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Auxiliary aids and services are available upon request. Please call the above listed telephone numbers, (808) 586-8847 (TTY), or 1-888-569-6859 (TTY neighbor islands). A request for a reasonable accommodation(s) should be made no later than ten working days prior to the needed accommodation(s).

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HIGHLIGHTS OF THE HAWAII PREPAID HEALTH CARE LAW

FOR EMPLOYERS AND EMPLOYEES

STATE OF HAWAII
Department of
Labor and Industrial Relations
DISABILITY COMPENSATION DIVISION

Form HC-2 (Rev. 1/01)

The information herein is intended to provide employers and employees with general understanding of the Prepaid Health Care Act. For comprehensive details, please refer to the law (Chapter 393, HRS).

PREPAID HEALTH CARE ACT

Originally enacted in 1974, the Hawaii Prepaid Health Care Act was the first in the nation to set minimum standards of health care coverage for workers. Preempted in October of 1981 by the Federal Employee Retirement Income Security Act of 1974 (ERISA), the Prepaid Health Care Act was reinstated effective March 1, 1983.

The Prepaid Health Care Act requires Hawaii employers to provide health care coverage for eligible employees to insure protection against the high cost of medical and hospital care for nonwork-related illness or injury.

EXCLUDED EMPLOYMENT

Services excluded from health care coverage include but are not limited to: 1) individuals who work less than twenty hours per week; 2) Federal, State, and County workers; 3) agricultural seasonal workers; 4) insurance or real estate salespersons paid solely by commission; 5) individuals working for son, daughter, or spouse; and 6) children under age 21 working for father or mother. (For a complete listing, refer to Section 393-5 of the law.)

SECURING COVERAGE

Employers may obtain health coverage: 1) by purchasing an approved health care plan from a health care contractor or a Hawaii licensed insurance carrier; 2) by adopting an approved self-insured health care plan; or 3) by negotiating a collective bargaining agreement.

Employees may form associations for the purpose of providing health care coverage as long as such health care protection is obtained from an authorized health care contractor.

ELIGIBILITY FOR ENROLLMENT

Employees who work twenty hours or more per week and earn a monthly wage of at least 86.67 times the Hawaii minimum hourly wage are deemed eligible after four consecutive weeks of employment. Health care coverage must then be provided to such eligible employees at the earliest enrollment date of the employer's health care contractor.

EXEMPTIONS FROM COVERAGE

Exempt Employees

The following categories of employees can claim an exemption from coverage:

1) those covered by a Federally established health insurance or prepaid health care plan, such as Medicare, Medicaid or medical care benefits provided for military dependents and military retirees and their dependents;
2) those covered as dependents under a qualified health care plan;
3) those who are recipients of public assistance or covered by a State-legislated health care plan governing medical assistance; and
4) those who are followers of religious groups who depend upon prayer or other spiritual means for healing.

"Employee Notification to Employer" (HC-5)

To claim an exemption, an employee must complete and submit form HC-5 to the employer who must then file the document with the Department of Labor and Industrial Relations.

The exemption notification is binding for one year and must be renewed every December 31.

CONCURRENT EMPLOYMENT

An employee who works concurrently for two or more employers is required to designate the principal and secondary employer and file notification (HC-5) with the employers for subsequent filing with the Department of Labor and Industrial Relations. The principal employer shall be the employer who pays the employee the most wages; only in cases where the employer who does not pay the most wages employs the employee for at least 35 hours per week does the employee determine which of the employers shall be the principal employer. The designated principal employer is required to provide coverage pursuant to the law.

An employee's determination of principal employer is binding for one year or until change of employment occurs. Whenever an employee elects to make a change with respect to the status of each, notification (HC-5) must be filed. (For complete details, refer to Section 393-6 of the law.)

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

PREMIUM PAYMENTS

The employer may elect to pay the entire premium amount or share the cost with the employee. The employer must pay at least one-half the premium cost; however, the employee's contribution cannot exceed 1.5% of the employee's monthly wages. In the event the employee's allowable share constitutes less than one-half of the premium, the employer is liable for the entire remaining portion. The employer is permitted to withhold the employee's contribution from the employee's wages.

An employee cannot agree to pay a greater share from wages except for the purpose of paying for the added cost of providing prepaid health care benefits for the employee's dependents under the same plan.

CONTINUATION OF COVERAGE PROVISION

In the event an employee is disabled and unable to work, the employer is obligated to enable the employee to continue health care coverage by continuing the employer's share of the premium costs for three months following the month during which the employee became disabled, or for the period for which the employer has undertaken payment of employee's regular wages, whichever is longer. The employee must maintain the employee's portion of the premium payments.

HEALTH CARE CONTRACTOR

Type

A prepaid health care contractor may fall in one of three groups: 1) any medical group or organization which provides health care benefits under a prepaid health care plan; 2) any nonprofit organization which defrays or reimburses in whole or in part the expenses of health care under a prepaid health care plan; or 3) any insurer who defrays or reimburses in whole or in part the expenses of health care under a prepaid health care plan.

Selection

The employer selects the health care contractor and the plan type.

HEALTH CARE PLANS

Type

There are two types of health care plans: 1) a plan by which a prepaid health care contractor would furnish health care, and 2) a plan by which the health care contractor would defray or reimburse, in whole or in part, the expenses of health care.

Benefits

To meet standards as prescribed by law, prepaid health care plans must include at least the following benefits: 1) hospital (including inpatient care for at least 120 days of confinement in each calendar year), 2) surgical, 3) medical, 4) diagnostic, and 5) maternity. (For further details, refer to Section 393-7 of the law.)

Plan Approval

All health care plans must be approved as meeting prescribed minimum standards by the State Department of Labor and Industrial Relations. Such determination is made by the Director under the advisement of a seven-member prepaid health care advisory council consisting of representatives from the medical and public health professions, from consumer interest, and from people experienced in prepaid health care protection.

PENALTIES

An employer who fails to comply with the coverage provisions of the law shall be subject to a penalty of not less than $25, or $1 for each employee for every day during which such failure continues, whichever sum is greater. If such 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 or any rule or regulation, may be fined not more than $200 for each violation.

Furthermore, any person who, after twenty-one days written notice and the opportunity to be heard by the director, is found to have violated any provision of Chapter 393 or rule adopted thereunder for which no penalty is otherwise provided, shall be fined not more than $250 for each offense.

APPEAL

When health care benefits are denied a worker, the employer or the prepaid health care contractor must promptly mail a notice of denial to the worker who then has twenty days in which to request a review by the Department of Labor and Industrial Relations. If the parties are not satisfied by the department's findings, the case will be referred to the Prepaid Health Care Appeals Referee. The decision of the referee shall be final and binding unless the aggrieved party appeals the decision.

SPECIAL FUND

The Prepaid Health Care Premium Supplementation Fund is established by general fund appropriation and used to defray the cost of providing health care benefits for employers with less than eight workers entitled to and covered under the Prepaid Health Care Act. To qualify for premium supplementation, the employer must meet the criteria outlined in Section 393-45 of the law.

The Fund may also reimburse health care expenses to workers of bankrupt employers and non-complaint employers. Benefits paid from the Fund shall be recovered from those defaulting employers.

ADMINISTERING AGENCY

The Disability Compensation Division of the Department of Labor and Industrial Relations administers the Hawaii Prepaid Health Care Law. For further information, please contact the offices listed on the back of this brochure.

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