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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

June 19, 2025
1:34 p.m. to 3:01 p.m.

<u>Council members present</u>
Ms. Bonnie Pang, Chair
Mr. Wayne Graves
Mr. Mike Hogan
Ms. Lauren Yee
Dr. John McDonnell

<u>Council member absent</u>
Ms. Leocadia Conlon

<u>Staff present</u>
JoAnn Vidinhar, Administrator
Ami Aiona
Jodie Murakami
Stacey Hiranaka
Misty Sumida
Kelly Ha, Deputy Attorney General

Call to Order

With a quorum present, Ms. Pang called the meeting to order at 1:34 p.m. The Council members in attendance identified themselves.

Review of Plans

Hawaii Medical Service Association (HMSA)

HMSA was represented by Austin Bunag, Kara Marlowe, and Kehau Guiles.

<u>Preferred Provider Plan</u> (information only)

Ms. Hiranaka stated Preferred Provider Plan (PPP) had started in 1992 and had become prevalent in 1996. It was a 7(a) preferred provider organization (PPO) plan targeted for employers who wanted to offer better benefits for going to a participating provider with a low $100 deductible. Benefits were generally covered 90/10, but some services were covered 80/20. Nonparticipating

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provider coverage was covered but at a higher cost share for members. PPP plans used HMSA's PPO network. This was HMSA's oldest plan design, and many large, long-time clients had this plan.

HMSA informed the Department of benefit and language changes made to the plan. Changes would be effective January 1, 2026.

Ms. Marlowe described the six changes impacting the plan: the Ornish program was replaced with intensive cardiac rehabilitation and the lifetime limit was removed; the exclusion of developmental delay for physical, occupational, and speech therapies was removed; the benefit category of Injections, Other than Self-administered was renamed Medical Drugs and expanded to include non-injection drugs such as topical, nasal, and other forms; coverage of disposable glucose monitors and insulin pumps moved to the drug plan for members with both HMSA medical and HMSA drug coverage; coverage of immunizations moved to the drug plan for members with both HMSA medical and HMSA drug coverage; and the maximum for orthodontic services for orofacial anomalies was modified to follow the amount set by State law and published by the Insurance Commissioner.

Ms. Yee asked about the difference between cardiac rehab and intensive cardiac rehab and why the benefits were listed separately. Ms. Marlowe stated that the definitions aligned with Center for Medicare and Medicaid Services (CMS) guidelines. Mr. Bunag explained that an intensive cardiac rehab program such as the Ornish program was more intensive for the member, had requirements such as a plant-based diet and a weekly time commitment, and was not easily accessible to all members. Cardiac rehab was less intensive, more flexible, and aligned with certain care providers' delivery. For example, if a member had a heart attack and was seen by a Queen's physician, the member could use Queen's specific cardiac rehab. Historically, it had been excluded and only Ornish would have been covered. Ms. Yee asked for clarification about whether cost shares remained the same on all plans or changed from $20 copay to a coinsurance. Mr. Bunag stated that each plan would follow that plan's typical rehabilitation benefit. He stated the $20 copay had been specific to the Ornish program. Cardiac rehabilitation had been introduced to the plans in 2025 and now the Ornish program was replaced with intensive cardiac rehab. The cost shares on the plans would align with the existing cardiac rehab benefit on each plan but would vary between plans. Ms. Yee thanked HMSA for aligning the cost share with speech, occupational, and physical therapies.

Ms. Yee asked if the exclusion of drugs for foreign countries; products not approved by the U.S. Food and Drug Association; and replacements for lost, stolen, or damaged drugs and supplies were new exclusions. Ms. Marlowe stated the exclusions had already existed.

Ms. Yee complimented HMSA on way the changes were shown in the redlined version. For example, the change from Other than Self-administered Injections to Medical Drugs was updated to highlight the essence of the change instead of striking the entire section. Mr. Bunag thanked her and would pass along her comment. Chair Pang added that when edits were not clear, the intent could be lost and marking the changes accurately made it easier for the staff and Council members to understand the essence of the change.

Chair Pang raised a concern regarding the speech therapy services provision that said the therapy cannot duplicate service from another therapy or available through schools and/or government

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programs. She asked whether a student receiving speech therapy at a public school would be prevented from using the HMSA benefit. Ms. Marlowe stated that the provision was in reference to government-funded programs and that she would need to check. She noted that public school services typically were not run through the member's insurance.

Preferred Provider Plan 2010

Ms. Hiranaka stated the Preferred Provider Plan 2010 (PPP 2010) was a 7(a) PPO plan that had started in 2010. It was similar to PPP but with copays for office visits to make the cost-share easy for members to understand. This was marketed to newer groups as copays were easier for groups and members to understand.

HMSA submitted to the Department benefit and language changes made to the plan and requested continued approval under Section 393-7(a). Changes would be effective January 1, 2026.

Ms. Marlowe described the six changes impacting the plan: the Ornish program was replaced with cardiac rehabilitation and the lifetime limit was removed; the exclusion of developmental delay for physical, occupational, and speech therapies was removed; the benefit category of Injections, Other than Self-administered was renamed Medical Drugs and expanded to include non-injection drugs such as topical, nasal, and other forms; coverage of disposable glucose monitors and insulin pumps moved to the drug plan for members with both HMSA medical and HMSA drug coverage; coverage of immunizations moved to the drug plan for members with both HMSA medical and HMSA drug coverage; and the maximum for orthodontic services for orofacial anomalies was modified to follow the amount set by State law and published by the Insurance Commissioner.

Mr. Graves asked how the changes that were made affected the services provided under the speech, physical, and occupational therapy benefits and if it had been done to be align with the Affordable Care Act (ACA). Ms. Marlowe stated that the removal of the exclusion for developmental delay aligned with Kaiser's change. Mr. Bunag explained that after HMSA made the change to its health maintenance organization (HMO) plans, HMSA wanted to make the same change to its PPO plans to keep the plans consistent. Historically, speech and occupational therapy had been provided if an accident or illness caused a loss of function but if a person did not have the function in the first place, as in the case of developmental delay, then the therapy had not been covered. But this change would allow coverage if the lack of function was due to developmental delay. Mr. Graves asked if it was limited so services could not be provided by a third party. Mr. Bunag stated that speech, physical, and physical therapy services were typically provided in a medical setting, but some services related to autism would be in an educational setting. Mr. Graves asked if in a situation where the services were not considered duplicative, would those services that had previously been excluded now be covered and would the benefit align with ACA. Mr. Bunag stated that aligning with ACA had not been the intent of the change. The benefit was already in HMSA's ACA qualified health plans for small employers and individuals so the change would help close some of the gap for large group plans that were not required to have all the essential health benefits. Ms. Yee summarized that services had not been covered if the member had been born without the function but services would be covered after

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the change, and she asked if her summary was correct. Mr. Bunag confirmed that was correct for developmental delay.

Chair Pang stated she appreciated the questions because it allowed everyone to contribute from everyone's experience and consider if the plans made sense from a consumer perspective.

Chair Pang repeated the changes.

A motion was made by Mr. Graves to recommend continued approval of the plan under Section 393-7(a). The motion was seconded by Ms. Yee and carried by unanimous vote.

Preferred Provider Plan - A

Ms. Hiranaka stated Preferred Provider Plan-A was a 7(a) PPO plan that had started in 2003. It was similar to the PPP 2010 but with copays for office visits and most other services covered 90/10. The target market was employers who wanted HMSA's richest plan for their employees.

HMSA submitted to the Department benefit and language changes made to this plan and requested continued approval under Section 393-7(a). Changes would be effective January 1, 2026.

Ms. Marlowe described the six changes impacting the plan: the Ornish program was replaced with intensive cardiac rehabilitation and the lifetime limit was removed; the exclusion of developmental delay for physical, occupational, and speech therapies was removed; the benefit category of Injections, Other than Self-administered was renamed Medical Drugs and expanded to include non-injection drugs such as topical, nasal, and other forms; coverage of disposable glucose monitors and insulin pumps moved to the drug plan for members with both HMSA medical and HMSA drug coverage; coverage of immunizations moved to the drug plan for members with both HMSA medical and HMSA drug coverage; and the maximum for orthodontic services for orofacial anomalies was modified to follow the amount set by State law and published by the Insurance Commissioner.

Mr. Graves asked if there was a net benefit change to the orthodontic treatment of orofacial anomalies or if there was only a wording change. Ms. Marlowe explained that it would align with the amount set by the Insurance Commissioner according to State law. Mr. Bunag stated the amount increased with inflation and that HMSA did not want to revise the plan each year. Ms. Sumida stated the redlined copy showed a dollar amount and asked if that was changed to be more general. Mr. Bunag replied that the plan would not state the specific maximum as it was expected to change each year and instead the plan would refer to the HMSA website which would have the information on the maximum.

Chair Pang repeated the changes.

A motion was made by Dr. McDonnell to recommend continued approval of the plan under Section 393-7(a). The motion was seconded by Mr. Graves and carried by unanimous vote.

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Preferred Provider Plan - B

Ms. Hiranaka stated Preferred Provider Plan-B was a 7(b) PPO plan that had started in 2002. It was for employers who want a PPO plan, contributed at least the required amount to dependent premiums but wanted the lowest costing premium plan available.

HMSA submitted to the Department benefit and language changes made to this plan and requested continued approval under Section 393-7(b). Changes would be effective January 1, 2026.

Ms. Marlowe described the six changes impacting the plan: the Ornish program was replaced with intensive cardiac rehabilitation and the lifetime limit was removed; the exclusion of developmental delay for physical, occupational, and speech therapies was removed; the benefit category of Injections, Other than Self-administered was renamed Medical Drugs and expanded to include non-injection drugs such as topical, nasal, and other forms; coverage of disposable glucose monitors and insulin pumps moved to the drug plan for members with both HMSA medical and HMSA drug coverage; coverage of immunizations moved to the drug plan for members with both HMSA medical and HMSA drug coverage; and the maximum for orthodontic services for orofacial anomalies was modified to follow the amount set by State law and published by the Insurance Commissioner.

Dr. McDonnell asked why this plan was reverting to using the Ornish program. Ms. Marlowe clarified that intensive cardiac rehabilitation was replacing the Ornish program so coverage would be expanded.

Chair Pang repeated the changes.

A motion was made by Dr. McDonnell to recommend continued approval of the plan under Section 393-7(b). The motion was seconded by Ms. Yee and carried by unanimous vote.

CompMED

Ms. Hiranaka stated CompMED plan was a 7(a) comprehensive plan that had started in 2004. It was for employers who wanted to provide their employees a benefit design that had benefits equal for both participating providers and non-participating providers. Participating provider coverage was lower than PPP, but in exchange, non-participating coverage was higher than PPP. This design was known as a comprehensive medical plan, with guidelines for this design established by the Department and prior Councils. CompMED plans used HMSA's PPO network in Hawaii.

HMSA submitted to the Department benefit and language changes made to this plan and requested continued approval under Section 393-7(a). Changes would be effective January 1, 2026.

Ms. Marlowe described the six changes impacting the plan: the Ornish program was replaced with intensive cardiac rehabilitation and the lifetime limit was removed; the exclusion of developmental delay for physical, occupational, and speech therapies was removed; the benefit category of Injections, Other than Self-administered was renamed Medical Drugs and expanded to include non-injection drugs such as topical, nasal, and other forms; coverage of disposable

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glucose monitors and insulin pumps moved to the drug plan for members with both HMSA medical and HMSA drug coverage; coverage of immunizations moved to the drug plan for members with both HMSA medical and HMSA drug coverage; and the maximum for orthodontic services for orofacial anomalies was modified to follow the amount set by State law and published by the Insurance Commissioner.

There were no questions. Chair Pang repeated the changes.

A motion was made by Dr. McDonnell to recommend continued approval of the plan under Section 393-7(a). The motion was seconded by Mr. Graves and carried by unanimous vote.

CompMED Choice

Ms. Hiranaka stated CompMED Choice was a 7(a) comprehensive plan that started in 2017. It was a comprehensive medical plan for employers who wanted to provide their employees a benefit design that had benefits equal for both participating providers and non-participating providers and were willing to have slightly higher deductible of $200 in exchange for a lower out-of-pocket maximum of $2,200, outpatient labs covered at 100%, and office visits and outpatient labels not subject to the deductible. With this design, the target market was employers who want to encourage prevention and early diagnosis and treatment for their employees. A prior Council established this "equivalency" and this plan was introduced in 2017.

HMSA submitted to the Department benefit and language changes made to this plan and requested continued approval under Section 393-7(a). Changes would be effective January 1, 2026.

Ms. Marlowe described the six changes impacting the plan: the Ornish program was replaced with cardiac rehabilitation and the lifetime limit was removed; the exclusion of developmental delay for physical, occupational, and speech therapies was removed; the benefit category of Injections, Other than Self-administered was renamed Medical Drugs and expanded to include non-injection drugs such as topical, nasal, and other forms; coverage of disposable glucose monitors and insulin pumps moved to the drug plan for members with both HMSA medical and HMSA drug coverage; coverage of immunizations moved to the drug plan for members with both HMSA medical and HMSA drug coverage; and the maximum for orthodontic services for orofacial anomalies was modified to follow the amount set by State law and published by the Insurance Commissioner.

Ms. Yee noted the emergency room coinsurance was 20% on this plan and the prevalent plan but on this plan, the benefit was subject to the $200 deductible while the deductible did not apply on the prevalent plan. She asked if this was acceptable. Chair Pang stated that the plan had been previously discussed and approved and that aspects of the plan were enhanced to offset the deductible. Mr. Bunag stated that federal laws required the in- and out-of-network benefit be the same for emergency room so there was some interplay of federal law for this benefit. Ms. Yee asked if it could be 20% without a deductible for PPO and NPO. Mr. Bunag responded that there could be a deductible or no deductible depending on the plan design. Ms. Yee asked if the plan could match the prevalent plan and have no deductible on both tiers. Mr. Bunag it was possible, but intent of the plan design was to encourage the member go to the primary care physician or urgent care first before going to the emergency room. Chair Pang asked what benefits in the plan

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were more generous than the prevalent plan to offset the deductible. Mr. Bunag stated that the benefits more generous than the prevalent plan were the outpatient labs at zero cost share with no deductible; maternity at zero cost share; and the out-of-pocket maximum was $2200 versus $2500 on the prevalent plan. Ms. Yee stated that the plan had a better cardiac rehab benefit at $12 but that the $200 deductible also was worse than the prevalent plan. She was unsure if the offsets were sufficient and how to compare offsets if different contractors have different types and amounts of offsets. She found it easier to compare the benefits row by row to determine if it met the prevalent plan and that it would help the contractors anticipate what the Council may object to, as well as be fair to all contractors. She thought it would be difficult to track offsets.

Chair Pang felt that plans did not need to be identical to the prevalent plans and that since the plan had already been approved, the Council was looking at just the changes. She asked Mr. Bunag to help the Council understand why the plan was a 7(a) plan. Mr. Bunag stated he understood the challenges because many of the guidelines had been set before he had joined HMSA, so HMSA tried to navigate but it was a struggle. The law stated a requirement of reasonably substitutable but the contractors struggled over finding a consistent standard so he was glad to collaborate with the Council's efforts to standardize it. He thought it may be possible for plan year 2027 since some 2026 plans were already approved and there were other plans yet to be reviewed.

Ms. Yee agreed with Mr. Bunag that guidelines would be helpful. While she was not opposed to leaving the benefits as they were, she was not proposing that recommendation. She commented that the statute specifies equal or medically reasonably substitutable. She suggested that an example of medically reasonably substitutable could be if 3D mammograms were newer technology than 2D mammograms and if the prevalent plan covered 2D mammograms, it could be medically reasonably substitutable for another plan to cover 3D mammograms instead of 2D mammograms. She was open to what other thought. For the part of the statute that referred to equal, she felt that a $100 deductible was not equal to a $200 deductible.

Ms. Vidinhar thanked Chair Pang and HMSA for the dialogue. She felt that there had been gray areas in the past and that the department was looking at ways to work with the Council to close the gaps and be more transparent although there would always be some gray areas. She stated Ms. Yee's example was medically reasonable and was something that was a new advancement. Ms. Vidinhar would honor the grandfathered plans, but new regulations would come into play such as ACA in 2010. She wanted to consider how things have advanced medically and due to law changes since 2010 and whether we kept up with the industry. She thanked HMSA for the explanations because the department wanted contractors to present explanations to the Council of what happened since the approval of the plan to address what was currently happening to the plan. Then the Council could look at if it was a 7(a) plan and how it was equal or medically reasonably substitutable. Ms. Vidinhar felt that was how we could hone in on and reduce the gray areas. For now, she appreciated the explanations and knew the transition would not be overnight but was going in the right direction. She appreciated HMSA's patience and view of it since we looked at it from the consumer's perspective and what they received.

Mr. Graves stated he understood the spirit of trying to preserve the legacy of the grandfathered plans and asked if the Council would want to put the brakes on a grandfathered plan if proposed

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changes would alter the plan so it was less beneficial. Chair Pang confirmed. She stated that understanding the process of obtaining the benefit was one example. She recalled asking how to get approval for speech therapy. The Council looked at the plan with a consumer lens and wanted to understand that if there would be a significant change, whether positive or negative, what it meant. She also expected that contractors would be able to answer if a substantive change was made to the procedure of approval, copayment, or coinsurance. She felt the Council wanted to understand the out-of-pocket impact on the member. For example, if the emergency room coinsurance was increased from 20% to 25%, the Council would want to know what the current average emergency room charge was so the Council could figure out the math. She stated contractors should be able to talk through those so the Council feels comfortable to make a recommendation.

Ms. Vidinhar confirmed Mr. Graves' and Chair Pang's statements and that we would honor what was approved but that did not mean we would not withdraw something or not allow it to continue. That was the purpose of coming forward every year. We recognized it was approved but the onus would be on the contractor to show that the plan was equal or better. That was where we really need to figure out where those areas were, and contractors needed to present that. The Council would then look at if that was sufficient. If it was not sufficient then we would ask the contractor for more because it was not a 7(a) plan. Ms. Vidinhar stated that we understood where we would be moving forward, and we needed to give everyone an opportunity to transition into the new place. We would be looking for more from the providers to really present to the Council what the plan provided and what the benefits were in comparison to the prevalent plan.

Ms. Yee stated that it was helpful knowing there would be an opportunity to look at it again to see if it was equivalent to the prevalent plan. She did not want to make changes mid-year, but it would be helpful in next year's submissions to have justification of how the $100 deductible would be equal to the $200 deductible and how the coinsurances at 90% PPO and 70% NPO were equal to 80% PPO/NPO. She questioned the value of the 80% NPO coinsurance and whether members would use non-participating providers since they would also be balance billed and the balance bill amount could be thousands of dollars because it would not be subject to the out-of-pocket maximum. She felt the non-participating tier was almost an illusory benefit that looked good on paper but substantively and in real life, it was not a real benefit. If she were an employee choosing a plan she would select the prevalent plan because of the better coinsurance, 90% versus 80%, and the better deductible, $100 versus $200. She stated she was not objecting to the benefit level this year but stated it would be helpful for HMSA to explain from a member's perspective how the CompMED Choice was better or equal to the prevalent plan.

Mr. Bunag stated HMSA was willing to work with the department and Council to resolve it. He asked that changes to the plan review be shared by August or September so HMSA could adjust before it files plans at the end of the year. He also mentioned that looking at benefits line by line may be disruptive to the employers because the plans, HMSA's and those of other contractors, have been on the market for a while. He wanted to make sure HMSA would have the opportunity to transition if it needed to append its entire portfolio.

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Ms. Yee asked if a new comprehensive medical plan would need to match the prevalent plan or a grandfathered CompMED plan. Chair Pang felt that the intent was not to have plans all be identical so that employer would have choices that fit the different employers and industries and to support choice in the community while also making sure there was alignment with the spirit of the law. Ms. Vidinhar stated that the intent of the law was to allow for variation and to look at plans holistically. Ms. Vidinhar stated new plans were required to match the prevalent plan and would not be compared to grandfathered plans. The grandfathered plans would be evaluated on how they kept up with the times and would need to transition a bit. The department was committed to working with HMSA. She stated the department wanted the prevalent plan earlier so all providers would know what the prevalent plan was. So the department wanted to meet often and early. Ms. Yee was comfortable with the response.

Chair Pang called for a motion as there was no further discussion. She repeated the changes.

A motion was made by Mr. Hogan to recommend continued approval of the plan under Section 393-7(a). The motion was seconded by Dr. McDonnell and carried by unanimous vote.

CompMED-B

Ms. Hiranaka stated CompMED-B was a 7(b) comprehensive plan that had started in 2004. It was for employers who wanted a plan with the same coverage level for participating and non-participating providers, contributed at least the required amount to dependent premiums but wanted the lowest costing premium plan available.

HMSA submitted to the Department benefit and language changes made to this plan and requested continued approval under Section 393-7(b). Changes would be effective January 1, 2026.

Ms. Marlowe described the six changes impacting the plan: the Ornish program was replaced with intensive cardiac rehabilitation and the lifetime limit was removed; the exclusion of developmental delay for physical, occupational, and speech therapies was removed; the benefit category of Injections, Other than Self-administered was renamed Medical Drugs and expanded to include non-injection drugs such as topical, nasal, and other forms; coverage of disposable glucose monitors and insulin pumps moved to the drug plan for members with both HMSA medical and HMSA drug coverage; coverage of immunizations moved to the drug plan for members with both HMSA medical and HMSA drug coverage; and the maximum for orthodontic services for orofacial anomalies was modified to follow the amount set by State law and published by the Insurance Commissioner.

There were no questions on the plan. Chair Pang repeated the changes.

A motion was made by Mr. Graves to recommend continued approval of the plan under Section 393-7(b). The motion was seconded by Mr. Hogan and carried by unanimous vote.

Health Plan Hawaii Plus

Ms. Hiranaka stated Health Plan Hawaii Plus was a 7(a) HMO plan that had started in 2002. It was for employers who wanted to provide their employees with HMSA’s 90/10 HMO plan, often

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sold alongside an HMSA PPO plan to give their employees options. Health Plan Hawaii (HPH) plans used HMSA's HMO network.

HMSA submitted to the Department benefit and language changes made to this plan and requested continued approval under Section 393-7(a). Changes would be effective January 1, 2026.

Ms. Marlowe stated the changes were the same as those made to the previous plan except the developmental delay exclusion on physical, occupational, and speech therapies was not being removed. The exclusion had already been removed in 2025. Ms. Marlowe described the five changes impacting the plan: the Ornish program was replaced with intensive cardiac rehabilitation and the lifetime limit was removed; the benefit category of Injections, Other than Self-administered was renamed Medical Drugs and expanded to include non-injection drugs such as topical, nasal, and other forms; coverage of disposable glucose monitors and insulin pumps moved to the drug plan for members with both HMSA medical and HMSA drug coverage; coverage of immunizations moved to the drug plan for members with both HMSA medical and HMSA drug coverage; and the maximum for orthodontic services for orofacial anomalies was modified to follow the amount set by State law and published by the Insurance Commissioner.

Ms. Yee asked about the 10% coinsurance for allergy testing office visit. She noted that the Kaiser prevalent plan benefit was $20 copay. Chair Pang asked for the dollar amount of a 10% coinsurance. Ms. Marlowe stated HMSA would need to look at the numbers. Ms. Yee asked if the Council could recommend that the benefit match the $20 copay of the prevalent plan. Ms. Vidinhar stated that if it did not match the prevalent plan, we would want clarification as to what additional benefit was provided to make the overall plan richer. If we knew what the 20% was, then it could be compared to the $20. The Council could recommend conditional approval on the understanding, if that were the only concern.

Ms. Yee stated other cost share concerns. The genetic testing and counseling office visit was 10% coinsurance but on the prevalent plan it was $20 copay. Growth hormone office visit was 10% coinsurance but the prevalent plan was $20 copay.

Ms. Vidinhar stated that the Council could recommend approval provided those three benefits meet the prevalent plan unless there was clarification as to how it met a richer benefit. That call could be left up to the director. Chair Pang asked if that would be a recommendation to approve provided it met the prevalent plan and the coinsurance was equitable but if it was not equitable, Council would need to see where the enhancement that would make the overall plan equitable.

Chair Pang asked that the plan's Health Center and PCP section have a description of the types of providers that could be a primary care provider (PCP). She suggested using the description from page 3: family practice, general practice, OB/GYN, internal medicine or pediatrics.

Chair Pang repeated the changes.

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

1. Allergy testing office visit copayment is capped at $20;
2. Genetic testing and counseling office visit copayment is capped at $20;

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3. Growth hormone therapy office visit copay is capped at $20; and
4. PCP includes definition of "family practice, general practice, OB/GYN, internal medicine, or pediatrics."

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

Health Plan Hawaii - A

Ms. Hiranaka stated Health Plan Hawaii-A was a 7(a) HMO plan that had started in 2017. It was for employers who wanted to provide their employees with HMSA's 80/20 HMO plan, often sold alongside an HMSA PPO plan to give their employees options.

HMSA submitted to the Department benefit and language changes made to this plan and requested continued approval under Section 393-7(a). Changes would be effective January 1, 2026.

Ms. Marlowe stated the changes were the same as those made to the previous plan. Ms. Marlowe described the five changes impacting the plan: the Ornish program was replaced with intensive cardiac rehabilitation and the lifetime limit was removed; the benefit category of Injections, Other than Self-administered was renamed Medical Drugs and expanded to include non-injection drugs such as topical, nasal, and other forms; coverage of disposable glucose monitors and insulin pumps moved to the drug plan for members with both HMSA medical and HMSA drug coverage; coverage of immunizations moved to the drug plan for members with both HMSA medical and HMSA drug coverage; and the maximum for orthodontic services for orofacial anomalies was modified to follow the amount set by State law and published by the Insurance Commissioner.

Ms. Marlowe stated HMSA would also be taking back the concerns on the coinsurance amounts as reflected for $20 and the definition of PCP would align with the previous Health Plan Hawaii plan.

Ms. Yee stated she had the same concerns from the previous plan for benefits for office visits for allergy testing, genetic testing and counseling, and growth hormone therapy. The prevalent plan had a $20 copay where this plan had 20% coinsurance.

Chair Pang repeated the changes.

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

1. Allergy testing office visit copayment is capped at $20;
2. Genetic testing and counseling office visit copayment is capped at $20;
3. Growth hormone therapy office visit copay is capped at $20; and
4. PCP includes definition of "family practice, general practice, OB/GYN, internal medicine, or pediatrics."

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

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Health Plan Hawaii – B

Ms. Hiranaka stated Health Plan Hawaii-B was a 7(b) HMO plan that had started in 2002. It was for employers who wanted an HMO plan, contributed at least the required amount to dependent premiums but wanted the lowest costing premium plan available.

HMSA submitted to the Department benefit and language changes made to this plan and requested continued approval under Section 393-7(b). Changes would be effective January 1, 2026.

Ms. Marlowe stated the changes were the same as those made to the previous plan. Ms. Marlowe described the five changes impacting the plan: the Ornish program was replaced with intensive cardiac rehabilitation and the lifetime limit was removed; the benefit category of Injections, Other than Self-administered was renamed Medical Drugs and expanded to include non-injection drugs such as topical, nasal, and other forms; coverage of disposable glucose monitors and insulin pumps moved to the drug plan for members with both HMSA medical and HMSA drug coverage; coverage of immunizations moved to the drug plan for members with both HMSA medical and HMSA drug coverage; and the maximum for orthodontic services for orofacial anomalies was modified to follow the amount set by State law and published by the Insurance Commissioner.

Ms. Marlowe stated HMSA would also be taking back the concerns on the coinsurance amounts for allergy testing, genetic testing and counseling, and growth hormone therapy as well as the definition of PCP. Ms. Yee stated she did not have the same concerns about the coinsurance because the 7(b) plan did not need to match the prevalent plan. Mr. Bunag stated HMSA would not evaluate the copayments but would include the PCP language.

Chair Pang repeated the changes.

A motion was made by Ms. Yee to recommend continued approval of the plan under Section 393-7(b) provided PCP includes definition of "family practice, general practice, OB/GYN, internal medicine, or pediatrics." The motion was seconded by Mr. Hogan and carried by unanimous vote.

Chair Pang thanked the staff, HMSA for providing extra information to the staff and being open to questions and feedback, and the Council members for their time. Ms. Vidinhar thanked the Council and providers for their dedication and commitment to the industry.

Adjournment

The meeting was adjourned at 3:01 p.m.