Band	**Projection Year**				
	2020	**2021**	**2022**	**2023**	**2024**
10.0%	$200	$205	$210	$215	$220
20.0%	$392	$402	$412	$422	$433
30.0%	$545	$559	$573	$587	$602
40.0%	$679	$696	$713	$731	$749
50.0%	$807	$827	$847	$869	$890
60.0%	$960	$984	$1,009	$1,034	$1,060
70.0%	$1,153	$1,181	$1,211	$1,241	$1,272
80.0%	$1,367	$1,401	$1,436	$1,472	$1,509
90.0%	$1,367	$1,401	$1,436	$1,472	$1,509
95.0%	$1,367	$1,401	$1,436	$1,472	$1,509
100.0%	$1,367	$1,401	$1,436	$1,472	$1,509
Average	**$884**	**$906**	**$928**	**$952**	**$975**

9. Summary of Total Hawaii PFL Results by State Model – Average Weekly Taxable Wage Base & Benefit Amounts

Exhibit 117

Average Weekly Taxable Wage Base by Eligible Labor Force in Hawaii under Each State Program					
State	**Projection Year**				
	2020	**2021**	**2022**	**2023**	**2024**
California	$917	$940	$964	$988	$1,012
District of Columbia	$1,122	$1,150	$1,179	$1,208	$1,238
Massachusetts	$999	$1,024	$1,049	$1,076	$1,102
New Jersey	$1,076	$1,103	$1,131	$1,159	$1,188
New York	$761	$780	$800	$820	$840
Rhode Island	$958	$982	$1,006	$1,032	$1,057
Washington	$1,057	$1,083	$1,110	$1,138	$1,167
Hawaii TDI	$884	$906	$928	$952	$975

Exhibit 118

Average Weekly Benefit Amount by Eligible Labor Force in Hawaii under Each State Program					
State	**Projection Year**				
	2020	**2021**	**2022**	**2023**	**2024**
California	$544	$557	$571	$586	$600
District of Columbia	$620	$630	$641	$652	$662
Massachusetts	$537	$550	$564	$578	$592
New Jersey	$635	$651	$667	$684	$701
New York	$457	$523	$536	$549	$563
Rhode Island	$584	$599	$613	$629	$645
Washington	$674	$691	$709	$726	$744
Hawaii TDI	$512	$525	$538	$552	$566

B. 5-Year Projection Results

This section provides the 5-year projection results of the model including key intermediate components. The projections are provided for 2020 (or Year 1) through 2024 (or Year 5) for Hawaii's population under each state model (including Hawaii TDI).

1. Projected Number of Eligible Claimants (Labor Force)

Based on Hawaii labor force projections and eligibility percentages estimated under the different state programs, the number of eligible claimants is projected by state for 2020 to 2024 in the following table. The number of eligible claims equals the product of projected labor force and eligibility percentages.

Exhibit 119

Determination of Projected Number of Eligible Claimant by State Model						
Employee Hawaii Labor Force						
State Model	**Projection Year**					
	2020	**2021**	**2022**	**2023**	**2024**	**Total**
	668,788	672,132	675,493	678,870	682,264	3,377,547
Eligibility Percentage by State Model						
California	65.2%	65.2%	65.2%	65.2%	65.2%	NA
District of Columbia	72.2%	72.2%	72.2%	72.2%	72.2%	NA
Massachusetts	60.8%	60.8%	60.8%	60.8%	60.8%	NA
New Jersey	81.0%	81.0%	81.0%	81.0%	81.0%	NA
New York	64.2%	64.2%	64.2%	64.2%	64.2%	NA
Rhode Island	56.8%	56.8%	56.8%	56.8%	56.8%	NA
Washington	74.0%	74.0%	74.0%	74.0%	74.0%	NA
Hawaii TDI	72.3%	72.3%	72.3%	72.3%	72.3%	NA
Projected Number of Eligible Claimant by State Model						
California	435,864	438,043	440,233	442,434	444,646	2,201,220
District of Columbia	482,935	485,350	487,776	490,215	492,666	2,438,943
Massachusetts	406,707	408,740	410,784	412,838	414,902	2,053,972
New Jersey	541,409	544,116	546,837	549,571	552,319	2,734,253
New York	429,116	431,262	433,418	435,585	437,763	2,167,146
Rhode Island	380,001	381,901	383,811	385,730	387,658	1,919,100
Washington	495,011	497,486	499,973	502,473	504,985	2,499,928
Hawaii TDI	483,312	485,729	488,158	490,598	493,051	2,440,848

2. Projected Number of Eligible Claims (Bonding, Family Care, Total)

The projected number of eligible claims is a function of eligible claimants and the eligible claim rate.

i. Bonding

Exhibit 120

Determination of Projected Number of Bonding Claims by State Model						
Eligible Claim Rate % for Bonding						
State Model	**Projection Year**					
	2020	**2021**	**2022**	**2023**	**2024**	**Total**
	1.33%	1.50%	1.60%	1.68%	1.73%	NA
Benefit Change Adjustment Factor for Bonding						
California	107.1%	107.1%	107.1%	107.1%	107.1%	NA
District of Columbia	114.0%	114.0%	114.0%	114.0%	114.0%	NA
Massachusetts	111.1%	111.1%	111.1%	111.1%	111.1%	NA
New Jersey	118.7%	118.7%	118.7%	118.7%	118.7%	NA
New York	104.0%	105.0%	105.0%	105.0%	105.0%	NA
Rhode Island	102.0%	102.0%	102.0%	102.0%	102.0%	NA
Washington	120.6%	120.6%	120.6%	120.6%	120.6%	NA
Hawaii TDI	99.0%	99.0%	99.0%	99.0%	99.0%	NA
Projected Number of Eligible Claims for Bonding						
California	6,210	7,052	7,564	7,942	8,247	37,014
District of Columbia	7,322	8,315	8,919	9,365	9,724	43,645
Massachusetts	6,010	6,825	7,320	7,686	7,981	35,821
New Jersey	8,547	9,706	10,411	10,931	11,350	50,945
New York	5,935	6,808	7,302	7,667	7,961	35,673
Rhode Island	5,155	5,854	6,279	6,592	6,845	30,724
Washington	7,943	9,020	9,675	10,158	10,548	47,342
Hawaii TDI	6,364	7,227	7,752	8,139	8,451	37,932

ii. Family Care

Exhibit 121

Determination of Projected Number of Family Care Claims by State Model						
Eligible Claim Rate % for Family Care						
State Model	**Projection Year**					
	2020	**2021**	**2022**	**2023**	**2024**	**Total**
	0.38%	0.39%	0.40%	0.41%	0.42%	NA
Benefit Change Adjustment Factor for Bonding						
California	119.7%	119.7%	119.7%	119.7%	119.7%	NA
District of Columbia	116.2%	116.2%	116.2%	116.2%	116.2%	NA
Massachusetts	113.3%	113.3%	113.3%	113.3%	113.3%	NA
New Jersey	135.2%	135.2%	135.2%	135.2%	135.2%	NA
New York	116.2%	117.4%	117.4%	117.4%	117.4%	NA
Rhode Island	109.1%	109.1%	109.1%	109.1%	109.1%	NA
Washington	118.3%	118.3%	118.3%	118.3%	118.3%	NA
Hawaii TDI	99.0%	99.0%	99.0%	99.0%	99.0%	NA
Projected Number of Eligible Claims for Family Care						
California	1,983	2,049	2,116	2,184	2,252	10,583
District of Columbia	2,133	2,204	2,276	2,349	2,422	11,385
Massachusetts	1,751	1,809	1,868	1,928	1,988	9,344
New Jersey	2,781	2,875	2,968	3,063	3,159	14,846
New York	1,895	1,978	2,043	2,108	2,174	10,198
Rhode Island	1,575	1,628	1,681	1,735	1,789	8,407
Washington	2,225	2,299	2,374	2,450	2,526	11,874
Hawaii TDI	1,818	1,879	1,940	2,002	2,065	9,705

iii. Total

This is the sum of total bonding and family care claims from the two tables above.

Exhibit 122

Projected Total Number of Eligible Claims by State Model						
State Model	**Projection Year**					
	2020	**2021**	**2022**	**2023**	**2024**	**Total**
California	8,193	9,101	9,680	10,125	10,498	47,597
District of Columbia	9,455	10,520	11,195	11,714	12,146	55,030
Massachusetts	7,760	8,634	9,188	9,614	9,969	45,165
New Jersey	11,328	12,581	13,379	13,994	14,509	65,791
New York	7,830	8,786	9,345	9,775	10,135	45,872
Rhode Island	6,730	7,481	7,960	8,327	8,634	39,132
Washington	10,167	11,319	12,049	12,608	13,074	59,217
Hawaii TDI	8,182	9,106	9,692	10,141	10,516	47,637

3. Projection of Average Number of Weeks & Total Number of Weeks (Duration)

Exhibit 123

Projection of Average Number of Weeks by State Model				
State Model	**Bonding**		**Family Leave**	
	2020	**2021-24**	**2020**	**2021-24**
California	6.6	6.6	4.3	4.3
District of Columbia	6.6	6.6	4.0	4.0
Massachusetts	8.2	8.2	4.5	4.5
New Jersey	7.5	8.2	4.4	4.5
New York	7.5	8.2	4.4	4.5
Rhode Island	3.8	3.8	3.2	3.2
Washington	8.2	8.2	4.5	4.5
Hawaii TDI	5.4	5.4	4.0	4.0

Exhibit 124

Maximum Number of Weeks for Bonding and Family Care by State Model				
State Model	**Bonding**		**Family Leave**	
	2020	**2021-24**	**2020**	**2021-24**
California	8	8	8	8
District of Columbia	8	8	6	6
Massachusetts	12	12	12	12
New Jersey	6/12*	12	6/12*	12
New York	10	12	10	12
Rhode Island	4	4	4	4
Washington	12	12	12	12
Hawaii TDI	6	6	6	6
* Effective 7/1/2020 New Jersey's maximum weeks increased from 6 to 12				

Exhibit 125 show the projection for the total number of weeks of benefit payments for bonding, family care, and in total.

Exhibit 125

Projected Total Number of Weeks of Received Benefit Payments for Bonding					
State Model	**Projection Year**				
	2020	**2021**	**2022**	**2023**	**2024**
California	40,984	46,542	49,922	52,416	54,427
District of Columbia	48,327	54,881	58,866	61,806	64,178
Massachusetts	49,291	55,976	60,040	63,039	65,458
New Jersey	64,102	79,609	85,390	89,655	93,096
New York	44,512	55,838	59,893	62,885	65,298
Rhode Island	19,587	22,244	23,859	25,051	26,012
Washington	65,144	73,979	79,351	83,315	86,512
Hawaii TDI	34,364	39,025	41,859	43,949	45,636
Projected Total Number of Weeks of Received Benefit Payments for Family Care					
California	8,526	8,811	9,099	9,390	9,683
District of Columbia	8,532	8,817	9,105	9,396	9,689
Massachusetts	7,878	8,141	8,407	8,675	8,946
New Jersey	12,294	12,935	13,358	13,784	14,214
New York	8,376	8,902	9,193	9,486	9,782
Rhode Island	5,040	5,209	5,379	5,551	5,724
Washington	10,011	10,346	10,684	11,025	11,369
Hawaii TDI	7,273	7,516	7,762	8,009	8,259
Projected Total Number of Weeks of Received Benefit Payments					
California	49,510	55,354	59,021	61,805	64,110
District of Columbia	56,859	63,698	67,971	71,202	73,867
Massachusetts	57,169	64,117	68,447	71,715	74,405
New Jersey	76,396	92,544	98,748	103,439	107,310
New York	52,888	64,740	69,086	72,371	75,080
Rhode Island	24,628	27,453	29,238	30,602	31,736
Washington	75,156	84,325	90,035	94,340	97,881
Hawaii TDI	41,637	46,541	49,620	51,959	53,895

4. Projection of Maximum Weekly Benefit Amount, Average Weekly Benefit Amount & Total Benefit per Claimant

The following tables in this section show the projected maximum weekly benefit amount, the projected average weekly benefit amount, and the projected total average benefit per claimant (bonding and family care claims combined).

Exhibit 126

Projected Maximum Weekly Benefit Amount by State Model						
State Model	**Projection Year**					
	2020	**2021**	**2022**	**2023**	**2024**	**Total**
California	$1,130	$1,158	$1,187	$1,217	$1,247	N/A
District of Columbia	$1,000	$1,000	$1,000	$1,000	$1,000	N/A
Massachusetts	$723	$741	$760	$779	$798	N/A
New Jersey	$791	$811	$831	$852	$873	N/A
New York	$678	$776	$795	$815	$836	N/A
Rhode Island	$960	$984	$1,009	$1,034	$1,060	N/A
Washington	$1,017	$1,042	$1,068	$1,095	$1,122	N/A
Hawaii TDI	$793	$813	$833	$854	$875	N/A

Exhibit 127

Projected Average Weekly Benefit Amount by State Model						
State Model	**Projection Year**					
	2020	**2021**	**2022**	**2023**	**2024**	**Total**
California	$544	$557	$571	$586	$600	N/A
District of Columbia	$620	$630	$641	$652	$662	N/A
Massachusetts	$537	$550	$564	$578	$592	N/A
New Jersey	$635	$651	$667	$684	$701	N/A
New York	$457	$523	$536	$549	$563	N/A
Rhode Island	$584	$599	$613	$629	$645	N/A
Washington	$674	$691	$709	$726	$744	N/A
Hawaii TDI	$512	$525	$538	$552	$566	N/A

Exhibit 128

Projected Total Benefit per Claimant by State Model						
State Model	**Projection Year**					
	2020	**2021**	**2022**	**2023**	**2024**	**Total**
California	$3,287	$3,391	$3,484	$3,575	$3,666	$17,403
District of Columbia	$3,726	$3,815	$3,891	$3,963	$4,026	$19,421
Massachusetts	$3,953	$4,084	$4,199	$4,310	$4,421	$20,968
New Jersey	$4,282	$4,788	$4,924	$5,054	$5,184	$24,232
New York	$3,085	$3,852	$3,961	$4,066	$4,170	$19,135
Rhode Island	$2,137	$2,196	$2,253	$2,311	$2,369	$11,266
Washington	$4,985	$5,150	$5,295	$5,434	$5,573	$26,437
Hawaii TDI	$2,608	$2,685	$2,757	$2,828	$2,899	$13,776

5. Projection of Total Annual PFL Claims Cost in Dollars & as a Percent of the Taxable Wage Base for Hawaii

The following tables show the projected annual claims costs (in $Millions) separately for bonding and family care claims. This is equal to the product of total eligible bonding claims multiplied by the average weekly benefit amount paid multiplied by the average duration for bonding and family care.

Exhibit 129

Projected Total Annual Cost for Bonding ($Millions) by State Model						
State Model	**Projection Year**					
	2020	**2021**	**2022**	**2023**	**2024**	**Total**
California	$22.3	$25.9	$28.5	$30.7	$32.7	$140.1
District of Columbia	$29.9	$34.6	$37.7	$40.3	$42.5	$185.0
Massachusetts	$26.4	$30.8	$33.8	$36.4	$38.8	$166.3
New Jersey	$40.7	$51.8	$57.0	$61.3	$65.3	$276.0
New York	$20.3	$29.2	$32.1	$34.5	$36.8	$152.9
Rhode Island	$11.4	$13.3	$14.6	$15.8	$16.8	$71.9
Washington	$43.9	$51.1	$56.2	$60.5	$64.4	$276.2
Hawaii TDI	$17.6	$20.5	$22.5	$24.3	$25.8	$110.7

Exhibit 130

Projected Total Annual Cost for Family Care ($Millions) by State Model						
State Model	Projection Year					
	2020	2021	2022	2023	2024	Total
California	$4.6	$4.9	$5.2	$5.5	$5.8	$26.1
District of Columbia	$5.3	$5.6	$5.8	$6.1	$6.4	$29.2
Massachusetts	$4.2	$4.5	$4.7	$5.0	$5.3	$23.8
New Jersey	$7.8	$8.4	$8.9	$9.4	$10.0	$44.5
New York	$3.8	$4.7	$4.9	$5.2	$5.5	$24.1
Rhode Island	$2.9	$3.1	$3.3	$3.5	$3.7	$16.5
Washington	$6.8	$7.2	$7.6	$8.0	$8.5	$37.9
Hawaii TDI	$3.7	$3.9	$4.2	$4.4	$4.7	$20.9

The following tables show the projected total annual Hawaii program costs (in $Millions) for bonding and family care combined, the projected total taxable wage base in Hawaii, and the projected total cost as a percentage of total taxable wage base in Hawaii.

Exhibit 131

Projected Total Annual PFL Program Cost ($Millions) by State Model						
State Model	Projection Year					
	2020	2021	2022	2023	2024	Total
California	$26.9	$30.9	$33.7	$36.2	$38.5	$166.2
District of Columbia	$35.2	$40.1	$43.6	$46.4	$48.9	$214.2
Massachusetts	$30.7	$35.3	$38.6	$41.4	$44.1	$190.0
New Jersey	$48.5	$60.2	$65.9	$70.7	$75.2	$320.6
New York	$24.2	$33.8	$37.0	$39.7	$42.3	$177.0
Rhode Island	$14.4	$16.4	$17.9	$19.2	$20.5	$88.4
Washington	$50.7	$58.3	$63.8	$68.5	$72.9	$314.1
Hawaii TDI	$21.3	$24.4	$26.7	$28.7	$30.5	$131.7
Projected Total Annual Hawaii Wages ($Millions) by State Model						
California	$20,787	$21,413	$22,058	$22,722	$23,407	$110,387
District of Columbia	$28,172	$29,021	$29,895	$30,796	$31,724	$149,609
Massachusetts	$21,123	$21,759	$22,415	$23,090	$23,786	$112,174
New Jersey	$30,301	$31,213	$32,154	$33,122	$34,120	$160,910
New York	$16,986	$17,497	$18,024	$18,567	$19,127	$90,201

Rhode Island	$18,929	$19,499	$20,087	$20,692	$21,315	$100,521
Washington	$27,203	$28,023	$28,867	$29,737	$30,633	$144,463
Hawaii TDI	$22,207	$22,876	$23,565	$24,275	$25,006	$117,929
Projected Total Cost (as percentage of Total Wages in Hawaii by State Model						
California	0.130%	0.144%	0.153%	0.159%	0.164%	0.151%
District of Columbia	0.125%	0.138%	0.146%	0.151%	0.154%	0.143%
Massachusetts	0.145%	0.162%	0.172%	0.179%	0.185%	0.169%
New Jersey	0.160%	0.193%	0.205%	0.214%	0.220%	0.199%
New York	0.142%	0.193%	0.205%	0.214%	0.221%	0.196%
Rhode Island	0.076%	0.084%	0.089%	0.093%	0.096%	0.088%
Washington	0.186%	0.208%	0.221%	0.230%	0.238%	0.217%
Hawaii TDI	0.096%	0.107%	0.113%	0.118%	0.122%	0.112%

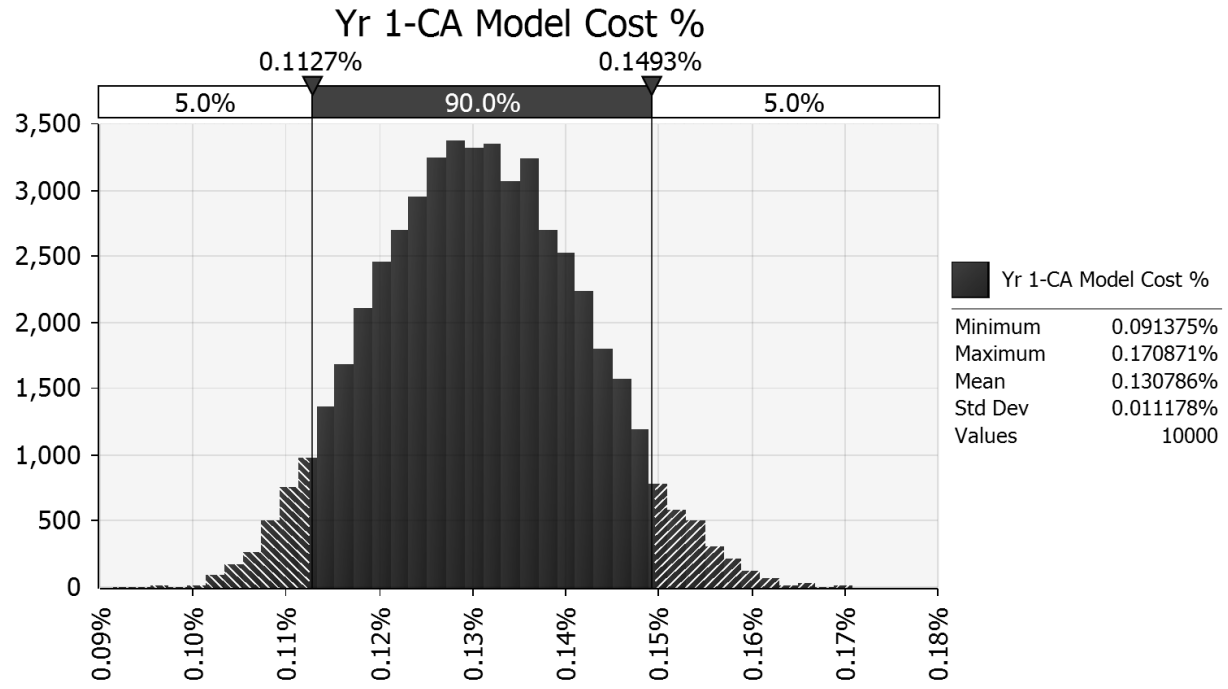
C. Simulation Model Technical Description

The simulation model considers expected variability in both incidence rates and duration of weekly benefits. A reasonable range of estimated incidence rates (low, central, high) is established separately for each leave type. The development of these ranges is detailed in Appendices A.5 and A.6 on pages 103 and 104 respectively. It is expected that the low- and high-end points will occur much less frequently than the central estimate, although estimating actual incident rates is inherently uncertain. To capture a portion of this uncertainty, a triangular distribution is utilized to model the variability across a reasonable range of results. This is a continuous probability distribution with a low limit (the selected low estimated incidence rate), an upper limit (the high selected incidence rate) and a mode (the central estimate incidence rate).

Similarly, there is possible variation in the actual duration of weekly benefits being paid. The expected range of durations is developed separately for bonding and family care claims. A triangular distribution is also used to model the variability across this range of results. These ranges are detailed in Appendix A.7.

The simulation follows a model where 10,000 randomly generated independent trials of projections are run through and evaluated. Each trial simulates a single point outcome of claim incidence rates and durations based on the selected triangular distributions. All other model variables, including projected labor force, eligibility percentage, benefit adjustment factor, average weekly benefit, and average weekly taxable wage base utilize the same single point central estimate for each simulated trial. As such, most of the variability is already captured in the incidence rate and duration distributions, which ultimately results in variation of total program costs. Exhibit 132 illustrates simulated claims cost output over the range of outcomes for California in 2020.

Exhibit 132



The range of outcomes between 5% and 95% are the selected low and high California claims cost rate outcomes.

It is important to note this does not represent the possible minimum and maximum range of program results because of both parameter risk and process risk. Parameter risk is the risk that actuarial methods underlying the estimates do not accurately represent the true characteristics of the risk. Process risk is the risk that actual results will vary from our ranges of actuarial central estimates based on random chance. Part of this is driven by the inherent uncertainty of where actual PFL results will fall due to lack of specific historical data, uncertainties around actual trends, participation and growth rates, and ultimate use of the benefits by the population of Hawaii.

D. Flat & Progressive Benefit Structure Differentials Calculation Description

The tables below summarize the three different benefit structures we used in each state model to reach the same average weekly benefit amount. The first approach is the actual approach adopted by the state and the other two approaches are for comparison purposes. Under the summary of the three approaches, we also summarize the weekly benefit amount received by population at different wage band side by side. Under California state model, a sample calculation for people at 50% wage band of weekly benefit under the three approaches is provided as well.

Exhibit 133

California: Benefit Differential Calculation Description					
Approach	**Program**	**Benefit Structure**	**Minimum Benefit**	**Maximum Benefit***	**Wage Replacement Ratio**
1	Actual	Progressive – Sharp Break Point	$50	100% of SAWW	70% if AWW ≤1/3 of SAWW; 60% if above
2	Model Equivalent	Progressive	$50	100% of SAWW	75% if AWW <= 1/3 of SAWW, sum of 75% of 1/3 SAWW and 50% of the difference of AWW and 1/3 SAWW if above
3	Model Equivalent	Flat	$50	100% of SAWW	60% of AWW
* California stipulates $1,252 as maximum weekly benefit amount in 2019, which is about 100% of SAWW					

Exhibit 134

California: Calculation of Projected Average Weekly Benefit Amount in 2021				
Wage Band	**AWW of Eligible Labor Force**	**Approach 1**	**Approach 2**	**Approach 3**
10.0%	$120	$84	$90	$73
20.0%	$278	$195	$208	$168
30.0%	$435	$261	$313	$263
40.0%	$585	$351	$388	$354
50.0%	$725	$435	$458	$438
60.0%	$872	$523	$531	$528
70.0%	$1,077	$646	$634	$651
80.0%	$1,373	$824	$781	$830
90.0%	$1,830	$1,098	$1,010	$1,107
95.0%	$2,420	$1,158	$1,158	$1,158
100.0%	$6,057	$1,158	$1,158	$1,158
Average	**$1,153**	**$557**	**$557**	**$557**

We illustrate below the sample calculation of three approaches for calculating weekly benefit amount for people at 50% wage band, under California's benefit structure.

Approach 1:

- AWW at 50% is $725, >1/3 of SAWW (1/3 of $1,158 = $386)
- AWBA = 60% of $725 = $435

Approach 2:

- AWW at 50% is $725, >1/3 of SAWW (1/3 of $1,158 = $386)
- AWBA = 75% of (1/3 of SAWW = $386) + 50% of ($725 - $386) = $459

Approach 3:

- AWBA = 60% x $725 = $435

The wage replacement ratio illustrated in Exhibit 135 for approach 2 and 3 are rounded numbers. The calculation in Exhibit 134 uses exact percentages to reach the same AWBA for different approaches. Therefore, the sample calculations above using rounded numbers may be a few dollars off from Exhibit 134.

Exhibit 135

Massachusetts: Benefit Differential Calculation Description					
Approach	**Program**	**Benefit Structure**	**Minimum Benefit**	**Maximum Benefit**	**Wage Replacement Ratio**
1	Actual	Progressive	None	64% of SAWW	80% if AWW ≤1/2 of SAWW; sum of 80% of 1/2 SAWW and 50% of the difference of AWW and 1/2 SAWW if above
2	Model Equivalent	Progressive	$100	64% of SAWW	84% if AWW ≤1/3 of SAWW; sum of 84% of 1/3 SAWW and 60% of the difference of AWW and 1/3 SAWW if above
3	Model Equivalent	Flat	$100	64% of SAWW	75% of AWW

Exhibit 136

Massachusetts: Calculation of Projected Average Weekly Benefit Amount in 2021				
Wage Band	**AWW of Eligible Labor Force**	**Approach 1**	**Approach 2**	**Approach 3**
10.0%	$201	$161	$168	$150
20.0%	$368	$295	$309	$275
30.0%	$503	$403	$393	$376
40.0%	$642	$495	$476	$479
50.0%	$775	$561	$556	$579
60.0%	$912	$630	$638	$681
70.0%	$1,117	$732	$741	$741
80.0%	$1,393	$741	$741	$741
90.0%	$1,814	$741	$741	$741
95.0%	$2,338	$741	$741	$741
100.0%	$5,199	$741	$741	$741
Average	**$1,149**	**$550**	**$550**	**$550**

Exhibit 137

District of Columbia: Benefit Differential Calculation Description					
Approach	**Program**	**Benefit Structure**	**Minimum Benefit**	**Maximum Benefit**	**Wage Replacement Ratio**
1	Actual	Progressive	$100	$1,000	90% if AWW ≤150% of weekly minimum wage (WMW)*; sum of 90% of 150% WMW and 50% of the difference of AWW and 150% WMW if above
2	Model Equivalent	Progressive	$100	$1,000	90% if AWW ≤1/3 of SAWW; sum of 90% of 1/3 SAWW and 69% of the difference of AWW and 1/3 SAWW if above
3	Model Equivalent	Flat	$100	$1,000	80% of AWW
* Hawaii's minimum wage per hour is $10.1 in 2018 and 2019 and will increase gradually. We used a growth rate of 2.5%					

Exhibit 138

District of Columbia: Calculation of Projected Average Weekly Benefit Amount in 2021				
Wage Band	**AWW of Eligible Labor Force**	**Approach 1**	**Approach 2**	**Approach 3**
10.0%	$115	$104	$104	$100
20.0%	$274	$247	$247	$220
30.0%	$432	$389	$378	$347
40.0%	$583	$525	$481	$468
50.0%	$723	$610	$577	$581
60.0%	$870	$683	$678	$699
70.0%	$1,075	$786	$819	$863
80.0%	$1,370	$933	$1,000	$1,000
90.0%	$1,827	$1,000	$1,000	$1,000
95.0%	$2,416	$1,000	$1,000	$1,000
100.0%	$6,044	$1,000	$1,000	$1,000
Average	**$1,150**	**$628**	**$628**	**$628**

Exhibit 139

New Jersey: Benefit Differential Calculation Description					
Approach	**Program**	**Benefit Structure**	**Minimum Benefit**	**Maximum Benefit**	**Wage Replacement Ratio**
1	Actual	Flat	None	70% of SAWW	85% of AWW*****
2	Model Equivalent	Progressive	None	70% of SAWW	90% if AWW ≤1/3 of SAWW; sum of 90% of 1/3 SAWW and 77% of the difference of AWW and 1/3 SAWW if above
3	Model Equivalent	Progressive	None	70% of SAWW	89% if AWW ≤1/2 of SAWW; sum of 89% of 1/2 SAWW and 65% of the difference of AWW and 1/2 SAWW if above
* This benefit structure will start from 7/1/2020 in New Jersey					

Exhibit 140

New Jersey: Calculation of Projected Average Weekly Benefit Amount in 2021				
Wage Band	**AWW of Eligible Labor Force**	**Approach 1**	**Approach 2**	**Approach 3**
10.0%	$279	$237	$251	$247
20.0%	$445	$378	$393	$394
30.0%	$584	$496	$499	$516
40.0%	$718	$610	$601	$603
50.0%	$863	$734	$712	$697
60.0%	$1,035	$811	$811	$809
70.0%	$1,245	$811	$811	$811
80.0%	$1,538	$811	$811	$811
90.0%	$1,942	$811	$811	$811
95.0%	$2,447	$811	$811	$811
100.0%	$5,639	$811	$811	$811
Average	**$1,269**	**$651**	**$651**	**$651**

Exhibit 141

New York: Benefit Differential Calculation Description					
Approach	**Program**	**Benefit Structure**	**Minimum Benefit**	**Maximum Benefit**	**Wage Replacement Ratio**
1	Actual	Flat	None	67% of SAWW	67% of AWW
2	Model Equivalent	Progressive	None	67% of SAWW	81% if AWW $\leq$ 1/3 of SAWW, sum of 81% of 1/3 SAWW and 50% of the difference of AWW and 1/3 SAWW if above
3	Model Equivalent	Progressive	None	71% of SAWW	71% if AWW <= 1/2 of SAWW, sum of 71% of 1/2 SAWW and 55% of the difference of AWW and 1/2 SAWW if above

Exhibit 142

New York: Calculation of Projected Average Weekly Benefit Amount in 2021				
Wage Band	**AWW of Eligible Labor Force**	**Approach 1**	**Approach 2**	**Approach 3**
10.0%	$150	$100	$121	$106
20.0%	$333	$223	$269	$236
30.0%	$482	$323	$359	$341
40.0%	$621	$416	$428	$434
50.0%	$756	$507	$496	$508
60.0%	$894	$599	$565	$584
70.0%	$1,093	$732	$664	$693
80.0%	$1,373	$776	$776	$776
90.0%	$1,792	$776	$776	$776
95.0%	$2,318	$776	$776	$776
100.0%	$5,040	$776	$776	$776
Average	**$1,117**	**$523**	**$523**	**$523**
* New York increased the maximum weekly benefit amount from 60% to 67% of SAWW and increased replacement ratio from 60% to 67% from 2020 to 2021				

Exhibit 143

Rhode Island: Benefit Differential Calculation Description					
Approach	**Program**	**Benefit Structure**	**Minimum Benefit**	**Maximum Benefit**	**Wage Replacement Ratio**
1	Actual	Flat	$98	85% of SAWW	60% of AWW (4.62% of total highest quarter wages in the base period)
2	Model Equivalent	Progressive	$98	85% of SAWW	72% if AWW $\leq$1/3 of SAWW; sum of 72% of 1/3 SAWW and 50% of the difference of AWW and 1/3 SAWW if above
3	Model Equivalent	Progressive	$98	85% of SAWW	65% if AWW $\leq$1/2 of SAWW; sum of 65% of 1/2 SAWW and 51% of the difference of AWW and 1/2 SAWW if above

Exhibit 144

Rhode Island: Calculation of Projected Average Weekly Benefit Amount in 2021				
Wage Band	**AWW of Eligible Labor Force**	**Approach 1**	**Approach 2**	**Approach 3**
10.0%	$336	$201	$243	$218
20.0%	$477	$286	$323	$310
30.0%	$607	$364	$388	$391
40.0%	$725	$435	$448	$451
50.0%	$844	$506	$507	$512
60.0%	$1,001	$601	$586	$592
70.0%	$1,210	$726	$690	$699
80.0%	$1,494	$897	$832	$844
90.0%	$1,920	$984	$984	$984
95.0%	$2,482	$984	$984	$984
100.0%	$6,107	$984	$984	$984
Average	**$1,291**	**$599**	**$599**	**$599**
***** Rhode Island stipulates $867 as maximum weekly benefit amount in 2019, which is about 85% of SAWW				

Exhibit 145

Washington: Benefit Differential Calculation Description					
Approach	**Program**	**Benefit Structure**	**Minimum Benefit**	**Maximum Benefit**	**Wage Replacement Ratio**
1	Actual	Progressive	$100	90% of SAWW	90% if AWW ≤1/2 of SAWW; sum of 90% of 1/2 SAWW and 50% of the difference of AWW and 1/2 SAWW if above
2	Model Equivalent	Progressive	$100	90% of SAWW	90% if AWW ≤1/3 of SAWW; sum of 90% of 1/3 SAWW and 64% of the difference of AWW and 1/3 SAWW if above
3	Model Equivalent	Flat	$100	90% of SAWW	77% of AWW

Exhibit 146

Washington: Calculation of Projected Average Weekly Benefit Amount in 2021				
Wage Band	**AWW of Eligible Labor Force**	**Approach 1**	**Approach 2**	**Approach 3**
10.0%	$205	$184	$184	$158
20.0%	$408	$367	$360	$313
30.0%	$569	$512	$462	$437
40.0%	$703	$583	$548	$540
50.0%	$837	$650	$633	$643
60.0%	$999	$731	$736	$768
70.0%	$1,201	$832	$864	$923
80.0%	$1,474	$968	$1,037	$1,042
90.0%	$1,893	$1,042	$1,042	$1,042
95.0%	$2,405	$1,042	$1,042	$1,042
100.0%	$5,309	$1,042	$1,042	$1,042
Average	**$1,214**	**$691**	**$691**	**$691**

Exhibit 147

Hawaii TDI: Benefit Differential Calculation Description					
Approach	**Program**	**Benefit Structure**	**Minimum Benefit**	**Maximum Benefit**	**Wage Replacement Ratio**
1	Actual	Flat	None	70.18% of SAWW	58% of AWW
2	Model Equivalent	Progressive	None	70.18% of SAWW	67% if AWW <= 1/3 of SAWW, sum of 67% of 1/3 SAWW and 50% of the difference of AWW and 1/3 SAWW if above
3	Model Equivalent	Progressive	None	70.18% of SAWW	62% if AWW <= 1/2 of SAWW, sum of 62% of 1/2 SAWW and 50% of the difference of AWW and 1/2 SAWW if above

Exhibit 148

Hawaii TDI: Calculation of Projected Average Weekly Benefit Amount in 2021				
Wage Band	**AWW of Eligible Labor Force**	**Approach 1**	**Approach 2**	**Approach 3**
10.0%	$205	$119	$136	$126
20.0%	$402	$233	$264	$248
30.0%	$559	$324	$343	$345
40.0%	$696	$403	$411	$416
50.0%	$827	$480	$477	$481
60.0%	$984	$571	$555	$560
70.0%	$1,181	$685	$654	$658
80.0%	$1,441	$813	$784	$788
90.0%	$1,838	$813	$813	$813
95.0%	$2,323	$813	$813	$813
100.0%	$4,883	$813	$813	$813
Average	**$1,173**	**$525**	**$525**	**$525**

E. Staffing Plan

Exhibit 149

Potential Staffing Plan for Administering a Paid Leave Program in Hawaii			
	Social Insurance Model through an Exclusive State Fund	**Social Insurance Model through an Exclusive State Fund**	**Governance Only Role**
Estimated Claim Volume by Case Type			
Estimated Number of PFL Claims - Central Range	9,101	8,828	0
▪ Bonding Claims	7,052	6,840	0
▪ Family Care Claims	2,049	1,988	0
Estimated Program Management Staff			
Director	1.0	1.0	1.0
Office Manager	1.0	1.0	1.0
Policy Developer	1.0	1.0	1.0
Communications & Outreach Manager	1.0	1.0	1.0
Administrative Support	1.0	1.0	1.0
Estimated Claims Administration Staff			
Senior Claim Specialists	3.0	2.0	0.0
Bonding Leave Resource			
Claim Specialists	2.0	2.0	0.0
Leave Only Resource			
Fixed Staff in Claim Operation			
Manager(s)	1.0	1.0	0.0
Supervisor	1.0	1.0	0.0
Clinical/Vocational Rehabilitation	0.5	0.5	0.0
Intake/Customer Service			
Intake/Customer Service Representatives	2.0	1.0	0.0
Intake Supervisor	Incl in Sup	Incl in Sup	0.0
Estimated Program Support Staff			
Audit/Quality Assurance and Fraud	2.0	2.0	0.0
Appeals	1.0	0.5	0.0
Client Training Specialist	1.0	1.0	0.0
Tax/Premium Contribution Collection	1.0	1.0	1.0
Private Plan Review	0.0	2.0	0.0
Estimated IT Staff			
System Integration Administrator	1.0	1.0	0.0
System Analyst and Coordinator (incl process and documentation)	1.0	1.0	1.0

Potential Staffing Plan for Administering a Paid Leave Program in Hawaii			
Data, Analytics and Reporting Specialist	0.5	0.5	0.5
System Team Support	0.5	0.5	0.0
Estimated Total Staff Count			
Estimated Total Staff Count	22.5	22.0	7.5
Staffing Costs			
Staffing Costs			
Director	$125,000	$125,000	$125,000
Office Manager	$100,000	$100,000	$100,000
Policy Developer	$100,000	$100,000	$100,000
Communications & Outreach Manager	$75,000	$75,000	$75,000
Administrative Support	$35,000	$35,000	$35,000
Senior Claim Specialists	$150,000	$100,000	$0
Claim Specialists	$80,000	$80,000	$0
Manager	$75,000	$75,000	$0
Supervisor	$55,000	$55,000	$0
Clinical/Vocational Rehabilitation	$37,500	$37,500	$0
Intake/Customer Service Representatives	$70,000	$35,000	$0
Audit/Quality Assurance/Fraud	$110,000	$110,000	$0
Appeals	$55,000	$26,974	$0
Client Training Specialist	$55,000	$55,000	$0
Tax/Premium Contribution Collection	$55,000	$55,000	$55,000
Private Plan Review	$0	$110,000	$0
System Integration Administrator	$75,000	$75,000	$0
System Analyst and Coordinator	$65,000	$65,000	$65,000
Data, Analytics and Reporting	$22,500	$22,500	$22,500
System Team Support	$17,500	$17,500	$0
Sub-Total Annual Staffing Costs	*$1,357,500*	*$1,354,474*	*$577,500*
Load for Benefits (60%)	*$814,500*	*$812,685*	*$346,500*
Load for Property & Equipment (5%)	*$67,875*	*$67,724*	*$28,875*
Total Annual Staffing Costs	*$2,239,875*	*$2,234,883*	*$952,875*
Software Costs			
Technology Lease/License Fees	$175,000	$175,000	$0
Implementation/Professional Service Fees	$175,000	$175,000	$0
Initial Development, Testing, Interface(s)	$130,000	$130,000	$0
Customization/Programming Fees	$50,000	$50,000	$0
Data Feed Fees	$30,000	$30,000	$0
Training Fees	$15,000	$15,000	$0
Sub-Total Software Costs	*$575,000*	*$575,000*	*$0*
Tools, Training and Marketing			
Annual Industry Memberships	$799	$799	$0
Initial Leave Administration Training	$2,995	$2,396	$0

Potential Staffing Plan for Administering a Paid Leave Program in Hawaii			
Annual Industry Conference Attendance	$5,000	$5,000	$0
Annual Marketing Strategy and Materials	$100,000	$100,000	$60,000
Sub-Total Tools and Training Costs	*$108,794*	*$108,195*	*$60,000*
External Support / Consulting Costs			
External Legal	$150,000	$150,000	$150,000
External Consultants & Actuaries	$500,000	$500,000	$500,000
External Consultants & Actuaries	$150,000	$150,000	$100,000
Sub-Total External Support Consulting Costs	*$800,000*	*$800,000*	*$750,000*
Total of Start Up Costs	**$1,100,000**	**$1,100,000**	**$660,000**
Total of Ongoing Costs	**$2,623,669**	**$2,618,078**	**$1,102,875**
Total Costs	**$3,723,669**	**$3,718,078**	**$1,762,875**

F. Legislation Reference Table

Exhibit 150

Statute	Chapter / Code	Section	Link
California Disability Insurance	California Unemployment Insurance Code, Division 1, Part 2, Disability Compensation	Cal. UIC §§260 – 3307	http://leginfo.legislature.ca.gov/faces/codes_displayexpandedbranch.xhtml?lawCode=UIC&division=1.&title=&part=2.&chapter=1.&article=&goUp=Y
California Paid Family Leave	California Unemployment Insurance Code, Division 1, Part 2, Chapter 7, Paid Family Leave	Cal. UIC §§3300 – 3307	http://leginfo.legislature.ca.gov/faces/codes_displayText.xhtml?lawCode=UIC&division=1.&title=&part=2.&chapter=7.&article=
District of Columbia Universal Paid Leave	Code of the District of Columbia, Title 32, Chapter 5, Subchapter IV, Universal Paid Leave	D.C. Code §§32-541.01 – 32-541.12	https://code.dccouncil.us/dc/council/code/titles/32/chapters/5/subchapters/IV/
Hawaii Temporary Disability Insurance Law	Hawaii Revised Statute, Chapter 392, Temporary Disability Insurance	Haw. Rev. Stat. §§392-1 – 392-101	http://www.capitol.hawaii.gov/hrscurrent/Vol07_Ch0346-0398/HRS0392/HRS_0392-.htm
Hawaii Prepaid Health Care	Hawaii Revised Statute, Chapter 393, Prepaid Health Care Act	Haw. Rev. Stat. §§393-1 – 393-51	http://www.capitol.hawaii.gov/hrscurrent/Vol07_Ch0346-0398/HRS0393/HRS_0393-.htm
Hawaii Family Leave Law	Hawaii Revised Statute, Chapter 398, Prepaid Health Care Act	Haw. Rev. Stat. §§398-1 – 398-29	http://www.capitol.hawaii.gov/hrscurrent/Vol07_Ch0346-0398/HRS0398/HRS_0398-.htm
Massachusetts Family and Medical Leave	Massachusetts General Laws, Part 1, Title XXII, Chapter 175 M,	Mass. Gen. Laws ch. 175M §§1 – 11	https://www.mass.gov/law-library/mass-general-laws-c175m

	Family and Medical Leave		
New Jersey Temporary Disability Benefits Law	New Jersey Code, Title 43, Section 43:21, Temporary Disability Benefits Law	N.J. Stat. Ann. §§43:21-25 – 43:21-65	https://myleavebenefits.nj.gov/labor/myleavebenefits/assets/pdfs/DILAW_July2014.pdf
New Jersey Family Leave Act	New Jersey Code, Title 34, Section 34:11B, Family Leave Act	N.J. Stat. Ann. §§34:11B-1 *et seq*.	https://law.justia.com/codes/new-jersey/2009/title-34/section-34-11b/
New Jersey Safe Act	New Jersey Chapter 82, New Jersey Safe and Financial Empowerment Act	N.J. P.L. 2013, c.82	https://www.njleg.state.nj.us/2012/Bills/PL13/82_.HTM
New York Disability Benefits Law and Paid Family Leave Benefits Law	Consolidated Laws of New York, Workers' Compensation, Article 9, Disability Benefits	N.Y. WKC §§200-242	https://www.nysenate.gov/legislation/laws/WKC/A9
Rhode Island Temporary Disability Insurance	Rhode Island, Title 28, Chapter 39 to 41, Temporary Disability Insurance	R.I. Gen. Laws §§28-39 – 28-41	http://webserver.rilin.state.ri.us/Statutes/TITLE28/28-39/INDEX.HTM
Rhode Island Temporary Caregiver Insurance	Rhode Island, Title 28, Chapter 41, Section 34, Temporary Caregiver Insurance	R.I. Gen. Laws §28-41-34	http://webserver.rilin.state.ri.us/Statutes/TITLE28/28-41/28-41-34.HTM
Washington Family and Medical Leave	Revised Code of Washington, Title 50A, Family and Medical Leave	Wash. Rev. Code §50A	https://app.leg.wa.gov/RCW/default.aspx?cite=50A

VII. Endnotes

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[19] The New Jersey Security and Financial Empowerment Act, P.L. 2013, c.82
[20] The New Jersey Division of Temporary Disability and Family Leave Insurance, 2019
[21] The New Jersey Division of Temporary Disability and Family Leave Insurance, 2019
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Jennifer Kagiwada
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HAWAIʻI COUNTY COUNCIL - DISTRICT 2

25 Aupuni Street · Hilo, Hawaiʻi 96720

DATE: March 21, 2025
TO: House Committee on Labor
FROM: Jennifer Kagiwada, Council Member
Council District 2
SUBJECT: HCR 179/HR 175

Aloha Chair Sayama, Vice Chair Lee, and Committee Members,

I write in support of HCR 179/HR 175 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

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Logan Okita
Vice President
Cheney Kaku
Secretary-Treasurer
Ann Mahi
Executive Director

TESTIMONY TO THE HAWAI'I HOUSE COMMITTEE ON LABOR

Item: HCR179/HR175

Position: Support

Hearing: Tuesday, March 25, 2025, 9:30 am, Room 309

Submitter: Osa Tui, Jr., President - Hawai'i State Teachers Association

Dear Chair Sayama, Vice Chair Lee, and members of the committee,

The Hawai'i State Teachers Association (HSTA) **supports** HCR179/HR175 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.

CATHOLIC CHARITIES HAWAIʻI

TESTIMONY IN SUPPORT OF HR 175 / HCR 79: 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: House Committee on Labor
FROM: Tina Andrade, President and CEO, Catholic Charities Hawaiʻi
Hearing: Tuesday, 3/15/25; 9:30 AM; via Videoconference or Room 309

Chair Sayama, Vice Chair Lee, and Members, Committee on Labor:

Catholic Charities Hawai`i **Strongly Supports HR 175 / HCR 179 ,** 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.

Hawai'i Nurses' association
The Voice That Makes The Difference
OPEIU Local 50

Rosalee Agas Yuu, RN
President

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The Thirty-Third Legislature
Hawai'i State Senate
Committee on Labor & Technology

Testimony by
Hawaii Nurses Association

TESTIMONY IN SUPPORT OF HCR 179 – RELATING TO THE PAID FAMILY
March 25, 2024, 9:30 PM
Conference Room 309, Hawaii State Capitol

Aloha Chair Sayama and Vice Chair Lee, and Honorable Members of the House Committee Labor:

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 HCR 179**, 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

TESTIMONY IN SUPPORT OF HCR179/HR175, 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.

HOUSE COMMITTEE ON LABOR
MARCH 25, 2025

Aloha Chair Sayama, Vice Chair Lee, and Members of the Labor Committee:

The Democratic Party of Hawai'i **SUPPORTS** HCR179/HR175. 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 HCR179/HR175. Should you have any questions or require further information, please contact the Democratic Party of Hawai'i at legislation@hawaiidemocrats.org.

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The State Legislature
House Committee on Labor
Tuesday, March 25, 2025
Conference Room 309 , 9:30 a.m.

TO: The Honorable Jackson Sayama, Chair
FROM: Keali'i Lopez, State Director, AARP Hawaii
RE: Strong Support for HR 175/HCR 179 -Relating to Working Group for Paid Family Leave

Aloha Chair Sayama and Members of the Committee:

I am Keali'i Lopez, State Director for AARP Hawai'i. AARP is a nonprofit, nonpartisan, social impact organization dedicated to empowering people 50 and older to choose how they live as they age. We advocate at the state and federal level for the issues that matter most to older adults and their families. On behalf of our nearly 135,000 members statewide, we thank you for the opportunity to share our testimony.

AARP is in strong support of HR 175/HCR 179 which convenes a legislative working group to develop recommendations for establishing and implementing a paid family and medical leave program for the state. We appreciate and thank the legislature for the opportunity to serve on this working group.

As noted in AARP's 2023 report, Valuing the Invaluable: Strengthening Supports for Family Caregivers, an estimated 154,000 family caregivers in Hawai'i provide $2.6 billion of unpaid care. Many of these caregivers work full- or part-time jobs while supporting their loved ones. Nationally, 60% of family caregivers of adults worked either full-time or part-time in 2023. Forty percent of caregivers cite the emotional stress of juggling caregiving with paid work as their biggest challenge. Many of these family caregivers, including adults sandwiched between caring for older family members and children at home, are struggling to manage both their caregiving responsibilities and the jobs they need. Thirty percent of all caregivers are caring for two generations. Many family caregivers must cut back their work hours or even leave the workforce to care for loved ones. Career disruptions and breaks due to caregiving can lead to substantial economic risk and even long-term financial struggles for caregivers.

HR 175/HCR 179's proposed working group can 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. Establishing a paid family leave program in Hawaii would allow workers to take time off

and still receive part of their income when they need to care for the health needs of their loved one(s), or to bond with a new child. Paid leave would provide a critical lifeline to working family caregivers, yet just 21 percent of workers have paid family leave through their jobs.

A paid family leave program in Hawaii will benefit workers, employers, and the economy by helping family caregivers remain at their jobs. According to AARP's Valuing the Invaluable report, "when caregivers are unable to continue balancing work and caregiving responsibilities, employers are faced with the loss of valuable, experienced workers and the cost of hiring new employees."

Results of a 2024 AARP Hawaii survey of voters 40 years of age and older indicated that most voters (88%) support some amount of paid family leave for working family caregivers. And a majority of voters (56%) want government to do more to support family caregivers. HR 175/HCR 179 demonstrates Hawaii's commitment to helping working Hawaii residents and their families, supporting small businesses, and will benefit workers, employers, and the economy by helping family caregivers remain at their jobs.

Thank you very much for the opportunity to testify in **Strong Support of HR 175/HCR 179.**

To: House Committee on Consumer Protections and Commerce
Hearing: February 12, 2025, 2:00 p.m., Rm.329
Re: SUPPORT of HCR179 and HR175 Relating to Paid Family Leave

Dear LAB Chair Sayama, Vice Chair Lee, and Committee Members,

Thank you for considering this SCR and reviewing this testimony in **support of HCR 17 and9 its companion bill HR175** which would create a working group to make recommendations 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.

holomua
COLLABORATIVE

OUR MISSION
To support and advance public policies that make Hawai'i affordable for all working families.

OUR VISION
Collaborative, sustainable, and evidence-based public policies that create a diverse and sustainable Hawai'i economy, an abundance of quality job opportunities, and a future where all working families living in Hawai'i can thrive.

827 Fort Street Mall, 2nd Floor
Honolulu, Hawai'i 96813

+1 (808) 542-4089
info@holomuacollaborative.org

HolomuaCollaborative.org

Committee:	**House Committee on Labor**
Bill Number:	**HCR 179/HR175 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 25, 2025, 9:30am (Room 309)**
Re:	**Testimony of Holomua Collaborative – Support**

Aloha Chair Sayama, Vice Chair Lee, and Members of the Committee:

Mahalo for the opportunity to submit testimony **in support** of HCR179 and HR175, which requests this Committee and the Senate Committee on Labor and Technology 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

Date: March 23, 2025

To: Representative Jackson D. Sayama, Chair
Representative Mike Lee, Vice Chair
Members of the House Committee on Labor

RE: Support for HCR 179/HR 175, 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 a paid family leave program

Hrg: Tuesday, March 25, 2025, at 9:30 AM, Conference Room 309

The Healthy Eating Active Living (HEAL) Coalition, convened by the Hawai'i PublicHealth Institute, **supports HCR 179/HR 175,** 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

HCR 179/HR 175, 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 25, 2025 · LAB HEARING

POSITION: Support.

RATIONALE: The Democratic Party of Hawai'i Education Caucus **supports** HCR 179/HR 175, 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

HCR 179/HR 175, 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 25, 2025 · LAB HEARING

POSITION: Support.

RATIONALE: Imua Alliance **supports** HCR 179/HR 175, 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.

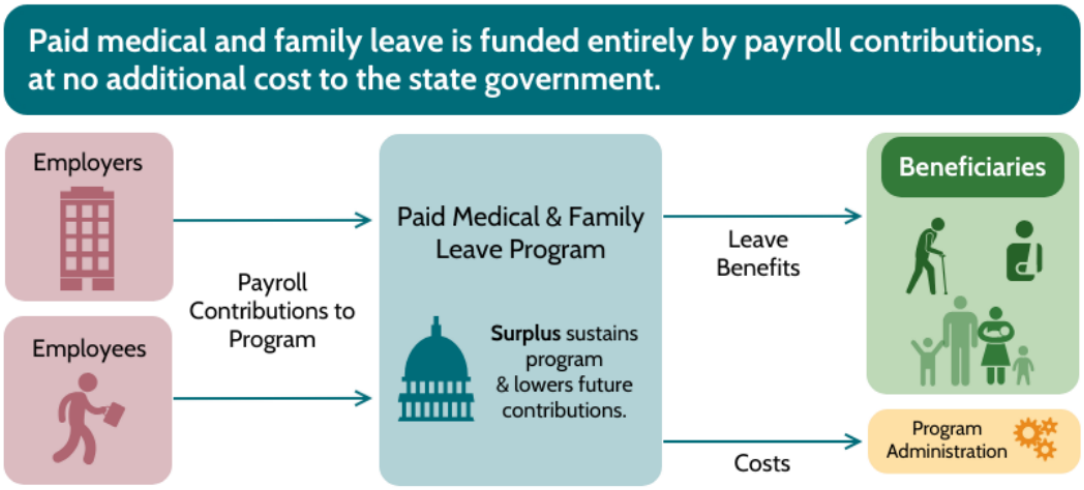
This program would help Hawaii's businesses. Family leave insurance increases worker retention and loyalty. Workers who have access to family leave benefits are more likely to return to work after their leave is over. In a 10-year study of the California family leave insurance program, businesses reported 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.

March 23, 2025

Subject: Support for HR175/HCR179

Chair Sayama and Members of the Committee:

I am writing today in **STRONG SUPPORT of HR 175 /HCR 179 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

HCR-179
Submitted on: 3/23/2025 10:59:02 PM
Testimony for LAB on 3/25/2025 9:30:00 AM

Submitted By	Organization	Testifier Position	Testify
Joell Edwards	Wainiha Country Market Inc	Support	Remotely Via Zoom

Comments:

Aloha 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!

Mahalo!

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 House of Representatives
Committee on Labor

Testimony by
Hawaii Government Employees Association

March 25, 2025

H.C.R. 179/H.R. 175 — 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 H.C.R. 179/H.R. 175, 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 H.C.R. 179/H.R. 175.

Respectfully submitted,

Randy Perreira
Executive Director

HAWAII STATE AFL-CIO

888 Mililani Street, Suite 501 • Honolulu, Hawaii 96813
Telephone: (808) 597-1441 • Fax: (808) 593-2149

The Thirty-Third Legislature
House of Representatives
Committee on Labor

Testimony by
Hawaii State AFL-CIO

March 25, 2025

TESTIMONY IN SUPPORT OF HR175/HCR179 – 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 Sayama, 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 HR175/HCR179 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

UNITED PUBLIC WORKERS

AFSCME Local 646, AFL-CIO

HOUSE OF REPRESENTATIVES
THE THIRTY-THIRD LEGISLATURE
REGULAR SESSION OF 2025

COMMITTEE ON LABOR
Rep. Jackson D. Sayama, Chair
Rep. Mike Lee, Vice Chair

Tuesday, March 25, 2025, 9:30 AM
Conference Room 309 & Videoconference

Re: Testimony on HCR179/HR175 – 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 Sayama, 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** HCR179/HR175, 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.

HEADQUARTERS
1426 North School Street
Honolulu, Hawaii 96817-1914
Phone 808.847.2631

HAWAII
362 East Lanikaula Street
Hilo, Hawaii 96720-4336
Phone 808.961.3424

KAUAI
2970 Kele Street, Suite 213
Lihue, Hawaii 96766-1803
Phone 808.245.2412

MAUI
841 Kolu Street
Wailuku, Hawaii 96793-1436
Phone 808.244.0815

1.866.454.4166
Toll Free - *Molokai/Lanai only*

The House Committee on Labor
March 25, 2025
Room 309
9:30 AM

RE: **HR 175/HCR 179, 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 Leave and Medical Leave Program for the State**

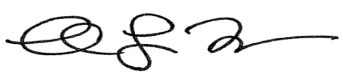
Attention: Chair Jackson Sayama, Vice Chair Mike Lee and members of the Committee

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 HR 175/HCR 179**, 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 HR 175/HCR 179 with the suggested amendment.

Respectfully submitted,



Christian L. Fern
Executive Director
University of Hawaii Professional Assembly

University of Hawaii
Professional Assembly
1017 Palm Drive ✦ Honolulu, Hawaii 96814-1928
Telephone: (808) 593-2157 ✦ Facsimile: (808) 593-2160
Website: www.uhpa.org

HCR-179
Submitted on: 3/24/2025 9:12:02 AM
Testimony for LAB on 3/25/2025 9:30:00 AM

Submitted By	Organization	Testifier Position	Testify
Pride at Work – Hawai‘i	Pride at Work – Hawai‘i	Support	Written Testimony Only

Comments:

Aloha Representatives,

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 House Concurrent Resolution 179.

We do ask that it be amneded to include representation from Hawai‘i's LGBTQIA+ communtiy.

We ask that you support this needed resolution.

Mahalo,

Pride at Work – Hawai‘i

HCANSpeaks!
Hawai'i Children's Action Network

Hawai'i Children's Action Network Speaks! is a nonpartisan 501c4 nonprofit committed to advocating for children and their families. Our core issues are safety, health, and education.

To: House Committee on Labor

Re: **HR 175 / HCR 179 – 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 25, 2025, 9:30 AM

Dear Chair Sayama, Vice Chair Lee, and Committee Members,

On behalf of Hawai'i Children's Action Network Speaks!, I am submitting this testimony in **SUPPORT of HR 175 / HCR 179**. 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

House Labor Committee
Rep. Sayama, Chair
Rep. Lee, Vice Chair

March 25, 2025, at 9:30 A.M.

RE: HCR179/HR175, Requesting the House and Senate Labor Standing Committees to convene a working group for establishing a Paid Family and Medical Leave Program

Aloha Chair Sayama, Vice Chair Lee, and members of the Committee:

Society for Human Resource Management – Hawaii ("SHRM Hawaii") respectfully offers comments on House Concurrent Resolution 179 and House Resolution 175:

HCR179 and HR175 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.

AFFILIATE OF SHRM SOCIETY FOR HUMAN RESOURCE MANAGEMENT

SHRM Hawaii, P. O. Box 3175, Honolulu, Hawaii (808) 447-1840

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

Chamber of Commerce HAWAII

2030 BLUEPRINT
ECONOMIC ACTION PLAN FOR HAWAII

Testimony to the House Committee on Labor
Representative Jackson D. Sayama, Chair
Representative Mike Lee, Vice Chair

Tuesday, March 25, 2025, at 9:30AM
Conference Room 309 & Videoconference

RE: HCR179/HR175 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

Aloha e Chair Sayama, Vice Chair Lee, and Members of the Committee:

My name is Sherry Menor, President and CEO of the Chamber of Commerce Hawaii ("The Chamber"). The Chamber offers the following comments on House Concurrent Resolution 179/House Resolution 175 (HB327), 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.

There is a critical need for the Chamber of Commerce to be included in the legislative working group developing Hawaii's paid family and medical leave program to ensure fair and effective representation of the business community, particularly small businesses. To address the broader challenges surrounding access to paid leave, the resolution calls for the creation of a legislative working group tasked with developing recommendations for a statewide paid family and medical leave program. This group is responsible for exploring implementation strategies, aligning the program with existing benefits like Temporary Disability Insurance, and defining key elements such as wage replacement, leave duration, eligibility, and employment protections.

While the proposed working group includes representatives from labor unions and advocacy organizations, including the Chamber will ensure that the business community has the opportunity to actively contribute to the development of the program. The Chamber's involvement will help shape a policy that is fair and supportive for workers, while also being realistic and manageable for employers—contributing to the program's long-term success and sustainability.

The Chamber of Commerce Hawaii is the state's leading business advocacy organization, dedicated to improving Hawaii's economy and securing Hawaii's future for growth and opportunity. Our mission is to foster a vibrant economic climate. As such, we support initiatives and policies that align with the 2030 Blueprint for Hawaii that create opportunities to strengthen overall competitiveness, improve the quantity and skills of available workforce, diversify the economy, and build greater local wealth.

Thank you for the opportunity to provide comments.

733 Bishop Street, Suite 1200, Honolulu, HI 96813 | (808) 545-4300 | info@cochawaii.org | www.cochawaii.org

HCR-179
Submitted on: 3/21/2025 12:15:49 PM
Testimony for LAB on 3/25/2025 9:30:00 AM

Submitted By	Organization	Testifier Position	Testify
Angela Serota	Individual	Support	Written Testimony Only

Comments:

Aloha Chair Sayama and Members of the Committee,

My name is Angela Serota. I was a family caregiver and currently work with several caregivers.I am in STRONG SUPPORT of HR 175/HCR 179. Family caregivers are a vital part of Hawaii's long term care system. Often, a family caregiver is responsible for meeting the needs of a loved one for 24 hours a day while working and taking care of dependent children. Developing a paid family leave policy would allow working family caregivers to care for a loved one without losing their job and income. Please support their ability to provide this necessay care.

Mahalo nui loa for hearing my testimony.

Angela Serota from Kilauea, Kauai

HCR-179
Submitted on: 3/21/2025 2:50:07 PM
Testimony for LAB on 3/25/2025 9:30:00 AM

Submitted By	Organization	Testifier Position	Testify
Sherrie Galdeira	Individual	Support	Written Testimony Only

Comments:

Aloha 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!

Mahalo!

HCR-179
Submitted on: 3/21/2025 3:02:10 PM
Testimony for LAB on 3/25/2025 9:30:00 AM

Submitted By	Organization	Testifier Position	Testify
Daphne Kahawai-Tom	Individual	Support	Written Testimony Only

Comments:

Aloha 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!

Mahalo!
Daphne Kahawai-Tom

HCR-179
Submitted on: 3/21/2025 3:06:04 PM
Testimony for LAB on 3/25/2025 9:30:00 AM

Submitted By	Organization	Testifier Position	Testify
Ka'ale'a Kyrstin Hanawahine	Individual	Support	Written Testimony Only

Comments:

Aloha 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!

Mahalo!

Kaʻaleʻa Hanawahine

HCR-179
Submitted on: 3/21/2025 3:33:44 PM
Testimony for LAB on 3/25/2025 9:30:00 AM

Submitted By	Organization	Testifier Position	Testify
Renee Hall	Individual	Support	Written Testimony Only

Comments:

Testimony in Support of HCR 179

I strongly support this resolutiohcrn 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,

HCR-179
Submitted on: 3/21/2025 3:51:00 PM
Testimony for LAB on 3/25/2025 9:30:00 AM

Submitted By	Organization	Testifier Position	Testify
Dan Gardner	Individual	Support	Written Testimony Only

Comments:

Chair Sayama and Members of the House Committee on Labor

My wife Deborah and I are in strong support of HR175/HCR179 which convenes a legislative working group for a paid family and medical leave program for Hawaii. The working group should develop recommendations to enable such a program for Family caregivers, the mainstay of Hawaii's long term care system. These caregivers provide countless hours of loving support 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. Please develop plans for a paid family and medical leave program allowing working family caregivers to continue caring for their loved ones without sacrificing their job and income. They are very deserving of our support. Thank you

HCR-179
Submitted on: 3/21/2025 4:10:28 PM
Testimony for LAB on 3/25/2025 9:30:00 AM

Submitted By	Organization	Testifier Position	Testify
Nai`a NEWLIGHT	Individual	Support	Written Testimony Only

Comments:

Testimony on House Resolution: HR 175/HCR 179

Convening legislative working group for Paid Family Leave

Tuesday, March 25, 2025 at pm

Conference Room 309 & Videoconference

State Capitol

415 South Beretania Street

Chair Sayama and Members of the Committee:

My name is Nadine Newlight, and I am a family caregiver. I am in **STRONG SUPPORT of HR 175 /HCR 179 which convenes a legislative working group for a paid family and medical leave program for the state.**

HCR-179
Submitted on: 3/22/2025 12:26:28 AM
Testimony for LAB on 3/25/2025 9:30:00 AM

Submitted By	Organization	Testifier Position	Testify
pamela anderson	Individual	Support	Written Testimony Only

Comments:

Aloha 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!

Mahalo!

HCR-179
Submitted on: 3/22/2025 7:55:09 AM
Testimony for LAB on 3/25/2025 9:30:00 AM

Submitted By	Organization	Testifier Position	Testify
Ashley Stone-Mason	Individual	Support	Written Testimony Only

Comments:

Aloha e Chair Sayama, 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

HOUSE COMMITTEE ON LABOR
Rep. Jackson D. Sayama, Chair
Rep. Mike Lee, Vice Chair

NOTICE OF HEARING
Tuesday, March 25, 2025: 9:30 a.m.

RE: HR175/HCR 179 REQUESTING THE CONVENING OF A LEGISLATIVE WORKING GROUP

Aloha Chair Sayama, Vice Chair Lee, and Members of the Committee: My name is Linda Dorset, and I am in STRONG SUPPORT of HR175/HCR 179. 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 HR175/HCR 179. 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

HCR-179
Submitted on: 3/22/2025 2:34:35 PM
Testimony for LAB on 3/25/2025 9:30:00 AM

Submitted By	Organization	Testifier Position	Testify
J. Kehau Lucas	Individual	Support	Written Testimony Only

Comments:

Aloha 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!

Aloha ʻāina,

J. Kēhau Lucas

HCR-179
Submitted on: 3/22/2025 2:40:01 PM
Testimony for LAB on 3/25/2025 9:30:00 AM

Submitted By	Organization	Testifier Position	Testify
Terri Yoshinaga	Individual	Support	Written Testimony Only

Comments:

I support this bill.

HCR-179
Submitted on: 3/22/2025 2:47:36 PM
Testimony for LAB on 3/25/2025 9:30:00 AM

Submitted By	Organization	Testifier Position	Testify
Elizabeth Hansen	Individual	Support	Written Testimony Only

Comments:

Aloha 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!
Mahalo!

HCR-179
Submitted on: 3/22/2025 4:17:25 PM
Testimony for LAB on 3/25/2025 9:30:00 AM

Submitted By	Organization	Testifier Position	Testify
Caroline Kunitake	Individual	Support	Written Testimony Only

Comments:

Aloha 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!

Mahalo!

HCR-179
Submitted on: 3/22/2025 8:15:07 PM
Testimony for LAB on 3/25/2025 9:30:00 AM

Submitted By	Organization	Testifier Position	Testify
Star Kemfort	Individual	Support	Written Testimony Only

Comments:

Aloha Chair Sayama, Vice Chair Lee, and Committee Members,

I strongly support HCR179/HR175 two resolutions that will allow the implementation of a working group to continue the discussion around paid family leave. I Star Kemfort believe there are many ways that the workforce in the state of Hawai‘i can protect individuals within the workforce and the ultimate solution is by passing Paid Family and Medical Leave (PFML). However due to it not being passed recently the efforts of individuals within the workforce advocating for this benefit in our state will not go unnoticed by the use of these two resolutions HCR179/HR175. People have a voice to advocate for changes that are important and in their best interest what better way to use it than to keep it heard in discussions around PFML. Whether privately amongst loved ones, or publicly with the general population it is crucial for Paid Family and Medical Leave to be a topic of discussion so more efforts are provided to get PFML passed. Please support these resolutions!

Mahalo!

Testimony on House Resolution: HR175/HCR179
Convening legislative working group for Paid Family Leave
Tuesday, March 25, 2025, at 9:30 a.m.
Conference Room 309 & Videoconference
State Capitol
415 South Beretania Street

Aloha Chair Sayama and Members of the Committee:

My name is Christina Enoka, and I am a former caregiver for my father who had stage 4 cancer. I am in STRONG SUPPORT of HR 175 / HCR 179 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.

During my father's illness, my sister and I helped our mother with the daily care and transport to doctor appointments which included chemotherapy and radiation treatment. Because my mother did not drive, it was necessary to help with weekly grocery shopping, errands to pick up medications and other household care. Additionally, home medical equipment was needed as my father was reaching the end stage of his life. The additional expenses experienced during this time of a health crisis were unplanned and stressful. Paid family and medical leave would have helped both my sister and I with our personal financial needs for our immediate families.

This past year, my sister's husband was diagnosed with pancreatic cancer. His illness was painfully challenging for my sister and her husband as he was in and out of the hospital many times and then needed care at home. My sister became the primary caretaker for her husband and initially did this while working her regular hours. However, as his illness progressed, she needed to take time off from work for more doctor visits, trips to the ER and chemotherapy. Eventually she had to take an extended leave of absence, without pay. The increase in medical equipment bought, added medications, with frequent changes due to his declining health, and ambulance transports affected their finances significantly. Paid family and medical leave would have been extremely helpful to her and to other Hawaii residents who are faced with similar challenges.

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 and keep a roof over their heads. Some are the sandwich generation caring for both aging kapua and younger keiki in school. Developing a paid family leave policy and program would allow working family caregivers to care for their loved ones without sacrificing their job and income. They all deserve our support.

Mahalo for the opportunity to testify!

Christina Enoka
Mililani, Oahu
Ncsmn150@gmail.com

HCR-179
Submitted on: 3/23/2025 9:06:24 AM
Testimony for LAB on 3/25/2025 9:30:00 AM

Submitted By	Organization	Testifier Position	Testify
Sandy Ma	Individual	Support	Written Testimony Only

Comments:

We need to support Paid Family and Medical leave because providing workers with paid family and medical leave ensures that workers are able to take extended leave, with pay, to care for a new child, recover from a serious illness or care for an ill family member, and that they are able to return to their job afterward. This is good for workers, families, and Hawaii busineses.

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

HCR-179
Submitted on: 3/23/2025 10:49:14 AM
Testimony for LAB on 3/25/2025 9:30:00 AM

Submitted By	Organization	Testifier Position	Testify
Younghee Overly	Individual	Support	Written Testimony Only

Comments:

Thank you for hearing HCR179/HR175, 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.

HCR-179
Submitted on: 3/23/2025 12:26:51 PM
Testimony for LAB on 3/25/2025 9:30:00 AM

Submitted By	Organization	Testifier Position	Testify
Noel Shaw	Individual	Support	Written Testimony Only

Comments:

Please pass this bill and support getting us closer to Paid Family Leave in Hawaii. This is so important to our ability to continue to be care takers in the ways we are called to be. Without it, our aloha is inhibited and our hearts harden to care because we are unsupported in that work.

Although I am disappointed the bills to support this Paid Family Leave didn't pass, I trust this space to use our collective resources to get us closer to getting it done. Mahalo.

House Committee On Labor
Testimony on House Resolution 179/HR 175
Relating to Family Leave Working Group
March 25, 2025

Aloha Chair Sayama 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 HCR 179/HR 175. 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 HCR 179/HR 175.

Mahalo for the opportunity to testify!

Deborah M. Oyakawa
Waikoloa, HI 96738
Email: deboyakawa@gmail.com

Testimony on House Bill No. 179/HR 175
RELATING TO WORKING GROUP FOR PAID FAMILY LEAVE
Tuesday, March 25, 2025 at 9:30 am
Conference Room 309 & Videoconference
State Capitol
415 South Beretania Street

Chair Sayama and Members of the Committee:

My name is Lynnette Sakamoto, and I am a former caregiver. I am in STRONG SUPPORT of HCR 179/HR 175 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 HCR 179/ HR 175 to work on a program for Hawaii families.

Mahalo for the opportunity to testify.

Lynnette Sakamoto
Kailua, HI

NOTICE OF HEARING
March 25, 2025

HCR 145/HR 175 - RELATING TO WORKING GROUP FOR PAID FAMILY LEAVE

Aloha Chair Sayama,Vice Chair Lee and members of the Committee on Labor. My name is Carol Wakayama and I wish to submit testimony in favor of H.C.R 179/ H.R. 175.

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.

HCR 179/HR 175 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 HCR 179/HR 175 be considered for passage. Thank you.

Carol Wakayama
1011 Prospect Street #804
Honolulu, HI 96822
ckwakayama@gmail.com

3/25/25
House Committee on Labor
HCR 179/HR 175 Paid Family Leave

Dear Chair Sayama and Committee members:

Our names are Sara and Daniel Medeiros. We live on the island of Hawaii and are retired. We are in STRONG SUPPORT of HCR 179/HR175 Paid Family Leave which establishes a working group to recommend 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 the resolution to establish the Paid Family Leave working group. They all deserve, and quite intimately so, our support.

Mahalo,

Sara and Daniel Medeiros
Kailua Kona, HI 96740

HCR-179
Submitted on: 3/23/2025 12:47:32 PM
Testimony for LAB on 3/25/2025 9:30:00 AM

Submitted By	Organization	Testifier Position	Testify
Leilani Kailiawa	Individual	Support	Written Testimony Only

Comments:

Aloha 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.

I have shared my personal testimony on zoom this 2025 and 2024 legislative session on the need for paid family leave. I am from Hawaii Island. Our family could have benefited from this when my youngest son was hospitalized for 7 months at Kapiolani Medical Center 9 years ago.

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!

HCR-179
Submitted on: 3/23/2025 2:58:39 PM
Testimony for LAB on 3/25/2025 9:30:00 AM

Submitted By	Organization	Testifier Position	Testify
Sai Peng Tomchak	Individual	Support	Written Testimony Only

Comments:

Dear Chair Sayama and Members of the Committee:

My name is Sai Peng Tomchak and a caregiver of my mother-in-law. I strongly support Bill HR 175/HCR 179, 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 ones, they have to face painful financial realities. For their employers, they have to go through costly and time consuming recruiting processes to hire their replacements.

I respectfully ask you to vote for this bill. The Hawaii caregivers are desperately in need of your support!

Mahalo,

Sai Peng Tomchak

HCR-179
Submitted on: 3/23/2025 3:39:04 PM
Testimony for LAB on 3/25/2025 9:30:00 AM

Submitted By	Organization	Testifier Position	Testify
Nancy Rustad	AAUW Hawaii	Support	Written Testimony Only

Comments:

Aloha 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!

Mahalo!

To: Hawaii State Senate Committee on Labor

Hearing Date/Time: Tuesday March 25, 2025, 9:30am

Place: Hawaii State Capitol, CR 309 & Videoconference

Re: Judith Ann Armstrong supports HCR179 / HR175 to Establish paid family leave program.

Dear Chair Rep. Jackson D. Sayama, Vice Chair Rep. Mike Lee and members of the Labor Committee

I, Judith Ann Armstrong, support HCR179 / HR175, 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 HCR179 / HR175.

Sincerely,

Judith Ann Armstrong

HCR-179
Submitted on: 3/23/2025 10:08:39 PM
Testimony for LAB on 3/25/2025 9:30:00 AM

Submitted By	Organization	Testifier Position	Testify
Chloe Pua'ena Vierra-Villanueva	Individual	Support	Written Testimony Only

Comments:

Aloha 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!

Mahalo,

Pua‘ena

(‘Ohana Leadership Council)

LATE *Testimony submitted late may not be considered by the Committee for decision making purposes.

HCR-179
Submitted on: 3/24/2025 11:06:23 AM
Testimony for LAB on 3/25/2025 9:30:00 AM

Submitted By	Organization	Testifier Position	Testify
Erin Vierra-Villanueva	Individual	Support	Written Testimony Only

Comments:

Aloha 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!

Mahalo!

HCR-179
Submitted on: 3/24/2025 3:01:42 PM
Testimony for LAB on 3/25/2025 9:30:00 AM

Submitted By	Organization	Testifier Position	Testify
Joan Johnson	Individual	Support	Written Testimony Only

Comments:

Aloha Chair Sayama, Vice Chair Lee and Committee Members,

I strongly support HCR179/HR175, 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 bills to protect our working families continues to grow. The economic success of our state is linked to the well-being of our workforce. Similar programs in other states demonstrate that paid family leave benefits both businesses and their employees.

Please support these resolutions. Thank you!

HCR-179
Submitted on: 3/25/2025 8:21:09 AM
Testimony for LAB on 3/25/2025 9:30:00 AM

Submitted By	Organization	Testifier Position	Testify
Kristy Arias	Individual	Support	Written Testimony Only

Comments:

"1 strongly support
HR 175,
which request a
working group to
continue the
discussion around
Paid Family Leave in
Hawaii."