

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

June 14, 2022
1:33 p.m. to 3:43 p.m.

Council members present

Ms. Carol Shimomura
Ms. Bonnie Pang
Mr. Mike Hogan (Acting Chair)
Mr. Derek Kanehira
Ms. Winona White
Dr. John McDonnell (2:10 pm)

Council member absent

Mr. Paul Marx, Chair

DC Staff Present

Royden Koito
Misty Sumida
Marisa Yagi
Stacey Hiranaka

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

APPROVAL OF MINUTES

Mr. Hogan asked if there were any changes to the circulated minutes of the April 19, 2022 meeting.

A motion was made by Mr. Kanehira to accept the minutes as circulated. The motion was seconded by Ms. Shimomura and carried by unanimous vote.

OTHER BUSINESS

University Health Alliance (UHA)

UHA was represented by Ms. Alyson Estrella and Ms. Jennifer Barad.

UHA 600

UHA 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. Hogan addressed Line 63 of the DCD review form (Summary of Plan Changes) that compares 2022 to 2023 the document updates regarding the policy name change, addition of licensed clinical social worker, addition of licensed mental health counselor, and addition of civil union partner under the infertility treatment section. Mr. Hogan further stated that these changes were made uniformly across the plans.

Ms. Estrella stated UHA reviewed the prior authorization language as related to transplant evaluation. If the transplant was evaluated in Hawaii, a prior authorization was not required, but if the transplant was evaluated on the mainland, a prior authorization was required. UHA removed the prior authorization for artificial insemination and outdated language from the section related to COBRA. UHA added language regarding dental anesthesia to match the prevalent plan.

Ms. White questioned the significance of changing the terminology for the policy name from “Referrals for Out-of-State Services” to “Out-of-State Referrals for Medical Services”. Ms. Estrella confirmed the policy name was updated to be consistent with the current policy on the website.

Mr. Kanehira questioned the definition of co-payment. The medical benefits guide (MBG) identified the co-payment as a flat fee (typical of co-payment) or a percentage of eligible charge (typical of coinsurance). The glossary had definitions for co-payments and coinsurance. Ms. Estrella stated UHA would update the language to reflect both distinctions of co-payment as related to a dollar amount and coinsurance as related to a percentage of eligible charge.

Ms. Shimomura questioned if hospital and facility services inpatient, psychological testing, should be covered at 20% coinsurance PPO as stated on the DCD review form or 10% coinsurance PPO as stated in the MBG. Ms. Estrella stated the MBG for hospital and facility services inpatient, psychological testing, should be covered at 10% coinsurance PPO and 30% coinsurance NPO.

Ms. Shimomura questioned which certain chemotherapy treatments require prior authorization. The MBG stated chemotherapy was covered, and prior authorization was not required unless the recommended treatment plan does not conform to one of the nationally recognized oncology compendia. Ms. Estrella hypothesized the prior authorization would be for the administered drug and referred to the website for an approved list. She assumed if the oncologist was prescribing or recommending a medication for chemotherapy, they would refer to the website or call health care services and explained this was not her area of expertise. Ms. Shimomura’s question was referring to the treatment plan, not the drug plan but concluded it was best to consult a physician.

Mr. Kanehira stated that oral chemotherapy drugs were covered, but only when a member does not have a prescription drug plan which provides coverage for oral chemotherapy. He questioned which drugs were covered. Ms. Estrella explained the oral chemotherapy drugs were listed on the UHA website. She elaborated that there was a certain subset of oral medications that were required to be covered under the medical plan if the member did not have a prescription drug plan and to determine whether the oral chemotherapy drug required prior authorization, the member should refer to the website. Ms. Estrella stated the benefit of coverage for oral chemotherapy drugs would only be provided under the state mandated benefit under this medical plan if the member did not have a drug plan.

Ms. Pang questioned what the member cost share was for telehealth. Ms. Estrella stated the member cost share would be the same as a visit not done through telehealth. Ms. Pang suggested to include this clarifying language under Physician's Services of the MBG. Ms. Estrella confirmed that UHA would make the changes.

Ms. White questioned the significance of adding the word "licensed" to clinical social worker and mental health counselor and stated the 2022 version provided clearer language. Ms. Estrella confirmed that UHA would revert to the language stated in the 2022 version.

Ms. Pang questioned if the reference to the UHA's preferred drug list was changed to step therapy drug list and if the intended change was the same reference. Ms. Estrella confirmed that UHA would make the appropriate changes.

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 ensure the definitions in the glossary for co-payment and coinsurance are aligned with the definitions in the medical benefits guide;
2. The language is amended to clarify that the cost share for physician services through telehealth is the same as for services received in-person; and
3. "Licensed" will be removed from clinical social worker and mental health counselor.

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

UHA 600-S

UHA 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).

Ms. Estrella stated UHA was agreeable to make all changes and clarifications that were discussed previously. She stated the plan was the small group ACA offering and changes were specific to the required coverage for the drug plan.

Ms. Shimomura questioned if physician emergency room visits should be covered at 10% coinsurance PPO and 30% coinsurance NPO as stated on the DCD review form or 10%

coinsurance PPO and NPO as stated in the MBG. Ms. Estrella confirmed the physician emergency room visit was 10% coinsurance PPO and NPO as stated in the MBG.

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

1. The language is amended to ensure the definitions in the glossary for co-payment and coinsurance are aligned with the definitions in the medical benefits guide;
2. The language is amended to clarify that the cost share for physician services through telehealth is the same as for services received in-person; and
3. “Licensed” will be removed from clinical social worker and mental health counselor.

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

UHA 600-T

UHA 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).

Ms. Estrella stated UHA was agreeable to make all changes and clarifications to this plan that were discussed in UHA 600 and UHA 600-S, and that the plan changes were specific to drug coverage as an essential health benefit. Ms. Estrella also stated that all language changes made would be uniform across the plans being presented.

Ms. Shimomura questioned if hospital and facility services inpatient, psychological testing, should be covered at 20% coinsurance PPO as stated on the DCD review form or 10% coinsurance PPO as stated in the MBG. Ms. Estrella stated the MBG for hospital and facility services inpatient, psychological testing, should be covered at 10% coinsurance PPO and 30% coinsurance NPO.

Ms. Shimomura questioned if the prescription drug benefit should be covered at \$10 co-payment (generic), \$35 co-payment (preferred brand), and \$65 co-payment (non-preferred brand) as stated on the DCD review form or \$10 co-payment (generic), \$30 co-payment (preferred brand), and \$65 co-payment (non-preferred brand) as stated in the MBG. Ms. Estrella confirmed the MBG was correct.

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

1. The language is amended to ensure the definitions in the glossary for co-payment and coinsurance are aligned with the definitions in the medical benefits guide;
2. The language is amended to clarify that the cost share for physician services through telehealth is the same as for services received in-person; and
3. “Licensed” will be removed from clinical social worker and mental health counselor.

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

UHA 3000

UHA 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).

Ms. Estrella stated UHA was agreeable to make all changes and clarifications that were discussed previously.

Ms. Shimomura questioned if the plan was filed as a 7(a) plan, referencing the previously approved annual deductible of \$200 (individual) and \$600 (family). Ms. Pang and Ms. Estrella stated the deductibles haven't changed.

Ms. Shimomura questioned if the co-payment for intensive medical care while hospitalized was \$12. Ms. Estrella stated their interpretation of the DCD review form was related to the physician services. She stated the hospital facility services coinsurance was 20% PPO and NPO.

Dr. McDonnell stated the hospital intensive care treatment was very intense. The intensivist would code the visit and procedure appropriately. He was unsure if the extra \$12 would cover the care being provided. Dr. McDonnell gave an example of coding a swan dance catheter placement that was built a certain way and should be covered according to the appropriate code. He thought the hospital may obtain \$12 per day, but there was more nursing care that was performed in an intensive care unit, that \$12 did not seem sufficient notating the high cost for moving into an intensive care unit.

Ms. Estrella requested clarity from the Department regarding the physician and hospital facility services section in the DCD review form as related to the MBG. She stated UHA would provide additional information if necessary. Ms. White commented on the sections being discussed were more descriptive of the physician services, whereas the hospitalization services were disbursed throughout the MBG.

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 ensure the definitions in the glossary for co-payment and coinsurance are aligned with the definitions in the medical benefits guide;
2. The language is amended to clarify that the cost share for physician services through telehealth is the same as for services received in-person; and
3. "Licensed" will be removed from clinical social worker and mental health counselor.

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

UHA 3000-S

UHA 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).

Ms. Estrella stated UHA was agreeable to make all changes and clarifications that were discussed previously.

Dr. McDonnell asked that rather than wait for UHA to bring back the changes that are asked of them, if the changes could be reviewed by the Council Chair and the Chair would decide whether to reconvene another meeting to discuss the UHA response. Mr. Hogan replied that once the minutes are memorialized and approved, this will give the Staff the instructions to require UHA to memorialize the changes that were discussed, and if the Council is comfortable, he will pass it on to the Chair to determine whether to convene a special meeting. Dr. McDonnell agreed and Mr. Hogan will bring it up to the Chair.

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

1. The language is amended to ensure the definitions in the glossary for co-payment and coinsurance are aligned with the definitions in the medical benefits guide;
2. The language is amended to clarify that the cost share for physician services through telehealth is the same as for services received in-person; and
3. "Licensed" will be removed from clinical social worker and mental health counselor.

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

UHA 3000-T

UHA 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).

Ms. Estrella stated UHA was agreeable to make all changes and clarifications that were discussed previously. She stated the plan changes were specific to drug coverage as an essential health benefit.

Mr. Hogan mentioned the DCD review form did not include all information regarding durable medical equipment. The MBG stated medical equipment and appliances required prior authorization when purchase was greater than \$500, or rental was greater than \$100/month with a 20% coinsurance PPO and NPO whereas the DCD Review Form did not include prior authorization. He also questioned if durable medical equipment should be covered at 20% coinsurance PPO and NPO as stated in the MBG, or at 80% PPO and 70% NPO per the DCD review form. Ms. Estrella confirmed the MBG was correct.

Ms. Shimomura questioned if the 32 units (1 unit per 15 minutes) for physical and occupation therapy services were a combined total. Ms. Estrella confirmed the services were combined.

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 ensure the definitions in the glossary for co-payment and coinsurance are aligned with the definitions in the medical benefits guide;
2. The language is amended to clarify that the cost share for physician services through telehealth is the same as for services received in-person; and
3. “Licensed” will be removed from clinical social worker and mental health counselor.

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

UHA 3000 90/10 Preferred

UHA 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).

Ms. Estrella stated UHA was agreeable to make all changes and clarifications that were discussed previously. She stated the plan changes were specific to drug coverage as an essential health benefit.

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 ensure the definitions in the glossary for co-payment and coinsurance are aligned with the definitions in the medical benefits guide;
2. The language is amended to clarify that the cost share for physician services through telehealth is the same as for services received in-person; and
3. “Licensed” will be removed from clinical social worker and mental health counselor.

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

One Plan

UHA 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).

Ms. Estrella stated UHA was agreeable to make all changes and clarifications that were discussed previously.

Mr. Kanehira questioned if in vitro fertilization should be covered at 20% coinsurance PPO and not covered for NPO as stated in the DCD review form or 20% coinsurance PPO and NPO as stated in the MBG. Ms. Estrella stated the MBG was correct and that it would be applicable to One Plan-T and other plans as it relates to in vitro fertilization.

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

1. The language is amended to ensure the definitions in the glossary for co-payment and coinsurance are aligned with the definitions that are defined in the medical benefits guide;

2. The language is amended to clarify that the cost share for physician services through telehealth is the same as for services received in-person; and
3. “Licensed” will be removed from clinical social worker and mental health counselor.

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

One Plan-T

UHA 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).

Ms. Estrella stated UHA was agreeable to make all changes and clarifications that were discussed previously. She stated the plan changes were specific to drug coverage as an essential health benefit.

Mr. Hogan questioned if the prescription drug benefit should be covered at \$10 co-payment (generic), \$30 co-payment (preferred brand), and \$65 co-payment (non-preferred brand) as stated on the DCD review form. Ms. Estrella confirmed the preferred tier should be \$35. Mr. Hogan clarified the co-payment for preferred brand was \$30, not \$35. Ms. Estrella confirmed.

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 ensure the definitions in the glossary for co-payment and coinsurance are aligned with the definitions that are defined in the medical benefits guide;
2. The language is amended to clarify that the cost share for physician services through telehealth is the same as for services received in-person; and
3. “Licensed” will be removed from clinical social worker and mental health counselor.

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

UnitedHealthcare (UHC)

UHC was represented by Ms. Sara Amos, Ms. Cindy Park, and Ms. Jessica Macon.

UnitedHealthcare Options PPO-SB

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

Ms. Park addressed the concern regarding the limitation of prescriptive drug tests per year for Lab, X-Ray, and Diagnostic – Outpatient. She confirmed that UHC would remove the testing limits.

Ms. Park addressed the concern regarding the change to the prior authorization requirement for obesity - weight loss surgery from five business days before obesity surgery was performed to

six-months prior to surgery or as soon as possible. She stated that six months may be required to complete the preoperative evaluation that includes a detail weight history, along with the dietary and physical activity patterns, and psychological behavior evaluation by an individual who was professionally recognized as a part of behavioral health discipline to provide screening and identification of risk factors of potential post operative changes that may contribute to poor, post operative outcome.

Mr. Kanehira questioned why the language was so subjective and how the six-month determination was made. His concern was based on the ability for the subscriber to appeal because there wasn't enough time to fulfill the pre-surgical requirements. Ms. Park explained the six-month duration was an expanded window for the subscriber to fulfill the requirements prior to surgery, but if the subscriber fulfilled the requirement sooner, surgery would be scheduled.

Ms. White and Mr. Hogan stated the language was confusing, but their understanding of the change was UHC would provide a longer window of six months, or sooner, for the subscriber to fulfill the requirements ensuring the subscriber was able to move forward with the surgery. Ms. Park explained the member had up to six months, or as soon as possible, to fulfill the requirements prior to surgery. Ms. Amos added the requirements were only for out-of-network benefits.

Ms. Shimomura questioned if the 24 manipulative treatments under the habilitative services included physical therapy, occupational therapy, and speech therapy. Ms. Amos confirmed the habilitative services were included in the 24 total visits.

Ms. Shimomura questioned the testing limitations for Lab, X-Ray, and Diagnostic – Outpatient. Ms. Park confirmed that UHC would remove the testing limits.

Mr. Kanehira questioned what the numbers associated with the table of contents represented. Ms. Park explained the schedule of benefits started on page 55, covered health care services, but because Hawaii required the COC (certificate of coverage) along with the schedule of benefits, it was embedded into the plan.

Ms. Pang commented on the language regarding eligible person. She recommended adding language to align the definition under the Hawaii Prepaid Health Care Act. Ms. Park explained that language in the plan was at the request of the Council from prior meetings. Ms. Pang agreed to keep the language as stated.

Ms. Pang questioned the penalty associated with the failure to obtain prior authorization in the amount of \$400 per incident with the total penalties to not exceed \$1,000. Ms. Park explained if the subscriber failed to obtain prior authorization for out-of-network benefits, the subscriber would be penalized \$400 up to \$1,000 per incident and the procedure may not be approved.

Mr. Kanehira questioned if the note regarding covered health services in the definition of co-payment was relevant to co-payment or covered health services. Ms. Amos explained that UHC would calculate the allowed amount based on the covered health services.

Mr. Kanehira questioned if the same would apply to co-insurance. Ms. Park confirmed the definition under co-insurance would apply.

Mr. Kanehira commented on the incorrect alphabetization of inborn error of metabolism and how it should appear after iatrogenic infertility. Ms. Park confirmed UHC would make the correction.

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

1. Lab, X-Ray, and Diagnostic – Outpatient testing limits are removed, and
2. Inborn error of metabolism and iatrogenic infertility are correctly alphabetized.

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

ADJOURNMENT

Meeting adjourned at 3:43p.m.