HAWAIʻI PREPAID HEALTH CARE ADVISORY COUNCIL
Disability Compensation Division
Department of Labor and Industrial Relations
State of Hawaiʻi

MINUTES OF MEETING

Date:	July 22, 2025
Time:	1:30 p.m.
In-Person Meeting Location:	Princess Ruth Keʻelikōlani Building 830 Punchbowl Street, Room 209 Honolulu, Hawaiʻi 96813
Virtual Participation:	Virtual Videoconference Meeting – Teams Meeting https://teams.microsoft.com/dl/launcher/launcher.html?url=%2F_%23%2Fl%2Fmeetup-join%2F19%3Ameeting_NWE5NmIwMDQtZTg0MS00M2YzLThhYzYtNmQ5NjUwMDlhY2Ni%40thread.v2%2F0%3Fcontext%3D%257b%2522Tid%2522%253a%25223847dec6-63b2-43f9-a6d0-58a40aaa1a10%2522%252c%2522Oid%2522%253a%25220e01c46d-3cbc-4950-be27-0bb63db71717%2522%257d%26anon%3Dtrue&type=meetup-join&deeplinkId=fbcee5ce-e487-4968-bf14-120f0c02b03b&directDl=true&msLaunch=true&enableMobilePage=true&suppressPrompt=true
Present:	Bonnie Pang, Chairperson Leocadia Conlon, Council Member Wayne Graves, Council Member Lauren Yee, Council Member Ami Aiona, Staff Chelsea Fukunaga, Staff Stacey Hiranaka, Staff Jodie Murakami, Staff Misty Sumida, Staff Jung Yun (Kelly) Ha, Deputy Attorney General
Excused:	John McDonnell, M.D. Mike Hogan
Teams Guests:	Aimee Achenach Austin Bunag Pomaikaʻi Canaday Denise Diaz Hawaiʻi -Western Management Group Inc. (HWMG) on behalf of Hawaiʻi Medical Assurance Association (HMAA) Alyson Estrella

Stratford Goto
May W. Goya
Chad Hertzog
HMAA
Kevin Lau
Katherine Linster
Kara Marlowe
Mark Mendoza
Dana Marie K. Miranda
Louis Matsumoto
Paul
Selena Perdido
Tammy Vitolo
HWMG on behalf of HMAA
Theresa L. Young

Agenda: The agenda for this meeting was posted to the State electronic calendar as required by Hawai'i Revised Statutes ("HRS") section 92-7(b).

Call to Order: The meeting was called to order at 1:30 p.m., at which time quorum was established.

Chair Pang welcomed everyone to the meeting and proceeded with a roll call of the Council members. All Council members confirmed that they were present.

Chair Pang introduced Chelsea Fukunaga, branch supervisor with the Department.

Approval of the May 27, 2025, Open Session Minutes: Chair Pang requested a motion to approve the meeting minutes from the May 27, 2025 meeting. It was moved by Mr. Graves, seconded by Ms. Conlon, and unanimously carried to approve the May 27, 2025 open session minutes with the following amendments:

Page two, paragraph 15, first sentence, should read:

> "Ms. Yee [~~questioned~~] **noticed** staff [~~calling out~~] **identified** cardiac rehab as an issue or concern."

Page three, paragraph two, fifth sentence, should read:

> "Ms. Yee [~~questioned~~] **solicited** the Council **for discussion regarding** [~~if~~] **whether** there is a problem where the coinsurance for the UHA plan is 20% and prevalent plan is 0% but UHA has no deductible and the prevalent plan has $100 deductible."

Page four, paragraph two, beginning from the fifth sentence, should read:

> "Ms. Yee asked if the 20% shown on page 21 refers to [~~inpatient or~~] outpatient PT/OT/ST and if the 10% shown on page 15 refers

to inpatient services. Ms. Estrella stated she would follow up with the benefit staff and will respond in writing to DLIR staff. Ms. Yee stated she brings it up because the prevalent plan is 10% no deductible for PT/OT participating provider inpatient and she would like to know if UHA's benefit is 10% no deductible on page 15 under the hospital benefit of if it is 20% no deductible on page 21 which [~~would need to be changed if it is because it does not~~] **may need to be revised to** match the **prevalent plan** 10% no deductible [~~from the prevalent plan~~].

Page eight, paragraph one, ninth sentence, should read:

"Ms. Estrella questioned whether this rationale or explanation would also apply to any other carrier [~~that has a plan with primarily 80/20 benefits, but does not offer a 90/10 plan~~]. Ms. Yee stated yes, if the plan being reviewed does not match up or equal to the prevalent plan then she would raise a concern no matter who the contractor is [~~or who is on the agenda~~]."

Page eight, paragraph one, fourteenth sentence, should read:

"Mr. Hogan stated he does not feel comfortable with ~~just because it was~~ **"just because it was"** in this specific case."

Page 10, paragraph six, beginning from the second sentence, should read:

"Ms. Yee [~~questioned~~] **asked** DLIR staff whether or not that recommendation by the Council was approved by the director. DLIR staff confirmed **it was**. Ms. Yee stated to Ms. Estrella this is an example that would apply to level of playing field for all contractors **that she had asked about** earlier and is putting it out there for Council discussion and recommending that UHA 3000 plan deductible will be reduced from $200 to $100 to [~~meet the prevalent plan or~~] match the prevalent plan and to treat all contractors the same since Cigna was asked to make that change."

Page 10, paragraph seven, beginning from the second sentence, should read:

"Ms. Yee stated on page 15 emergency room is 20% and subject to the deductible and questioned Ms. Estrella if she was reading it correctly. Ms. Estrella concurred. Ms. Yee stated in the prevalent plan page 14 it's the [~~same cost share or~~] same coinsurance of 20% but not subject to the deductible. Ms. Yee recommended that UHA remove the subject to deductible for emergency room on the participating and non-participating provider tiers **to match the prevalent plan**."

Page 11, paragraph three, sixth sentence, should read:

> "Ms. Yee concurred and stated that neither the participating or the non-participating is subject to the deductible for **the prevalent plan** inpatient PT/OT/ST."

Page 11, paragraph four, beginning from the eight sentence, should read:

> "Ms. Yee [~~questioned~~] **asked** if at one point HMSA CompMED plan as the prevalent plan. Chair Pang [~~disagreed~~] **said no it wasn't**. Mr. Hogan stated back in the 80's it was HMSA Plan 4 and this was before the preferred provider networks were built and was the equivalent almost to the CompMED plans today. Ms. Yee recalled **the name** Plan 4 [~~as a benchmark at the time~~]."
>
> Deleted language is bracketed and struck through. New language is bolded and underlined.

Approval of the June 19, 2025, Open Session Minutes:

Chair Pang requested a motion to approve the meeting minutes from the June 19, 2025 meeting. It was moved by Mr. Graves, seconded by Ms. Yee, and unanimously carried to approve the June 19, 2025 open minutes with the following amendments:

Page three, paragraph 5, eleventh sentence, should read:

> "Ms. Yee [~~summarized that services had not been covered if the member had been born without the function but services would be covered after the change,~~] **tried to summarize her understanding of what was just said. Previously therapy would only be covered if it were due to illness or injury and it would not be covered. However now under the new language, in addition to therapy due to injury or illness still being covered, therapy will also be covered even if the patient was born without the function.** [~~and she~~] **She** asked if her summary was correct."

Page six, paragraph seven, fifth sentence, should read:

> "Ms. Yee asked [~~if it could be~~] **if that meant the federal law would allow** 20% without a deductible for **both [**~~PPO and NPO~~] **in- and out-of-network (PPO and NPO)**."

Page seven, paragraph one, seventh sentence, should read:

> "She thought it [~~would~~] **might** be difficult [~~to~~] **keep** track **of the varying different contractor** offsets **in the long term**."

Page seven, paragraph three, should read:

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 statue 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~~.] **While she was not opposed to leaving the benefits as they were for 2026, for 2027 it would be helpful if the contractor could help provide the rationales why CompMED Choice was at least equal to the Prevalent Plan. Like Mr. Bunag, she also struggled with the law's meaning of reasonably substitutable (when the plan wasn't equal to the Prevalent Plan). She commented that the statute specifies "medically reasonably substitutable." The Prepaid Health Care Act didn't say "financially substitutable" nor even "reasonably substitutable." It specifically used the word "medically" related to reasonably substitutable. Thus she was thinking it must not be financially substitutable but medically substitutable. The only layperson example she could make up of medically reasonably substitutable was if, say, 3D mammograms were the new evidence based gold standard published in the medical journals, and 2D mammograms were the older technology. If the prevalent plan only covered 2D mammograms because they hadn't updated their language yet to include the new gold standard 3D mammograms, it could be medically reasonably substitutable for another plan to cover 3D mammograms and exclude 2D mammograms thus not matching the Prevalent Plan.** She was open to what [~~other~~**]** **others** thought."

Page eight, paragraph three, should read:

"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.~~] **review it again in the future to explore if the CompMED Choice deductible is 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 the contractor share how the $100 deductible would be equal to the $200 deductible. For example, if the trade off between the Par and Non Par coinsurances were used as a justification for the higher CompMED Choice deductible, it would be helpful to have the contractor share a little more how the prevalent plan coinsurances at 90% Par and 70% Non Par were equal to the CompMED Choice 80% Par and Non Par. She wondered about the actual value of the 80% Non Par coinsurance. She wondered if this was a substantive trade off meaning do members use Par and Non Par providers equally as much? She asks because when using Non Par providers, members are balanced billed and the balance bill amount could be thousands of dollars which are not subject to the out-of-pocket maximum. Is her feeling wrong that because of that fear the majority of the members use Par providers versus Non Par providers? If Par providers are used the majority of the time, she felt the Non Par tier was almost an illusory benefit meaning it looked good on paper but in actual practice it was not a substantive benefit and therefore not a fair trade off to use as justification for the higher CompMED Choice deductible.**"

Page nine, paragraph one, ninth sentence should read:

"Ms. Yee was comfortable with the response **that new plans would be compared to the Prevalent Plan and not previously approved CompMED plans.**"

Page 10, paragraph four, should read:

"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~~] **should** 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%~~] **10%** was, then it could be compared to the $20. The Council could recommend conditional approval on the understanding, if that were the only concern."

Page 10, paragraph five, should read:

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

Page 11, paragraph seven, should read:

> "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 **for all three benefits**."

Page 12, paragraph 4, should read:

> "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 **for those three benefits** because [~~the~~] **this was a** 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."
>
> Deleted language is bracketed and struck through. New language is bolded and underlined.

Review of Plans:

A. Review of Plans

(i) Hawai'i Management Alliance Association (HMAA)

Ms. Murakami provided a brief review of all HMAA plans. Ms. Murakami reported that the HMAA plans are geared towards Hawai'i-based employers who want to provide their employees with a high-level of customer service and a wide choice of providers through our PPO network offering. While HMAA's primary focus is on small employers, their product offerings are also purchased by large employers within the state. HMAA also promotes preventative care and wellness through their programs, such as the "Baby and Me" program. In addition, HMAA has identified and expanded their benefits to include coverage for all telehealth services rendered by a network provider (100% coverage when provided through their 24/7 HiDoc platform) that is equivalent to services provided in-person, oral surgery including extraction of wisdom teeth, and parking fees when tied to the diagnosis/treatment of cancer.

a. Option Plus One

Ms. Murakami reported that the Option Plus One plan was established in 1995 and is a 7(a) PPO plan. It is HMAA's most popular plan. This plan is geared to help employers attract and retain employees by offering benefits such as: low out-of-pocket maximums, Chiropractic Care, Acupuncture, Naturopathic, Wellness and Preventive Care, and Employee Assistance Programs.

HWMG informed the Department of changes made to the plan and requested continued approval under Section 393-7(a). Changes would be effective January 1, 2026.

Ms. Vitolo stated that the following revisions were made to all plans submitted for Council review:

1. Verbiage added for clarification and compliance with State and Federal network adequacy requirements;

2. Verbiage added for mental health parity Federal compliance;

3. Cardiac Rehabilitation section was added with benefits in compliance with HRS Chapter 393. Cardiac rehabilitation would be covered at 90% before the deductible for participating providers and 70% after the deductible for nonparticipating providers.

4. Updates based on Federal and State laws including special benefits for homebound terminal or long-term care verbiage was revised for clarification and compliance with Mental Health Parity and Addiction Equity Act (MHPAEA) Federal law;

5. Under the General Provisions section, "Categories of Coverage" was added for clarification and definition purposes;

6. Chapter 10 General Provisions Other Applicable Federal and State laws was revised and updated to include the following:

    a. Health Insurance Portability and Accountability Act (HIPAA) effective August 1, 1996;
    b. The HIPAA Reproductive Health Care Act of 2024 effective December 23, 2024;
    c. The HIPAA Privacy Rule and Reproductive Health Care Act of 2024 effective February 16, 2026;
    d. The Transparency and Coverage Rule of 2020;
    e. Non-disclosure of adolescent mental health services effective 2021 and updated effective 2025;
    f. The Consolidated Appropriations Act of 2021 effective 2021;

g. The final rule regarding the non-quantitative treatment limitation comparative analysis required under MHPAEA effective January 2026;
h. The No Surprises Act effective January 2022;
i. The out-of-state prescriptions mandate that was effective June 27, 2024; and
j. The mammogram benefit levels, which became effective in 2025.

7. Chapter 12 glossary was updated to add revised verbiage and relevant definitions including the following: “cardiac rehabilitation”, “dependent”, “family coverage”, “family member”, “member”, “qualified medical child support order”, “single coverage”, “spouse, subscriber”, “substance abuse services”, and “you and your family”.

Chair Pang thanked Ms. Vitolo for presenting HMAA’s requested changes and asked whether the Council had any questions pertaining to HMAA’s Option Plus One Plan.

Ms. Yee asked if there was a typographical error on page 26, under the section, “Physical and Occupational Therapy”, for the term, “individual t26-reatment plan”. Ms. Vitolo confirmed it was a typo and that it would be fixed.

Ms. Yee commented that, “regular and special diets” and “general nursing services” were not listed as hospital benefits. She added that Council has previously recommended that this language be added to align with the requirements of HRS Chapter 393.

Ms. Diaz asked whether Ms. Yee was requesting that “regular and special diets” and “general nursing services” be specifically stated within the Description of Coverage. Ms. Yee confirmed that is what she was requesting.

Ms. Yee further recommended the removal of the 90-day limit on physical and occupational therapy on page 26, as there was no limit in the prevalent plan.

Lastly, on page 44, under the “Developmental Delay” section, Ms. Yee asked for clarification regarding the statement, “You are not covered for treatment of developmental delay or services related to developmental delay that are available through government programs or agencies”. Ms. Yee stated that there are two parts to that statement: 1) exclusion of treatment for developmental delay; and 2) exclusion of services related to developmental delay that are available through government programs. She noted that the prevalent plan had removed the exclusions specific to speech therapy and government programs and agencies.

Chair Pang clarified that for government programs, the contractors were requested to follow up with the Department to confirm whether benefits specific to autism were still covered.

Ms. Yee stated that the noted exclusions in the prevalent plan had been explained to the Council's satisfaction and did not need to be removed. However, Ms. Yee was concerned that the statement, "You are not covered for treatment of developmental delay" was a blanket exclusion not present in the prevalent plan and asked if it should be removed.

Ms. Diaz responded that HMAA's interpretation was that the entire sentence was related to programs that are available through government agencies. Ms. Diaz stated that HMAA did not have any issues with the language being removed.

Chair Pang clarified that the Council was not requesting to have the language removed, rather the Council wants confirmation that treatment specific to autism was covered. She stated that the prevalent plan carriers were asked to provide a clear explanation of how that benefit reads. Chair Pang asked whether department staff received a response. Ms. Murakami replied staff were still waiting for a reply.

Ms. Diaz asked for guidance with drafting acceptable language regarding Council's recommendations. Chair Pang directed her to work with the department staff to craft appropriate language.

Chair Pang asked if the Council had any further comments of questions regarding this plan.

Ms. Conlon stated that she was concerned about the language on the cover page of chapter one regarding the, "About Your Preferred Provider Organization ("PPO")" section. Specifically, the following statement, "Your health care coverage is a Preferred Provider Organization. This means you have medical benefits for your health care needs including office visits, inpatient facility services, outpatient facility services, and other provider services. The coverage offers you flexibility in the way you get medical benefits. Your opportunity to take an active role in your health care decisions makes this coverage special."

Ms. Conlon commented that the statement was in every plan and she felt it was odd. She continued, adding that the statement was misleading because a person's active role in healthcare should not be based on the kind of coverage they select. She agreed with the statement that stated that the plan offers flexibility in the way patients get medical benefits. However, whether the patient takes an active role in their health care coverage is based on basic medical ethics and patient autonomy. She recommended the statement be removed.

Ms. Diaz said the plans used a PPO network which gives members the opportunity to choose providers unlike in a health maintenance organization ("HMO").

Ms. Conlon clarified that the statement, "an active role in healthcare" was more than just selecting a provider. She added that the inclusion of, "flexibility in the way you get medical benefits in conjunction with the previous statement was odd from a medical ethics and patient autonomy perspective. Ms. Conlon asked if the reverse would be true if a patient doesn't have this plan, are they not able to take an active role in their healthcare?

Chair Pang commented that if HMAA's intent was to instruct patients to see participating providers and obtain prior authorization for certain services, the plan should plainly state that. Chair Pang explained that she believes that the Council's role is to review these plans from the consumers' and employers' perspectives and evaluate: whether the plans make sense, whether it is clear how the benefit is going to be administered, and the costs involved.

Chair Pang explained further that there have been questions in the past regarding requests to approve changes to copayment and coinsurance. She stated that in the future, contractors may be asked to provide additional information to clarify their requests for changes as the Council would like to have a better understanding of the impact to the consumer.

Ms. Conlon requested the plan also include a reference showing where to find the policies on colonoscopy and fecal occult blood test within the plan. She had observed that where a service was provided in accordance with HMAA's policies, there was a reference to where to find it. But for colonoscopy and fecal occult blood test, there was no reference for where to find the policy.

Ms. Conlon requested "physician's assistant" be corrected to "physician assistant" throughout the plan to accurately reflect the definition in HRS Chapter 453 which establishes the professional licensing requirements for physician assistants in the State.

Chair Pang asked whether the plan had a limit on cardiac rehabilitation on page 12, noting that the limit had been removed from other plans.

Mr. Graves confirmed it had been removed on other plans.

Ms. Diaz confirmed there was no limit on this plan.

Chair Pang asked if the plan covered developmental delay specific to autism.

Ms. Diaz confirmed that there was an entire section devoted to autism to verify that the plan provides coverage for autism.

Chair Pang asked for a motion to recommend continued approval of the plan with conditions. It was moved by Mr. Graves, seconded by Ms. Conlon, and unanimously carried to recommend continued approval of the plan under Section 393-7(a) provided:

1. The plan specifies regular and special diets as a hospital benefit;
2. The plan specifies general nursing as a hospital benefit;
3. Physical Therapy limit of 90 days is removed;
4. Occupational Therapy limit of 90 days is removed;
5. Correct spelling of the title "Physician's Assistant" to "Physician Assistant" throughout the plan;
6. Exclusion of treatment of developmental delay is removed; and
7. Screening Colonoscopy and Fecal Occult Blood Test sections contain references to the location of medical policies.

b. Option Plus Two

Ms. Murakami reported that the Option Plus Two plan is a 7(a) PPO plan that was established in 1998. It is HMAA's most comparable plan to Hawai'i's largest Preferred Provider Plan with added benefits that include: Chiropractic Care, Acupuncture, Naturopathic, Wellness and Preventive Care, and Employee Assistance Programs.

HWMG informed the Department of changes made to the plan and requested continued approval under Section 393-7(a). Changes would be effective January 1, 2026.

Ms. Vitolo stated that the following revisions were made to all plans submitted for Council review:

1. Verbiage added for clarification and compliance with State and Federal network adequacy requirements;

2. Verbiage added for mental health parity Federal compliance;

3. Cardiac Rehabilitation section was added with benefits in compliance with HRS Chapter 393. Cardiac rehabilitation would be covered at 90% before the deductible for participating providers and 70% after the deductible for nonparticipating providers.

4. Updates based on Federal and State laws including special benefits for homebound terminal or long-term care verbiage was revised for clarification and compliance with MHPAEA;

5. Under the General Provisions section, “Categories of Coverage” was added for clarification and definition purposes;

6. Chapter 10 General Provisions Other Applicable Federal and State laws was revised and updated to include the following:

    a. HIPAA effective August 1, 1996;
    b. The HIPAA Reproductive Health Care Act of 2024 effective December 23, 2024;
    c. The HIPAA Privacy Rule and Reproductive Health Care Act of 2024 effective February 16, 2026;
    d. The Transparency and Coverage Rule of 2020;
    e. Non-disclosure of adolescent mental health services effective 2021 and updated effective 2025;
    f. The Consolidated Appropriations Act of 2021 effective 2021;
    g. The final rule regarding the non-quantitative treatment limitation comparative analysis required under MHPAEA effective January 2026;
    h. The No Surprises Act effective January 2022;
    i. The out-of-state prescriptions mandate that was effective June 27, 2024; and
    j. The mammogram benefit levels, which became effective in 2025.

7. Chapter 12 glossary was updated to add revised verbiage and relevant definitions including the following: “cardiac rehabilitation”, “dependent”, “family coverage”, “family member”, “member”, “qualified medical child support order”, “single coverage”, “spouse, subscriber”, “substance abuse services”, and “you and your family”.

Ms. Yee and Ms. Conlon had the same concerns as on the previous plan. Ms. Conlon noted that in the glossary “physician assistant” was spelled correctly.

Chair Pang asked for a motion to recommend continued approval of the plan with conditions. It was moved by Mr. Graves, seconded by Ms. Yee, and unanimously carried to recommend continued approval of the plan under Section 393-7(a) provided:

1. The plan specifies regular and special diets as a hospital benefit;
2. The plan specifies general nursing as a hospital benefit;
3. Physical Therapy limit of 90 days is removed;
4. Occupational Therapy limit of 90 days is removed;
5. Correct spelling of the title “Physician’s Assistant” to “Physician Assistant” throughout the plan;
6. Exclusion of treatment of developmental delay is removed; and

7. Screening Colonoscopy and Fecal Occult Blood Test sections contain references to the location of medical policies.

c. Comprehensive Plus

Ms. Murakami reported that the Comprehensive Plus plan (formerly known as Summerlin Easy Hawai'i Comprehensive Plus) plan was acquired from Summerlin Life & Health Insurance Company in 2010. It is a 7(a) Comprehensive plan that is a lower-cost alternative to HMAA's Option Plus One and Option Plus Two plans. This plan offers fixed copayments for office visits and minimal copayments for preventive benefits. In addition, the Comprehensive Plus plan includes: Chiropractic, Acupuncture, Naturopathic, Wellness and Preventive Care, and Employee Assistance Programs.

HWMG informed the Department of changes made to the plan and requested continued approval under Section 393-7(a). Changes would be effective January 1, 2026.

Ms. Vitolo stated that the following revisions were made to all plans submitted for Council review:

1. Verbiage added for clarification and compliance with State and Federal network adequacy requirements;

2. Verbiage added for mental health parity Federal compliance;

3. Cardiac Rehabilitation section was added with benefits in compliance with HRS Chapter 393. Cardiac rehabilitation would be covered at 90% before the deductible for participating providers and 70% after the deductible for nonparticipating providers.

4. Updates based on Federal and State laws including special benefits for homebound terminal or long-term care verbiage was revised for clarification and compliance with MHPAEA;

5. Under the General Provisions section, "Categories of Coverage" was added for clarification and definition purposes;

6. Chapter 10 General Provisions Other Applicable Federal and State laws was revised and updated to include the following:

    a. HIPAA effective August 1, 1996;
    b. The HIPAA Reproductive Health Care Act of 2024 effective December 23, 2024;
    c. The HIPAA Privacy Rule and Reproductive Health Care Act of 2024 effective February 16, 2026;
    d. The Transparency and Coverage Rule of 2020;

Non-disclosure of adolescent mental health services effective 2021 and updated effective 2025;
e. The Consolidated Appropriations Act of 2021 effective 2021;
f. The final rule regarding the non-quantitative treatment limitation comparative analysis required under MHPAEA effective January 2026;
g. The No Surprises Act effective January 2022;
h. The out-of-state prescriptions mandate that was effective June 27, 2024; and
i. The mammogram benefit levels, which became effective in 2025.

7. Chapter 12 glossary was updated to add revised verbiage and relevant definitions including the following: “cardiac rehabilitation”, “dependent”, “family coverage”, “family member”, “member”, “qualified medical child support order”, “single coverage”, “spouse, subscriber”, “substance abuse services”, and “you and your family”.

Ms. Yee and Ms. Conlon had the same concerns as on the previous plan. There were no additional concerns.

Chair Pang asked for a motion to recommend continued approval of the plan with conditions. It was moved by Ms. Conlon, seconded by Mr. Graves, and unanimously carried to recommend continued approval of the plan under Section 393-7(a) provided:

1. The plan specifies regular and special diets as a hospital benefit;
2. The plan specifies general nursing as a hospital benefit;
3. Physical Therapy limit of 90 days is removed;
4. Occupational Therapy limit of 90 days is removed;
5. Correct spelling of the title “Physician’s Assistant” to “Physician Assistant” throughout the plan;
6. Exclusion of treatment of developmental delay is removed; and
7. Screening Colonoscopy and Fecal Occult Blood Test sections contain references to the location of medical policies.

d. <u>HMAA 90/10 PPO</u>

Ms. Murakami reported that the HMAA 90/10 PPO plan (formerly known as Summerlin Easy Hawai’i 90/10 PPO) is a 7(a) PPO plan that was acquired from Summerlin Life & Health Insurance Company in 2010. This plan is geared towards major medical and prevention, similar to HMSA’s Preferred Provider 2010 plan but with copays for office visits and most other services covered at 90/10. The target market for this plan are employers who want a plan similar to HMAA’s richest plan.

HWMG informed the Department of changes made to the plan and requested continued approval under Section 393-7(a). Changes would be effective January 1, 2026.

Ms. Vitolo stated that the following revisions were made to all plans submitted for Council review:

1. Verbiage added for clarification and compliance with State and Federal network adequacy requirements;

2. Verbiage added for mental health parity Federal compliance;

3. Cardiac Rehabilitation section was added with benefits in compliance with HRS Chapter 393. Cardiac rehabilitation would be covered at 90% before the deductible for participating providers and 75% after the deductible for nonparticipating providers

4. Updates based on Federal and State laws including special benefits for homebound terminal or long-term care verbiage was revised for clarification and compliance with MHPAEA;

5. Under the General Provisions section, “Categories of Coverage” was added for clarification and definition purposes;

6. Chapter 10 General Provisions Other Applicable Federal and State laws was revised and updated to include the following:

    a. HIPAA effective August 1, 1996;
    b. The HIPAA Reproductive Health Care Act of 2024 effective December 23, 2024;
    c. The HIPAA Privacy Rule and Reproductive Health Care Act of 2024 effective February 16, 2026;
    d. The Transparency and Coverage Rule of 2020;
    e. Non-disclosure of adolescent mental health services effective 2021 and updated effective 2025;
    f. The Consolidated Appropriations Act of 2021 effective 2021;
    g. The final rule regarding the non-quantitative treatment limitation comparative analysis required under MHPAEA effective January 2026;
    h. The No Surprises Act effective January 2022;
    i. The out-of-state prescriptions mandate that was effective June 27, 2024; and
    j. The mammogram benefit levels, which became effective in 2025.

7. Chapter 12 glossary was updated to add revised verbiage and relevant definitions including the following: “cardiac rehabilitation”, “dependent”, “family coverage”, “family member”, “member”,

"qualified medical child support order", "single coverage", "spouse, subscriber", "substance abuse services", and "you and your family".

There were no additional concerns beyond those mentioned on previous plans.

Chair Pang asked for a motion to recommend continued approval of the plan with conditions. It was moved by Mr. Graves, seconded by Ms. Conlon, and unanimously carried to recommend continued approval of the plan under Section 393-7(a) provided:

1. The plan specifies regular and special diets as a hospital benefit;
2. The plan specifies general nursing as a hospital benefit;
3. Physical Therapy limit of 90 days is removed;
4. Occupational Therapy limit of 90 days is removed;
5. Correct spelling of the title "Physician's Assistant" to "Physician Assistant" throughout the plan;
6. Exclusion of treatment of developmental delay is removed; and
7. Screening Colonoscopy and Fecal Occult Blood Test sections contain references to the location of medical policies.

e. Executive Plan Option

Ms. Murakami reported that the Executive Plan Option was established in 1995. It is a 7(b) PPO plan for employers who contribute at least half of the cost of the coverages of dependent premiums but want a PPO plan with a lower premium option.

HWMG informed the Department of changes made to the plan and requested continued approval under Section 393-7(b). Changes would be effective January 1, 2026.

Ms. Vitolo stated that the following revisions were made to all plans submitted for Council review:

1. Verbiage added for clarification and compliance with State and Federal network adequacy requirements;

2. Verbiage added for mental health parity Federal compliance;

3. Cardiac Rehabilitation section was added with benefits in compliance with HRS Chapter 393. Cardiac rehabilitation would be covered at 90% before the deductible for participating providers and 70% after the deductible for nonparticipating providers.

4. Updates based on Federal and State laws including special benefits for homebound terminal or long-term care verbiage was revised for clarification and compliance with MHPAEA

5. Under the General Provisions section, “Categories of Coverage” was added for clarification and definition purposes;

6. Chapter 10 General Provisions Other Applicable Federal and State laws was revised and updated to include the following:

    a. HIPAA effective August 1, 1996;
    b. The HIPAA Reproductive Health Care Act of 2024 effective December 23, 2024;
    c. The HIPAA Privacy Rule and Reproductive Health Care Act of 2024 effective February 16, 2026;
    d. The Transparency and Coverage Rule of 2020;
    e. non-disclosure of adolescent mental health services effective 2021 and updated effective 2025;
    f. The Consolidated Appropriations Act of 2021 effective 2021;
    g. The final rule regarding the non-quantitative treatment limitation comparative analysis required under MHPAEA effective January 2026;
    h. The No Surprises Act effective January 2022;
    i. The out-of-state prescriptions mandate that was effective June 27, 2024; and
    j. The mammogram benefit levels, which became effective in 2025.

7. Chapter 12 glossary was updated to add revised verbiage and relevant definitions including the following: “cardiac rehabilitation”, “dependent”, “family coverage”, “family member”, “member”, “qualified medical child support order”, “single coverage”, “spouse, subscriber”, “substance abuse services”, and “you and your family”.

There were no additional concerns beyond those mentioned on previous plans.

Chair Pang asked for a motion to recommend continued approval of the plan with conditions. It was moved by Ms. Yee, seconded by Mr. Graves, and unanimously carried to recommend continued approval of the plan under Section 393-7(b) provided:

1. The plan specifies regular and special diets as a hospital benefit;
2. The plan specifies general nursing as a hospital benefit;
3. Physical Therapy limit of 90 days is removed;
4. Occupational Therapy limit of 90 days is removed;

5. Correct spelling of the title “Physician’s Assistant” to “Physician Assistant” throughout the plan;
6. Exclusion of treatment of developmental delay is removed; and
7. Screening Colonoscopy and Fecal Occult Blood Test sections contain references to the location of medical policies.

f. HMAA PPO Plan

Ms. Murakami reported that the HMAA PPO Plan like the Executive Plan Option is geared towards major medical and prevention for employers who contribute at least half of the cost of the coverages of dependent premiums but want a PPO plan with a lower premium option. It is also a 7(b) plan, but it was acquired from Summerlin Life & Health Insurance Company and was formerly known as Summerlin Easy Hawai‘i PPO Plan.

HWMG informed the Department of changes made to the plan and requested continued approval under Section 393-7(b). Changes would be effective January 1, 2026.

Ms. Vitolo stated that the following revisions were made to all plans submitted for Council review:

1. Verbiage added for clarification and compliance with State and Federal network adequacy requirements;

2. Verbiage added for mental health parity Federal compliance;

3. Cardiac Rehabilitation section was added with benefits in compliance with HRS Chapter 393. Cardiac rehabilitation would be covered at 90% before the deductible for participating providers and 75% after the deductible for nonparticipating providers

4. Updates based on Federal and State laws including special benefits for homebound terminal or long-term care verbiage was revised for clarification and compliance with MHPAEA;

5. Under the General Provisions section, “Categories of Coverage” was added for clarification and definition purposes;

6. Chapter 10 General Provisions Other Applicable Federal and State laws was revised and updated to include the following:

    a. HIPAA effective August 1, 1996;
    b. The HIPAA Reproductive Health Care Act of 2024 effective December 23, 2024;
    c. The HIPAA Privacy Rule and Reproductive Health Care Act of 2024 effective February 16, 2026;
    d. The Transparency and Coverage Rule of 2020;

e. Non-disclosure of adolescent mental health services effective 2021 and updated effective 2025;
f. The Consolidated Appropriations Act of 2021 effective 2021;
g. The final rule regarding the non-quantitative treatment limitation comparative analysis required under MHPAEA effective January 2026;
h. The No Surprises Act effective January 2022;
i. The out-of-state prescriptions mandate that was effective June 27, 2024; and
j. The mammogram benefit levels, which became effective in 2025.

7. Chapter 12 glossary was updated to add revised verbiage and relevant definitions including the following: “cardiac rehabilitation”, “dependent”, “family coverage”, “family member”, “member”, “qualified medical child support order”, “single coverage”, “spouse, subscriber”, “substance abuse services”, and “you and your family”.

There were no additional concerns beyond those mentioned on previous plans.

Chair Pang asked for a motion to recommend continued approval of the plan with conditions. It was moved by Ms. Conlon, seconded by Mr. Graves the plan under Section 393-7(b) provided:

1. The plan specifies regular and special diets as a hospital benefit;
2. The plan specifies general nursing as a hospital benefit;
3. Physical Therapy limit of 90 days is removed;
4. Occupational Therapy limit of 90 days is removed;
5. Correct spelling of the title “Physician’s Assistant” to “Physician Assistant” throughout the plan;
6. Exclusion of treatment of developmental delay is removed; and
7. Screening Colonoscopy and Fecal Occult Blood Test sections contain references to the location of medical policies.

Next Meeting: Thursday, August 7, 2025

In-Person Meeting Location: Princess Ruth Keʻelikōlani Building
830 Punchbowl Street, Room 209
Honolulu, Hawaiʻi 96813

Virtual Videoconference Meeting – Teams Meeting

Adjournment: The meeting adjourned at 2:26 p.m.

( ) Minutes approved as is.
( ) Minutes approved with changes: