Draft

Prepaid Health Care Advisory Council Meeting

State of Hawaii
Department of Labor and Industrial Relations
830 Punchbowl Street, Room 209
Hearing Room #3
Honolulu, HI 96813

Also via Microsoft Teams

October 15, 2024
1:01 p.m. to 2:22 p.m.

Council members present
Ms. Bonnie Pang, Chair
Mr. Wayne Graves
Mr. Mike Hogan
Ms. Lauren Yee
Dr. John McDonnell (1:53 p.m.)

Council members absent
Ms. Winona White
Mr. Derek Kanehira

Staff present
Ami Aiona
Jodie Murakami
Stacey Hiranaka
Misty Sumida
Chelsea Maja, Deputy Attorney General
Dale Fujimoto, Deputy Attorney General

With a quorum present, Chair Pang called the meeting to order at 1:01 p.m. The members in attendance identified themselves.

Approval of minutes

Chair Pang asked if there were any additions, corrections, or comments to the circulated minutes of the June 18, 2024 executive session meeting and the August 14, 2024 meeting. Ms. Yee amended the minutes of the June 18, 2024 executive session meeting by removing her name from the final sentence in the last paragraph on page 2. There were no additional amendments. A motion was made by Mr. Hogan to approve the minutes of the June 18, 2024 executive session meeting as amended and the minutes of the August 14, 2024 meeting as circulated. The motion was seconded by Mr. Graves and carried by unanimous vote.

New Contractor Plans

Cigna Health and Life Insurance Company (Cigna)

Hawaii Open Access Plus Copay Plan

Cigna was represented by Peter Welch, Amanda Leipold, Jacob Wagner, and Sarang Chehrazi.

Cigna submitted to the Department this new Copay plan effective January 1, 2025 and requested approval under Section 393-7(a).

Mr. Welch stated Cigna had been filing plans for approval on a case-by-case basis but was currently filing for approval of a formal 7(a) plan.

Ms. Leipold confirmed Cigna had reviewed the Summary Sheet from the Department and could meet the requirements stated but had some questions. For item 11 regarding the specialist physician home visit with an office visit copayment maximum of $12, she asked if the item was regarding home or office visits. Chair Pang and Ms. Aiona confirmed the item was regarding the home visit copayment and parity with the office visit copayment.

Ms. Yee asked about the $12 limit and whether it was based on matching the prevalent plan or another 7(a) plan such as the HMSA CompMED plan. Chair Pang stated the prevalent plan had a coinsurance of 10%. Mr. Welch asked if there was flexibility for a $15 or $20 copay as $12 was an odd copay number and Cigna preferred a consistent approach such as $15 or $20. Ms. Sumida stated that the HMSA PPP 2010, PPP-A, and Small Business PPA-A plans were 7(a) plans with $12 office copayments. Ms. Yee stated pages 15 and 16 of the Cigna plan had a $20 copayment for specialty care physician office visits and she suspected the Department suggested $12 to match the HSMA PPP-A plan. She suggested a $14 copayment might be acceptable because the CompMED plan had a $14 copayment. Ms. Leipold asked if a $20 copayment would be acceptable. Mr. Welch stated the $20 copay would match Cigna's outpatient specialist copayment. Ms. Sumida stated the CompMED and CompMED-A plans had $20 copayments for consultations, but the plans had richer out-of-network benefits. Chair Pang suggested Cigna verify the copayment amount with the Department. Ms. Leipold stated Cigna could accommodate the $12 but administering the amount would be more difficult than a $10, $15 or $20 copay. Mr. Welch confirmed the $12 would be a more manual process.

Mr. Welch asked whether the home and office visit copays should be the same. Chair Pang confirmed the copayments should be the same. Copayments could vary between primary care and specialty care but were the same regardless of setting.

Mr. Welch asked for the Council's perspective on flexibility on the copayments if the out-of-pocket limit were lower than the prevalent plan. Ms. Aiona stated the Department is working with the Council to establish flexibility in the plans but specifically for the office and home visit copayments, the $12 matches an approved plan. Mr. Welch reiterated that the $12 copayment was acceptable and that in the future Cigna would like to explore a lower out-of-pocket limit and different copayment. Ms. Yee stated she had been more familiar with balancing the cost shares in 393-7(b) plans because 393-7(a) says "equal to" and was stricter. Mr. Welch stated the intent was not to increase cost share to the member, but he would like to weigh a $15 copay versus a $500 difference in out-of-pocket limit in the future.

Ms. Leipold asked about item 45 - the removal of the exclusion of injectable prescription drugs to the extent they do not require physician supervision and are typically considered self-administered drugs, non-prescription drugs, and investigational and experimental drugs, except

as provided in this plan. She clarified that the exclusion was to state that non-injectable prescription drugs that don't require physician supervision were not covered by this plan. The plan did not generally offer prescription drug coverage so the employer could purchase that under a separate plan. The prescription drug coverage was not required by the PHC Act, so it was carved out of the plan. Chair Pang stated some injectable drugs were covered under the medical plan. Ms. Aiona stated that the prevalent plan covered drugs which could be non-injectable, so the exclusion did not allow for the coverage of those. She also referenced item 44 regarding drugs that should be covered by the plan. Ms. Leipold said they had no issue with item 44 and that the conversation had cleared up the confusion over item 45.

Chair Pang called for questions from the Council.

Mr. Hogan asked if Cigna would address the general comments and clarification items on the summary sheet. Ms. Leipold confirmed that corrections had been made to the items including correcting pages numbers on the table of contents and formatting to remove empty space. Also Cigna had clarified the schedule of benefits table to explicitly state "You pay..." or "Insurance pays..." to clarify what the member pays or the insurance covers. Other changes included removing brackets from page 7, rewording page 31 to make it clear genetic testing was covered and to split up the genetic testing and counseling benefits on the page, correcting the incomplete sentence on page 50, and rewording the sentence on page 56 regarding dependents coverage and highlighted text. Ms. Leipold explained that the information regarding Section 125 tax regulations on page 61 was Cigna's standard language for cafeteria plans and that she could answer questions about specific parts of it. Mr. Chehrazi explained the section was a reference to the IRS code that allows employees to use pre-tax money to pay for health insurance premiums. The purpose was to inform the employer using Section 125 to provide benefits of the requirements to qualify for the program and avoid tax implications. Ms. Yee stated she recognized elements of the information and that other carriers may not have labelled it the info under Section 125. She asked for clarification on item G regarding reduction of work hours and the requirement for 30 work hours per week and if this would conflict with the Prepaid Health care requirement of 20 hours per week. Mr. Welch stated the language would reflect the 20-hour requirement of under the PHC Act. Mr. Chehrazi confirmed the definition of eligible employee would be consistent throughout the document. Ms. Yee asked if the change would be made in item G. Mr. Chehrazi confirmed section G would refer to "eligible employee as is otherwise defined in the certificate" which would be correctly defined elsewhere. Ms. Leipold addressed the next clarification item regarding the statement on page 13 of the plan that the plan pays 90% in-network and 70% out-of-network. She explained that statement was a catch-all showing the benefit level for all covered expenses listed in the plan that were not specifically enumerated in the schedule.

Chair Pang asked if the condition-specific care and the travel benefit maximum of $600 per procedure on page 22 applied to a Neighbor Island member who had to fly to Oahu to see a specialist. Mr. Chehrazi replied that it was not a reference to general routine services; it was a value-added program available when Cigna bundled an episode of care. As an example, the member could get back surgery under the terms of the plan or if the member wanted to join the condition-specific care program and met the criteria, the member could get the surgery at a participating facility with a participating surgeon, anesthesiologist, and other participating

specialists. That episode of care would be a $0 benefit to the member. It was voluntary and based on certain conditions and the election of the member.

Ms. Yee asked that the plan add coverage of regular and special diets as stated in Section 393-7(c)(1)(A)(ii), HRS.

Ms. Yee stated that for item 6, oxygen should be removed because the plan covers oxygen on page 37.

Ms. Yee asked that the plan cover antibiotics.

Ms. Yee stated the benefit for item 7, physician surgical services for cutting surgery, was the same as the prevalent plan.

Ms. Yee stated that Cigna's benefit for item 8, physician surgical services for non-cutting surgery, was better than the prevalent plan. Page 18 of Cigna's certificate listed the benefit as 90%, no deductible, while the prevalent plan benefit was 80%. Ms. Aiona stated the certificate did not differentiate between cutting and non-cutting surgery so the non-cutting surgery should be a covered benefit at least at the same level as the prevalent plan. Ms. Yee asked if "surgeon" refers to cutting and non-cutting surgery. Ms. Leipold confirmed and stated that Cigna did not make a distinction between noncutting and cutting surgery.

For item 18, screening mammogram, Ms. Yee stated that Cigna's benefit on page 18 is the same as the prevalent plan.

Ms. Yee stated that items 22 and 26, physical and occupational therapy benefits, should be covered at 90 days per occurrence instead of 90 visits per occurrence.

Ms. Yee stated that the deductible should be removed from all in-network transplants in addition to corneal and kidney transplants in item 29. Ms. Aiona asked for clarification from Cigna for other transplants because page 29 described the benefit as 100% at LifeSOURCE center, otherwise deductible then 90%. Mr. Welch stated Cigna worked with certain centers of excellence and those were under the umbrella of LifeSOURCE. If a patient used the center of excellence, Cigna would pay 100% and include benefits for family travel, and lodging. If the patient was not willing or interested in traveling to a center of excellence, then the benefit was subject to the deductible and coinsurance. Ms. Yee asked if the patient did not go to a LifeSOURCE center but was still in-network would the benefit be the deductible then 90%. Mr. Welch confirmed that was the in-network benefit. Ms. Yee stated the benefit did not meet the prevalent plan which was 90% with no deductible, so the deductible should be removed.

For item 30 regarding the removal of the plan deductible for out-of-network adult and child well-care visits, Ms. Yee stated that for well-child visits the plan deductible needed to be removed. But she noted that on pages 17-18 of its plan, Cigna covered in-network adult preventive care visits at 100% without a deductible. She asked Cigna if that was correct. Ms. Leipold confirmed. Ms. Yee stated per page 17 of the prevalent plan, adult preventive care was covered at 70% subject to the deductible. She felt that Cigna had a better benefit, so the deductible did not need to be removed for out-of-network adult well care visits.

Ms. Yee asked if bariatric surgery was covered. Mr. Welch confirmed it was covered if medically necessary but was unsure if it was specifically called out in the plan. Ms. Yee asked

for the cost share. Mr. Welch stated it was typically subject to deductible and coinsurance, but he would need to check. Mr. Chehrazi stated the plan included the cost share in the Obesity Bariatric Surgery section on page 31. Ms. Yee commented that page 50 listed an exclusion in the second column, second bullet that seemed like a broad exclusion of bariatric surgery. She also stated that the prevalent plan covered it in-network at 90%, no deductible. Mr. Welch stated Cigna could change the language to remove the exclusion as being subject to the deductible and covered at 90%.

For item 44, Ms. Yee stated Cigna met the requirements for covering contraceptives and US Preventive Services Task Force Recommended drugs.

Ms. Yee stated Cigna's exclusion on pages 36 and 39 matched the prevalent plan's definition of parent, child, and spouse for item 48. She stated Cigna's plan did not mention immediate household, which was a prevalent plan term. She was unsure of the issue. Ms. Sumida stated that the Cigna plan excluded services provided by people other than a parent, child, or spouse of the member. Ms. Yee asked if Cigna's exclusion was broader than the prevalent plan's. Ms. Sumida confirmed. Ms. Leipold stated Cigna could match the exclusion.

Dr. McDonnell joined the meeting at 1:53 p.m. and stated he did not have questions for Cigna regarding the plan.

Ms. Yee asked about the limit on the invitro fertilization (IVF) benefit and if Cigna had to increase its limit of one attempt per lifetime to include an additional attempt if the member changed employers. Chair Pang's understanding was that the limit was per plan so the member would need to change plans. Kara Marlowe of HMSA confirmed Chair Pang's understanding of the prevalent plan and said there was a third possible attempt if the member changed employers. If the member worked for Employer A who offered an HMO and a PPO, the member could get one attempt under the HMO and one attempt under the PPO. If the member switched to a new employer group, the member could get one additional attempt under the new employer. Mr. Graves asked for confirmation that there were three possible attempts. Ms. Marlowe confirmed. Ms. Yee wondered if the requirement came from HIPAA. Mr. Graves thought HMSA had been tracking that and capped the attempts at three. He asked if Ms. Yee if her understanding was that a change in ACA required it to be unlimited. Ms. Yee was not familiar with an ACA requirement but was aware of a Federal HIPAA regulation that came out years ago that required a benefit refresh when the member changed employers. Ms. Marlowe state that due to ACA limits, it was not capped at three attempts. Mr. Graves commented that it was no longer capped. Ms. Marlowe confirmed.

Mr. Hogan asked about the "Effect of Section 125" language as he did not recall seeing it in the prevalent plan or other local plans. Ms. Aiona stated she did not see a specific reference to the tax regulation but that portions were embedded in the prevalent plan, especially portions specific to employees.

There were no additional questions. Chair Pang summarized the additional comments that were discussed and called for a motion.

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

1. The eligibility requirement is compliant with the PHC Act;
2. Enrollment is allowed when coverage is required due to a termination of the Form HC-5 waiver;
3. A private room is a benefit when deemed medically necessary;
4. The plan specifies regular and special diets as a hospital benefit;
5. The plan specifies general nursing services as a hospital benefit;
6. The plan specifies surgical supplies as a hospital benefit;
7. The plan specifies drugs, dressings, and antibiotics as a hospital benefit;
8. The plan specifies physician surgical services – cutting surgery as a surgical benefit;
9. The plan specifies physician surgical services – non-cutting surgery as a surgical benefit;
10. The plan specifies physician home visits as a medical benefit;
11. Physician emergency room visits benefit is at least 90% in-network and out-of-network with no deductible;
12. The plan specifies specialist physician home visits as a medical benefit and the copayment is capped at twelve dollars ($12);
13. Lab/path inpatient benefit is at least 90% in-network without a deductible and 70% out-of-network;
14. Radiology inpatient benefit is at least 90% in-network without a deductible and 70% out-of-network;
15. Radiotherapeutic services outpatient benefit is at least 80% in-network without a deductible and 70% out-of-network;
16. Radiotherapeutic services inpatient benefit is at least 90% in-network without a deductible and 70% out-of-network;
17. Mental health and substance abuse physician services outpatient benefit is at least 90% in-network without a deductible and 70% out-of-network;
18. Mental health and substance abuse physician services inpatient benefit is at least 90% in-network without a deductible and 70% out-of-network;
19. Chemotherapy benefit is at least 80% in-network and 70% out-of-network;
20. Home health care benefit is covered for at least 150 visits per calendar year;
21. Medical foods benefit is at least 80% in-network and out-of-network without a deductible;
22. Physical therapy is covered for at least 90 days per occurrence;
23. Physical therapy inpatient benefit is at least 90% in-network without a deductible and 70% out-of-network;
24. Speech therapy limit of 30 days is removed;
25. Speech therapy inpatient benefit is at least 90% in-network without a deductible and 70% out-of-network;
26. Occupational therapy is covered for at least 90 days per occurrence;
27. Occupational therapy inpatient benefit is at least 90% in-network without a deductible and 70% out-of-network;
28. Plan deductible for in-network skilled nursing facility is removed;
29. Plan deductible for in-network transplants is removed;
30. Plan deductible for out-of-network child well-care visits is removed;

31. Hearing aid benefit is at least 80% in-network and 70% out-of-network once every 60 months;
32. Evaluations for Hearing Aids in the office of a physician or audiologist are covered;
33. Diagnosis and treatment of Autism Spectrum Disorders is covered including Behavioral health treatment, Benefits for Applied Behavior Analysis rendered by a Recognized Behavior Analyst, Psychiatric care, Psychological care, and Therapeutic care;
34. Medically necessary non-surgical treatment of obesity is covered;
35. Age limit for orthodontic services for treatment of orofacial anomalies resulting from birth defects or birth defect syndrome is removed;
36. Genetic counseling limit of 3 visits per person is removed;
37. Gender identity services deemed medically necessary are covered;
38. Growth hormone therapy is covered;
39. Injections – other than self-administered for services and supplies for the injection or intravenous administration are covered;
40. Inhalation therapy is covered;
41. Artificial insemination is covered;
42. Polysomnography is covered;
43. Home IV therapy is covered;
44. Drugs to treat autism spectrum disorders, oral chemotherapy drugs, diabetic drugs and supplies, and insulin are covered;
45. Exclusion of "injectable prescription drugs to the extent they do not require Physician supervision and are typically considered self-administered drugs, non-prescription drugs, and investigational and experimental drugs, except as provided in this plan" is removed;
46. Exclusion of benefits for therapy or treatment intended primarily to improve or maintain general physical condition or for the purpose of enhancing job, school, athletic or recreational performance, including but not limited to routine, long term, or maintenance care which is provided after the resolution of the acute medical problem and when significant therapeutic improvement is not expected is modified by removing the word "or";
47. Exclusion of benefits for treatment of an injury or sickness which is due to war, declared, or undeclared is modified by adding the phrase "to the extent permitted by law.";
48. Exclusions of benefits for services provided by the insured; a member of the insured's immediate family; a member of the insured's immediate household; a parent, child or spouse of the patient's family; and a person who is a parent, child or spouse who normally resides in the patient's house, your house, or the dependent's house are modified to only exclude services provided by a parent, child or spouse of the insured;
49. Exclusion of "any medications, drugs, services or supplies for the treatment of male or female sexual dysfunction such as, but not limited to, treatment of erectile dysfunction" is covered if it is due to an organic cause or to treat gender dysphoria; and
50. Exclusion of varicose vein treatment is removed;
51. In-Virto Fertilization limit of 1 attempt per lifetime is removed;
52. Brackets around text are removed;
53. The plan specifies genetic testing pre/post testing is covered; and

54. Incomplete sentence on page 56 “this plan does not cover if dependents are covered; add highlighted text” is fixed.

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

Hawaii Open Access Plus Coinsurance Plan

Cigna submitted to the Department this new Coinsurance plan effective January 1, 2025 and requested approval under Section 393-7(a).

Ms. Leipold stated Cigna was amenable to make the changes listed in items 1 through 48 and provided responses the general comments listed on the summary sheet. Cigna had corrected the page numbers on the table of contents and page formatting with empty spaces. Cigna had clarified by using “You pay...” and “Insurance pays...” to describe the coverage.

Ms. Leipold provided clarification on the items listed on the summary sheet. Brackets had been removed; language had been added to make it clear that genetic testing was covered with genetic counseling; and the incomplete sentence on page 51 had been corrected. On page 56, expenses for which a third party may be responsible had been corrected. She stated Cigna explained the “Effect of Section 125 Tax Regulations” section and could answer any other questions. She explained that on page 14, the description of the 90% in-network benefit and 70% out-of-network benefit was the catch-all for the covered expenses listed in the plan that were not specifically called out in the schedule of benefits.

Ms. Yee had the concerns about the limit on IVF attempts, the lack of general nursing services benefits, the lack of regular and special diet benefits, the lack of antibiotics coverage, the limit for physical therapy must be at least 90 days per occurrence, the limit for occupational therapy must be at least 90 days per occurrence, the lack of bariatric surgery coverage, and the removal of the limit on genetic counseling visits. Ms. Yee felt Cigna did not need to modify the oxygen benefit, the non-cutting surgery benefit, the radiology in-network benefit, the mental health and substance abuse physician services outpatient benefit, the screen mammogram benefit, and coverage of contraceptives and US Preventive Service Task Force Recommended drugs.

There were no additional questions. Chair Pang repeated the additional requirements and called for a motion.

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

1. The eligibility requirement is compliant with the PHC Act;
2. Enrollment is allowed when coverage is required due to a termination of the Form HC-5 waiver;
3. Annual deductible is capped at $100 per person and $300 per family;
4. A private room is a benefit when deemed medically necessary;
5. The plan specifies regular and special diets as a hospital benefit;
6. The plan specifies general nursing services as a hospital benefit;
7. The plan specifies surgical supplies as a hospital benefit;

8. The plan specifies drugs, dressings, and antibiotics as a hospital benefit;
9. The plan specifies physician home visits as a medical benefit;
10. The plan specifies specialist physician home visits as a medical benefit;
11. Lab/path inpatient benefit is at least 90% in-network without a deductible and 70% out-of-network;
12. Radiotherapeutic services outpatient benefit is at least 80% in-network without a deductible and 70% out-of-network;
13. Radiotherapeutic services inpatient benefit is at least 90% in-network without a deductible and 70% out-of-network;
14. Chemotherapy benefit is at least 80% in-network and 70% out-of-network;
15. Home health care benefit is covered for at least 150 visits per calendar year;
16. Hospice care benefit is at least 100% in-network;
17. Physical therapy is covered for at least 90 days per occurrence;
18. Physical therapy inpatient benefit is at least 90% in-network without a deductible and 70% out-of-network;
19. Speech therapy limit of 30 days is removed;
20. Speech therapy inpatient benefit is at least 90% in-network without a deductible and 70% out-of-network;
21. Occupational therapy is covered for at least 90 days per occurrence;
22. Occupational therapy inpatient benefit is at least 90% in-network without a deductible and 70% out-of-network;
23. Plan deductible for in-network transplants is removed;
24. Hearing aid benefit is at least 80% in-network and 70% out-of-network once every 60 months;
25. Evaluations for Hearing Aids in the office of a physician or audiologist are covered;
26. Diagnosis and treatment of Autism Spectrum Disorders is covered including Behavioral health treatment, Benefits for Applied Behavior Analysis rendered by a Recognized Behavior Analyst, Psychiatric care, Psychological care, and Therapeutic care;
27. Medically necessary non-surgical treatment of obesity is covered;
28. Age limit for orthodontic services for treatment of orofacial anomalies resulting from birth defects or birth defect syndrome is removed;
29. Genetic counseling limit of 3 visits per person is removed;
30. Gender identity services deemed medically necessary are covered;
31. Growth hormone therapy is covered;
32. Injections – other than self-administered for services and supplies for the injection or intravenous administration are covered;
33. Inhalation therapy is covered;
34. Artificial insemination is covered;
35. Polysomnography is covered;
36. Home IV therapy is covered;
37. Drugs to treat autism spectrum disorders, oral chemotherapy drugs, diabetic drugs and supplies, and insulin are covered;

38. Exclusion of "injectable prescription drugs to the extent they do not require Physician supervision and are typically considered self-administered drugs, non-prescription drugs, and investigational and experimental drugs, except as provided in this plan" is removed;
39. Exclusion of benefits for therapy or treatment intended primarily to improve or maintain general physical condition or for the purpose of enhancing job, school, athletic or recreational performance, including but not limited to routine, long term, or maintenance care which is provided after the resolution of the acute medical problem and when significant therapeutic improvement is not expected is modified by removing the word "or";
40. Exclusion of benefits for treatment of an injury or sickness which is due to war, declared, or undeclared is modified by adding the phrase "to the extent permitted by law.";
41. Exclusions of benefits for services provided by the insured; a member of the insured's immediate family; a member of the insured's immediate household; a parent, child or spouse of the patient's family; and a person who is a parent, child or spouse who normally resides in the patient's house, your house, or the dependent's house are modified to only exclude services provided by a parent, child or spouse of the insured;
42. Exclusion of "any medications, drugs, services or supplies for the treatment of male or female sexual dysfunction such as, but not limited to, treatment of erectile dysfunction" is covered if it is due to an organic cause or to treat gender dysphoria; and
43. Exclusion of varicose vein treatment is removed;
44. In-Virto Fertilization limit of 1 attempt per lifetime is removed;
45. Brackets around text are removed;
46. The plan specifies genetic testing pre/post testing is covered; and
47. Incomplete sentence on page 56 "this plan does not cover if dependents are covered; add highlighted text" is fixed.

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

Chair Pang thanked everyone for their work. Chair Pang asked Cigna for future submissions to please provide corrections or updates in a redlined version to make review easier.

Adjournment

The meeting was adjourned at 2:22 p.m.