

Prepaid Health Care Advisory Council Meeting

State of Hawaii
Department of Labor and Industrial Relations
830 Punchbowl Street, Room 310
Honolulu, HI 96813

November 21, 2019
1:30 p.m. to 2:50 p.m.

Council members present

Mr. Paul Marx, Chair
Ms. Laudra Eber
Dr. John McDonnell
Mr. Michael Moss
Ms. Bonnie Pang

Council members not present

Ms. Carol Shimomura

DC Staff Present

Lois Iyomasa
Stacey Hiranaka
Kimi Kaneda
Misty Sumida

Others Present

Nessay Sanderson, Kaiser
Mitchell Lau, Kaiser
Brendon Kumabe, HMSA
Austin Bunag, HMSA
Tammy Vitolo, HWMG
Paul Kaiser, HWMG
Adam Rosenberg, Attorney General's Office

With a quorum present, Chair Marx called the meeting to order at 1:30 p.m. He announced that Mr. Moss would be leaving the Council and thanked Mr. Moss for his service.

Approval of Minutes

Chair Marx asked if there were any changes to the circulated minutes of the July 22, 2019 meeting. Dr. McDonnell had some grammatical concerns regarding pronouns and proper nouns but had no substantive issues, so he did not make any changes. A motion was made by Ms. Eber to approve the minutes as circulated. The motion was seconded by Ms. Pang and carried by unanimous vote.

Review of plans

Scholastic Book Fairs, Inc
Self-funded



Choice Plus Hawaii POS 2018 Plan

This PPO medical plan has a \$300 individual deductible, 80% (PPO)/70% (NPO) benefit and \$3000 (all) out-of-pocket limit including the deductible and copayments.

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

Enthuse, LLC
Cigna Health and Life Insurance Company



OAP Medical Benefits Hawaii Plan

This PPO medical plan has a \$250 individual deductible, 90% (PPO)/70% (NPO) benefit and \$2500 (PPO)/\$3000 (NPO) (all) out-of-pocket maximum including the deductible and copayments.

Ms. Eber stated the employer did not provide necessary information regarding the employee contribution for dependents' coverage which was necessary since the plan may be approved under Section 393-7(b). Although the employee may have single coverage now, the employee may want dependent coverage in the future.

Ms. Pang was concerned about the exclusion for charges arising out of or relating to any violation of a health-related state or federal law or which themselves are a violation of a healthcare-related state or federal law. In researching this she found the prevalent plan covers injuries or accidents that occur in the event of an illegal situation. It would be subrogated only if it were brought to HMSA's attention by documentation, such as a law suit or claim filed, that there was another party involved. This includes injuries that happen when committing a crime.

Ms. Eber stated it was not clear to her what health-related laws the exclusion was concerned about. She could only think of two health-related laws: the requirement that a person to notify a partner if the person has HIV and laws against abortion. Dr. McDonnell added that it may be illegal to intentionally try to hurt someone by spreading HIV.

Mr. Moss asked if the intent was to inform the employer that the exclusion was not allowed. Chair Marx did not know if it was proper to have the exclusion or not. Dr. McDonnell felt the employer should be notified the plan could be approved if the exclusion was removed. Chair Marx concurred. Mr. Moss asked if this meant that the prevalent plan covers the services described in the exclusion. Ms. Eber agreed.

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

1. PPO benefit is at least 80% for Inpatient Hospital Physician's Visits/Consultations;
2. PPO benefit is at least 80% for Inpatient Hospital Professional Services;
3. PPO benefit is at least 80% for all subsequent Prenatal Visits, Postnatal Visits and Physician's Delivery Charges;
4. Charges made by a Nurse, other than a member of your family or your Dependent's family, is modified to only exclude services provided by a parent, child, or spouse of the insured;
5. Exclusion for Home Health Services and Hospice Services by a person who is a parent, child or spouse who normally resides in your house or your Dependent's house is modified to exclude only a parent, child, or spouse of the insured; and
6. The exclusion for charges arising out of or relating to any violation of a health-related state or federal law or which themselves are a violation of a healthcare-related state or federal law is removed.

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


Hiossen, Inc. 
Cigna Health and Life Insurance Company

Hawaii OAP HDHP Plan

This PPO medical plan has a \$300 individual deductible, 100% (PPO)/70% (NPO) benefit and \$2500 (PPO)/\$3000 (NPO) (all) out-of-pocket maximum including the deductible and copayments.

Chair Marx asked if there were concerns about the plan or about the out of network services and Pennsylvania law. Ms. Pang felt it was appropriate to obtain clarification of the exclusion.

A motion was made by Ms. Pang to request clarification of the NPO emergency services charges and Pennsylvania law. The motion was seconded by Dr. McDonnell and carried by unanimous vote.

Sales Partnerships, Inc 
Cigna Health and Life Insurance Company

Open Access Hawaii

This PPO medical plan has a \$0 (PPO)/\$300 (NPO) individual deductible, 90% (PPO)/70% (NPO) benefit and \$2500 (PPO)/\$3000 (NPO) (all) out-of-pocket maximum including the deductible and copayments.

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

1. The \$250 NPO penalty for not obtaining outpatient certification for outpatient diagnostic testing and outpatient procedures prior to the date the testing or procedure is performed is removed;
2. The exclusion of home health services and hospice services by a person who is a parent, child, or spouse who normally resided in your house or your dependent's house is modified to exclude only home health services and hospice services by a parent, child, or spouse of the insured;
3. The 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 removed or modified by removing the word "or;" and
4. The exclusion of benefits for or in connection with an injury or sickness arising out of, or in the course of, any employment for wage or profit is replaced with a subrogation clause entitling the insurer to a right of recovery.

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


Stearns Conrad and Schmidt (SCS) Consulting Engineers, Inc. 
Self-funded

UnitedHealthcare Hawaii Options PPO Plan

This PPO medical plan has a \$100 individual deductible, 90% (PPO)/70% (NPO) benefit and \$2500 (all) out-of-pocket maximum including the deductible and copayments.

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

The Council discussed concerns that numerous Cigna plans have been submitted, either by Cigna or employers, with the similar issues and how the repeated issues affect the review process and employee's benefits.

Roland Corporation 
Cigna Health and Life Insurance Company

OAP Medical Benefits Hawaii Plan

This PPO medical plan has a \$300 individual deductible, 90% (PPO)/70% (NPO) benefit and \$2300 (PPO)/\$3000 (NPO) (all) out-of-pocket maximum including the deductible and copayments.

Mr. Moss wondered what the employer had been doing since the documents showed two different effective dates of 2017 and 2018 but the plan was being reviewed by Council in 2019. He was concerned that the employer looking for retroactive approval of a plan could be at risk

because the employer may not have been following the law and could be responsible for the full cost of the services that were not covered but should have been.

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

1. Outpatient in-vitro fertilization expenses are covered for at least one attempt;
2. Charges made by a Nurse, other than a member of your family or your Dependent's family, for professional nursing services, is modified to only exclude services provided by a parent, child, or spouse of the insured;
3. Private hospital rooms are covered if medically necessary;
4. Exclusion of benefits for or in connection with an Injury or Sickness arising out of, or in the course of, any employment for wage or profit, is replaced with a subrogation clause entitling the insurer a right to recovery;
5. Exclusion of charges made by any covered provider who is a member of your family or your Dependent's Family is modified to only exclude services provided by a parent, child, or spouse of the insured; and
6. Exclusion of Home Health Services and Hospice Services by a person who is a parent, child or spouse who normally resides in your house or your Dependent's house is modified to exclude only a parent, child, or spouse of the insured.

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

Accredo Health Group, Inc.
Self-funded



Express Scripts Health Reimbursement Account Traditional Plan

This PPO medical plan has a \$2000 (PPO)/\$4000 (NPO) individual deductible, 80% (PPO)/50% (NPO) benefit and \$3500 (PPO)/\$7000 (all) out-of-pocket maximum including the deductible and copayments.

The Council discussed that this plan includes a health reimbursement account (HRA). The HRA was different from a health savings account (HSA), which had been disapproved by the department in the past, although there were similarities between the two. Ms. Eber recalled that HRAs have been approved in the past. Mr. Moss recalled that the HSA was disapproved because the department could not enforce the terms of the HSA.

Ms. Pang felt this could open a larger discussion because the HRA was very similar to the HSA that she was familiar with previously. She suggested going to the director for further discussion then asked for a description of the HRAs approved in the past. Ms. Eber recalled that the plan had a high deductible and the HRA was funded with an amount that made up the difference between an acceptable deductible and the plan's actual deductible.

Mr. Moss stated that the HRAs were approved previously but in the interim the HSAs were not approved. He suggested a discussion with the director whether the department has the same concerns with this plan as with the HSAs.

Ms. Eber noted that as submitted, the employer was not funding a sufficient amount to the HRA. She suggested spelling out to the employer the exact dollar amount that the employer must fund into the HRA.

Ms. Pang pointed out that there would be a penalty if HSA funds were used for other purposes. Mr. Moss agreed but explained that on a simplistic level, if the HSA funds were used for other purposes, it would not reduce the deductible and out-of-pocket maximum to acceptable amounts. In contrast, the HRA funding was restricted to benefits of the prepaid health care plan and could not be used for other expenses.

Mr. Moss reiterated that the director should review the Council's advice and consider any concerns the director has about the HRA, including enforcement, before final approval on the plan.

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

1. Annual individual deductible (with employer HRA funding) is capped at \$350;
2. HRA funding is not prorated for mid-year enrollees if HRA funding is used to meet the annual individual deductible cap in Item 1 above;
3. Annual individual out-of-pocket limit (with employer HRA funding) is capped at \$3000 including the deductible and all copayments;
4. Eligibility requirement is in compliance with the PHC Act;
5. Waiting period for late enrollees is waived when coverage is required due to a termination of the Form HC-5 waiver;
6. Penalty for noncompliance with the preadmission certification program is at least a 70% benefit with a maximum penalty of \$400/admission and, in the aggregate, \$1000/year;
7. NPO benefit is at least 70%;
8. At least 12 well-child (preventive) care visits are covered without a deductible for children under age 6 whether services are received in- or out-of-network;
9. Exclusion of services for and any fees associated with Surrogacy/Gestational Carriers is modified to cover the insured who is a surrogate;
10. Exclusion of services rendered by a non-participating provider, unless authorized by the Medical Management Program is removed;
11. Exclusion of services rendered by a Provider who is a close relative or member of your household is modified to only exclude services provided by a parent, child, or spouse of the insured;
12. Exclusion of services paid under Medicare or which would have been paid if the Member had applied for Medicare and claimed Medicare benefits is removed;
13. Exclusion of services for any disease or injury resulting from a war, declared or not, or any military duty or any release of nuclear energy, is modified by adding the phrase "to the extent permitted by law";
14. Exclusion of care for any condition or Injury recognized or allowed as a compensable loss through any Workers' Compensation, occupational disease or similar Law, is replaced with a subrogation clause entitling the insurer a right to recovery; and
15. Full medical coverage is continued for a disabled employee for at least three months following the month of disability.

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

Electronic Arts, Inc
Self-funded



OAP Medical Benefits Hawaii Plan

This PPO medical plan has a \$200 (PPO)/\$300 (NPO) individual deductible, 90% (PPO)/70% (NPO) benefit and \$2000 (PPO)/\$3000 (NPO) (all) out-of-pocket maximum including the deductible and copayments.

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

1. NPO hospital admission deductible for abortions is removed;
2. Charges made by a Nurse, other than a member of your family or your Dependent's family, for professional nursing services, is modified to only exclude services provided by a parent, child, or spouse of the insured;
3. Private hospital rooms are covered if medically necessary;
4. Exclusion of benefits for or in connection with an Injury or Sickness arising out of, or in the course of, any employment for wage or profit, is replaced with a subrogation clause entitling the insurer a right to recovery;
5. Exclusion of charges made by any covered provider who is a member of your family or your Dependent's Family is modified to only exclude services provided by a parent, child, or spouse of the insured; and
6. Exclusion of Home Health Services and Hospice Services by a person who is a parent, child or spouse who normally resides in your house or your Dependent's house is modified to exclude only a parent, child, or spouse of the insured.

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

One Source Virtual HR, Inc.
Cigna Health and Life Insurance Company



OAP Medical Benefits Hawaii Plan

This PPO medical plan has a \$300 individual deductible, 90% (PPO)/70% (NPO) benefit and \$3000 (all) out-of-pocket maximum including the deductible and copayments.

Ms. Eber stated the employer did not provide necessary information regarding the employee contribution for dependents' coverage which was necessary since the plan may be approved under Section 393-7(b).

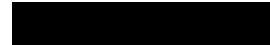
A motion was made by Ms. Pang to recommend approval of the plan under Section 393-7(b) provided:

1. The premium allocation for dependent coverage is in compliance with the PHC act;

2. Charges made by a Nurse, other than a member of your family or your Dependent's family, for professional nursing services, is modified to only exclude services provided by a parent, child, or spouse of the insured;
3. Private hospital rooms are covered if medically necessary;
4. Exclusion of benefits for or in connection with an Injury or Sickness arising out of, or in the course of, any employment for wage or profit, is replaced with a subrogation clause entitling the insurer a right to recovery;
5. Exclusion of charges made by any covered provider who is a member of your family or your Dependent's Family is modified to only exclude services provided by a parent, child, or spouse of the insured; and
6. Exclusion of Home Health Services and Hospice Services by a person who is a parent, child or spouse who normally resides in your house or your Dependent's house is modified to exclude only a parent, child, or spouse of the insured.

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

Travel Helpline, Inc.
Cigna Health and Life Insurance Company



OAP Medical Benefits Hawaii Plan

This PPO medical plan has a \$100 individual deductible, 90% (PPO)/70% (NPO) benefit and \$2500 (all) out-of-pocket maximum including the deductible and copayments.

The Council discussed whether the exclusion of services rendered and separately billed by employees of hospitals, laboratories or other institutions was acceptable. Ms. Eber and Chair Marx felt the exclusion was not acceptable. For example, when surgery was performed, the anesthetist may bill for services separately from the hospital and those services were covered by the medical plan. As an opposing example, Mr. Moss explained that a hospital may do its own labs and bill for the labs or if it had another company on site do labs, the company could bill separately from the hospital. Dr. McDonnell provided an example of acceptable separate billing when a cardiologist who was not a hospital employee billed separately for performing a procedure. However, a hospitalist, an employee of the hospital, would not bill separately for a procedure because the hospital bills for the procedure. Chair Marx summarized that the Council's advice on this item was no. Dr. McDonnell explained that the plan was excluding the coverage of a hospitalist billing separately from the hospital. Chair Marx stated the Council felt the exclusion was permissible.

The Council discussed whether the exclusion of expenses incurred to the extent that payment is unlawful where the person resides when the expenses are incurred was acceptable. Ms. Pang wondered if this was referring to services in Canada, Mexico, and elsewhere outside the country. She, Dr. McDonnell and Ms. Eber felt the employer should provide clarification or an example. Mr. Moss stated that if a procedure were not approved or recognized by the plan, it could be excluded from coverage in the plan. Dr. McDonnell agreed and stated that it was unusual to apply the term "unlawful" in this type of exclusion.

A motion was made by Ms. Pang recommended approval of the plan under Section 393-7(b) provided:

1. The employer clarifies the exclusion of expenses incurred to the extent that payment is unlawful where the person resides when the expenses are incurred;
2. Charges made by a Nurse, other than a member of your family or your Dependent's family, for professional nursing services, is modified to only exclude services provided by a parent, child, or spouse of the insured;
3. Limitation to facilities as defined by New York Mental Hygiene for Mental Health Care Services and Chemical Dependency Services is removed;
4. Exclusion of benefits provided under any workers' compensation employers' liability or occupational disease law is replaced with a subrogation clause entitling the insurer a right to recovery;
5. Exclusion of services performed a member of the covered person's immediate family is modified to only exclude services provided by a parent, child, or spouse of the insured; and
6. Home Health Services and Hospice Services by a person who is a parent, child or spouse who normally resides in your house or your Dependent's house is modified to exclude only a parent, child, or spouse of the insured.

The motion was seconded by Mr. Moss.

Dr. McDonnell interjected that he was not comfortable recommending approval when the provision about unlawful payments was not clear. He asked if the Council should wait for more information before making any recommendation. He stated in the past action has been deferred until the Council received more information.

Ms. Pang and Mr. Moss retracted the motion and second.

A motion was made by Ms. Pang to defer action on the plan. The motion was seconded by Mr. Moss and carried by unanimous vote.

Cigna Health and Life Insurance Company
Self-funded



Cigna Companies Hawaii Preferred Provider Medical Benefits

This PPO medical plan has a \$0 (PPO)/\$300 (NPO) individual deductible, 90% (PPO)/70% (NPO) benefit and \$3000 (all) out-of-pocket maximum including the deductible and copayments.

Ms. Eber stated the employer did not provide necessary information regarding the employee contribution for dependents' coverage which was necessary since the plan may be approved under Section 393-7(b).

Chair Marx felt the plan should be deferred until the employer clarified the exclusion of services where payment is unlawful where the person resides when the expenses are incurred.

Dr. McDonnell felt the exclusion for charges arising out of or relating to any violation of a health-related state or federal law or which themselves are a violation of a healthcare-related state or federal law should be removed.

A motion was made by Ms. Eber to defer action on the plan. The motion was seconded by Ms. Pang and carried by unanimous vote.

The Foundation Center
Cigna Health and Life Insurance Company



OAP Medical Benefits Hawaii Plan

This PPO medical plan has a \$0 (PPO)/ \$300 (NPO) individual deductible, 100% (PPO)/80% (NPO) benefit and \$2500 (PPO)/\$3500 (NPO) (all) out-of-pocket maximum including the deductible and copayments.

Ms. Pang stated the plan has exclusions for services rendered and separately billed by employees of hospitals, laboratories or other institutions and for expenses incurred to the extent that payment is unlawful where the person resides when the expenses are incurred. She suggested action should be deferred while the employer clarifies the latter exclusion.

A motion was made by Ms. Pang to defer action on the plan. The motion was seconded by Ms. Eber and carried by unanimous vote.

American Advisors Group
Cigna Health and Life Insurance Company



OAP Medical Benefits Hawaii Plan

This PPO medical plan has a \$300 individual deductible, 80% (PPO)/70% (NPO) benefit and \$3000 (all) out-of-pocket maximum including the deductible and copayments.

Ms. Eber stated the employer did not provide necessary information regarding the employee contribution for dependents' coverage which was necessary since the plan may be approved under Section 393-7(b).

The Council discussed the \$50 per visit copayment for advanced radiological imaging billed by a facility as part of an emergency room visit. Mr. Moss asked if anyone was familiar with the cost of advanced radiological imaging. Ms. Eber considered the copayment acceptable.

Dr. McDonnell mentioned that a chest CT was not uncommon and could be considered advanced but was unsure of the cost. Ms. Pang read the plan details that described the services to include MRI or PET scans and stated that the provider would basically be charging upfront. Ms. Nessay Sanderson of Kaiser explained that Kaiser has separate copayments for emergency room and advanced imaging. Mr. Mitchell Lau of Kaiser added that the advanced imaging has a 20% coinsurance. Chair Marx, Dr. McDonnell, and Ms. Pang stated the copayment was acceptable.

The Council discussed the \$25 per visit copayment for advanced radiological imaging billed by a facility as part of an urgent care visit. Dr. McDonnell wondered whether an urgent care facility would perform advanced radiological imaging. He felt urgent care providers may do imaging on fractures with some limitations and that more complex imaging would be directed to a hospital. He also questioned whether an urgent care facility would have a radiologist on staff for the advanced imaging. Mr. Moss and Ms. Eber stated the \$25 copayment was acceptable.

The Council discussed the \$40 per visit copayment for lab services and radiology services at an office visit. While Ms. Eber stated the copayment was lower than what she had experienced. Dr. McDonnell stated a complete blood count or CBC would cost about \$7 if a person without insurance paid cash. Based on this cost, a \$40 copayment was high. Ms. Eber asked if the \$40 copayment was acceptable if the person had multiple tests performed in one visit. Dr. McDonnell acknowledged the \$40 may be acceptable if the person had multiple tests. Ms. Pang stated the coinsurance for labs on the prevalent plan was 10%. Mr. Austin Bunag of HMSA confirmed the coinsurance was 10%. He also stated HMSA has a plan with a lab copayment of \$10 and that if the lab costs less than \$10, HMSA charges the cost of the lab. Dr. McDonnell was concerned that a provider may charge the full \$40 copayment even if the cost of the lab was less than the copayment. Ms. Pang and Dr. McDonnell suggested the copayment be capped at the lesser of the cost of the lab or the copayment. Mr. Moss stated that this wording would mean the patient received no benefit if the lab costs less than \$40. For example, if the lab costs \$36, the patient would pay the full \$36 because it was less than a \$40 copayment, and the insurance would not pay anything because the insurance was responsible only for the amount over \$40. Dr. McDonnell stated this does not match the prevalent plan that has a 10% coinsurance, but this was being reviewed as a 7(b) plan. Ms. Eber felt the \$40 was an acceptable copayment.

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

1. In-network benefit is at least an 80% benefit;
2. Out-of-network benefit is at least a 70% benefit;
3. The deductible is not applied to services with a copay;
4. The in-network benefit for laboratory services at an office visit is the lesser of the actual cost of the lab or the \$40 per visit copayment, then 100%;
5. The exclusion of charges made by a nurse, other than a member of your family or your dependent's family, for professional nursing service is modified to exclude only charges made by a nurse who is a parent, child, or spouse of the insured;
6. The exclusion of home health services and hospice services by a person who is a parent, child, or spouse who normally resides in your house or your dependent's house is modified to exclude only home health services and hospice services by a parent, child, or spouse of the insured;
7. The 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 removed or modified by removing the word "or;" and

8. The exclusion of charges made by any covered provider who is a member of your family or your Dependent's family is modified to exclude only charges made by a provider who is a parent, child, or spouse of the insured.

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

Unrelated to the plan, Mr. Moss reminded the Council that a while ago when the 7(b) maximum deductible had moved from \$300 to \$350, the Council wanted it on the agenda so it could be reviewed regularly.

Adjournment

Mr. Marx adjourned the meeting at 2:50 p.m. The next meeting may be scheduled for February 20 or February 27, 2020.

Administratively approved plans:

Teach for America, Inc.
The Queen's Medical Center
Astrazeneca Pharmaceutical LP
Cape Environmental Management, Inc.
The Money Source
Harrington Industrial Plastics LLC
QSI, Inc.
Charter Communications LLC
Prudential Insurance Company
Raytheon Company
CBIZ Network Solutions LLC
The Queen's Health Systems
United Healthcare Services, Inc.
Optum 360 Services, Inc.
Batesville Logistics, Inc.
American City Business Journals