Hawaii: Prepaid Health Care Act

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The Hawaii Prepaid Health Care (PHC) Act requires private sector employers to provide minimum health care coverage to their eligible employees. Originally enacted in 1974, the PHC Act was the first U.S. law to set minimum standards for workers' health coverage.

The federal Affordable Care Act (ACA) also requires applicable large employers (ALEs)— employers with 50 or more full-time employees, including full-time equivalents —to provide a certain level of health coverage to full-time employees (and their dependents) or risk a penalty. This employer mandate took effect on Jan. 1, 2015, though certain mid-sized ALEs could qualify for a one-year delay. The ACA does not reduce the employer's responsibility to offer minimum health care coverage in accordance with Hawaii's PHC Act. Large employers in Hawaii should review their compliance with the ACA's employer mandate in addition to the PHC Act.

COVERED EMPLOYERS

In general, **all employers with one or more employees**, whether full-time or part-time, permanent or temporary, are required to provide PHC Act coverage to their eligible employees in Hawaii unless the employees fall into an excluded category (see "exempt employees" below).

ELIGIBLE EMPLOYEES

Employers must provide health care coverage to employees who:

- Work at least 20 hours per week; and
- Earn a monthly wage of at least 86.67 times Hawaii's current minimum hourly wage (as of Oct. 1, 2022, $12.00 x 86.67 = $1,041).

Employees who meet these criteria must be eligible for health care coverage after **four consecutive weeks** of employment. Health coverage must then be provided to eligible employees at the earliest enrollment date of the employer's health care contractor.

EXEMPT EMPLOYEES

These employees are automatically exempt from the PHC Act's coverage requirement:

- Individuals who work less than 20 hours per week;
- Federal, state and county workers;
- Agricultural seasonal workers;
- Insurance or real estate salespersons paid solely by commission;
- Individuals working for a spouse or child; and
- Children under age 21 working for their father or mother.

Some categories of employees may voluntarily elect to be exempt from coverage, including employees who are:

- Covered by a federally established health insurance or prepaid health care plan (for example, Medicare);
- Covered as dependents under another qualified health care plan;
- Recipients of public assistance or covered by a state-legislated health care plan governing medical assistance; and
- Followers of religious groups who depend upon prayer or other spiritual means for healing.

To claim an exemption, an employee must submit a completed Form HC-5, Employee Notification to Employer, to his or her employer. The exemption notification is binding for one year, and must be renewed every December 31.

OBTAINING COVERAGE

Employers may obtain health coverage by:

- Purchasing an approved plan from a health care contractor or a Hawaii-licensed insurance carrier;
- Adopting an approved self-insured health care plan; or
- Purchasing an insured plan of their choice (the employer selects the health care contractor and the plan type).

As a **self-insurer**, the employer must show proof of financial solvency and ability to pay benefits by providing the DLIR with the most recently audited financial statements for review. Following the initial approval, the audited financial statements must be filed annually for continued approval of the employer's self-insured plan.

All health care plans, whether sold by health care contractors or submitted by employers, must be reviewed by the DLIR as meeting prescribed minimum standards. Upon approval, plans are designated as "7(a) plans" or "7(b) plans."

- Plans designated as **7(a) plans** are equal to or better than the benefits offered by the plan with the largest number of subscribers in the state.
- Plans designated as **7(b) plans** provide for basic health care benefits, but the plans' benefits may be more limited than the benefits provided by 7(a) plans. Plans designated as 7(b) plans require the employer to pay **half of the cost for dependent coverage**.

PAYMENT OF PREMIUMS

The employer may elect to pay the entire premium amount or share the cost with employees. The employer must pay **at least half of the premium cost**. However, the employees' share cannot exceed **1.5%** of the employee's monthly gross wages. If the employee's allowable share constitutes less than half of the premium, the employer is liable for the entire remaining portion.

The employer may withhold the employee's contribution from his or her wages.

Cost-sharing for dependents is determined by plan type.

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

CONCURRENT EMPLOYMENT

An employee who works concurrently for two or more employers must designate the principal and secondary employer and file notification (Form HC-5) with the employers. The designated principal employer is required to provide coverage pursuant to the PHC Act.

Generally, the principal employer is the employer who pays the employee the most wages. The employee determines the principal employer only in cases where the employer that does not pay the most wages employs the employee for at least 35 hours per week. An employee's designation of principal employer is binding for one year or until the employee has a change of employment. Whenever an employee elects to make a change with respect to the status of his or her employers, notification (Form HC-5) must be filed.

Employers are prohibited from coercing, interfering or influencing an employee in making a determination of principal employer.

CONTINUATION OF COVERAGE

If an employee cannot work due to disability, the employer must allow the employee to continue health care coverage by continuing the employer's share of the premium costs for the longer of:

- Three months following the month during which the employee became disabled; or
- The period for which the employer has undertaken payment of employee's regular wages.

The employee must maintain his or her portion of the premium payments.

PENALTIES

An employer that fails to comply with the PHC Act's coverage provisions is subject to a penalty of the greater of:

- **$25**; or
- **$1 for each employee for every day during which the failure continues**.

If the default extends for 30 days, the employer's business may be closed for as long as the default continues.

An employer, employee or health care contractor who willfully fails to comply with any other provision of the PHC Act may be fined up to **$200 for each violation**.

In addition, any person who, after 21 days' written notice and the opportunity to be heard by the DLIR, is found to have violated any provision of the PHC Act for which no penalty is otherwise provided, will be fined up to **$250 for each offense**.

APPEAL

When health care benefits are denied to an employee, the employer or the health care contractor must promptly mail a notice of denial to the employee. The employee has 20 days to request a review by the DLIR. If the parties are not satisfied by the DLIR's findings, the case will be referred to the PHC Appeals Referee. The decision of the Referee is final and binding, unless the aggrieved party appeals the decision.

PREMIUM SUPPLEMENTATION FUND

The PHC Premium Supplementation Fund is established by general fund appropriation and used to defray the cost of providing health care benefits for employers with **fewer than eight workers** covered under the PHC Act. To qualify for premium supplementation, employers must meet the following criteria and file a claim (Form HC-6) with the Audit Section of the DLIR within two years after the close of the employer applicant's taxable year:

- The employer's share of the cost of providing PHC coverage must exceed 1.5% of the total wages payable to the employees; and
- The amount of the excess must be greater than 5% of the employer's income, before taxes, directly attributable to the business in which the employees are employed.

The Fund may also reimburse health care expenses to workers of bankrupt or non-compliant employers.

MORE INFORMATION

For more information, please see the DLIR's Frequently Asked Questions about prepaid health care.