Hawaii employee health and leave benefits may need special attention

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In this article

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. ERISA does not preempt the Hawaii mandates, and penalties for noncompliance can be substantial. In addition, the state's temporary disability insurance law mandates coverage through an authorized insurer or an approved self-insured (self-funded) plan. Compliance with Hawaii laws is increasingly important for multistate employers, given an uptick in hybrid and remote workers.

Prepaid Health Care Act (PHCA)

Hawaii's Prepaid Health Care Act requires private employers to provide healthcare coverage for all eligible Hawaii employees. The PHCA 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 coverage to employees or implement 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 participants).
- 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 must offer coverage at the earliest time that the healthcare contractor can provide it, typically the first of the month following the month in which eligibility criteria were met; see this FAQ. Employers do not have to provide coverage for retirees. If an 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. The PHCA does not apply to governmental employers, agricultural seasonal workers, insurance or real estate salespersons paid solely by commission, individuals working for a son, daughter or spouse, and children under age 21 working for a father or mother.

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 no later than Dec. 31 each year; additional substantiation is not required. Even if all Hawaii employees waive coverage, an employer still must have an approved plan. Otherwise, there is no coverage to waive.

Employees must also complete Form HC-5 to request coverage when a previously approved waiver reason no longer applies. Form HC-5 has four major waiver reasons; the only reason that triggers the DLIR submission is that the employee has obtained other coverage from a healthcare contractor.

Contributions

Employers can require employees to contribute to the cost of coverage, but the required contribution cannot 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 dependents 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 f dependent coverage.

> *Example 1.* Ed earns $10,000 per month. The monthly premium for his health coverage is $250. Ed cannot be required to contribute more than $125 per month (50% of the premium since 1.5% of his monthly wages — $150 — would be higher).
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> *Example 2.* Beth earns $2,000 per month. Her coverage also costs $250 per month. Although 50% of the cost of coverage is $125, Beth cannot be required to contribute more than $30 per month (1.5% of her monthly wages).

Example 3. Theresa has family coverage. The self-only premium is $250 per month; the family premium is $1,000 per month. In addition to paying the required employee share (the lesser of 50% of $250 or 1.5% of monthly wages), Theresa's employer must pay at least $375 (50% of the additional $750 for family coverage).

Example 4. Maui Rentals wants to maintain a consistent employee contribution structure for its 7(a) plan that does not vary based on compensation. Monthly premiums for all PHCA-eligible employees range from $1,000 to $9,000. The self-only premium is $250 per month. Maui Rentals sets the employee self-only contribution for all eligible employees at $15 per month (1.5% of the lowest monthly wages, $1,000), which is less than $125 (50% of the premium).

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

Example 5. 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 $750. Although Ed's contribution for his own coverage cannot exceed $125, he can be charged the full difference in cost ($750 - $250 = $500) for adding his spouse to the plan. So his maximum allowable contribution is $625 ($125 + $500).

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 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 6. Beth (from example 2) works for an employer with two plans. Beth is enrolled in the lowest-cost plan with a monthly premium of $250. At open enrollment, Beth elects a plan with richer benefits and a premium of $500 per month. Beth can be required to contribute $280 toward the cost of coverage — $250 for the difference in cost of the plans plus $30 for 1.5% of her monthly wages.

What should an employer do if monthly compensation fluctuates, perhaps because an employee is a commissioned or tipped employee or because the work schedule varies?
The maximum employee contribution is based on monthly pay. Therefore, an employer should monitor employee compensation and contributions up to 12 times per year (at the end of each month) to ensure that employees are not contributing more than what is allowed and refund excess withholdings when applicable. If an employee is no longer employed and cannot be located, an employer must deposit the excess amount in the premium supplementation fund, described below.

Example 7. Joyce is a tipped employee whose compensation varies widely based on the shifts she works. Joyce elects self-only coverage with a standard monthly premium of $250. Joyce's employer reasonably estimates — based on past experience — that her compensation will be $3,000 at the start of August and deducts $45 from her pay ($3,000 X 1.5% since 50% of the premium — $125 — would be higher). Joyce actually earns only $2,000 in August, requiring a maximum contribution of $30. Her employer must refund her $15, presumably on a taxable basis if contributions are pretax.

Required benefits

The PHCA 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 PHCA 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 PHCA 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, 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 eight to 12 months (and often longer) 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 guidelines, the DLIR described how to determine whether self-insured employers meet the "ability to pay" standards for self-insuring required health benefits. These 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).

These guidelines may serve as a starting point for employers considering whether to self-insure their mandated Hawaii coverage. Regulators may also 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.

Self-insurers have annual obligations. Audited financial reports are due to DLIR. Also, plan changes must be sent to DLIR for approval. Plan changes may be due to modifications initiated by the plan sponsor or the third-party administrator (TPA) administering the plan. Other changes may be required based on a new insurance mandate or changes to Hawaii plan targets.

Notices

The PHCA requires employers to notify 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 premium cost by using wellness plans or spousal surcharges may find those strategies less effective in Hawaii.

Tobacco use surcharge

Because the PHCA 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 cannot impose further surcharges.

> *Example 8.* 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 that offer a 7(a) plan, this is not a problem because these plans do not require employer contributions for dependents' coverage. If the employer offers a 7(b) plan, however, the employer must pay at least 50% of the cost for the dependent coverage. If the employer typically contributes more than that amount, a spousal surcharge may apply, but only up to the maximum.

Example 9. Jerry (from example 6) 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 PHCA prohibits any surcharge that would increase Jerry's contribution above that amount.

Variable-hour employees

The minimum eligibility requirements (20 hours per week for four consecutive weeks) present challenges to employers with employees whose work hours fluctuate. Technically, an employer could terminate coverage when these employees drop below the thresholds. This effort may prove more trouble than it is worth:

- The employer would need to constantly track work hours and renew an offer of coverage when employees again become eligible, causing considerable disruption and increasing administrative burdens.
- These strict eligibility rules would need to be clearly communicated, including in the health plan's summary plan description (SPD).
- Affected employers should review and confirm the enrollment and disenrollment process with their insurer for fully insured plans or third-party administrator (TPA) for self-funded plans.

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 higher 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 will not find this to be an option.

State continuation coverage

Hawaii has a limited state continuation mandate, applicable to fully insured medical, dental and vision plans that are not subject to federal continuation requirements under COBRA. Specifically, covered employers must provide up to three months of additional coverage following the month in which an employee becomes hospitalized or disabled. Contributions must be at the active employee rate. Continuation coverage extends beyond three months if wage payments continue beyond the three-month duration.

Premium supplementation fund

The PHCA (HI Rev. Stat. § 393-45) provides a fund to help employers defray the cost of providing healthcare benefits. It is available for employers with fewer than eight eligible employees. Employers

must submit Form HC-6 (along with necessary documentation) to DLIR within two years after the applicable tax year ends.

Penalties

Hawaii imposes potentially steep penalties for noncompliance with the PHCA:

- 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 PHCA (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 PHCA that existed before ERISA took effect in 1975 and does not apply to any amendment that provides for more than the PHCA's "effective administration."

Impact on the Affordable Care Act and other federal laws

Despite the ERISA preemption carve-out for the PHCA, 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 PHCA and ACA provisions. IRS Information Letter 2021-0011 explains that the PHCA'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 is not exempt from other federal benefit laws like COBRA, the Health Insurance Portability and Accountability Act and the Mental Health Parity and Addiction Equity Act.

Temporary disability benefits and other leaves

Hawaii also requires employers to provide 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. Unlike other states, Hawaii does not require paid family leave benefits and has no paid sick and safe leave mandate applicable to private employers.

TDI in a nutshell

The 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, whether with one employer or multiple employers) 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. For information on current rates, see 2024 state paid family and medical leave contributions and benefits (Jan. 31, 2024).

Funding

Employers pay for the cost of coverage but can require employee contributions up to 50% of the premium cost, capped at 0.5% of the worker's weekly taxable wages. The DLIR sets an annually adjusted maximum weekly wage base for disability premiums, which is typically published in the fall of each year.

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 premium payments. Employees must receive notice of the right to continue benefits and the amount due within two weeks of the disability start date. Employers also must give at least two weeks' advance notice before discontinuing health coverage.

Job protection

The TDI mandate does not include job protection during paid leave. However, the federal Family and Medical Leave Act (FMLA) provides job protection during TDI leave if eligible leave under those two laws runs concurrently.

Plan implementation

Hawaii permits employers to provide TDI coverage only through an approved plan. An employer may purchase coverage through an authorized insurer. 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 TPA can administer a self-insured plan. A report is due to the state annually on March 1 and 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.

Unpaid leaves

The state requires employers to provide two types of leave.

Domestic violence/sexual violence victims leave

Per the statute, employers with 50 or more employees must allow Hawaii employees to take up to 30 days of unpaid leave per calendar year; employers with 49 or fewer employees must provide up to five days. The job-protected leave is available for the employee and his or her minor children when they are victims of domestic violence and sexual violence. Qualifying reasons include seeking medical attention, obtaining social services and counseling. Employers may require documentation in some circumstances.

Family leave

Per the statute, employers with 100 or more employees must provide 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. Employees must have at least six consecutive months of service. Employees may substitute any accrued paid leave. There is no minimum work hours requirement like there is with FMLA. While state law does not provide any job protection when an employee's own health condition causes absences, FMLA does. See this FAQ.

Insurance coverage

Given that most health coverage in Hawaii is fully insured, plan sponsors should have a working knowledge of uncommon insurance provisions applicable in the state, including laws related to civil unions, dependents, gender-affirming treatment, pharmacy benefit managers (PBMs) and telehealth.

Civil Unions

Per the statute, Hawaii requires civil union partners in the state to have the same rights, benefits, protections and responsibilities under the law as spouses. This includes benefits coverage. For details, see Domestic partner benefits remain popular but present challenges (July 11, 2023).

Dependents

Per the statute, insured plans (except health maintenance organizations) must cover reciprocal beneficiaries that have a registered declaration with the Department of Health (DOH). A reciprocal beneficiary relationship is defined as one where two adults have a significant personal, emotional and economic relationship but are prohibited from marrying. The family law statute gives an example of a widowed mother and an unmarried son. See this DOH webpage and state attorney general legal opinion.

Gender-affirming treatment

Under a 2022 law, fully insured plans must cover medically necessary gender-affirming treatments and procedures. See Roundup of selected state health developments, second-quarter 2022 (Aug. 22, 2022).

PBMs

Per the statute, PBMs must register with the Department of Commerce and Consumer Affairs in order to do business in the state. Per another statute, PBMs may not use individual health information for marketing purposes, except when medically necessary, required by federal regulations or in situations where the individual has provided written consent. For example, a participant's protected health information may be used to improve the health and safety of that participant.

Telehealth

Hawaii is one of several states with a statute requiring health plan reimbursement parity between telehealth and in-person providers, requiring equivalent rates. This statute expires on Dec. 31, 2025. An exception exists for mental health services, where the telehealth reimbursement rate can be as low as 80% of the in-person reimbursement rate. For details, see Roundup of selected state health developments, second-quarter 2023 (Aug. 14, 2023).

Other state laws

Employers should be aware of other considerations that may have an indirect impact on insurance and benefits, including payroll deductions, final paychecks and state taxation.

Payroll deductions

Cafeteria plan regulations permit employees to pay for health and other benefits on a pretax basis. The Hawaii statute confirms that these deductions are permissible as long as an employer obtains an employee's written authorization.

Final pay

Former employees must receive their last paycheck no later than the next working day after an employer-initiated termination, whether with or without cause. By contrast, employers have until the next regular payday to pay employees who resign, unless an employee provides greater than one pay period's notice; in that event, an employer may pay wages on the last day of work. A 2005 state supreme court decision confirmed that employers need not pay unused vacation pay, absent an express policy or contractual obligation to the contrary.

State taxation

Hawaii has a state income tax. The state taxation statute conforms to the federal Internal Revenue Code in relevant respects, except that civil union partners are treated as spouses for tax purposes.

Relevant federal law issues

Two federal laws (the ACA and COBRA) present nuanced issues for Hawaii employers.

ACA

The Employer shared responsibility (ESR) mandate requires employees with at least 50 full-time employees to offer health coverage meeting certain minimum-value and affordability standards or risk paying an IRS assessment. The regulations provide three affordability safe harbors for the § 4980H(b) ESR assessment, including one based on the federal poverty line (FPL). Hawaii's (and Alaska's) FPL amounts are higher than the FPL for the 48 contiguous states (and Washington, DC); the regulations confirm that employers may use the FPL for Hawaii (and Alaska) employees — based on the state where they are employed — for affordability purposes related to the § 4980(b) ESR assessment.

The same is true when calculating an individual's eligibility for the premium tax credit (PTC), used for reducing health coverage premiums obtained through the Health Insurance Marketplace. Regulations confirm that Hawaii (and Alaska) residents must use their state's higher FPL amounts (resulting in a lower percentage of the FPL) for PTC eligibility.

COBRA

COBRA issues arise when a qualified beneficiary moves to or from Hawaii. In the first instance (as stated above), the PHCA does not require employers to obtain approved health coverage for the sole purpose of covering COBRA coverage to a former employee. In the second instance, the general rule is that an employer's obligation is simply to offer the same coverage the qualified beneficiary had the day before the qualifying event. The regulations provide two exceptions to this rule:

- **Relocation.** If the qualified beneficiary participates in a region-specific benefit package (like an HMO), the employer must give the qualified beneficiary a reasonable period to request other coverage available to similarly situated active employees. The region-specific plan must provide no

coverage in the area where the qualified beneficiary is relocating; it is not enough that the coverage ceases to be of value to the qualified beneficiary.

- **Open enrollment.** Virtually all employers provide open enrollment for employees, enabling them to switch plans at the start of the next plan year. This right extends to qualified beneficiaries. Thus, an individual anticipating a move out of Hawaii early in the next plan year could switch to another plan option during open enrollment.

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. Here are some steps to consider taking:

- 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 PHCA-compliant coverage may merit an annual (or even monthly) review.
- Confirm that the benefit package for Hawaii employees includes an approved TDI plan.
- Review the SPD and other communications for appropriate information on Hawaii-specific benefits.
- Confirm that payroll processes comply with state law related to final pay and state taxation.
- Address potential COBRA issues for qualified beneficiaries relocating to or from Hawaii.

Related resources

Non-Mercer resources

Hawaii

- Prepaid Health Care Act (HI Rev. Stat. Ch. 393)
- PHCA regulations (DLIR, Feb. 28, 2011)
- Forms HC-4, HC-5, HC-6 and HC-61 (DLIR PHCA forms)
- PHCA 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. 8, 2018)
- Guidelines to determine whether an applicant meets the "self-insurer" requirements of HRA § 12-12-24 (DLIR, June 21, 2004)
- Victims leave law (HI Rev. Stat. § 378-72)
- Family leave law (HI Rev. Stat. Ch. 398)
- Family leave FAQ (DLIR)
- Civil union partners law (HI Rev. Stat. Ch. 572B)
- Reciprocal beneficiary family coverage law (§ 431:10A-601)
- Reciprocal beneficiary relationships webpage (Department of Health)
- Health Insurance Coverage for Reciprocal Beneficiaries letter (Attorney general legal opinion, Dec. 2, 1997)
- Nondiscrimination on the basis of actual gender identity or perceived gender identity (HI Rev. Stat. § 431:10A-118.3)
- Pharmacy benefit manager law (HI Rev. Stat. Ch. 431S)
- Telehealth law (HI Rev. Stat. § 431:10A-116.3)
- Wage withholding law (HI Rev. Stat. § 388-6)
- Conformance to the federal Internal Revenue Code (HI Rev. Stat. § 235.3)

Federal

- Employee Retirement Income Security Act
- Family and Medical Leave Act
- 26 CFR § 1.36B-1 (Premium tax credit)
- 26 CFR §§ 1.125-1-7 (Cafeteria plans)
- 26 CFR § 54.4980B-5 (COBRA coverage)
- 26 CFR §§ 54.4980H-1-6 (Employer shared responsibility)

- 26 CFR § 54.9802-1 (Health factor nondiscrimination, wellness programs)
- Information Letter 2021-0011 (IRS)
- IRS Pub. 969 (Health Savings Accounts and Other Tax-Favored Health Plans)

Mercer Law & Policy resources

- 2024 state paid family and medical leave contributions and benefits (Jan. 31, 2024)
- Some states require group health plan sponsor reporting (Dec. 5, 2023)
- Roundup of selected state health developments, second-quarter 2023 (Aug. 14, 2023)
- Domestic partner benefits remain popular but present challenges (July 11, 2023)
- Roundup of selected state health developments, second-quarter 2022 (Aug. 22, 2022)

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