

**PREPAID HEALTH CARE ADVISORY COUNCIL MEETING**

**State of Hawaii  
Department of Labor and Industrial Relations  
830 Punchbowl Street, Room 320  
Honolulu, HI 96813**

**August 30, 2018  
1:45 p.m. to 3:20 p.m.**

Council members present

Mr. Paul Tom, Chair  
Mr. Michael Moss  
Dr. John McDonnell  
Ms. Laudra Eber  
Mr. Paul Marx  
Ms. Carol Shimomura

Council member not present

Ms. Sharon Leng

DC Staff Present

Marisa Yagi  
Misty Sumida

Others Present

Tammy Vitolo, HWMG  
Paul Kaiser, HWMG  
Austin Bunag, HMSA  
Adam Rosenberg, Attorney General's Office

With a quorum present, Chair Tom called the meeting to order at 1:45 p.m.

APPROVAL OF MINUTES

Chair Tom asked if there were any corrections, amendments, deletions, or changes to the circulated minutes of the June 28, 2018 meeting. There were no corrections, amendments, deletions, or changes. A motion was made by Dr. McDonnell to approve the June 28, 2018 meeting minutes as circulated. The motion was seconded by Ms. Eber and carried by unanimous vote.

REVIEW OF PLANS

Community Counselling Service Co., LLC  
Self-funded



Community Counselling Service Open Access Core (Hawaii) Plan

This EPO medical plan has no individual deductible, 100% benefit and \$3,000 out-of-pocket limit including copayments.

Ms. Eber inquired about the network for the plan. Chair Tom requested the staff have the employer confirm whether the plan uses MDX Hawaii's provider network.

Ms. Shimomura questioned whether the plan is to be effective 2008. Chair Tom requested staff check the effective date of the plan for Hawaii employees.

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

1. Medically necessary surgical and non-surgical treatment of obesity is covered, and
2. Exclusion of payment for or in connection with an injury or illness arising out of, or in the course of, any employment for wage or profit is replaced with a subrogation clause entitling the insurer a right to recovery.

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

MITRE Corporation

Self-funded

Aetna Choice POS II-100/80 Plan (Flex Care PPO) for Hawaii Population

This PPO medical plan has a \$0 (PPO)/\$100 (NPO) individual deductible, 100% (PPO)/80% (NPO) benefit and \$1,000 (all) out-of-pocket limit including the deductible and copayments.

The Council discussed the exclusion of benefits for non-urgent use of an urgent care provider. It was noted that other provisions of the plan inform the participant that non-urgent use may not be covered by the plan, so the exclusion should be deleted.

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

1. NPO benefit, after the penalty for noncompliance with the preadmission certification program, is at least a 70% benefit with a maximum penalty of \$400/admission and, in the aggregate, \$1000/year;
2. Cornea transplants are covered;
3. Physical therapy is covered for at least 30 visits each year;
4. Medically necessary surgical and non-surgical treatment of obesity are covered;
5. Exclusion of benefits for surrogates is modified to cover the insured who is a surrogate;
6. Exclusion of benefits for non-urgent use of urgent care provider is removed; and
7. Full medical coverage is continued for a disabled employee for at least three months following the month of disability.

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

AstraZeneca Pharmaceuticals LP

Self-funded

Hawaii Choice POS II

This PPO medical plan has a \$0 (PPO)/ \$200 (NPO) individual deductible, 100% (PPO)/80% (NPO) benefit and \$1,300 (PPO)/\$1,800 (NPO) (all) out-of-pocket limit including the deductible and copayments.

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

1. Waiting period requirement for late enrollees is waived when coverage is required due to a termination of the Form HC-5 waiver;
2. NPO benefit, after the penalty for noncompliance with the preadmission certification program, is at least a 70% benefit with a maximum penalty of \$400/admission and, in the aggregate, \$1000/year;
3. At least 48 hours are allowed to report emergency admissions to the insurer for certification program;
4. At least 12 well-child (preventive) care visits are covered without a deductible for children under age 6 whether services are received in- or out-of-network;
5. Skilled nursing facility is covered for at least 100 days each year;
6. Speech and physical therapy are each covered for at least 30 visits per year;
7. Outpatient blood transfusions and dialysis are covered;
8. Exclusion of services provided by a spouse, domestic partner, parent, child, step-child, brother, sister, in-law or any household member is modified to exclude only services furnished by a parent, child, or spouse of the insured;
9. Exclusion of any care in a hospital or other facility owned or operated by any federal, state or other governmental entity is removed;
10. Exclusion of benefits when a source of coverage or reimbursement will be considered available even if the right to payment from that source was waived is removed;
11. Exclusion of benefits for any services and supplies related to births occurring in the home or in a place not licensed to perform deliveries is modified to cover such services and supplies in emergency situations;
12. Exclusion of benefits for surrogates is modified to cover the insured who is a surrogate; and
13. Full medical coverage is continued for a disabled employee for at least three months following the month of disability.

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

Stantec Consulting Services Inc

Self-funded

Stantec Open Access Plus Medical Benefits (Hawaii) HRA Plan

This PPO medical plan has a \$900 (all) individual deductible, 80% (PPO)/70% (NPO) benefit and \$3,000 (all) out-of-pocket limit including the deductible and copayments. The employer funds a health reimbursement account (HRA) in the amount of \$600/year for employee-only coverage and \$1,000/year for family coverage.

The Council discussed that as a result of prorating the HRA funding when an employee begins employment mid-year, the HRA may not offset the deductible to an acceptable amount.

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

1. Annual individual deductible (with HRA funding) is capped at \$350 (PPO/NPO combined);
2. Annual individual out-of-pocket limit (with HRA funding) is capped at \$3000 (PPO/NPO combined) including the deductible and all copayments;
3. Liability for payment of premium is compliant with the PHC Act;
4. Professional nursing services provided by a nurse, other than a member of your family or your dependent's family is modified to professional nursing services provided by a nurse, other than a parent, child, or spouse of the insured;
5. Exclusion of Home Health Services and Hospice Services by a person who is a parent, child or spouse who normally resides in your house or your dependent's house is modified to exclude services furnished by a parent, child, or spouse of the insured; and
6. Special enrollment rights are allowed when coverage is required due to a termination of the HC-5 waiver.

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

Harrington Industrial Plastics LLC  
CIGNA Health and Life Insurance Company



Open Access Plus Medical Benefits

This PPO medical plan has a \$0 (PPO)/\$100 (NPO) individual deductible, 90% (PPO)/70% (NPO) benefit and \$2,500 (PPO)/\$3,000 (NPO) (all) out-of-pocket limit including the deductible and copayments.

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

1. Coverage of charges made by a Nurse, other than a member of your family or your Dependent's family, for professional nursing service is modified to exclude only charges made by a Nurse who is the insured's parent, child, or spouse;
2. Exclusion of home health services and hospice services by a person who is a parent, child or spouse who normally resides in your house or your Dependent's house is modified to exclude only services provided by a parent, child, or spouse of the insured; and
3. Exclusion of charges made by any covered provider who is a member of your family or your Dependent's family is modified to exclude only charges made by a provider who is a parent, child, or spouse of the insured.

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

Level Access, Inc.

CIGNA Health and Life Insurance Company

Open Access Plus HI Plan

This PPO medical plan has a \$300 (all) individual deductible, 80% (PPO)/70% (NPO) benefit and \$3,000 (all) out-of-pocket including the deductible and copayments.

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

1. Either the urgent care copayment or coinsurance requirement is removed;
2. Coverage of charges made by a Nurse, other than a member of your family or your Dependent's family, for professional nursing service is modified to exclude only charges made by a nurse who is the insured's parent, child, or spouse;
3. Exclusion of home health services and hospice services by a person who is a member of your family or your Dependent's family or who normally resided in your house or your Dependent's house is modified to exclude only home health services and hospice services by a parent, child, or spouse of the insured; and
4. Full medical coverage is continued for a disabled employee for at least three months following the month of disability.

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

Vector Oncology Solutions, LLC

CIGNA Health and Life Insurance Company

Open Access Plus Medical Benefits (Hawaii) Plan

This PPO medical plan has a \$300 (all) individual deductible, 80% (PPO)/70% (NPO) benefit and \$3,000 (PPO)/\$9,000 (NPO)(all) out-of-pocket including the deductible and copayments.

The Council discussed patient liability if a participating provider did not obtain prior authorization for services. Chair Tom asked Paul Kaiser of HWMG about participating providers obtaining preauthorization for HMAA's 7(a) plans. Mr. Kaiser stated HMAA's contracts with the participating providers require the providers, not the patients, to obtain the preauthorization. Chair Tom stated that while it is up to each insurer to write its provider contracts, the insurer's plan cannot limit coverage for patients using participating providers. Mr. Moss added that it would be confusing for providers to have different language in the provider contracts for 7(a) and 7(b) plans. Chair Tom summarized that the penalty for failing to obtain preauthorization would not apply to a patient who goes to a participating provider, so the patient should not receive a PPO benefit less than 80% on a 7(b) plan.

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

1. Medically necessary surgical and non-surgical treatment of obesity is covered;
2. Professional nursing services provided by a nurse, other than a member of your family or your dependent's family is modified to professional nursing services provided by a nurse, other than a parent, child, or spouse of the insured;
3. Exclusion of benefits for covered services for, or in connection with an injury or sickness arising out of, or in the course of, any employment for wage or profit is replaced with a subrogation clause entitling the insurer a right to recovery;
4. Exclusion of Home Health Services and Hospice Services by a person who is a parent, child or spouse who normally resides in your house or your dependent's house is modified to exclude services furnished by a parent, child, or spouse of the insured; and
5. Special enrollment rights are allowed when coverage is required due to a termination of the HC-5 waiver.

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

## OTHER BUSINESS

### UnitedHealthcare Insurance Company UnitedHealthcare Options PPO

UnitedHealthcare Insurance Company is informing the Department of changes and clarifications being made to the plan effective January 1, 2018. UnitedHealthcare is requesting continued approval of the plan under Section 393-7(a).

The plan excludes services provided at freestanding facilities or diagnostic hospital-based facilities without an order written by a physician or other provider, services self-directed to a freestanding facility or diagnostic hospital-based facility, services ordered by a physician or other provider who is an employee or representative of a freestanding facility or diagnostic hospital-based facility when that physician or other provider has been involved in the patient's medical care prior to ordering the service, or is not involved in the patient's medical care prior to ordering the service, or is not involved in the patient's medical care after the service is received. Ms. Eber was concerned how this would affect urgent care since a person usually does not have a written order to seek urgent care. The Council discussed the exclusion and determined it is not acceptable.

The Council discussed the exclusion of rehabilitation services for speech therapy. Dr. McDonnell explained that speech therapist may be used for issues other than speech impediments. One example is that patient with asthma may need to see speech therapist for a swallowing study. Chair Tom said that the exclusion is not acceptable as it does not say what is excluded, only what is included.

Ms. Eber was concerned that the plan should not be a 7(a) plan because it requires all plan participants to obtain preauthorization approval instead of requiring providers in the PPO network to obtain preauthorization approval on behalf of plan participants using PPO providers, and subjects the plan participants using the PPO network to a penalty if preauthorization approval is not obtained. This is evident because the Prior Authorization Requirement states that

the amount the plan participant will be required to pay if no preauthorization approval is obtained, “will be increased to 30%,” which is already the NPO coinsurance. The increase must, therefore, refer to an increase to the PPO coinsurance. The plan also states there is a “maximum penalty” of \$400 per incident but does not set a maximum total penalty per year. The plan used to have a \$1000 maximum for the total penalties per year but the new phrasing caps the 30% coinsurance, not the total penalty, at \$1000.

Chair Tom agreed that the prevalent plan requires the PPO providers to obtain preauthorization approval for the insured.

Ms. Eber was also concerned that the plan could use an eligible charge of 50% of Center for Medicare and Medicaid Services rates for some NPO services if there is no negotiated eligible charge. Chair Tom felt this was not typical of current plans. In the past, plans had a lower NPO eligible charge but that was before HMSA’s PPP became the prevalent plan.

Chair Tom suggested the plan was significantly different than the prevalent plan, so the contractor should be asked to mimic the prevalent plan and refile the plan.

The Council discussed possible motions.

A motion was made by Ms. Eber to recommend disapproval of the plan with the changes and clarifications effective January 1, 2018 under Section 393-7(a). The motion was seconded by Dr. McDonnell and carried by unanimous vote.

As a result of the review for continued approval, an additional motion was made by Ms. Eber to recommend disapproval of the current plan under Section 393-7(a), recommend the insurer resubmit the plan in total to comply with the prevalent plan if the insurer desires approval under Section 393-7(a), and find the insurer is not in compliance. The motion was seconded by Dr. McDonnell and carried by unanimous vote.

#### ADJOURNMENT

Chair Tom adjourned the meeting at 3:20 p.m. The next meeting is tentatively scheduled for November 8, 2018.