

## Prepaid Health Care Advisory Council Meeting

State of Hawaii  
Department of Labor and Industrial Relations  
P.O. Box 3769  
Honolulu, HI 96812-3769

Via Microsoft Teams

October 7, 2021  
1:30 p.m. to 2:58 p.m.

### Council members present

Mr. Paul Marx  
Ms. Carol Shimomura  
Ms. Bonnie Pang  
Mr. Mike Hogan  
Mr. Derek Kanehira

### Council member absent

Dr. John McDonnell

### DC Staff Present

Royden Koito  
Lois Iyomasa  
Misty Sumida  
Marisa Yagi  
Stacey Hiranaka

With a quorum present, Chair Marx called the meeting to order at 1:30 p.m.

Chair Marx requested Council members to announce themselves for the record. He stated if technical difficulties occurred, the meeting would resume on October 12, 2021 at 1:30pm. The presenters excluded, Chair Marx asked that all speakers limit testimony to five-minutes and announce themselves prior to speaking.

### APPROVAL OF MINUTES

Chair Marx asked if there were any changes to the circulated minutes of July 13, 2021. A motion was made by Mr. Hogan to approve the minutes as circulated. The motion was seconded by Mr. Kanehira and carried by unanimous vote.

The Chairman deviated from the order of the agenda to acknowledge his gratitude for Ms. Laudra Eber's many years of service to the Council.

## REVIEW OF PLANS

Kaiser Foundation Health Plan, Inc.

Kaiser was represented by Ms. May Goya and Mr. Chad Hertzog. Kaiser Permanente Insurance Company (KPIC) was represented by Mr. Jeffrey Young.

### **Kaiser Permanente Group Plan** (Informational Only)

Kaiser informed the Department of changes and clarifications being made to the prevalent plan effective January 1, 2022.

Chair Marx offered Kaiser the opportunity to present to the Council topics for discussion regarding the plans. Ms. Goya stated there were no cost share changes, but there were language clarifications and all the language changes would be the same in all the plans being reviewed today.

Ms. Goya addressed the staff's Question One regarding the cost share for non-grandfathered and grandfathered plans. She explained the plans were designed to have the same verbiage for the narrative in chapters one through eleven with a customized cost share chart based on the status of the plan, whether it was grandfathered or non-grandfathered.

With respect to the staff's Question Two, Ms. Goya acknowledged that Kaiser would delete the blank Riders page from the guide.

Ms. Goya addressed the staff's Question Three whether the terms "EOC" and "Guide" were used interchangeably throughout the document. She clarified the terms were being used consistently, and if a benefit or a provision was also in the Rider or the group agreement (which was not made available to the Council), Kaiser used the broader term of "EOC" (Evidence of Coverage).

Ms. Goya addressed the staff's Question Four regarding the bariatric surgery program that was listed as an exclusion. She clarified the program was a health education class and all classes do not count toward the out-of-pocket maximum. It was listed in the guide as an exclusion and was not counted toward the out-of-pocket maximum. Ms. Goya stated the bariatric surgery program was different from the bariatric surgery which was covered and does count toward the out-of-pocket maximum.

Ms. Goya addressed the staff's Question Five regarding the discrepancy that the implanted internal prosthetics were covered if prescribed by a physician and pre-authorized, but on page 56 of the Plan Guide pacemakers and other surgically implanted internal prosthetic devices were not. Ms. Goya clarified that the exclusion applied to the braces benefit itself.

Ms. Goya addressed the staff's Question Six regarding the discrepancy between page 46 of the Plan Guide that stated that diabetic supplies were covered for supplies necessary to administer insulin and to operate diabetes equipment, and page 53 that listed prescribed drugs or diabetes

supplies that were necessary were not covered. Ms. Goya clarified the exclusion was related to the overall general exclusion where the plan does not cover supplies related to an excluded service. This particular diabetes supplies exclusion was a subcategory of the general exclusion of drugs or diabetic supplies that were necessary but associated with services that were excluded or not covered.

Ms. Goya addressed the staff's Question Seven regarding the "Related Items Exclusion" on page 61 of the Plan Guide. The exclusion stated, "You are not covered for any service or supply that is directly or indirectly related to an excluded or exhausted Service, or Service that is not listed as covered." The phrase "or Service that is not listed as covered" was contrary to the department's position that services that were excluded need to be identified. Ms. Goya confirmed that Kaiser would delete the last phrase, "or service that was not listed as covered."

Ms. Goya addressed the staff's Question Nine regarding the probationary period of the group (page 67 of the Plan Guide) during which a new employee may not enroll and which may be misinterpreted to allow an employer to delay enrollment for a new eligible employee. Ms. Goya assured the Council that Kaiser was communicating an administrative process for member enrollment and was not giving employers permission to not comply with the Prepaid Health Care Act. Ms. Goya stated that the plan also specified in Chapter Ten of the Plan Guide that employers were responsible for compliance for all applicable federal and state rules, including the Hawaii Prepaid Health Care Act.

Ms. Goya addressed the staff's Question Ten regarding the member termination provisions when an individual was never eligible to enroll based on the behavior or action of other members of the family unit. The provision stated no person was eligible to enroll under this EOC (Evidence of Coverage) if the person or any other person in his or her family unit was terminated from a particular plan. Ms. Goya clarified under this EOC that if the member was terminated from the current plan, the member may enroll in another Kaiser plan (individual or group) for which they were eligible.

Ms. Goya addressed staff's Question Eight regarding transportation other than covered ambulance services. In the EOC guide, Kaiser stated that transportation other than covered ambulance services were not covered. Ms. Goya stated in their February 17, 2021 letter that Kaiser's administrative policy, which was not listed in the EOC guide to members, stated that if requested services were not available or cannot be accessed within two weeks, any necessary air transportation to transport the member would be covered by Kaiser. The administrative policy ensured that members receive medically necessary services within the State of Hawaii.

Mr. Hogan requested Mr. Jeff Young and Mr. Chad Hertzog provide additional information about their roles within Kaiser so that the Council had a better understanding to whom to direct their questions. Mr. Young stated he was responsible for Kaiser Permanente Insurance Company's document which covered the PPO coverage. Mr. Hertzog stated he was a part of the

product development team and could address any questions related to the changes to the Kaiser 7(b) plans and the out-of-pocket maximum.

Ms. Shimomura questioned the information presented in Item 42 Durable Medical Equipment in the DCD review form which reflected a coinsurance of 90%. Ms. Goya confirmed the DCD review form should state a coinsurance of 80% and that the 90% was a typo.

Ms. Shimomura asked why prescription drugs and miscellaneous treatment were included under the Office Use Only column in Line 60 of the DCD review form, yet the vision benefit was not. Misty Sumida replied that DCD would include that item in the next round of plans.

Mr. Kanehira commented that the page number 30 next to the Total Care Services description listed on roman numeral VII in the benefit summary does not need to be there. He stated the page number was listed on all benefit summaries and believed the page number listed was a typo.

Mr. Kanehira thanked Ms. Goya for explaining the language regarding the grandfathered and non-grandfathered plans. He suggested, for future consideration, not to include the language that was not applicable to the plan. Mr. Kanehira said as an example the plan addressed orthodontic care for treatment of orofacial anomalies and referenced the 2016 contract where members would be responsible for all charges after the plan paid the maximum benefit or \$5,500 per treatment phase. He stated that in this case, the 2016 contract would not be applicable to new plans and therefore the language need not be included. Ms. Goya stated that Kaiser would remove or reword that section and that Kaiser's intent was to reflect the 2016 dollar amount that the Department of Insurance allocated.

### **KP Added Choice Platinum**

Kaiser and KPIC informed the Department of the new plan effective January 1, 2022 and requested approval of the plan under Section 393-7(a).

Ms. Goya stated the language edits were the same for all the KP Group plans and as her responses to the questions in the DCD review sheet are identical for all plans, she asked if the Council would like her to itemize the discussion points again. The Council felt it was best to discuss specific questions or concerns that were not addressed previously.

Mr. Young addressed the PPO document and how it referenced the service agreement. He stated that term may be outmoded and was sometimes used as reference to the group agreement. This contract was given from the HMO to the employer and KPIC's PPO coverage referenced the HMO document in several places. Mr. Young would confirm with Ms. Goya regarding the use of this term and if the term was not current, KPIC would update its document.

Mr. Young addressed the concern that the covered charges for diabetic drugs and insulin should contribute toward satisfying the annual deductible and the out-of-pocket maximum. Mr. Young explained that he could make the change to include the charges in the out-of-pocket maximum but the plan would always be offered with a drug rider so the drugs and insulin would be covered

by the drug rider. The deductible would not apply for this benefit so no change would be made to include the charges in meeting the deductible. He confirmed KPIC would make the change to include the charges in the out-of-pocket maximum.

Ms. Goya and Mr. Young addressed the question whether plan amendments (ACA1 – ACA5 for HMO and pages 84 – 85 for PPO) should be incorporated into the plan to avoid confusion about benefit payments. Ms. Goya explained the cost share chart and the guide narrative were the same base verbiage used for all plans, whether grandfathered or non-grandfathered. When the plan was an Affordable Care Act (ACA) small group plan, Kaiser added the ACA amendment to describe the benefits that were required by the ACA. For the PPO portion of the plan, Mr. Young explained that KPIC was trying to use one certificate to support both large and small group plans. Amended items unique to the KP Added Choice Platinum plan were reflected in the Rider in the back of the plan. The Rider was not optional and would be attached to every small group. He noted that KPIC in previous years had used the Rider to update ACA changes to the plan. KPIC's intention was to limit the number of certificates published.

Mr. Kanehira asked why Kaiser had created this new plan and if the intent for the creation of the plan was to fill a certain need in the market. Mr. Hertzog stated Kaiser currently offered an Added Choice product for large groups but does not have a similar product to offer ACA small group employers. He explained because Kaiser had employer groups that could fall into the category of small or mid-large, Kaiser wanted to ensure if a group changed its category because of an employee level change, the group could maintain the Added Choice product and offer a comparable plan to its employees.

Ms. Goya addressed the question whether the Benefit and Payment Chart for contraceptive drugs and devices under Special Services for Women should state the cost share rather than refer to the Prescription Drug section of the chart for information. Ms. Goya stated that since the benefit for contraceptive drugs and devices was listed under both the Special Services for Women and Prescription Drug section, Kaiser would remove the contraceptive drug and devices from the special services for women section and keep the contraceptive drug and devices only in the prescription drug section.

Chair Marx commented on the language referred to in the service area on page 107 and how it does not note the excluded zip codes noted in the PPO plan. Mr. Young confirmed KPIC would remove the outdated zip codes.

Ms. Goya asked the Council if it would be acceptable to make the changes regarding the contraceptive drugs and devices for the 2023 plan year. Mr. Kanehira stated he felt it was a reasonable request because the plan was submitted in early 2021 and was not reviewed until October. The Council unanimously agreed.

A motion was made by Mr. Kanehira to recommend continued approval of the plan under Section 393-7(a) provided:

1. The blank Riders page in the Guide is deleted;
2. The language for Related Item Exclusion is amended so that services are not automatically excluded when a service is not listed;
3. The references to Page # 30 under the Total Care Services heading in the Benefit Summary section is deleted;
4. The reference to the 2016 contracts example under the Benefit Description for Orthodontic Care for the Treatment of Orofacial Anomalies (from birth) is deleted;
5. References to “Service Agreement” are replaced with the current term Kaiser Permanente uses when referring to the HMO part of the plan document;
6. Covered charges for diabetic drugs and insulin contribute toward the satisfaction of the out-of-pocket maximum;
7. Contraceptive Drugs and Devices under the Special Services for Women Benefit Summary is deleted in plan year 2023; and
8. The outdated service area zip codes are deleted.

The motion was seconded by Ms. Shimomura and carried by unanimous vote.

### **KP Platinum II - \$20 Plan**

Kaiser informed the Department of the new plan effective January 1, 2022 and requested approval of the plan under Section 393-7(a).

Mr. Kanehira questioned why the benefit & payment chart noted a \$20 co-payment for family planning visits, but page ACA-1 noted there was no cost share. Ms. Goya confirmed the ACA plan required no cost share for certain family planning visits, but there may be family planning visits that were not mandated by ACA, and those visits would default to the office visit co-payment.

Ms. Goya stated the ACA required no cost share for certain self-administered drugs. However, if the drug was not covered by the ACA mandate, the benefit would default to the drug co-payment if the member had a drug rider.

A motion was made by Mr. Hogan to recommend continued approval of the plan under Section 393-7(a) provided:

1. The blank Riders page in the Guide is deleted;
2. The language for Related Item Exclusion is amended so that services are not automatically excluded when a service is not listed;
3. The references to Page # 30 under the Total Care Services heading in the Benefit Summary section is deleted; and
4. The reference to the 2016 contracts example under the Benefit Description for Orthodontic Care for the Treatment of Orofacial Anomalies (from birth) is deleted.

The motion was seconded by Ms. Pang and carried by unanimous vote.

**Kaiser Permanente Group \$20/20%/\$300 Plan**

Kaiser informed the Department of changes made to the plan effective January 1, 2022 and requested continued approval of the plan under Section 393-7(b).

The referenced plan appeared on the agenda as Kaiser Permanente Group \$20/20%/\$350 Plan to reflect the increase in annual deductible per individual from \$300 to \$350. This plan was reviewed as a new plan because of its new name and proposed changes to the increased out-of-pocket maximum and deductibles.

Kaiser planned to increase the out-of-pocket maximum from \$3,000 to \$4,000. Mr. Hertzog asked for consideration for the increased \$4,000 out-of-pocket maximum. The \$4,000 out-of-pocket maximum would provide some rate relief and sustainability to prevent requests for increase every year or two. Mr. Herzog stated that Kaiser would accept the recommendation of \$3,500 out-of-pocket maximum.

Ms. Shimomura commented that the \$12,000 family unit annual co-payment maximum was kind of high but understood the rate consideration and the ability to provide richer benefits in other areas. She agreed that it was a good balance.

Chair Marx asked when the last time the out-of-pocket maximum was addressed. Mr. Hertzog stated it had been more than a decade and that discussion with previous Council members regarding the increase of deductible should be discussed on a regular cadence of every other year or every few years. At that time Kaiser would discuss the deductible and the out-of-pocket maximum to see if it was the right time to make changes.

Ms. Shimomura asked how Kaiser determined whether the family unit annual co-payment maximum was going to be multiplied by three or two times the individual out-of-pocket maximum. Mr. Hertzog stated the large group portfolio had a three times multiplier and small group portfolio had a two times multiplier because of the ACA regulations and guidelines.

Ms. Pang recalled the past discussions where there were concerns that the Council did not move a significant amount of cost over to the employees. She understood the effort to balance cost as well as ensuring members have coverage, but the increased maximum was a topic that eventually needed to be addressed. Ms. Pang stated Kaiser had a steady co-payment maximum longer than most plans.

Chair Marx asked Mr. Hertzog to clarify how the increase of \$500 occurred and if there was a methodology. Mr. Hertzog explained in previous meetings, there was a general benchmark on the deductible between increments of \$50 to \$100 and the out-of-pocket maximum was around \$500. Due to the lag time, Kaiser decided to submit the \$4,000 annual co-payment maximum for discussion. He stated that in the ACA world, the out-of-pocket maximum for the individual market was significantly higher, and that Kaiser recognized that \$4,000 annual co-payment

maximum per member and \$12,000 annual co-payment maximum for a family unit appeared to be high, but compared to the individual and ACA market, the amount was significantly lower.

Ms. Pang questioned if the out-of-pocket maximum accumulates for only the medical plan or if it was also embedded in the prescription drug plan. Mr. Hertzog stated the majority of the Kaiser plans include a combined accumulator of medical and prescription drug plan, but there were some small and large groups that may have a separate drug out-of-pocket maximum.

Mr. Kanehira questioned what Kaiser expects by increasing the out-of-pocket maximum to \$4,000 and what the rate relief would be for employer groups. Mr. Hertzog stated the rate would vary by group and that he would need to check with the underwriting team to see if they have an average. However, as the renewals have been completed for 2022, the underwriting team would need to recalculate the rate relief.

Chair Marx questioned if Kaiser was looking for approval in 2022 or 2023. Mr. Hertzog stated Kaiser was agreeable to either 2022 or 2023. Kaiser would accept the increased \$3,500 annual co-payment maximum per member, with the consideration that a future decision for \$4,000 be considered. Kaiser was also amenable to the Council allowing Kaiser an incremental increase every year.

Chair Marx stated the annual co-payment maximum seemed to be a part of Kaiser's annual review process and that it would be appropriate to review this with the Council every year. The request for an increase would not be accepted every time, but it would be a good topic to discuss with the Council.

Mr. Bunag from HMSA questioned if the Council was going to approve the increase, whether this increased amount would be the new standard for all 7(b) status plans. Historically, maximum for 393-7(b) status plans were \$3,000 with a times three for the annual co-payment maximum family unit and \$350 deductible with a times three for the annual co-payment maximum family unit and generally it was an 80/20 plan.

The Council decided to postpone the decision for another time with the need for further clarification on the effect this change would have on other plans. Mr. Hogan commented anytime there was a carrier specific request that may impact the prevalent plan, appropriate vetting would need to occur. Further discussion occurred regarding the challenges the Council managed when dealing with the intent of the Prepaid Health Care Law versus the Affordable Care Act and the federal mandates.

Chair Marx asked Mr. Hertzog if the Council had given Kaiser enough information to resume the conversation in the future by having Kaiser provide more detail behind their decision-making to increase the maximum co-pay. Mr. Hertzog acknowledged and thanked the Council.

Chair Marx confirmed the Council was accepting the plan as submitted and that no increase in the co-pay maximum was approved. The Council deferred any discussion on increasing the annual co-payment maximum to \$4,000 pending due diligence and review.

A motion was made by Mr. Hogan to recommend continued approval of the plan under Section 393-7(b) provided:

1. The annual out-of-pocket maximum is capped at \$3,000;
2. The blank Riders page in the Guide is deleted;
3. The language for Related Item Exclusion is amended so that services are not automatically excluded when a service is not listed;
4. The references to Page # 30 under the Total Care Services heading in the Benefit Summary section is deleted; and
5. The reference to the 2016 contracts example under the Benefit Description for Orthodontic Care for the Treatment of Orofacial Anomalies (from birth) is deleted.

The motion was seconded by Mr. Kanehira and carried by unanimous vote.

#### OTHER BUSINESS

Kaiser Foundation Health Plan, Inc.

#### **KP Platinum - \$14 Plan**

Kaiser informed the Department of changes made to the plan effective January 1, 2022 and requested continued approval of the plan under Section 393-7(a).

Ms. Goya stated there were no new concerns listed; and that the concerns were the same as the other plans.

Mr. Hogan commented it was understood that all language or terminology changes discussed would apply unanimously to all motions for the individual plans. Chair Marx confirmed and stated the minutes would reflect the comments on each plan being reviewed and accepted or denied based on the Council's recommendation.

Ms. Pang questioned if unexpected mass population immunizations were covered. Ms. Goya confirmed it was covered.

A motion was made by Ms. Shimomura to recommend continued approval of the plan under Section 393-7(a) provided:

1. The blank Riders page in the Guide is deleted;
2. The language for Related Item Exclusion is amended so that services are not automatically excluded when a service is not listed;
3. The references to Page # 30 under the Total Care Services heading in the Benefit Summary section is deleted; and

4. The reference to the 2016 contracts example under the Benefit Description for Orthodontic Care for the Treatment of Orofacial Anomalies (from birth) is deleted.

The motion was seconded by Ms. Pang and carried by unanimous vote.

Chair Marx asked Kaiser to provide a general overview of the process for having various plans, \$14, \$15, and \$20, and why the difference of co-payments when there was a dollar amount increment. Mr. Hertzog responded that historically the \$14, \$15, and \$20 were the market standard for mid-large groups, and when ACA regulations became a requirement, Kaiser began submitting small group specific plans to comply with the Department of Insurance for ACA plans.

### **KP Platinum - \$15 Plan**

Kaiser informed the Department of changes made to the plan effective January 1, 2022 and requested continued approval of the plan under Section 393-7(a).

Ms. Shimomura questioned if occupational therapy outpatient cost share was \$15 per visit as stated in the plan document or \$20 per visit as stated in the DCD review form. Ms. Messay Sanderson of Kaiser confirmed the benefit for occupational therapy outpatient cost share was \$15, as stated in the plan document.

A motion was made by Ms. Shimomura to recommend continued approval of the plan under Section 393-7(a) provided:

1. The blank Riders page in the Guide is deleted;
2. The language for Related Item Exclusion is amended so that services are not automatically excluded when a service is not listed;
3. The references to Page # 30 under the Total Care Services heading in the Benefit Summary section is deleted; and
4. The reference to the 2016 contracts example under the Benefit Description for Orthodontic Care for the Treatment of Orofacial Anomalies (from birth) is deleted.

The motion was seconded by Mr. Kanehira and carried by unanimous vote.

### **KP Platinum I - \$20 Plan**

Kaiser informed the Department of changes made to the plan effective January 1, 2022 and requested continued approval of the plan under Section 393-7(a).

Ms. Goya stated that she had no additional comments concerning the plan.

A motion was made by Ms. Pang to recommend continued approval of the plan under Section 393-7(a) provided:

1. The blank Riders page in the Guide is deleted;

2. The language for Related Item Exclusion is amended so that services are not automatically excluded when a service is not listed;
3. The references to Page # 30 under the Total Care Services heading in the Benefit Summary section is deleted; and
4. The reference to the 2016 contracts example under the Benefit Description for Orthodontic Care for the Treatment of Orofacial Anomalies (from birth) is deleted.

The motion was seconded by Ms. Shimomura and carried by unanimous vote.

### **KP Gold I - \$20 Plan**

Kaiser informed the Department of changes made to the plan effective January 1, 2022 and requested continued approval of the plan under Section 393-7(a).

Ms. Goya stated that she had no additional comments concerning the plan.

A motion was made by Mr. Hogan to recommend continued approval of the plan under Section 393-7(a) provided:

1. The blank Riders page in the Guide is deleted;
2. The language for Related Item Exclusion is amended so that services are not automatically excluded when a service is not listed;
3. The references to Page # 30 under the Total Care Services heading in the Benefit Summary section is deleted; and
4. The reference to the 2016 contracts example under the Benefit Description for Orthodontic Care for the Treatment of Orofacial Anomalies (from birth) is deleted.

The motion was seconded by Mr. Kanehira and carried by unanimous vote.

### **Kaiser Permanente Group \$25/\$150 (20% Lab, Imaging, and Testing) Plan**

Kaiser informed the Department of changes made to the plan effective January 1, 2022 and requested continued approval of the plan under Section 393-7(b).

Ms. Goya stated that she had no additional comments concerning the plan.

Ms. Shimomura questioned how to compare a plan with a percentage-based co-insurance (e.g. a 80% hospital benefit) to a plan with a copay (e.g. \$150 per day). She questioned what the cost of a hospital room was currently. Mr. Young stated he was not able to provide any local information and deferred to Ms. Goya and Mr. Hertzog to provide that information later. Mr. Hogan commented on how Kaiser's model versus the fee-for-service model was different and that providing this feedback would be of value.

(2:52 p.m. Ms. Shimomura lost connection with the meeting.)

Chair Marx stated that the Council would hold off on any further discussion on the \$150 a day amount, subject to further clarification from Kaiser.

A motion was made by Mr. Kanehira to recommend continued approval of the plan under Section 393-7(b) provided:

1. The blank Riders page in the Guide is deleted;
2. The language for Related Item Exclusion is amended so that services are not automatically excluded when a service is not listed;
3. The references to Page # 30 under the Total Care Services heading in the Benefit Summary section is deleted; and
4. The reference to the 2016 contracts example under the Benefit Description for Orthodontic Care for the Treatment of Orofacial Anomalies (from birth) is deleted.

The motion was seconded by Mr. Hogan and carried by unanimous vote.

### **KP Gold - \$15 Plan**

Kaiser informed the Department of changes made to the plan effective January 1, 2022 and requested continued approval of the plan under Section 393-7(b).

(2:55 p.m. Ms. Shimomura rejoined the meeting via phone.)

Ms. Goya stated that she had no additional comments concerning the plan.

A motion was made by Ms. Pang to recommend continued approval of the plan under Section 393-7(b) provided:

1. The blank Riders page in the Guide is deleted;
2. The language for Related Item Exclusion is amended so that services are not automatically excluded when a service is not listed;
3. The references to Page # 30 under the Total Care Services heading in the Benefit Summary section is deleted; and
4. The reference to the 2016 contracts example under the Benefit Description for Orthodontic Care for the Treatment of Orofacial Anomalies (from birth) is deleted.

The motion was seconded by Ms. Shimomura and carried by unanimous vote.

### **ADJOURNMENT**

Meeting adjourned at 2:58 p.m. The next meeting was tentatively scheduled for December 2, 2021 with a tentatively scheduled back-up meeting for December 9, 2021.