

Understanding the Hawaii Prepaid Health Care Act

Background

The 1974 Hawaii Prepaid Health Care Act (PHCA) was the first law requiring employers to provide health care benefits to employees. Notably, the Employee Retirement Income Security Act (ERISA) was also signed into law in 1974. Within a few years of enactment, a federal appeals court held that ERISA preempted the PHCA, rendering it unenforceable. However, in 1983 Congress exempted the PHCA from ERISA preemption. Hawaii remains the only state with a statutory exemption to ERISA preemption. In addition to its unprecedented employer mandate, the PHCA establishes certain minimum standards for employee health care benefits, fixes employee cost sharing, and requires continuation of coverage during certain periods of incapacity. These and other requirements are discussed below.

The Employer Mandate

Employers with Hawaii employees, excluding all governmental employers, are required to provide health care coverage to employees who work at least twenty (20) hours per week and earn 86.67 times the current Hawaii minimum wage a month (for 2024, $\$14 \times 86.67 = \$1,213.38$; $\$16/\text{hr}$ Jan. 1, 2026, and $\$18/\text{hr}$ Jan. 1, 2028.). Coverage must commence no later than the first of the month following four (4) consecutive weeks of qualifying employment. Only a few categories of employee are excluded from this mandate, including:

- Agricultural seasonal workers employed doing seasonal activity for less than a combined 26 calendar weeks over 12 consecutive months,
- Insurance and real estate agents paid exclusively by commission, and
- Certain domestic service workers providing care for Medicaid recipients or otherwise paid through state assistance programs.

Working for Multiple Employers

Employees working for two or more employers must formally designate their principal and secondary employers. The principal employer must provide the required coverage. The secondary employer does not need to provide coverage unless notified that it has become the principal employer. The employer paying the highest amount in wages is generally deemed the principal employer. However, an exception to this rule applies if an employer employs an employee for at least 35 hours per week but does not pay the highest amount wages. In such cases, the principal employer is not determined by the amount of wages but is instead selected by the employee. This designation is made on Form HC-5, as described below.

Plan Review and Approval

Every health care plan offered to employees under the PHCA must be approved by the Director of the Department of Labor and Industrial Relations (DLIR) with guidance from a seven-member Prepaid Health Care (PHC) Advisory Council. Employers can choose one of the three ways to provide approved coverage to their employees. The employer election is generally binding for one year.

1. Purchase an existing approved plan. Insurance companies can sell pre-approved plans to Hawaii employers directly. Active insurers with approved plans include:
 - Hawaii Management Alliance Association
 - Hawaii Medical Service Association
 - Kaiser
 - United HealthCare
 - University Health Alliance

2. Submit another insured plan for approval. Employers with operations outside of Hawaii can submit their proposed insured plan to DLIR for review and approval.
3. Submit a self-funded plan for approval. Employers with operations outside of Hawaii can submit their self-funded plan to DLIR for review and approval. These employers must also complete an application for self-insurance (Form HC-61) and show proof of financial solvency by furnishing DLIR with their latest audited financial statements for review. Audited financial statements must be filed annually for continued approval.

Plan Designation and Its Implications

Approved plans are designated as 7(a) or 7(b) plans. Plans designated as 7(a) are equal to or better than the benefits offered by the plan with the largest number of subscribers in Hawaii (the prevalent plan). Plans designated as 7(b) provide for sound basic coverage but the deductible, out of pocket limits, and copays, generally make 7(b) benefits less rich than 7(a) plans. Regardless of plan designation, employers must pay at least 50% of the premium cost for employee only coverage, but the employees' share cannot exceed the lesser of 50% of the premium cost or 1.5% of the employees' monthly gross earnings. Plans qualifying as 7(b) also require the employer to pay one-half of the cost for dependents' coverage. Employers are not required to subsidize the cost of dependent coverage under 7(a) plans.

If employers purchase a pre-approved plan, the insurer is responsible for informing the employers of their plan designation and whether they are responsible for contributing toward dependent coverage. If employers submit a plan for approval, DLIR is responsible for informing the employers of their plan approval designation and whether they are responsible for contributing toward dependent coverage.

Employee Exemptions, Waivers, and the Annual Form HC-5

Employees can claim an exemption or waiver under an employer's health care plan (or can change a prior exemption or waiver) by completing and submitting Form HC-5 to the employer (available [here](#)). This exemption or waiver is binding for one year and employees must renew it annually by December 31.

The following categories of employees can make a voluntary exemption or waiver election:

- Employees working for two or more employers that are receiving coverage under another employer's health plan (i.e., the other employer is the principal employer);
- Employees already covered as dependents under an approved plan,
- Employees with religious beliefs that use prayer or spiritual means for healing,
- Employees covered by state or federally legislated plans (generally, Medicare, Medicaid, or Tricare), and
- Employees who have obtained health care coverage through another health care plan contractor.

If an employee selects box #4 on the Form HC-5 (i.e., health care coverage obtained through another health care plan contractor), the employee must provide a copy of the plan in which he/she is enrolled with the completed Form.

In the event an employee selects box #4, an employer is required to provide a copy of the Form HC-5 (along with a copy of the employee's plan provided) to the DLIR. If the DLIR does not approve the employee's plan, it will notify the employer of its finding. Upon receiving notice of the DLIR's disapproval, the employer should enroll the employee in one of the employer's plans or ensure that the employee properly waives coverage by checking a different applicable box on Form HC-5.

An employer may also be required to provide copies of Form HC-5 to the Director of the DLIR upon request. Employers should retain the original copy of the completed Form HC-5 for a minimum of two years.

Benefits Continuation during Illness or Incapacity

In addition to providing an employer coverage mandate, the PHCA also mandates health care benefit continuation and cost sharing if an employee is hospitalized or otherwise prevented by illness or injury from working. Specifically, the PHCA requires employers continue eligibility and contributions towards health care coverage for the greater of: (1) a period of three months following the month in which the employee is unable to work, or (2) any period during which the employee is continuing to receive regular payment of wages. For disabled employees on leave, the 1.5% limitation on the employee cost sharing is based on the employee's continuing salary or wages in the last complete month of work. Coverage can be terminated early if an employee fails to pay their portion of the premium.

Example: An employee becomes disabled in the month of January and the employee has exhausted his/her paid leave. The employer must continue to pay its share of the employee's premium until the end of April.

The PHCA requirements are different than what the Family and Medical Leave Act (FMLA) requires. Therefore, employers complying only with FMLA requirement will not be compliant under the PHCA. Employers should ensure compliance with both PHCA and FMLA requirements, as applicable. Below is a chart offering a quick and high-level comparison of PHCA versus FMLA.

Requirement	PHCA	FMLA
Covered Employers	All	Employers with 50 or more employees
Covered Employees	Employees covered under the employer's health care plan that become disabled and are unable to work	Employees who worked for a covered employer for a total of at least 12 months (not necessarily consecutively) and at least 1,250 hours during the 12 months preceding the start of a "qualifying" leave
Benefits	Health care benefit in which the employee is enrolled	All health benefits that the employee is enrolled in (e.g., health, dental, vision, health FSA)
Duration	Greater of: (1) three months following the month in which the employee is unable to work, or (2) any period during which the employee is continuing to receive regular payment of wages	Up to 12 weeks or 26 weeks (to care for military/service member that is the spouse, child, or next of kin)
Contributions	Generally, 1.5% employee cost sharing based on employee's continuing salary or wages in the last complete month of work	Employer contributions must remain the same for coverage in which employee is enrolled

Telecommuting and other Jurisdictional Issues

There does not need to be a nexus between the employer and Hawaii for employees working and residing in the state to be covered by the PHCA. Specifically, the PHCA provides that covered "employment" includes an

individual's entire service performed within Hawaii. It includes service performed both within and outside Hawaii if:

- The service is localized in Hawaii; or
- The service is not localized in any state but some of the service is performed in Hawaii, and
 - 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 Hawaii; or
 - 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 Hawaii.

This means an employee residing in Hawaii and telecommuting for an out of state employer would be covered by the PHCA. The only exception would be where someone worked in the state on temporary basis for a very short duration. Notably, insurers offering pre-approved plans cannot deny coverage to an employer even when the potential eligible population consists of a single telecommuting employee.

Coordination with the ACA

In general, because the PHCA is a more broadly applicable employer mandate that requires richer more affordable coverage, employers in compliance with the PHCA will generally not have Affordable Care Act (ACA) Pay or Play penalty concerns with respect to Hawaii employees. A large employer with significant operations outside of Hawaii could still fail to offer coverage to substantially all of its ACA full-time employees while offering PHCA compliant coverage to its Hawaii employees. Hawaii employees, however, will not be part of the ACA's "margin of error," which if exceeded could result in the large Part(a) penalty, and they will not trigger the Part(b) penalty that can attach to ACA full-time ineligible employees or if an employer's offer of coverage is unaffordable or not for a minimum value plan.¹ A notable difference is that the PHCA exempts governmental employers whereas the ACA does not. Importantly, determining ACA full-time status and ACA reporting is for Hawaii employees is still required. A comparison of the employer mandates in two laws is instructive.

Requirement	PHCA	ACA
Covered Employers	All non-governmental employers	Employers with 50 or more FT and FTE employees measured over the prior calendar year
Covered Employees	Employees who work at least 20 hours per week for 4 consecutive weeks	Employees who work 30 hours a week/130 hours per month measured monthly or over a 12 month measurement period
Required Benefits	Approved plans with comprehensive coverage	Any employer sponsored plan; 60% minimum actuarial value to avoid penalty risk
Affordability	Employer contributes 50% of premium but employee's share cannot be more than 1.5% of employee wages	Lowest cost minimum value plan should not cost more than 9.5% (indexing not shown) of employee household income at employee only coverage tier

¹ These employees would also need to enroll in subsidized Exchange coverage. For more information on ACA pay or play penalties see our Alliant Insight, Calculating Pay or Play Penalties.

Dependent Coverage	Not required but generally offered	Plans must cover dependent children but without cost sharing or affordability requirements
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Required Notice and Postings

Employers must conspicuously post a written notice stating that it has obtained health care coverage required by law. DLIR provides model posters. Employers are also required to notify newly eligible employees of their coverage options and costs and must notify employees that are unable to work due to illness or incapacity of their right to continuation coverage.

Enforcement and Penalties

Employers failing to provide required coverage may be liable for the health care costs incurred by eligible employees during the period of the failure. The following penalties may also apply:

- The greater of \$25 or \$1 for each employee for every day during which such failure continues. If a failure extends for 30 days, the employer may be enjoined from carrying on its business in the state for as long as noncompliance continues.
- An employer who willfully fails to comply may be fined not more than \$200 for each violation.
- An employer after twenty-one days written notice that is found to have violated a provision of the PHCA for which no penalty is otherwise provided may be fined \$250 for each offense.
- An employer that directly or indirectly coerces or attempts to coerce an employee to make a waiver may be fined up to \$200.

Complaints (Form DC-54) related to non-coverage by employers can be filed with the nearest DLIR office.

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