ACT 334 H.B. NO. 1358

A Bill for an Act Relating to the Public Employees Health Fund.

Be It Enacted by the Legislature of the State of Hawaii:

SECTION 1. Chapter 87, Hawaii Revised Statutes, is amended to read as follows:

1. By amending section 87-1 (8) to read:

" "Health benefits plan"[1] means (A) a group insurance contract or medical, hospital, surgical, prescribed drugs, vision, or dental service agreement in which a carrier agrees to provide, pay for, arrange for, or reimburse the cost of health,[1] prescribed drugs, vision, [or] dental services, or long-term care services as determined by the board; or (B) a similar schedule of benefits established by the board and provided through the fund on a noninsured basis;"

2. By amending section 87-3 to read:

"§87-3 Purpose of the fund. The fund shall be used for the purpose of providing employee-beneficiaries and dependent-beneficiaries with a health benefits plan, provided that the fund may be used for other expenses necessary to effectuate the purpose and provided further that any rate credit or reimbursement from any carrier or any earning or interest derived therefrom shall be used in addition to such purposes to (1) finance state and county contributions for the dental benefits plan for children under the age of nineteen, as described in section 87-4; and (2) finance the employee's portion of the monthly contribution of a health benefits plan for a retired employee, as described in section 87-1(5)(A)(ix), or upon the retired employee's death the retired employee's beneficiary as described in section 87-1(6).

To the extent that contributions are provided for group life insurance benefits in section 87-4, the fund shall also be used for the purpose of providing group life insurance benefits to employees.

To the extent that contributions are received from employee-beneficiaries for long-term care insurance benefits under section 87-22, the fund shall also be used for the purpose of providing long-term care insurance benefits to eligible participants."

3. By amending section 87-6 (a) and (b) to read:

"(a) Each employee-beneficiary shall make a monthly contribution to the fund amounting to the difference between the monthly charge of the health benefits plan selected by the employee-beneficiary and the State's and county's contribution to the fund[.] and including the monthly charge of the long-term care insurance plan if selected by the employee-beneficiary.

(b) During the period the health benefits plan and, if applicable, the long-term care plan selected by an employee-beneficiary [is] are in effect, the employee-beneficiary shall authorize, if allowed under present laws, that [his] the employee-beneficiary's contribution be withheld and transmitted to the fund monthly by the comptroller or finance officer from whom [he] the employee-beneficiary receives [his] compensation, pension, or retirement pay. If, however, an employee-beneficiary's contribution to the fund is not withheld and transmitted to the fund, the employee-beneficiary shall pay [his] the monthly contribution (1) directly to the fund by the tenth day of each month, in the case of an employee-beneficiary who normally receives [his] the compensation from the comptroller of the State, or (2) in the case of all other employee-beneficiaries, to the respective finance officer from whom [he] the employee-beneficiary normally receives [his] compensation for transmittal to the fund by the tenth day of each month."

4. By amending section 87-22 to read:

"§87-22 Determine health benefits plan; contract with carriers. The board of trustees shall determine the health benefits plan, which shall be excepted

from the minimum group requirements of chapter 431. The health benefits plan shall provide, pay for, arrange for, or reimburse the cost of hospitalization, surgery, medical, dental treatment, and care, and may include prescribed drugs, medicines, prosthetic appliances, hospital in-patient and out-patient service benefits, vision treatment and care, medical, [and] dental indemnity benefits[.], and long-term care benefits.

The board may contract for the following health benefits plans; provided that benefits provided under any respective plan shall be equally available to all employee-beneficiaries and dependent-beneficiaries selecting the plan regardless of age, as provided for below:

(1) A statewide indemnity benefit plan under which a carrier agrees to pay certain sums of money not in excess of the actual expenses incurred for health services.

(2) A statewide service benefit plan under which payment is made by a carrier under contracts with physicians, hospitals, or other providers of health services, or, under certain conditions, payment is made by a carrier to an employee-beneficiary.

(3) Health maintenance organization plans, which provide or arrange health services for members on a prepaid basis, with professional services provided by physicians practicing individually or as a group in a common center or centers.

(4) A plan to offer dental benefits through either a statewide indemnity plan, a statewide service benefit plan, or health maintenance organization plans.

(5) A plan to offer prescription drug benefits through either a statewide indemnity plan, a statewide service benefit plan, health maintenance organization plans, or a combination thereof.

(6) A plan to offer vision care benefits through either a statewide indemnity plan, a statewide service benefit plan, health maintenance organization plans, or a combination thereof.

(7) A not for profit plan to offer reasonably priced long-term care benefits at affordable premium rates through either a group long-term care plan, a franchise long-term care plan, individual long-term care plan, including home care services or a combination thereof. Salient features of the plan shall include:

(A) The plan shall be a self-funded, not for profit plan developed or contracted by the board;

(B) The plan shall meet the minimum requirements established by the insurance commissioner for long-term care insurance;

(C) The plan shall be voluntary and shall be funded by the contributions made by enrollees;

(D) The spouses of employee-beneficiaries shall be allowed to enroll in the long-term care insurance plan during the enrollment period open to employee-beneficiaries;

(E) During the first three months of the initial enrollment period for the plan, all retirees who are receiving benefits under chapter 88 as of the effective date of this section, shall be automatically eligible to enroll in the plan for a flat annual premium rate to be developed by the board, which shall be uniformly applicable to all such retirees regardless of age;

(F) The plan shall provide that eligibility to receive benefits under it shall require prior certification of need by the board or its designated representative;

(G) The plan shall provide for an annual review of its operations and adequacy of the premium structure. Since the plan is established as a not-for-profit plan, excess revenues over operating costs shall be returned to enrollees for the covered period by either a premium adjustment or improvement of benefits. Likewise, a deficit that cannot be covered by a reserve to be established by the board may require an adjustment in the premium for the following fiscal period; and

(H) The plan shall provide that pending actual operating expenditure requirements, the board shall invest the funds available in safe, liquid investments to provide continuing growth of the funds for the operation.

[(7)][1] (8) A noninsured schedule of benefits similar to any of the schedule of benefits set forth in health benefit plans authorized in paragraphs (1) to [(6).] (7).

For the purposes of this section, "long-term care insurance" means any insurance policy or rider advertised, marketed, offered, or specialty designed to provide coverage for not less than twelve consecutive months for each covered person on an expense incurred, indemnity, prepaid, or other basis, for one or more necessary or medically necessary diagnostic, preventive, therapeutic, rehabilitative, maintenance, or personal care services, provided in a setting other than an acute care unit of a hospital. The term includes group and individual policies or riders whether issued by insurers, fraternal benefit societies, nonprofit health, hospital, and medical service corporations, prepaid health plan, health maintenance organizations or any similar organization. Long-term care insurance shall not include any insurance policy, which is offered primarily to provide basic Medicare supplement coverage, basic hospital expense coverage, basic medical surgical expense coverage, hospital confinement indemnity coverage, major medical expense coverage, disability income protection coverage, accident only coverage, specified disease or specified accident coverage, or limited benefit health coverage."

SECTION 2. In accordance with Section 9 of Article VII of the Constitution of the State of Hawaii and sections 37-91 and 37-93, Hawaii Revised Statutes, the legislature has determined that the appropriation contained in this Act will cause the state general fund expenditure ceiling for fiscal year 1989-1990 to be exceeded by $72,700, or .003190 per cent. The reasons for exceeding the general fund expenditure ceiling are that the appropriation made in this Act are necessary to serve the public interest and to meet the need provided for by this Act.

SECTION 3. There is appropriated out of the general revenues of the State of Hawaii the sum of $72,700, or so much thereof as may be necessary for fiscal year 1989-1990, to implement the long-term insurance benefits plan.

SECTION 4. The sum appropriated shall be expended by the Hawaii public employees health fund for the purposes of this Act.

SECTION 5. Statutory material to be repealed is bracketed. New statutory material is underscored.

SECTION 6. This Act shall take effect upon July 1, 1989.

(Approved June 15, 1989.)

Note

1. So in original.