JOSH GREEN, M.D.
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DIRECTOR

WILLIAM G. KUNSTMAN
DEPUTY DIRECTOR

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

March 17, 2026

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

Date: Tuesday, March 17, 2026
Time: 9:30 a.m.
Place: Conference Room 309, State Capitol

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

Re: S.B. 2088 S.D.1 RELATING TO HEALTH CARE PLANS FOR WORKERS

I. OVERVIEW OF PROPOSED LEGISLATION

The **DLIR strongly opposes** this measure as the Department lacks the statutory role, infrastructure, and resources to design or administer health insurance programs. This proposal may also conflict with federal Employee Retirement Income Security Act (ERISA) requirements, exposing the State to litigation and compliance challenges.

SB2088 SD1 proposes to:

- Require the DLIR, in consultation with the Insurance Commissioner, to establish and implement a five-year voluntary Nontraditional Workforce portable Health Care Benefit Plan Pilot Program; and
- Provide high deductible or catastrophic health plans to nontraditional workers who are ineligible for health benefits provided by the Hawaii employer-union health benefits trust fund or prepaid health care plans under the Prepaid Health Care (PHC) Act.

II. CURRENT LAW

HRS Chapter 393, the Prepaid Health Care Act (PHCA), requires employers to provide health care coverage to employees who meet the minimum requirements set by the law.

III. COMMENTS ON THE SENATE BILL

While the intent of this measure is commendable, it could create significant

unintended consequences that undermine existing worker protections and the integrity of the PHCA. The Department is not in the business of providing health insurance and does not have the infrastructure or expertise to operate such a program. Additionally, any new program will divert resources and impact our existing program priorities. These consequences include:

- Weakening the protections the PHCA has afforded Hawaii's workforce. For decades, the PHCA has ensured broad, affordable health coverage for Hawaii's workforce. Introducing alternative plans with limited benefits risks weakening these protections and undermining the integrity of Hawaii's highly regarded health care framework.

- Creating a voluntary portable health care option for "nontraditional" workers which could unintentionally motivate employers to improperly shift employees into independent contractors, gig, or part-time roles to avoid PHCA requirements. This would erode comprehensive coverage standards and destabilize Hawaii's workforce.

- Expanding the use of nontraditional work arrangements may result in reduced benefits, increased dependence on state-funded assistance, and widening health inequities for already vulnerable populations. Workers could experience more unstable employment conditions and insufficient access to essential health services.

- Putting the DLIR at risk of failing to meet the requirements of this proposal because of its limited resources. DLIR does not have the specialized legal expertise, staffing and resources to design, oversee, or enforce a new health insurance program. The Department's current responsibilities are confined to reviewing plans through the PHC Advisory Council and not developing or managing health plans. This proposal would impose substantial new obligations without the necessary resources.

Furthermore, the DLIR notes that ERISA broadly preempts state laws connected to employee benefit plans. If the portable plans created under this pilot resemble employer-sponsored coverage, the plans may fall under ERISA and potentially invalidate portions of this measure:

- Contributions by hiring parties, even if labeled voluntary, may be construed as evidence of an employment relationship, exposing employers and the State to litigation.

- Plans classified as ERISA-governed would be subject to complex federal requirements such as reporting rules, fiduciary duties, and Consolidated Omnibus Budget Reconciliation Act (COBRA), all of which the DLIR is not equipped to administer.

- Any conflict with federal standards could invalidate key provisions, creating legal uncertainty and exposing the State to significant risk.

For these reasons the Department strongly opposes this measure.

JOSH GREEN, M.D.
GOVERNOR | KE KIAʻĀINA

SYLVIA LUKE
LIEUTENANT GOVERNOR | KA HOPE KIAʻĀINA

STATE OF HAWAII | KA MOKUʻĀINA ʻO HAWAIʻI
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DEPUTY DIRECTOR | KA HOPE LUNA HOʻOKELE

Testimony of the Department of Commerce and Consumer Affairs

Before the
House Committee on Labor
Tuesday, March 17, 2026
9:30 a.m.
State Capitol, Conference Room 309 and via videoconference

On the following measure:
S.B. 2088, S.D. 1, RELATING TO HEALTH CARE PLANS FOR WORKERS

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

My name is Scott K. Saiki, and I am the Insurance Commissioner of the Department of Commerce and Consumer Affairs' (Department) Insurance Division. The Department offers comments on this bill.

The purpose of this bill is to (1) require the Department of Labor and Industrial Relations, in consultation with the Insurance Commissioner, to establish and implement a five-year voluntary Nontraditional Workforce Portable Health Care Benefit Plan Pilot Program that offers high deductible health plans or catastrophic health plans to nontraditional workers who are ineligible for health benefits provided by the Hawaiʻi Employer-Union Health Benefits Trust Fund or prepaid health care plans under the Prepaid Health Care Act (PHCA); (2) require reports to the Legislature; and (3) appropriate funds.

While the Department supports efforts to expand coverage to individuals not eligible for employer-sponsored health plans, the Department is concerned that the bill's definition of "portable health care benefit plan" could be in conflict with federal law.

Page 9, line 19 – page 10, line 6 of the bill defines a "portable health care benefit plan" as a "group health care plan that: (3) Is assigned to an individual beneficiary and is not associated with a specific employer or hiring party." Under federal law, health insurance is classified as either individual or group coverage. Specifically, 29 U.S.C. § 1002(1) defines "group health plan" as an employee welfare benefit plan established or maintained by an employer or by an employee organization. Since the proposed portable health care benefit plans will be sold to individuals, they would likely be classified as individual plans under federal law.

If these plans are classified as individual plans, they must comply with the Affordable Care Act's (ACA) single risk pool requirement. Under 45 C.F.R. § 156.80, a health insurance issuer must "consider the claims experience of all enrollees in all health plans . . . in the individual market in a state, including those enrollees who do not enroll in such plans through the Exchange, to be members of a single risk pool."

If the portable health care benefit plan pilot program treats the workers participating in program as a separate group for pricing or risk purposes, it would violate the single risk pool requirement.

Finally, the Department notes that high-deductible health plans, catastrophic health plans, and health savings accounts (HSAs) are already available to individuals who do not receive employer sponsored health insurance under the PHCA. Due to recent federal changes, all Bronze and Catastrophic level health insurance plans meet the definition of a high-deductible health plan. While these plans do offer the benefit of lower monthly premiums, they are characterized by high annual deductibles that may present a financial hurdle for participants. For the 2026 plan year, Bronze plans in Hawaii have an average deductible of approximately $6,700. Catastrophic plans are required to have a deductible equal to the annual out-of-pocket maximum, which for 2026 is $10,600 for an individual. The overall financial design of Bronze and

Catastrophic tiers means that enrollees would likely face significant out-of-pocket expenses for any major medical events before insurance coverage fully applies.

Thank you for the opportunity to testify on this bill.

HPCA
HAWAI'I PRIMARY CARE ASSOCIATION

Testimony to the House Committee on Labor
Tuesday, March 17, 2026; 9:30 a.m.
State Capitol, Conference Room 309
Via Videoconference

RE: SENATE BILL NO. 2088, SENATE DRAFT 1, RELATING TO HEALTH CARE PLANS FOR WORKERS.

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

The Hawaii Primary Care Association (HPCA) is a 501(c)(3) organization established to advocate for, expand access to, and sustain high quality care through the statewide network of Community Health Centers throughout the State of Hawaii. The HPCA **SUPPORTS THE INTENT** of Senate Bill No. 2088, Senate Draft 1, RELATING TO HEALTH CARE PLANS FOR WORKERS.

By way of background, the HPCA represents Hawaii's Federally Qualified Health Centers (FQHCs). FQHCs provide desperately needed medical services at the frontlines to over 150,000 patients each year who live in rural and underserved communities. Long considered champions for creating a more sustainable, integrated, and wellness-oriented system of health, FQHCs provide a more efficient, more effective and more comprehensive system of healthcare.

This measure, as received by your Committee, would require the Department of Labor and Industrial Relations to:

(1) Establish a voluntary portable health care benefit plan pilot program (Pilot Program) to offer high deductible health plans or catastrophic health plans to workers not covered by the Hawaii Employer-Union Health Benefits Trust Fund or the Prepaid Health Care Act; and

(2) Submit annual reports to the Legislature on the Pilot Program.

This bill would also appropriate an unspecified amount of general funds for fiscal year 2026-2027 to develop and implement the Pilot Program and take effect on January 1, 2077.

ADD 1003 BISHOP STREET PAUAHI TOWER SUITE 1810 HONOLULU, HI 96813 TEL 808.536.8442 WEB HAWAIIPCA.NET

I. The Problem

During the interim following the Adjournment Sine Die of the 2025 Regular Session, three events took place that have enormous ramifications on Hawaii's social safety net. These were: the enactment of House Resolution No. 1 (H.R. 1), the "One Big Beautiful Bill" Act, which was signed into law on July 4, 2026; the reversal of interpretation of "federal public benefit" under the Personal Responsibility and Work Opportunity Reconciliation Act of 1996, or "PRWORA", by the United States Department of Health and Human Services; and the announcement that the Center for Medicare and Medicaid Services will share personal data of Medicaid enrollees to Immigration and Customs Enforcement officials.

In tandem, these three developments will fundamentally alter Hawaii's Medicaid Program by shifting current Medicaid recipients to the uninsured population. Among other things, H.R. 1 will:

(1) Prohibit the use of federal matching funds for health care services to immigrants not lawfully present under federal law, effective October 1, 2026;

(2) Establish work or volunteer requirements for all Medicaid recipients of at least 80 hours per month (or 20 hours per week), effective December 31, 2026; and

(3) Require redeterminations for every Medicaid recipient every six-months, also effective December 31, 2026.

Currently, Hawaii's uninsured population is estimated to be 38,400 or 2.8% of the total population. Based on research provided by the Kaiser Family Foundation as well as our review of Medicaid enrollment historically in Hawaii, we believe the uninsured population will at least double within two to three years if nothing is done.

Without health insurance coverage, citizens will no longer be able to manage chronic disease such as diabetes, high blood pressure, and other maladies. When they become ill, they will not get treated until the situation becomes so bad that they will need to go to a provider for emergency treatment. By then, the illness has become much more severe and costly to remedy. Also, by law, the emergency provider will have to provide stabilizing treatment to the patient regardless of the patient's ability to pay. These costs will subsequently be borne by the provider, creating additional stress to the safety net that is already facing reduced funding and reimbursement.

In the worst case scenario, hospitals and FQHCs will not be able to treat the increase in indigent patients. While federal law requires FQHCs to provide services to all patients who are not eligible for Medicaid or private insurance on a sliding fee scale based on their ability to pay, federal grant funding to offset these costs were not adjusted to address the increase that will occur. As such, should Hawaii

experience the largest projected increase in uninsured (and assuming that the level of services currently provided remains the same), FQHCs will run out of funds within two to three months.

II. A Possible Solution

On December 19, 2025, the Senate Joint Committee on Health and Human Services and Consumer Protection was briefed by MedQUEST and the State Health Planning and Development Agency (SHPDA) on the impacts of these federal policy changes. During that briefing, SHPDA Administrator Jack Lewin stated that during the Waihee Administration, the Department of Health ran a very successful program that provided coverage for persons who could not obtain employer-sponsored health insurance under the Prepaid Health Care Act, but were not eligible for Medicaid because of income restrictions. This coverage offered a significantly reduced package of benefits (i.e., up to 6 doctor visits and some prescription drugs) and was provided by Medicaid managed care plans under an agreement with the State. According to Lewin, the State agreed to cover loss costs that go beyond a certain level. However, Lewin stated that loss costs never reached that point and that the expenditure of additional general funds were not necessary.

When the State established the MedQUEST Program, the "gap group" coverage was transferred from the Department of Health to the Department of Human Services. However, according to Meredith Nichols, acting MedQUEST Administrator, when the Center for Medicare and Medicaid Services reviewed the coverage for the "gap group", they disallowed MedQUEST from offering it citing the need for coverages offered under the State's Medicaid Program to meet certain baseline benefit standards.

Despite this, the Green Administration did not submit a bill as part of his Legislative Package that would reestablishment of the "gap group" coverage under the Department of Health. However, there are measures pending further action that could conceivably address this problem:

- House Bill No. 1546, House Draft 1, which would establish a three-year Health Coverage Continuity Pilot Program to assist individuals who have lost Medicaid health insurance coverage and lack access to other health insurance options; and

- Senate Bill No. 2087, the companion to House Bill No. 1546.

Both measures would require the infusion of a significant amount of State funds to either capitalize a new insurance program, or subsidize thousands of Medicaid enrollees who will shortly be disenrolled and become uninsured.

III. High Stakes

The establishment of a high deductible or catastrophic health plan could result in unintended consequences. Hawaii is the only state that requires employers to offer health insurance to employees who work more than 20 hours per week. Hawaii is able to do this because the Prepaid Health Care Act is exempted from federal preemption under the Employee Retirement Income Security Act of 1974. Hawaii retains this exemption so long as the substantive terms of the Prepaid Health Care Act are not materially changed.

It will be vital that the provision of a high deductible or catastrophic health plan not be construed by federal regulators as materially altering the Prepaid Health Care Act. Conceivably, this could happen if the implementation of such a program shifts the manner in which the Prepaid Health Care Act is enforced. Should that happen, such action could invalidate the preemption exemption that is necessary for the Prepaid Health Care Act to operate.

In addition, H.R. 1, includes provisions that require any program intended to replicate Medicaid benefits to a prohibited population be solely general funded. Violations of this could lead to the loss of more federal funding and the imposition of penalties to Hawaii's Medicaid Program.

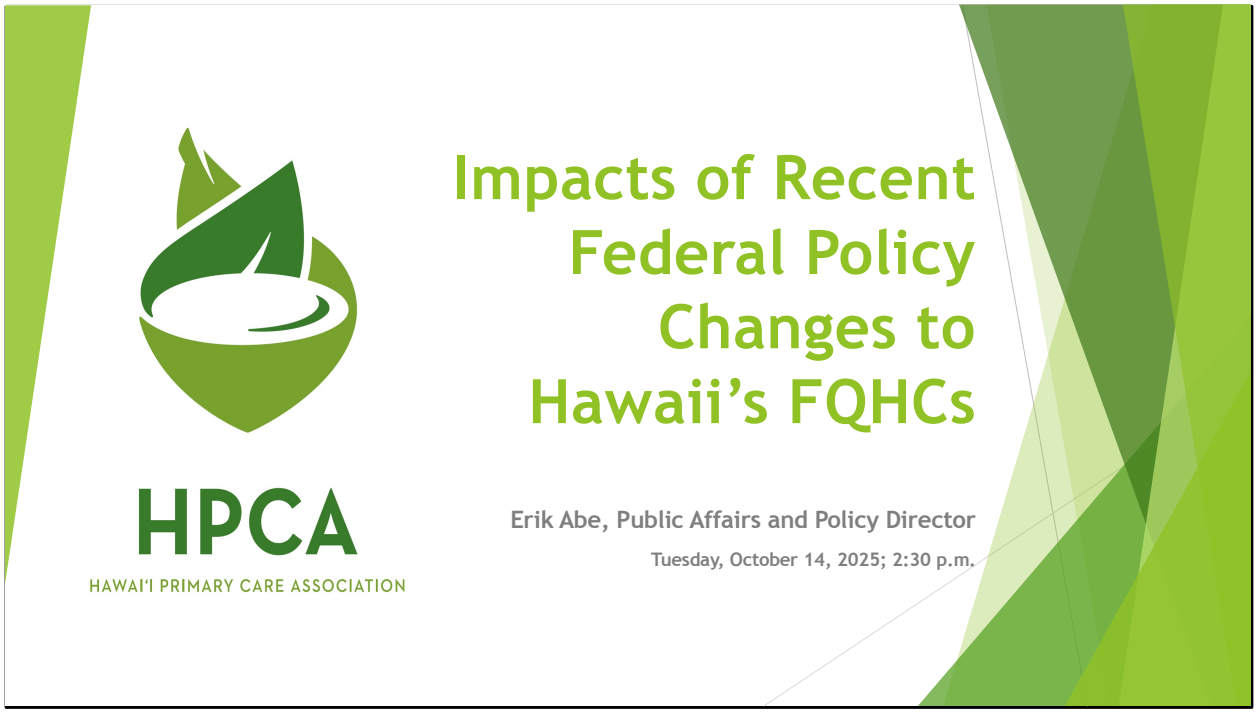
Because of this, it will be vital for the Program proposed under this bill to be coordinated jointly by the Departments of Labor and Industrial Relations (Prepaid Health), Health (SHPDA), and Human Services (Medicaid).

In light of this, the HPCA respectfully urges your favorable consideration of this bill.

For your information and files, attached please find the slides from a presentation given to the Office of the Governor in October 2025.

Thank you for the opportunity to testify. Should you have any questions, please do not hesitate to contact Public Affairs and Policy Director Erik K. Abe at 536-8442, or eabe@hawaiipca.net.

attachment

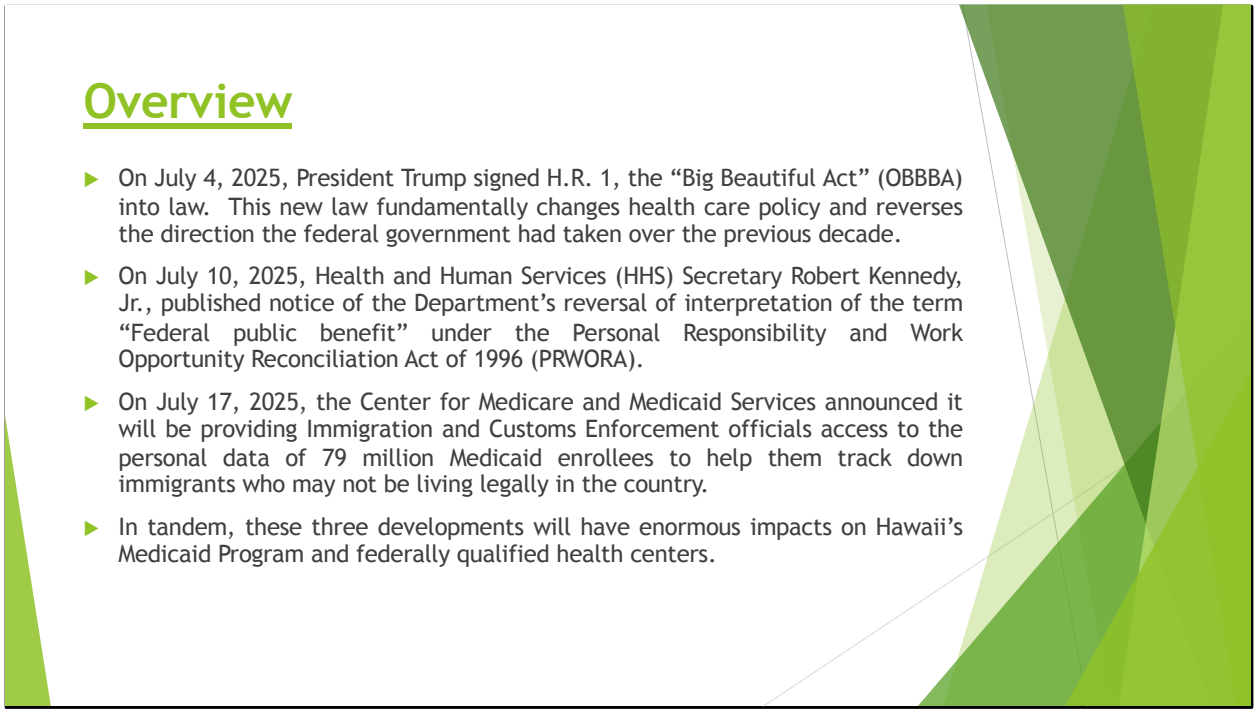


Thank you for this opportunity to present HPCA's analysis of recent federal policy changes to Hawaii's FQHCs and our Medicaid System.

If I do this right, I should be able to get through this presentation in15 minutes.

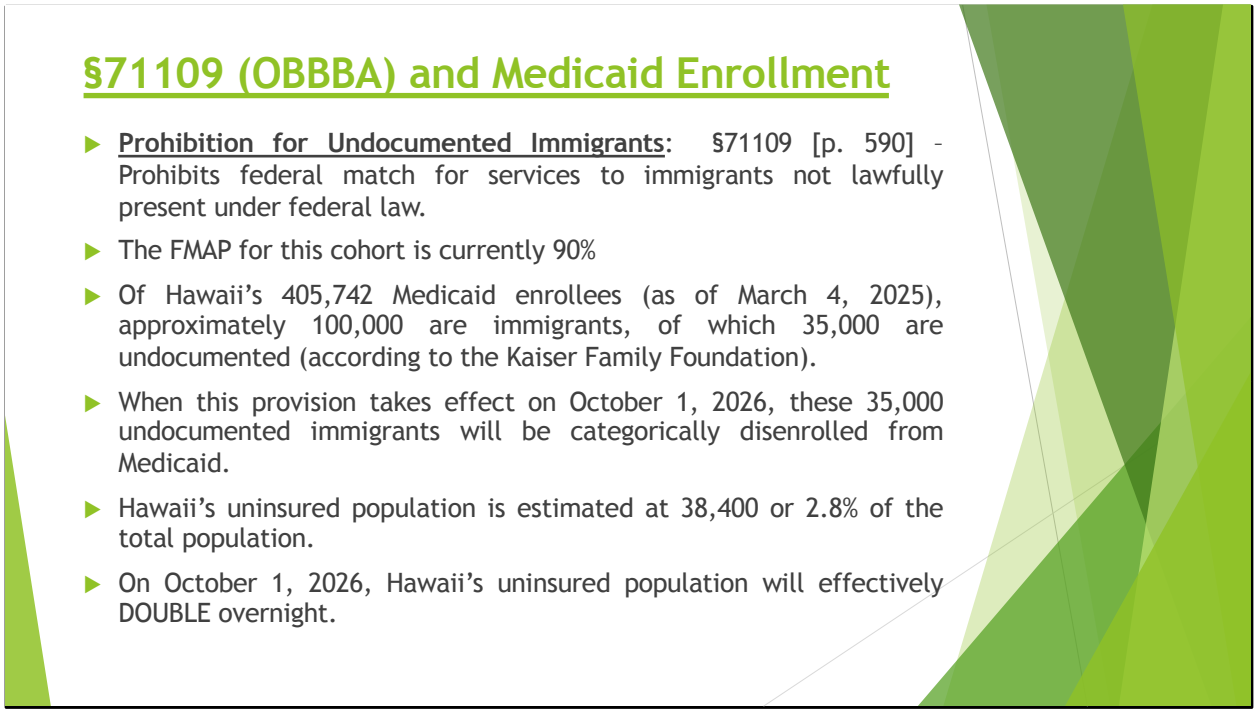
I. CHANGES TO FEDERAL LAW AND POLICY

Part I is entitled changes to federal law and policy.



There were three events that took place that change things -- the enactment of the "Big Beautiful Act"; the reversal of interpretation of "federal public benefit" under the Personal Responsibility and Work Opportunity Reconciliation Act of 1996, or "PRWORA"; and the announcement that the Center for Medicare and Medicaid Services will share personal data of Medicaid enrollees to Immigration and Customs Enforcement Officials.

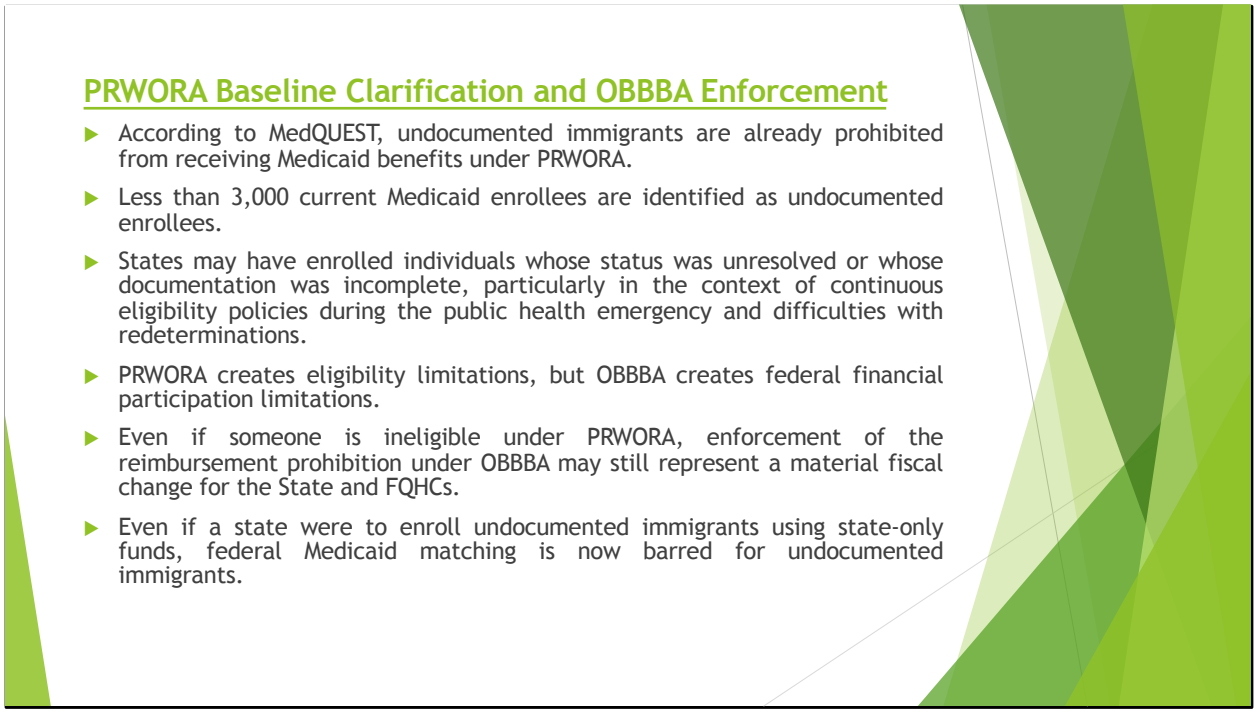
In tandem, these three developments have enormous impact on Hawaii's Medicaid Program and federally qualified health centers.



Prior to the enactment of the Big Beautiful Act, the federal government paid 90% of the costs incurred by immigrant Medicaid enrollees. However, Section 71109 of the Big Beautiful Act creates a categorical exclusion for service providers to receive federal reimbursement for undocumented immigrants.

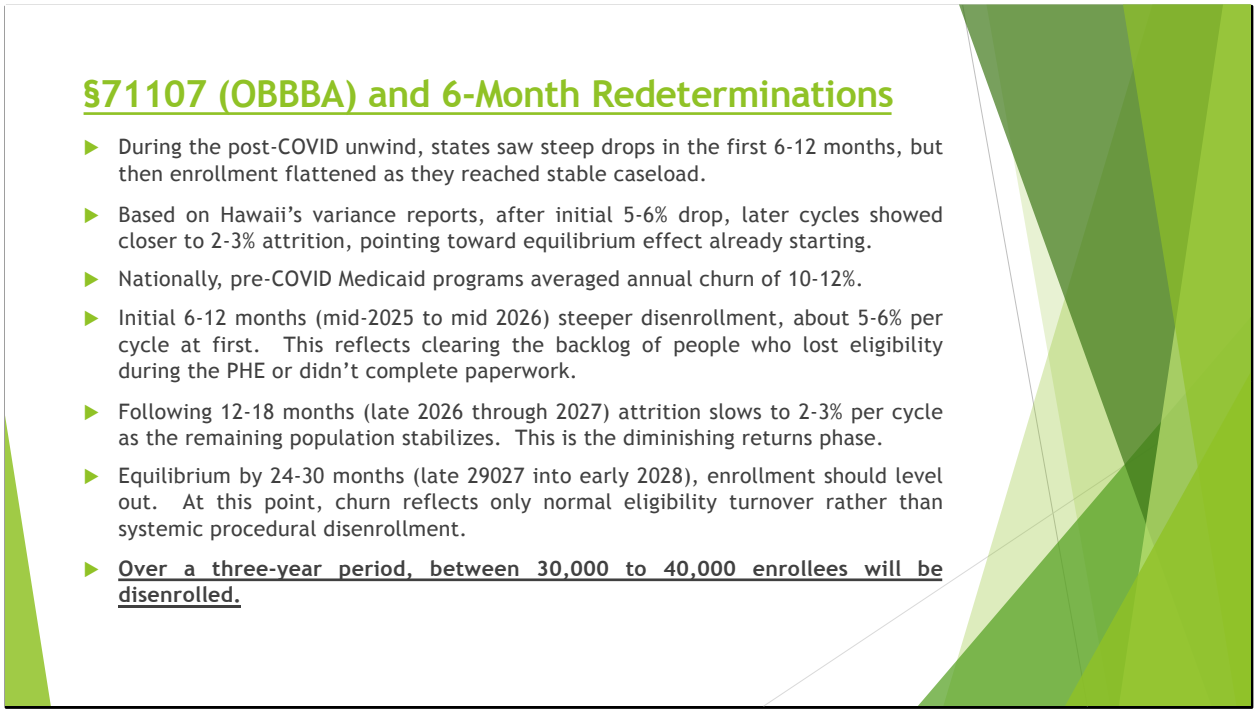
According to the Kaiser Family Foundation, of the 400,000 Medicaid enrollees in Hawaii, one-fourth or 100,000 are believed to be immigrants, of which 35,000 are thought to be undocumented. When this provision takes effect on October 1, 2026, these 35,000 undocumented immigrants will be shifted from Medicaid enrollees to the uninsured.

Currently, the uninsured rate is 2.8 percent of the population or approximately 38,400. On October 1, 2026, this rate will effectively DOUBLE overnight.



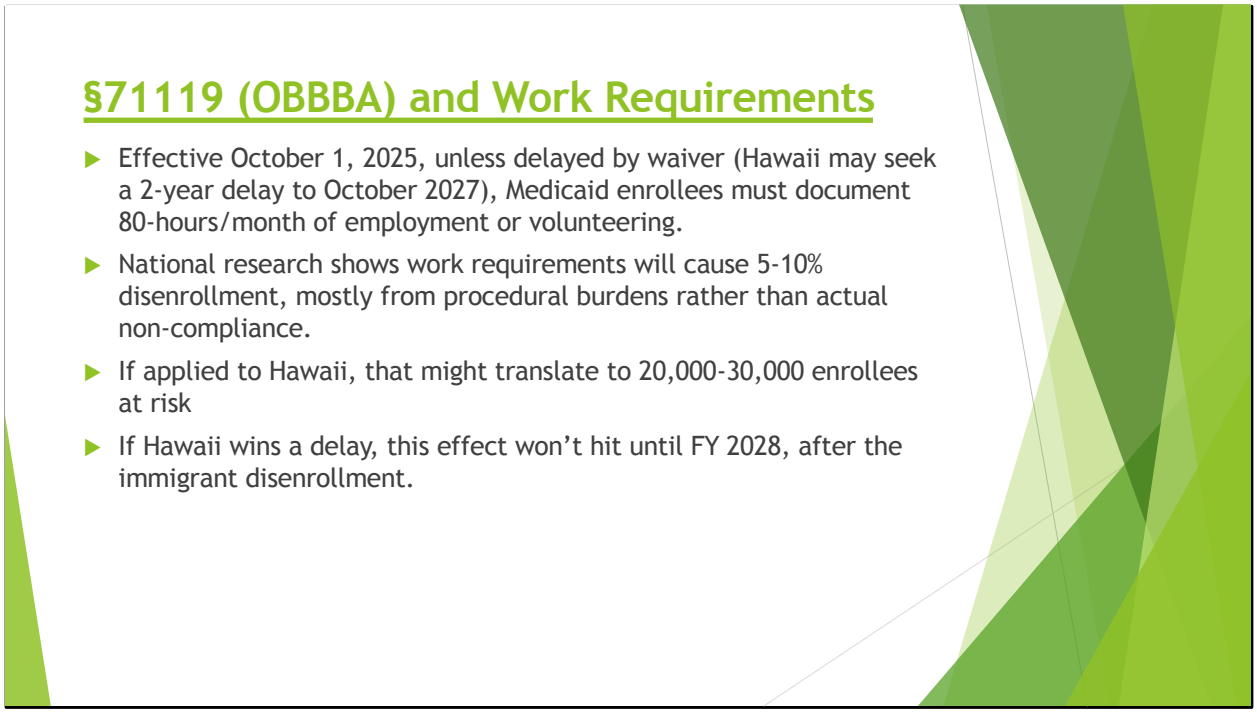
When we shared this information with our partner safety net organizations, MedQUEST responded that currently, less than 3,000 were logged in their system as "undocumented enrollees". We believe there are many more immigrants who are receiving benefits because while PRWORA establishes eligibility limitations at the time of application, these limitations do not preclude the states from paying for these benefits through general funds, as is the case with California, and Illinois, most notably. Because of this, we believe there are many more undocumented immigrants already enrolled in Medicaid.

The Big Beautiful Act changes things by establishing a federal reimbursement prohibition and enforcement mechanisms that will place greater responsibility on the States and providers to verify the eligibility of all Medicaid recipients.



The Big Beautiful Act also shortens the redetermination period for Medicaid enrollees from annually to every six months. Based on the Hawaii experience after the COVID flexibilities were removed prior to President Trump taking office, we believe that Hawaii will see a similar sharp decline in enrollment in the first twelve months and then a flattening over the following 24 months to an equilibrium point of 2-3% attrition every redetermination cycle.

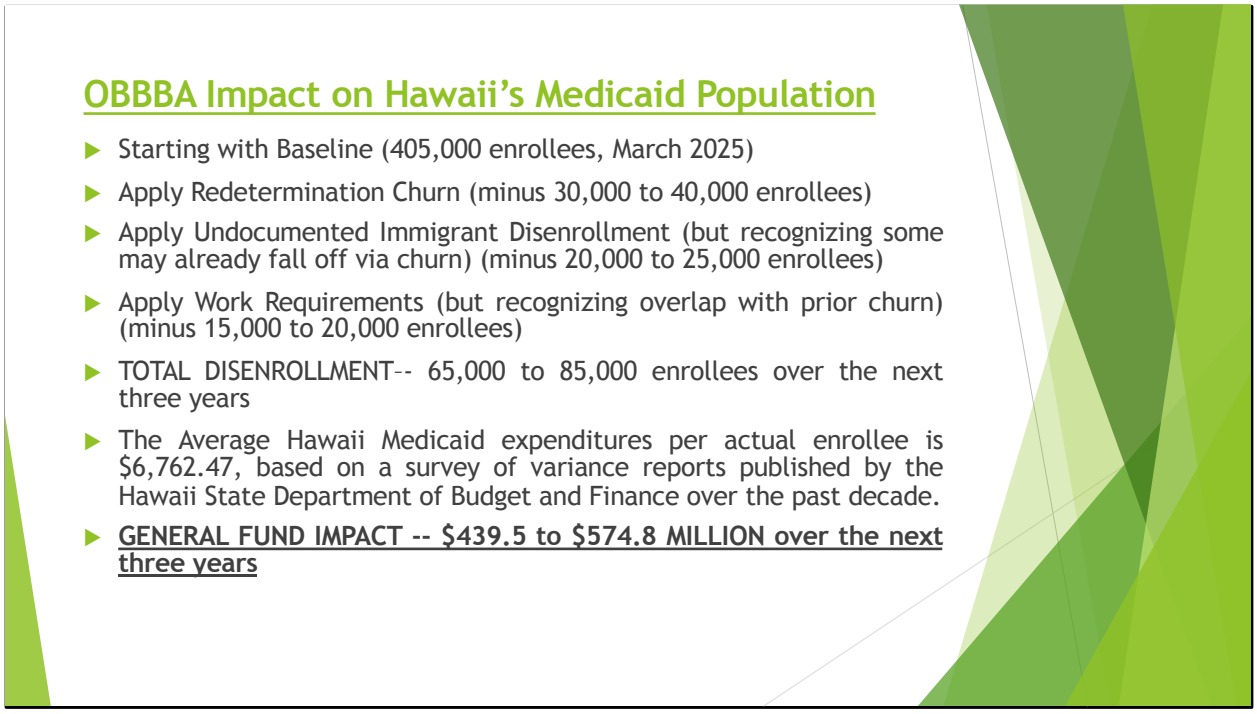
Over the next three years, we believe between 30,000 and 40,000 Medicaid enrollees will be disenrolled.



The Big Beautiful Act also establishes a requirement that all enrollees must work or volunteer at least 80 hours per month to remain eligible for Medicaid. National research indicates that work requirements will cause between 5 to 10% disenrollment, mostly from procedural burdens rather than actual non-compliance.

If applied to Hawaii, that might translate to 20,000 to 30,000 enrollees at-risk.

Hawaii might be able to delay this by two years if MedQUEST is successful in obtaining a two-year waiver from HHS.



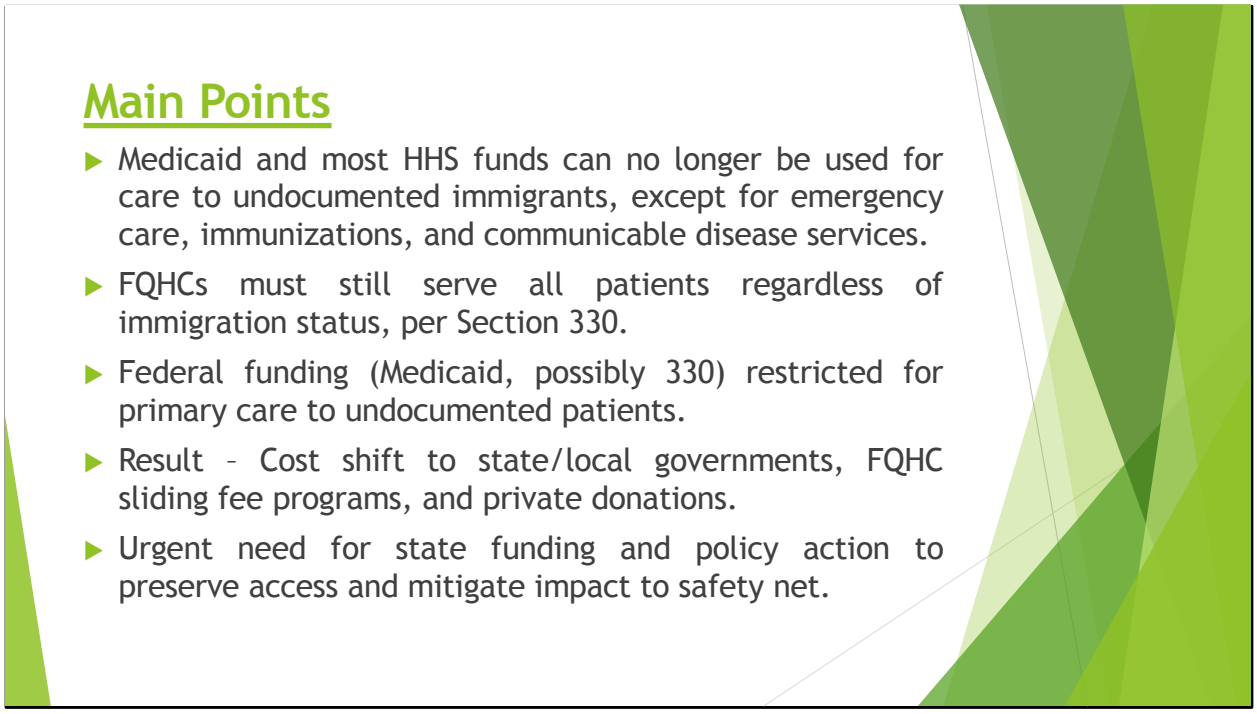
When you look at the entire picture taking into account duplication from persons who might be disenrolled for more than one reason, the HPCA used various models to get an idea of the scale of the impacts. A lot of assumptions were made in analyzing the worst-case scenario to get an idea of the fiscal impact.

We believe that between 65,000 to 85,000 enrollees will be disenrolled over the next three years if Hawaii is not able to obtain a two-year waiver for work requirements. If we get the waiver, this might be stretched over five years.

We looked at the total expenditures from HMS401, Hawaii's Medicaid Program, over the past 10 fiscal years as reported in the variance reports. Using the number of enrollees listed in those reports, we found the average expenditure per enrollee to be $6,762.47. Applying that average to the projected number of persons disenrolled, we believe the fiscal impact to be between $439.5 to $574.8 million over the next three to five years.

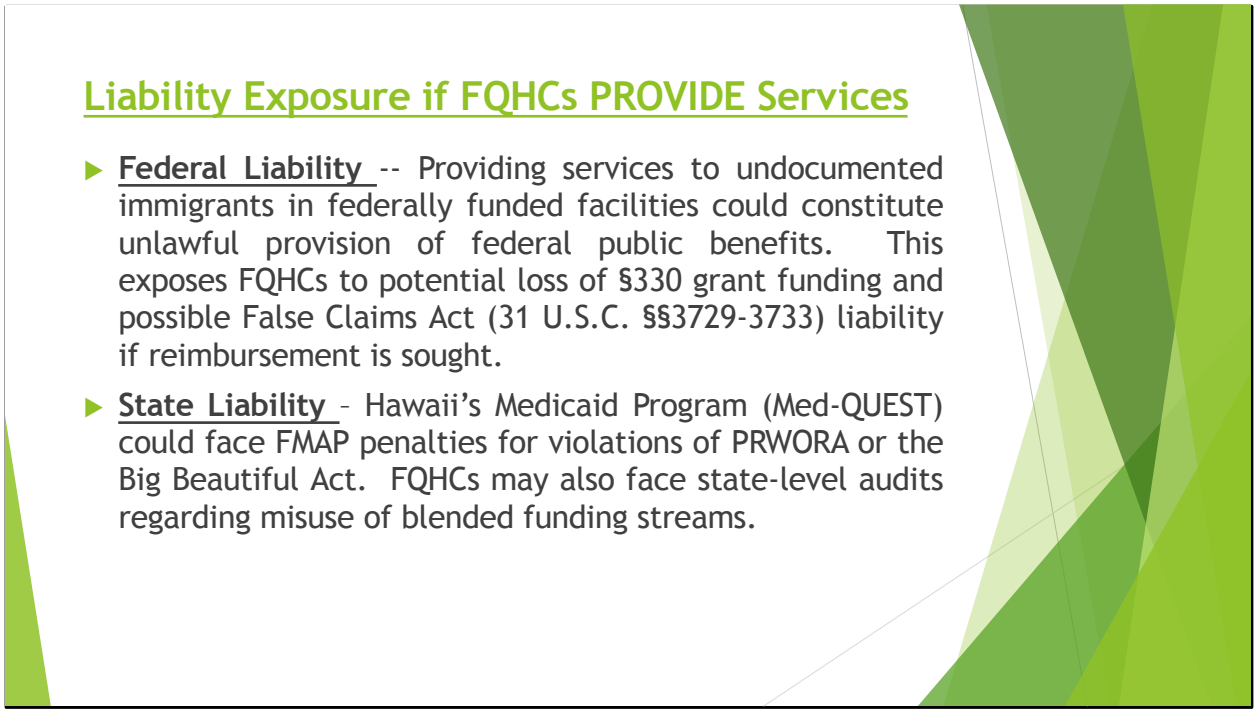
II. IMPACTS ON HAWAII'S FQHCS

Keeping all of this in mind, I'd like to now share how we think this will impact FQHCs and the Social Safety Net.



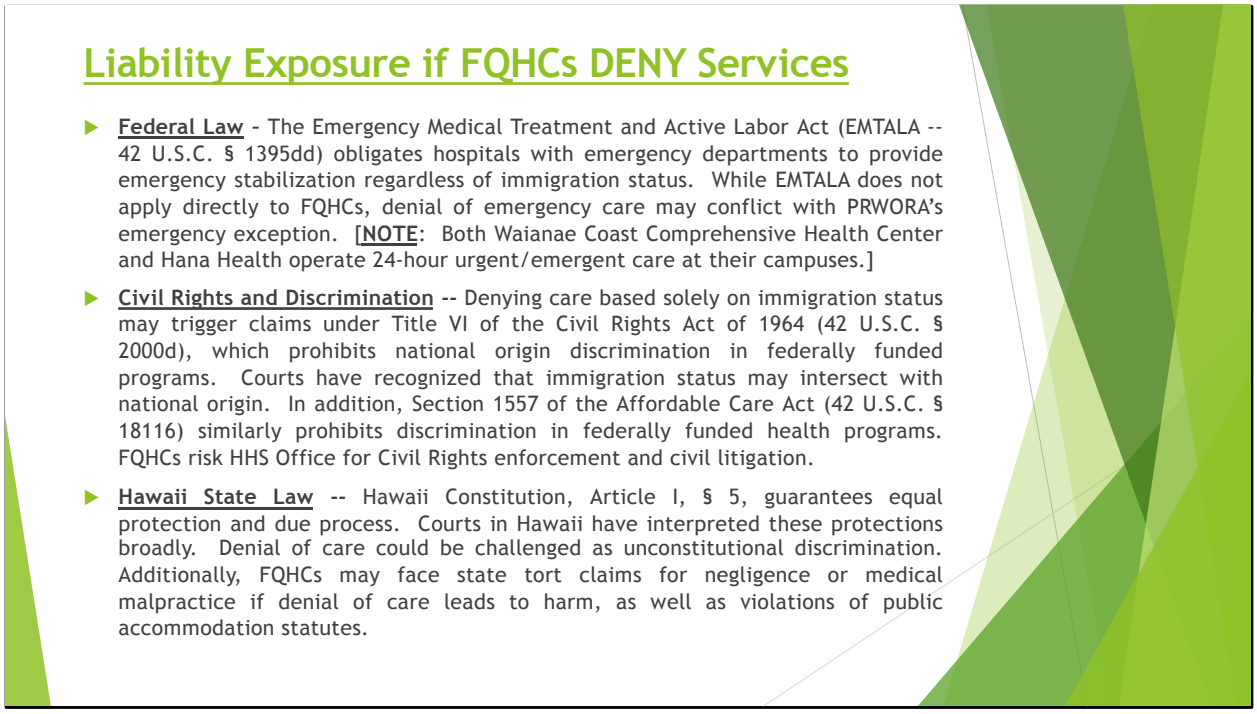
In a nutshell, Medicaid and most HHS funds cannot be used for undocumented immigrants. Yet, FQHCs must still serve all patients regardless of immigration status. This will result in a cost shift to state and local governments, our sliding fee program, and donations. Because of this, there is a need for new funding mechanisms and policy action to protect and preserve the safety net.

During our preliminary research, if FQHCs continue to provide the same level of services to undocumented immigrants without Medicaid reimbursement, FQHCs would have to rely on our 330 grant funds to cover this shortfall. Based on current grant funds available, those funds will be exhausted within two to three months.



FQHCs are in a no-win situation. If an FQHCs PROVIDES service to an undocumented immigrant at their respective campuses, that FQHC could be subject to federal liability for the unlawful provision of federal public benefits, and be exposed to the potential loss of §330 grant funding and possible False Claims Act liability if reimbursement is sought.

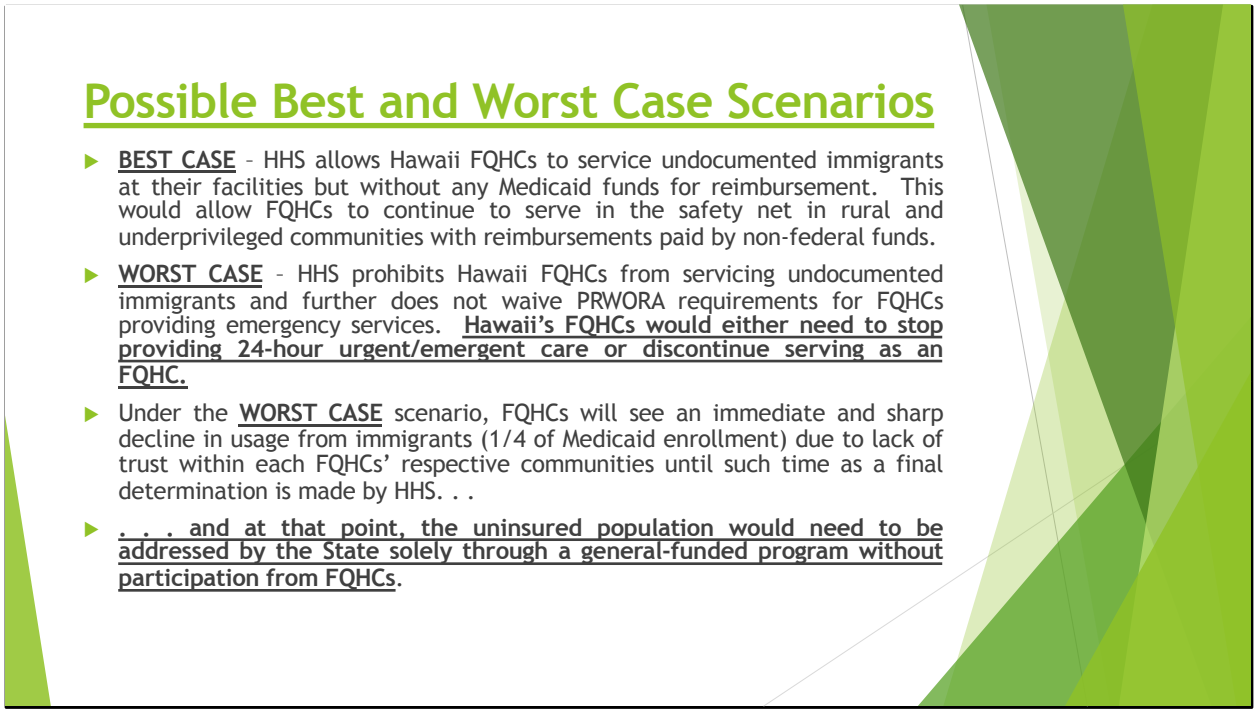
MedQUEST could face FMAP penalties for violations of PRWORA and the Big Beautiful Act, and the FQHC might also face state-level audits regarding misuse of blended funding streams.



If FQHCs DENY services to undocumented immigrants, denial might violate the Emergency Medical Treatment and Active Labor Act, or EMTALA, which requires emergency stabilization regardless of immigration status. While this law applies directly to hospitals with emergency departments, both Waianae Coast Comprehensive Health Center and Hana Health provide 24-hour urgent/emergent care at their campuses.

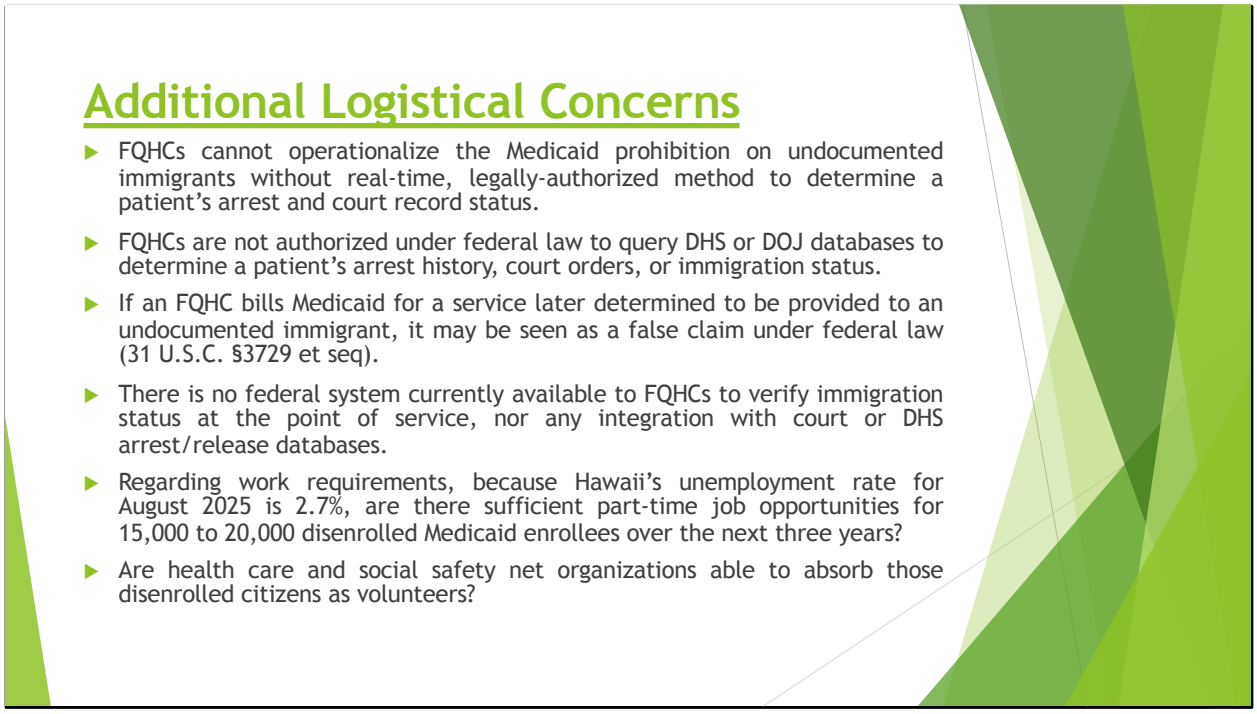
Denial of service based solely on immigration status may trigger claims under Title VI of the Civil Rights Act of 1964, which prohibits national origin discrimination in federally funded programs. Denial might also violate provisions of the Affordable Care Act, which prohibits discrimination in health programs.

Denial of service could trigger state action if the denial is construed as unconstitutional discrimination. Further, the FQHC could be in violation of Hawaii's public accommodations statutes.



Based on the information available, best-case and worst-case scenarios could be imagined. In the best-case scenario, HHS allows FQHCs to provide services to immigrants but not allow federal funds for reimbursement. Under this scenario, FQHCs would remain in the safety net, but would need to find non-federal funds to provide services to this cohort.

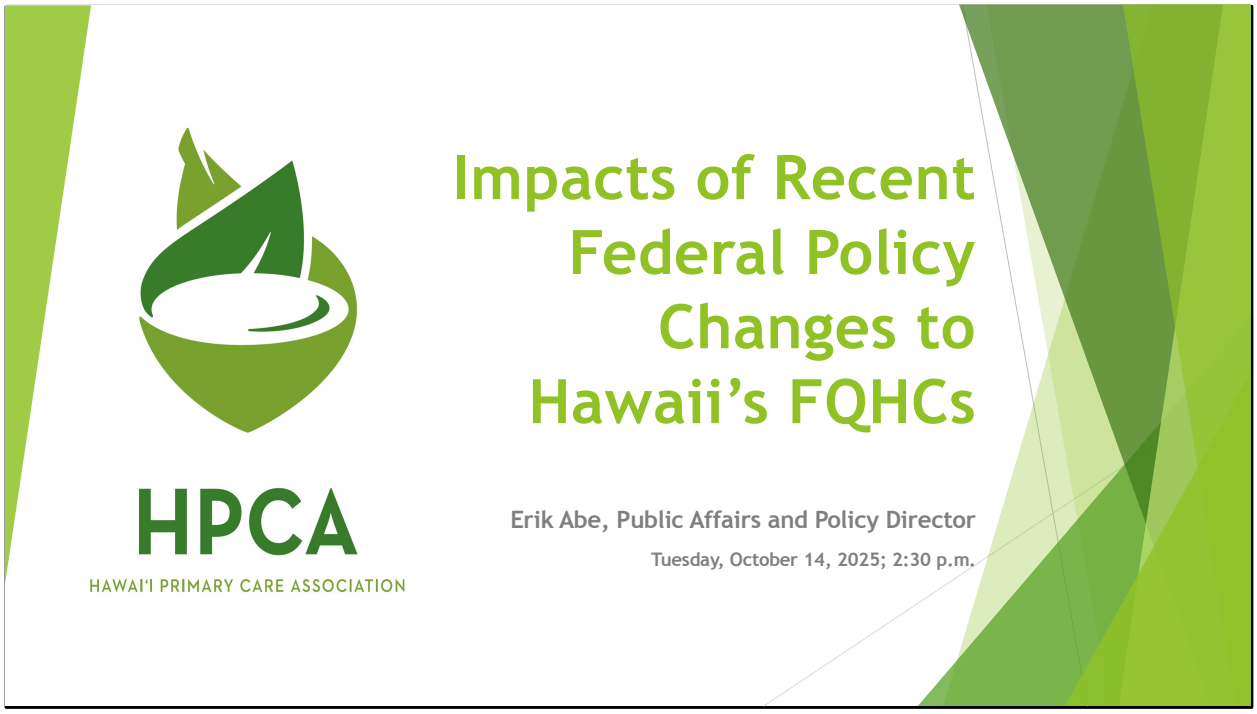
Under the worst-case scenario, HHS prohibits FQHCs from even using their facilities to provide services to undocumented immigrants. This scenario would effectively dislodge FQHCs from the safety net and leave it to the State to determine how the health care needs of this population will be served.



Lastly, FQHCs will need to be able to determine a patient's Medicaid eligibility before services can be provided. Because a person's immigration status can change from the time documentation is verified at application, without the means of determining eligibility before service is provided, there would be no way for the FQHC to ensure that a subsequent request for reimbursement is legitimate. It should be noted that a person's immigrant status can change based on a person's arrest and court record status prior to conviction. Currently as a public accommodation, FQHCs are prohibited from denying medical services to a person based on their arrest and court record status under State Law.

Also, given Hawaii's low unemployment rate, are there sufficient job opportunities available in rural, isolated communities to keep Hawaii's unemployed Medicaid enrollees with coverage?

The HPCA has had preliminary discussions with various nonprofit organizations to determine their capacity to recruit and engage volunteers in rural communities. Because many of these organizations have focused their grassroots activities in urban areas, it will likely take time for nonprofits to establish sufficient volunteer opportunities for Medicaid enrollees unable to gain part-time employment.



This concludes the presentation. I'd be happy to answer any questions.

An Independent Licensee of the Blue Cross and Blue Shield Association

March 17, 2026

The Honorable Jackson D. Sayama, Chair
The Honorable Mike Lee, Vice Chair

House Committee on Labor

Re: SB 2088 SD1– RELATING TO RELATING TO HEALTH CARE PLANS FOR WORKERS

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

Hawaii Medical Service Association (HMSA) appreciates the opportunity to provide comments on SB 2088 SD1, which will require the Department of Labor and Industrial Relations, in consultation with the Insurance Commissioner, to establish and implement a five-year voluntary Nontraditional Workforce Portable Health Care Benefit Plan Pilot Program that offers high deductible health plans or catastrophic health plans to nontraditional workers ineligible for health benefits provided by the Hawai‘i Employer-Union Health Benefits Trust Fund or prepaid health care plans under the Prepaid Health Care Act.

We appreciate the Legislature's ongoing efforts to address the uncertainty facing Hawai‘i residents, particularly regarding access to healthcare amid ongoing federal-level changes that affect the affordability of health insurance premiums. Hawai‘i's Prepaid Health Care Act of 1974 was the first law in the nation to establish minimum standards for employer-sponsored health care benefits, and it has long served as a model for protecting workers' access to coverage. However, nontraditional workers—including certain part-time employees, independent contractors, and self-employed individuals—now comprise a growing segment of the State's workforce, and many may experience instability in their health care coverage.

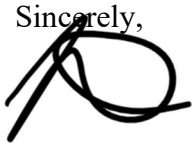
While the bill directs the Department of Labor and Industrial Relations (DLIR) to establish a health plan to support these nontraditional workers, we respectfully raise several questions regarding the bill's implementation as it advances.

- When the Affordable Care Act (ACA) was implemented, it included key market-stabilizing mechanisms—such as risk adjustment, risk corridors, and reinsurance—to ensure a viable and sustainable environment for health plans to participate. We ask whether the State would be able to implement similar mechanisms for the proposed plan.
- We also seek guidance on how the State anticipates providing subsidies to individuals who do not meet existing federal eligibility requirements.
- Furthermore, we hope the Department will consider operational factors related to enrollment, including Open Enrollment Periods (OEP), Special Enrollment Periods (SEP), and verification requirements, which currently apply to traditional commercial insurance products and may affect the design or administration of a new coverage option.

An Independent Licensee of the Blue Cross and Blue Shield Association

We appreciate the opportunity to offer these comments and look forward to working with the State to address this important issue for Hawai‘i’s evolving workforce.

Sincerely,



Walden Au
Director of Government Relations

Hawaii Association of Health Plans

March 17, 2026

To: Chair Sayama, Vice Chair Lee and Members of the House Committee on Labor (LAB)

From: Hawaii Association of Health Plans Public Policy Committee
Date/Location: Mar. 17, 2026; 9:30 a.m./Conference Room 309 & Videoconference

Re: Testimony with comments on SB 2088 SD1 – Relating to Health Care Plans for Workers

The Hawaii Association of Health Plans (HAHP) offers comments on SB 2088 SD1. HAHP is a statewide partnership that unifies Hawaii's health plans to improve the health of Hawaii's communities together. A majority of Hawaii residents receive their health coverage through a plan associated with one of our organizations.

HAHP is grateful for the continued efforts of state lawmakers to safeguard Hawaii residents' access to health insurance coverage. Especially as forthcoming federal changes are expected to make it more difficult to maintain Medicaid eligibility. However, while we support efforts to expand coverage options for nontraditional workers, we respectfully raise concerns about the viability of the proposed pilot program. Because enrollment in this plan would be entirely voluntary, there is a significant risk of adverse selection, where only individuals with immediate health care needs choose to enroll. Over time, this dynamic could substantially increase premiums and make the program financially unsustainable.

We encourage further discussion to ensure that any new coverage pathway is both actuarially sound and complementary to Hawai'i's long-standing Prepaid Health Care Act framework.

Thank you for the opportunity to share comments on SB 2088 SD1.

Sincerely,

HAHP Public Policy Committee
cc: HAHP Board Members

The House Committee on Labor
March 17, 2026
Room 309
9:30 AM

RE: SB 2088 SD1, Relating to Health Care Plans for Workers

Attention: Chair Jackson D. Sayama, Vice Chair Mike Lee, 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, supports any measure that helps to address health coverage gaps for Hawai'i's workforce.

While full-time and part-time faculty with .50 FTE appointments are eligible to be covered by the Hawaii Employer-Union Health Benefits Trust Fund (EUTF), many part-time lecturers whose appointments do not meet the .50 FTE threshold are not entitled to coverage under the Hawaii EUTF. We believe programs such as the one being proposed could provide a vital safety net for all of Hawaii‘s workforce by offering them access to portable health care benefits that are currently unavailable to them.

While the goals of the proposed program are commendable, significant questions remain regarding funding mechanisms, employer participation, and long-term solvency. These issues warrant further transparent public dialogue and thoughtful discussion to ensure that any program ultimately adopted and promulgated is financially sustainable, broadly supported, and capable of meaningfully meeting the health care needs of Hawai‘i’s workforce.

Respectfully submitted,

Christian L. Fern
Executive Director
University of Hawaii Professional Assembly

University of Hawaii
Professional Assembly

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Website: www.uhpa.org

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

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

Date: March 17, 2026
From: Hawaii Medical Association (HMA)
Elizabeth Ann Ignacio MD - Chair, HMA Public Policy Committee

RE SB 2088 SD1 Relating to Healthcare Plans for Workers: DLIR; Insurance Commissioner; Nontraditional Workforce; Portable Health Care Benefits; Voluntary Pilot Program; High Deductible Health Plan; Catastrophic Health Plan; Health Savings Account; Reports; Appropriation ($)
Position: Support with comments

This measure would require the Department of Labor and Industrial Relations, in consultation with the Insurance Commissioner, to establish and implement a five-year voluntary Nontraditional Workforce Portable Health Care Benefit Plan Pilot Program that offers high deductible health plans or catastrophic health plans to nontraditional workers, requires reports to the Legislature, and appropriates funds. Effective 1/1/2077. (SD1)

Hawaii's workforce includes a growing segment of nontraditional workers — including part-time employees, independent contractors, gig workers, sole proprietors, and self-employed individuals — who are not covered under our existing Hawaii Prepaid Health Care Act (PHCA) or tied to employer benefit eligibility. These workers often rely on high-cost private plans or limited federal subsidies, leaving access to essential care uncertain and increasingly unaffordable.

HMA acknowledges the legitimate concerns of DCCA and DLIR. This pilot program may improve the nontraditional worker's healthcare access for preventive services, chronic disease management, and timely medical care, and the portability will also maintain the worker's continuity of coverage across employment status changes. Annual reporting requirements to the Legislature will allow for evaluation of impacts on coverage, affordability, and outcomes.

HMA supports the intent of this measure to provide healthcare benefits for nontraditional workers in Hawaii, improving and maintaining access to the essential medical services that they need and deserve.

Thank you for allowing Hawaii Medical Association to testify in support of this measure.

REFERENCES

Winger, Aubrey, et al. *Part-Time Workers Have Less Access to Employer-Based Coverage Than Full-Time Workers: Key Characteristics of the Part-Time Workforce*. Kaiser Family Foundation, 19 Sept. 2025, www.kff.org/private-insurance/part-time-workers-have-less-access-to-employer-based-coverage-than-full-time-workers/

Liou, W. *On-Demand Economy Survey: Characteristics of Hawaii residents who worked in the gig economy.* Hawaii Workforce Development Council, Department of Labor and Industrial Relations. Jan 2021.