Hawaii employee health and leave benefits may need special attention

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Health plan sponsors looking for new ways to hold down soaring healthcare costs have increased employee contributions, expanded cost-sharing provisions and restrained benefit levels. For employers with plans and operations in Hawaii, a 1974 state law can block efforts to implement these cost-reduction changes. In addition, the state's temporary disability benefits law mandates coverage through an authorized insurer or an approved self-insured (self-funded) plan. ERISA doesn't preempt the Hawaii mandates, and penalties for noncompliance can be substantial.

Hawaii Prepaid Health Care Act

The Hawaii Prepaid Health Care Act (HPHCA) requires private employers to provide healthcare coverage for all eligible Hawaii employees. The HPHCA strictly caps employee contributions and requires minimum benefit levels (HI Rev. Stat. § 393-7) and specific plan provisions. The state's Department of Labor and Industrial Relations (DLIR) must approve all plans before employers can offer the coverage to employees or implement any plan changes — including deductibles and out-of-pocket maximums. Once approved, plans are then designated as either a 7(a) or 7(b) status plan:

- 7(a) plans offer benefits equal to or better than those of the state's prevalent plan (the plan with the largest number of subscribers).
- 7(b) plans may have more limited benefits and require a greater employer contribution. Eligible employees

Employers must provide coverage to any employee who works in Hawaii for 20 or more hours a week for four consecutive weeks and earns a monthly wage at least 86.67 times the state's minimum hourly wage. Employers don't have to provide coverage for retirees, and public employers are exempt. If an

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employer's only Hawaii employee terminates employment, the employer does not have to maintain a Hawaii plan for the sole purpose of providing COBRA coverage to the former employee.

Waivers

Employees may waive employer coverage if any of the following apply:

- They have coverage through another plan as a dependent or through their principal employer — the employer that pays the employee the most wages or for which the employee works at least 35 hours.
- They are covered by a federally established healthcare plan or are recipients of public assistance/state-legislated health plan coverage.
- They depend on prayer or other spiritual means for healing.

Employees waiving coverage for any reason must file Form HC-5 with the employer and annually resubmit the waiver request. If the waiver is due to having other coverage from a healthcare contractor, the employer must forward the form to the DLIR.

Contributions

Employers can require employees to contribute to the cost of coverage, but the required contribution can't exceed the *lesser* of 50% of the coverage cost or 1.5% of the employee's monthly wages. Wages include salary, tips, commissions and the cash value of any other noncash compensation. Coverage of an employee's family members is not required for 7(a) health plans (the most prevalent plans). For 7(b) health plans, employers must pay at least 50% of the premium for family members' coverage.

> *Example 1.* Ed earns $5,000 per month. The monthly premium for his health coverage is $100. Ed cannot be required to contribute more than $50 per month (half the premium since 1.5% of his monthly wages — $75 — would be higher).

> *Example 2.* Beth earns $2,000 per month. Her coverage also costs $100 per month. Although half the cost of coverage is $50, Beth can't be required to contribute more than $30 per month (1.5% of her monthly wages).

For 7(a) plans, the contribution limits apply only to employee coverage. The employer can charge the employee the full cost of coverage for any spouse or dependent covered under a 7(a) plan.

> *Example 3.* Ed (from example 1) gets married. He has employee-only coverage under a 7(a) plan but wants to add his wife to the plan. The monthly premium for employee-plus-one coverage is $200. Although Ed's contribution for his own coverage can't exceed $50, he can be charged the full difference in cost ($100) for adding his spouse to the plan. So his maximum allowable contribution is $150.

In addition, if an employer provides more than one plan, the maximum employee contribution is calculated for all plans using the employee-only premium for the least expensive plan. Thus, employees

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electing a higher-cost plan will pay 1.5% of monthly wages plus the premium differential between the lowest-cost plan and the plan elected.

> *Example 4.* Beth (from example 2) works for an employer that offers more than one plan. Beth is enrolled in the lowest-cost plan with a monthly premium of $100. At open enrollment, Beth elects a plan with richer benefits and a premium of $150 per month. Beth can be required to contribute $80 toward the cost of coverage — $50 for the difference in the cost of the plans plus $30 for 1.5% of her monthly wages.

Required benefits

The HPHCA requires health plans to offer minimum benefits that include hospital, surgical, medical, diagnostic and maternity coverage — but not dental or vision benefits. A plan may qualify for approval under the HPHCA if it provides benefits equal to or "*reasonably substitutable for*" the benefits provided by the most prevalent health plan in the state. This requirement applies to the types and level of benefits, as well as to exclusions and limitations on cost-sharing provisions, such as deductibles and coinsurance.

Although neither the HPHCA nor its related regulations address specific benefit levels, the DLIR, which must approve all plans, has historically required plans to adhere to the benefit levels of the state's prevalent health plan. DLIR also limits cost-sharing provisions, generally permitting relatively low deductibles and annual out-of-pocket maximums compared with the amounts set by plans in the rest of the US. In addition, plans commonly must include other state-mandated benefits and meet network sufficiency requirements.

HMOs and insurers licensed in Hawaii typically offer plans approved by the DLIR. Insurers and self-insurers must obtain approval for each plan offered in the state.

Plan approval for self-insurers

Approval for a new self-insured plan may take a minimum of six to eight months once the employer completes and submits the necessary documents. The process often involves the need to make agency-recommended revisions and respond to additional document requests before final review. Employers use Form HC-4 and Form HC-61 for this purpose.

The DLIR requires employers to demonstrate they are financially solvent and able to pay for medical benefits. In 2004 guidance, the DLIR recommended guidelines for determining whether self-insured employers meet the "ability to pay" standards for self-insuring required health benefits. The 2004 guidelines call for a self-insured employer to submit an independent certified public accountant's "unqualified audit opinion" on the employer's financial statement within the past year. In addition, the plan sponsor will have to maintain specified surplus reserves, monthly deposits to the account funding the benefits, cash on hand and in virtually all cases, stop-loss coverage (unless the plan sponsor has at least 1,500 employees).

To what extent the DLIR continues to rely on these guidelines is unclear. However, they may serve as a starting point for employers considering whether to self-insure their mandated Hawaii coverage.

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Regulators also may look at other factors for employers with “unique or extraordinary circumstances” and annually monitor self-insured employer plans to ensure they continue to meet the solvency and “ability to pay” guidelines.

Notices

The HPHCA requires employers to notify all newly eligible employees that they are entitled to coverage under the Hawaii law and provide:

- The healthcare contractor’s name
- The plan and group numbers
- The effective date of coverage
- The employee’s cost

Employers must give employees at least 30 days’ notice before changing the plan or the healthcare contractor. The law and regulations do not specify how to provide these notices, including whether electronic distribution is acceptable.

The employer also must conspicuously post at the business location notices stating that the employer has obtained the healthcare coverage required by law. Posting DLIR’s two-page highlights document meets this requirement.

Unique considerations

Plan sponsors seeking to contain their share of the premium cost by using wellness plans or spousal surcharges may find those strategies less effective in Hawaii.

Tobacco use surcharge

Because the HPHCA strictly controls employee contributions, rising healthcare costs result in most Hawaii employers charging employees 1.5% of their wages for benefits, since that amount is typically less than 50% of the premium. As a result, employers can’t impose further surcharges.

> *Example 5.* Jerry, a smoker who works in Hawaii, earns $1,000 per week ($4,333 per month). The total annual cost of Jerry’s healthcare coverage is $12,000, or $1,000 per month. He contributes $65 per month ($4,333 x 1.5%), the lesser of 1.5% of monthly wages or 50% of the coverage cost ($500). Jerry’s employer wants to add a 30% contribution surcharge for tobacco users. However, since Jerry already pays the maximum permitted in Hawaii, no surcharge can apply, even though federal regulations would allow this surcharge.

Spouse, domestic partner or civil union partner surcharge

Employers often add a surcharge to coverage for employees’ spouses, domestic partners or civil union partners to encourage them to take coverage under their own employer-provided plan. For employers

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that offer a 7(a) plan, this is not a problem because these plans don't require employer contributions for family members' coverage. If the employer offers a 7(b) plan, however, the employer must pay at least 50% of the cost for the family members' coverage. If the employer typically contributes more than that amount, a spousal surcharge may apply, but only up to the maximum.

> *Example 6.* Jerry (from example 5) marries Claire and adds her to his 7(b) plan for employee plus one. Claire's coverage is an additional $6,000 per year ($500 per month) for a total of $18,000 per year ($1,500 per month). The maximum monthly contribution Jerry's employer can charge is $315: $65 for Jerry's coverage and $250 for Claire's ($500 x 50%). The HPHCA prohibits any surcharge that would increase Jerry's contribution above that amount.

HDHPs compatible with health savings accounts

Federal law (IRS Pub. 969) requires high-deductible health plans (HDHPs) to have deductibles and out-of-pocket maximums considerably larger than Hawaii's benchmark essential health benefit plan — the HMSA Preferred Provider Plan 2010. That plan imposes a $100 individual deductible for out-of-network provider care, none for in-network care, a $12 office visit copayment and a maximum $2,500 annual copayment for individual coverage. Because of Hawaii's much lower cost-sharing requirements, plan sponsors seeking to offer qualified HDHPs to employees in the state may find this option challenging or even impossible.

Penalties

Hawaii imposes potentially steep penalties for noncompliance with the HPHCA:

- Failure to comply within 30 days of a noncompliance notice may result in business closure until the employer complies.
- Failure to maintain coverage could leave the employer responsible for paying the healthcare costs incurred by any eligible employee.
- An employer that fails to provide approved coverage for all eligible employees, charges employees contributions higher than permitted or discontinues required employer contributions while an employee is disabled can face penalties up to $1 per day per employee, with a $25 minimum penalty assessment.
- A willful violation of any other provision can incur a fine of up to $200 for each violation.
- If no other penalty applies, an employer that has received notice of a violation and has had a chance to appeal may be fined up to $250 per violation.

Preemption

As a general matter, ERISA preempts state laws that "relate to" an employee benefit plan. But ERISA provides a carve-out specifically for the state's HPHCA (29 USC § 1144(b)(5)(A)), allowing Hawaii to determine what healthcare benefits an employer may and must provide. The exception is limited to the

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HPHCA that existed before ERISA took effect in 1975 and doesn't apply to any amendment that provides for more than the HPHCA's "effective administration."

Impact on the Affordable Care Act and other federal laws

Despite the ERISA preemption carve-out for the HPHCA, the Affordable Care Act (ACA) applies in Hawaii to the same extent as any other state. Employers in the state must comply with both the HPHCA and ACA provisions. IRS Information Letter 2021-0011 explains that the HPHCA's ERISA "exemption does not prevent the application of federal law (including ERISA and the ACA), which may add additional requirements to employers in a state." On a side note, Hawaii participates in the ACA's federally facilitated health insurance marketplace. Hawaii also isn't exempt from other federal benefit laws like COBRA and the Health Insurance Portability and Accountability Act.

Temporary disability benefits

Hawaii requires employers to provide employees not only health coverage but also temporary disability insurance (TDI). Unlike many other states with similar laws, Hawaii provides no state plan other than a special fund — financed by employer and insurer assessments — for employees of noncompliant or bankrupt employers and for individuals who lose their coverage during unemployment. As a result, employers with any Hawaii workers must either purchase TDI coverage or self-insure.

TDI in a nutshell

The Hawaii TDI mandate applies to employers with any Hawaii employees. The plan must provide benefits for current employees who have worked least 20 hours per week for 14 weeks (whether consecutive or not) in the past 52 weeks, during each of which the employee earned at least $400. Employees can take up to 26 weeks of partially paid leave in a 52-week period for their own nonwork-related disability. To qualify, the injury or illness must prevent the employee from performing regular work duties, and the employee must be under the care of a licensed healthcare professional. TDI benefits equal 58% of an employee's average weekly wage in the preceding 52-week period, up to an annually adjusted maximum benefit. Employers must conspicuously post in the workplace a notice of TDI rights.

Funding

Employers pay for the cost of coverage but can require employees to contribute to the plan. Employee contributions can't exceed one-half of the premium cost up to 0.5% of the worker's weekly taxable wages. The DLIR sets an annually adjusted maximum weekly wage base for disability premiums.

Health benefits

Employers must allow employees receiving TDI to continue health coverage and must contribute the employer's share of the premium for three months. The employee must continue to pay his or her portion of the premium payments. Notice of the employee's right to continue benefits and the amount due to continue benefits must go to the employee within two weeks of the disability start date. Employers also

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must give at least two weeks' advance notice before discontinuing a disabled employee's health coverage.

Job protections

The TDI mandate doesn't include job protections. In addition, protection under the Hawaii Family Leave Law provides only up to four weeks of unpaid family leave each calendar year to bond with a newborn or newly adopted child or to care for the employee's child, spouse, reciprocal beneficiary or parent with a serious health condition. While state law doesn't provide any job protection when an employee's own health condition causes absences, the federal Family and Medical Leave Act does.

Plan implementation

Hawaii permits employers to provide TDI coverage only through an approved plan. An employer may purchase coverage through an insurer authorized to write TDI coverage in Hawaii. Alternatively, regulations permit an employer to apply to the state for an approved TDI plan.

Self-insured approach

All self-insured plans intended to comply with TDI must gain DLIR approval. Employers applying for approval must submit a complete description of the plan and a copy of their annual financial report demonstrating their ability to pay claims. Self-insuring employers may have to provide a surety bond to guarantee the payment of benefits. Employers use Form TDI-15 to apply for approval of a self-insured plan.

Either the employer or a third-party administrator can administer a self-insured plan. A report due to the state each March 1 must detail information related to wages, contributions and claims. Any employee contributions must be kept in a separate fund. A notice conspicuously posted in the workplace must state that the employer is directly providing for the payment of required disability benefits.

Employer considerations

Employers with employees in Hawaii will need to consider the impact of these laws on the organization's overall benefit structure. For employers with national plans and operations in Hawaii, efforts to implement uniform cost reductions and other plan design changes may require special considerations. Health plan sponsors should ensure that all plans offered to employees in Hawaii are approved, and all eligible employees receive coverage or submit an approved waiver. Employee contribution limits for HPHCA-compliant coverage may merit an annual review. Employers should also confirm their benefit package for Hawaii employees includes an approved TDI plan.

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Related resources

Non-Mercer resources

- Hawaii Prepaid Health Care Act (HI Rev. Stat. ch. 393)
- Hawaii Prepaid Health Care Act regulations (DLIR, Feb. 28, 2011)
- Forms HC-4, HC-5 and HC-61 (DLIR HPHCA forms)
- Prepaid Health Care Act website (DLIR Disability Compensation Division)
- Temporary disability insurance (HI Rev. Stat. ch. 392)
- TDI regulations (HI Code R. § 12-11-1 *et seq.*)
- TDI website (DLIR Disability Compensation Division)
- Form TDI-15 (DLIR self-funded TDI plan certification and agreement form)
- Highlights of Hawaii Prepaid Health Care Law (DLIR, Oct. 11, 2018)

Mercer Law & Policy resources

- States update group health plan sponsor reporting obligations (Jan. 21, 2022)
- 2022 state paid family and medical leave contributions and benefits (Jan. 19, 2022)

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