Draft

Prepaid Health Care Advisory Council Meeting

State of Hawaii
Department of Labor and Industrial Relations
830 Punchbowl Street, Room 210
Honolulu, HI 96813

Also via Microsoft Teams

April 19, 2022
1:33 p.m. to 2:30 p.m.

Council members present
Ms. Carol Shimomura
Ms. Bonnie Pang (Acting Chair)
Mr. Mike Hogan
Mr. Derek Kanehira
Ms. Winona White
Dr. John McDonnell (1:47pm)

Council member absent
Mr. Paul Marx, Chair

DC Staff Present
Royden Koito
Misty Sumida
Marisa Yagi
Stacey Hiranaka

With a quorum present, Ms. Pang called the meeting to order at 1:33 p.m.

APPROVAL OF MINUTES

Ms. Pang asked if there were any changes to the circulated minutes of the February 17, 2022 meeting.

A motion was made by Mr. Hogan to accept the minutes as circulated. The motion was seconded by Mr. Kanehira and the minutes were approved as presented.

OTHER BUSINESS

Hawaii Management Assurance Association (HMAA)

HMAA was represented by Mr. Paul Kaiser.

Option Plus One

HMAA informed the Department of changes made to the plan to be effective January 1, 2023 and requested continued approval of the plan under Section 393-7(a).

Mr. Kaiser stated the changes made to the plan were either non-substantive clarifications, revisions to comply with the prevalent plan (i.e., incontinence supplies), clarifications for ongoing compliance with federal or state law, and additional new definitions.

Mr. Kanehira questioned if question four in the summary of provider categories chart was contradictory. Question four stated, "Do you pay the provider deductibles, copayments and coinsurance? If so, we send benefit payment directly to the provider." The chart went on to state for the non-participating provider (in or out-of-state) "Yes, and you may need to pay the provider in full if we send benefit payments to you." Ms. Vitolo (from HMAA) stated the language changes were made to comply with the federal law regarding the No Surprises Act (NSA). She explained that some claims submitted by non-participating providers cannot be balanced billed and would need to go through a different process (i.e., processed through the NSA or the standard process). Mr. Kanehira suggested deleting the sentence, "If so, we send benefit payment directly to the provider." By deleting this sentence, the contradiction would be removed and would support the NSA requirement. Mr. Kaiser stated the NSA requires certain types of bills to be paid to out-of-network providers for emergent or for services rendered in the hospital setting when a person would not have the decision-making authority to choose a particular provider (e.g. for services rendered by an anesthesiologist or pathologist). This requirement does not apply to all claims so HMAA could have some claims being paid to the member in a non-participating situation. Mr. Kanehira questioned if the correct response under the non-participating provider column would be changed from "Yes" to, "Perhaps, and you may need to pay the provider in full if we send benefit payments to you." Mr. Kaiser confirmed HMAA could use "perhaps" in all plans considered. Mr. Hogan concurred.

Ms. Shimomura requested clarification on the special benefits for women, specifically well women exams which were covered at 20% non-participating cost to the patient as compared to a well care visit for adults (as notated in the DCD review form) which were covered for $10 copayment plus 80% non-participating benefit. She questioned if the $10 copayment was an error, and the DCD review form should only state 80% non-participating benefit. Mr. Kaiser confirmed the plan document would take precedence and stated the benefit for a well woman exam by a non-participating provider would be 80%.

Dr. McDonnell joined the meeting.

Ms. Shimomura questioned the behavioral health non-participating benefits for Hospital & Facility Services - Inpatient. According to the plan, the patient's portion of the cost for a non-participating provider is $200 (per 1st confinement in calendar year) + 20%. Ms. Shimomura said that the DCD review form, however, truncated that cost to "$200 (per 1st confinement in calendar y." Ms. Shimomura also questioned the Physician's Services – Outpatient. According to the

plan, the cost to the patient is $10 + 20% for non-participating provider; however, the chart shows the benefit as 80%. Mr. Kaiser confirmed that the plan was correct. Ms. Shimomura also questioned the Physician Services – Inpatient. According to the plan, the cost to the patient is 20%, but the chart shows the cost to be "$200 (per 1st confinement …). Mr. Kaiser confirmed the costs and benefits were as stated in the plan document.

Ms. White questioned where the pre-admission certification penalty was located in the document; adding if the approval was not received, would the benefits be denied? Ms. Pang stated the document referred to Chapter Eight, dispute resolution, but no details were found. Ms. Shimomura questioned if the penalty was the denial of benefits versus a penalty of a dollar amount. HMAA confirmed the penalty was the denial of benefits. Mr. Kaiser stated HMAA would add a sentence to the plan document for clarification. Ms. White suggested to add language informing the claimant that all services being denied would be the responsibility of the claimant. Mr. Kaiser stated if the claimant elected to have the procedure without a pre-admission certification, the claimant would be responsible for the cost. Mr. Hogan concurred.

Ms. Pang questioned if HMAA's HiDoc service had contact information such as a website or phone number for the member and the plan sponsor to reference. Mr. Kaiser stated HMAA would add this information.

Mr. Kanehira commented on the additional language regarding extended care facility. The plan document read, "Care is for skilled nursing case, sub-acute care, or long-term acute care rendered in an extended care facility." Mr. Kaiser stated the more appropriate word for "case" would be "care". Mr. Kanehira agreed. Mr. Kaiser agreed to change the word across all plans.

Ms. Shimomura questioned if the non-participating benefit for hospice care was 100%. Mr. Kaiser confirmed.

Ms. Pang questioned the procedure regarding eligibility for coverage and the enrollment process. She questioned if a member did not submit their enrollment form within the four-week window, would an exception be allowed to enroll in the plan after the fact. Mr. Kaiser stated HMAA would evaluate the situation on a case-by-case basis, further exploring the cause of the situation. Ms. Pang asked if there was a time limit for the review. Mr. Kaiser explained HMAA would look at all the issues surrounding the facts and circumstances of that particular situation. He stated it was easier if the incident occurred within three months of the date and HMAA may ask the member to answer some medical questions. HMAA wanted to ensure the late enrollment was not done intentionally.

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

1. The language is amended to clarify if HMAA will send benefit payments directly to the provider or the member based on the circumstance;

2. The language is amended to inform the member they could be responsible for expenses from a non-participating provider if they do not receive an authorization from HMAA for pre-certification;
3. The language is amended to include contact information (website or phone number) for HiDoc services; and
4. "Extended case facility" is corrected to "Extended care facility."

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

Option Plus Two

HMAA informed the Department of changes made to the plan to be effective January 1, 2023 and requested continued approval of the plan under Section 393-7(a).

Mr. Kaiser stated the changes made in Options Plus One will be implemented in Options Plus Two.

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

1. The language is amended to clarify if HMAA will send benefit payments directly to the provider or the member based on the circumstance;
2. The language is amended to inform the member they could be responsible for expenses from a non-participating provider if they do not receive an authorization from HMAA for pre-certification;
3. The language is amended to include contact information (website or phone number) for HiDoc services; and
4. "Extended case facility" is corrected to "Extended care facility."

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

Comprehensive Plus Plan

HMAA informed the Department of changes made to the plan to be effective January 1, 2023 and requested continued approval of the plan under Section 393-7(a).

Mr. Kaiser stated the changes made in the previous plan will be implemented in the Comprehensive Plus Plan.

Mr. Kanehira questioned why the plan document omitted the question in the summary of provider categories grid regarding the lowering of coinsurance percentage. Mr. Kaiser stated the question was not applicable.

Mr. Hogan mentioned the benefits for physical and occupational (outpatient) therapy for the NPO in the DCD review form conflicted with what was in the Plan. The benefit in the Plan was

80% NPO, while the benefit in the Review Sheet was 80% NPO for 90 days. Mr. Kaiser confirmed the benefits were as stated in the plan document.

Mr. Hogan mentioned the DCD review form appeared to have been missing information regarding the benefits for naturopathic services. The benefit was 80% PPO and 80% NPO up to a combined annual maximum of $1,000 per the plan document, but the review form did not identify the $1,000 maximum. Mr. Kaiser confirmed the benefits were as stated in the plan document.

Ms. Shimomura questioned if the physician surgical services (cutting surgery) should be a 90% benefit versus an 80% benefit. Mr. Kaiser confirmed the benefit was 80%.

Ms. Shimomura questioned if pregnancy termination was omitted in error from the special benefits for women section. Mr. Kaiser stated the omitted section was an oversight and that HMAA would include the language in the plan document.

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

1. The language is amended to clarify if HMAA will send benefit payments directly to the provider or the member based on the circumstance;
2. The language is amended to inform the member they could be responsible for expenses from a non-participating provider if they do not receive an authorization from HMAA for pre-certification;
3. The language is amended to include contact information (website or phone number) for HiDoc services;
4. “Extended case facility” is corrected to “Extended care facility;” and
5. Pregnancy termination is covered.

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

HMAA 90/10 PPO Plan

HMAA informed the Department of changes made to the plan to be effective January 1, 2023 and requested continued approval of the plan under Section 393-7(a).

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

1. The language is amended to clarify if HMAA will send benefit payments directly to the provider or the member based on the circumstance;
2. The language is amended to inform the member they could be responsible for expenses from a non-participating provider if they do not receive an authorization from HMAA for pre-certification;
3. The language is amended to include contact information (website or phone number) for HiDoc services; and

4. "Extended case facility" is corrected to "Extended care facility."

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

HMAA PPO (7B)

HMAA informed the Department of changes made to the plan to be effective January 1, 2023 and requested continued approval of the plan under Section 393-7(b).

Mr. Kaiser stated the similar changes made to the 7(a) plans would be made to the 7(b) plan.

Ms. Shimomura questioned the difference between the behavioral health (mental health and substance abuse) section of the benefit and payment chart versus the DCD review form. She stated the plan document indicated the physician services (outpatient) was $15 participating copayment and $25 non-participant copayment but highlighted that the DCD review form indicated 80% participating provider and 75% non-participating provider benefits. Mr. Kaiser confirmed the benefits were as stated in the plan document.

Ms. Shimomura questioned the difference between the behavioral health (mental health and substance abuse) section of the benefit and payment chart versus the DCD review form. She stated the plan document indicated the physician services (inpatient) was 100% participating provider benefit and 75% non-participating provider benefits but highlighted that the DCD review form indicated 80% participating provider and 75% non-participating provider benefits. Mr. Kaiser confirmed the benefits were as stated in the plan document.

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

1. The language is amended to clarify if HMAA will send benefit payments directly to the provider or the member based on the circumstance;
2. The language is amended to inform the member they could be responsible for expenses from a non-participating provider if they do not receive an authorization from HMAA for pre-certification;
3. The language is amended to include contact information (website or phone number) for HiDoc services; and
4. "Extended case facility" is corrected to "Extended care facility."

The motion was seconded by Dr. McDonnell and carried by unanimous vote.

Executive Plan Option (EPO)

HMAA informed the Department of changes made to the plan to be effective January 1, 2023 and requested continued approval of the plan under Section 393-7(b).

Mr. Kaiser stated the similar changes made to the PPO 7(b) would be made to the EPO plan.

Mr. Hogan mentioned the DCD review form appeared with missing information regarding the deductible for vision, dental, prescribed drug, or other categories of benefits. As per the plan document, the benefit was up to a combined annual maximum of $1,000. Mr. Kaiser confirmed.

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

1. The language is amended to clarify if HMAA will send benefit payments directly to the provider or the member based on the circumstance;
2. The language is amended to inform the member they could be responsible for expenses from a non-participating provider if they do not receive an authorization from HMAA for pre-certification;
3. The language is amended to include contact information (website or phone number) for HiDoc services; and
4. “Extended case facility” is corrected to “Extended care facility.”

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

Mr. Kanehira commented on the helpfulness of definitions as related throughout the document. He suggested for the future to ensure the definitions in the document align with the definitions in the glossary. Mr. Kanehira gave the example of the definition found in the document for benefit maximum and how the document addressed services and supplies; but the glossary addressed only services. Mr. Kaiser stated HMAA would make the changes in the 2024 documents.

ADJOURNMENT

Meeting adjourned at 2:30p.m. The next meeting was tentatively scheduled for June 14, 2022 with a tentatively scheduled back-up meeting for June 22, 2022.