Draft

Prepaid Health Care Advisory Council Meeting

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

Also via Microsoft Teams

August 10, 2023
1:35 p.m. to 2:55 p.m.

Council members present
Mr. Paul Marx, Chair
Ms. Bonnie Pang, Acting Chair
Ms. Winona White
Mr. Derek Kanehira
Mr. Wayne Graves

Council members absent
Mr. Mike Hogan
Dr. John McDonnell

DLIR/DC Staff present
Jade Butay, Director
Lois Iyomasa
Misty Sumida
Adam Rosenberg (Deputy Attorney General)

With a quorum present, Ms. Pang called the meeting to order at 1:35 p.m.

Approval of minutes

Ms. Pang asked if there were any changes to the circulated minutes of the June 26, 2023 meeting. There were no changes. A motion was made by Mr. Kanehira to approve the June 26, 2023 meeting minutes as circulated. The motion was seconded by Ms. White and carried by unanimous vote.

Review of plans

Kaiser Foundation Health Plan Inc (Kaiser Permanente) and Kaiser Permanente Insurance Company (KPIC)

Kaiser Permanente Group Added Choice Plan

Kaiser Permanente was represented by May Goya and Chad Hertzog. KPIC was represented by Conrad Llaguno.

Kaiser Permanente and KPIC submitted the new plan to be effective January 1, 2024. It would have an HMO component administered by Kaiser Permanente and a non-HMO component administer by KPIC. Kaiser Permanente and KPIC requested approval of the plan under Section 393-7(a).

Mr. Hertzog explained that the plan was a new Added Choice product with a lower cost plan design that paired the Kaiser Permanente Group Plan, an HMO, with an indemnity, out-of-network product designed after plans that were approved under Section 393-7(a). Kaiser Permanente viewed it as a point of service plan with three tiers with each of the tiers already approved individually as 7(a) plans. Mr. Herztog explained that the three tiers: (1) the KPG plan including providers in all Kaiser Permanente regions including those in California, Oregon, Washington, and the mid-Atlantic states; (2) a contracted network of over 3000 providers in Hawaii and Cigna PPO providers in non-Kaiser Permanente states on the mainland; and (3) noncontracted providers.

Ms. Pang read the preliminary review of the plan which indicated the plan could meet the current requirements of Section 393-7(a) provided the:

1. Annual individual deductible is capped at $100 (PPO/NPO combined);
2. Annual individual out-of-pocket maximum accumulates across the entire plan;
3. NPO benefit is at least 80% if less than 50% of the physicians/facilities in Hawaii participate in the network;
4. PPO benefit for hospital room and board is at least 90% without a deductible;
5. PPO benefit for outpatient hospital is at least 90% without a deductible;
6. PPO benefit for physicians office visits is at least 90% without a deductible;
7. PPO benefit for physician hospital visits is at least 90% without a deductible;
8. PPO benefit for lab and x-ray is at least 90% without a deductible;
9. PPO benefit for maternity is at least 90% without a deductible;
10. PPO benefit for pregnancy termination is at least 90% without a deductible;
11. PPO benefit for home health care is 100% without a deductible;
12. PPO benefit for hospice care is 100% without a deductible;
13. PPO benefit for treatment of infertility is at least 90% without a deductible;
14. PPO benefit for extended care/skilled nursing facility is at least 90% without a deductible;
15. PPO benefit for mental health and substance abuse is at least 90% without a deductible;
16. PPO benefit for urgent care is at least 90% without a deductible;
17. PPO benefit for adult well care visits is 100% without a deductible; and
18. PPO benefit for child well care visits is at 100% without a deductible.

Ms. Pang asked for the percentage of providers in Hawaii in the contracted network. Mr. Hertzog needed to check with the appropriate department to confirm.

Ms. Pang asked if the emergency benefit was 20% both in- and out-of-network. Mr. Herzog confirmed it was.

Mr. Kanehira questioned what would happen to other 7(a) plans either already approved or to be reviewed in the future if this plan were approved as is. He suggested it could change the floor for 7(a) plans. Mr. Marx responded it would be setting up changes. Ms. White also was concerned about the Council's authority to make changes and the impacts in the future, to the past, and to other carriers. Ms. Iyomasa stated the plans had been compared to the prevalent plan, that the preliminary review noted the differences between the proposed plan and the prevalent, and that one option was to defer action. Ms. White wondered about how questions regarding process authority and protocols clarified could be answered.

Ms. Pang stated that the Director has the final say about approval of 7(a) and 7(b) plans. The Council makes a recommendation based on the staff review and the Director makes the determination. Director Butay confirmed he would look at the Council's recommendation.

Mr. Marx felt the discussion should include an actuarial calculation to compare to the prevalent plan. He also felt that the Council could meet to review ground rules and make sure it was working within the parameters of its authority. In the past the Council had a range of acceptable benefit levels used to recommend approval to the Director, but Mr. Marx struggled between the due diligence done by the department and the Council's review and Council's accepting of the staff review for recommendation to the director. Mr. Marx suggested the Council could move this plan forward with the recommendation for the Director to review it and see where he feels it falls.

Mr. Graves asked about past protocol and actuarial equivalency as a check of the staff review. He also wanted staff to clarify if, based on the individual forms that were submitted, most of the deviations were in the out-of-plan coverage. Staff confirmed. Mr. Graves felt that it would be a huge deviation to recommend approval of the plan without changes due to the numerous exceptions. He was concerned that the benefits were mostly 80% instead of 90%.

Ms. Pang felt it could be a 7(b) plan instead of a 7(a) plan.

Mr. Graves felt that the HMO benefits met 7(a) standards, but the out-of-plan benefits were insufficient. He also wondered about the usage of the out-of-plan benefits and how many claims would be going through that component. Mr. Hertzog stated that for the existing Added Choice plan, 96% of claims were on tiers one or two. Of those claims 75% of the claim were on tier one which was the HMO component.

Mr. Hertzog described the PPO component on this plan as a hybrid, not a true PPO, because the plan was a point-of-service plan with three tiers of benefits.

Mr. Marx suggested the Council forward the plan to the Director with the numerous issues that should be amended, have Kaiser explain the deviations to the Director, then the Director could inform the Council on his position on the plan. Mr. Marx felt the Council did not have the due diligence in front of it during the meeting, but the Director had staff available that could further review and clarify. Mr. Graves and Ms. White felt Mr. Marx's comments were helpful.

Ms. White asked for an explanation of the Council's options. Ms. Pang stated the Council could approve the plan with the recommendations or defer a decision and redirect it for further review. Mr. Marx confirmed.

Ms. White asked if an actuarial analysis of the plan would confirm the usage of the tiers described by Mr. Hertzog and give the Council an idea of equivalency. Mr. Marx's understanding was that the actuarial review would take into consideration what had been discussed with the department for a while. The department provided reviews that were very granular in which the Council could see what was going on and which raised questions like comparing a 90% benefit on the prevalent plan to a $14 copayment on a reviewed plan. The Council did not know the amount charged so Council did not know if $14 was a good deal. The idea of an actuarial value was to give clarity on how the plans were financially different for the plan participants.

Mr. Austin Bunag of HMSA asked if the rationale for approving a plan that deviated from the current 7(a) standards would be available to all the contractors. Ms. Iyomasa stated the plan had been compared to the prevalent plans so based on the Council's recommendation, it could be approved under Section 393-7(a) if the plan were more in line with the current 7(a) plans. Mr. Marx felt the question related to Mr. Kanehira's earlier question. Mr. Bunag stated HMSA was not opposed to new plan designs but wanted to understand how to get a different plan design approved. Ms. Iyomasa did not have an answer at the time.

Mr. Graves asked Mr. Marx if he intended to use the actuarial value as a standard for fairness. Mr. Marx confirmed. Mr. Graves stated he agreed.

Ms. Pang called for additional discussion. There was none so she asked if the Council would defer making a recommendation and instead refer the plan to the Director. Mr. Marx stated he seconded the motion. The motion was carried by unanimous vote.

KP Platinum Added Choice

Kaiser Permanente and KPIC submitted the new plan to be effective January 1, 2024, replacing the KP Platinum Added Choice - $20 plan. It would have an HMO component administered by Kaiser Permanente and a non-HMO component administered by KPIC. Kaiser Permanente and KPIC requested approval of the plan under Section 393-7(a).

The plan had been approved as KP Platinum Added Choice - $20, but Ms. Goya explained the name change to KP Platinum Added Choice. There had been a bit of confusion on the file documents that had been submitted and the name approved by the Department so the staff had requested Kaiser change the name so everything would be in alignment. Changing the name required filing a new plan.

Ms. Pang reviewed the items that staff would be requesting of Kaiser for approval of the plan including a letter discontinuing the prior version of the plan and confirming the deductible and out-of-pocket maximums accumulate across the two components of the plan. Ms. Goya confirmed that if the plan were approved, a discontinuation of the prior version of the plan would

be submitted. Ms. Goya and Mr. Hertzog were unsure of the second item because the deductible and out-of-pocket maximums remained unchanged and the benefits were unchanged. Mr. Hertzog stated the HMO piece had no deductible but had an out-of-pocket maximum and the Added Choice piece had a separate out-of-pocket maximum just like the current plan that had initially been approved in October 2021.

Ms. Pang suggested Kaiser work on it with the staff for the necessary clarification.

Mr. Graves pointed out that on the staff identified several things including that the cost share for hearing aids had been reduced. He asked about Mr. Hertzog's statement that the plan had no benefit changes. Mr. Hertzog stated that the benefits that were covered remained unchanged, there was no deductible for the HMO pieces, the out-of-pocket maximums were separate for the HMO and the Added Choice pieces, and the Added Choice had separate accumulators for the contracted and non-contracted providers.

Mr. Graves felt most of the HMO benefits were more generous than required of 7(a) plans. He asked if recommended for approval, would the approval also pertain to the out-of-plan coverage? Ms. Pang stated the approval would be for only this plan. Mr. Graves explained he was looking at the PHC review form from KPIC for the KP Platinum Added Choice plan and asked if that plan would have a separate vote. Ms. Pang confirmed this plan was separate.

Mr. Graves asked whether the physician services in-patient benefit of 90% coinsurance was more generous than a $20 copayment per visit. Mr. Marx stated that historically the Council had ranges of acceptable amounts and the staff looked at the fluctuations. He stated that it was difficult to compare percentages and dollar amounts. Mr. Graves asked Ms. Iyomasa if the Council could assume the amount was acceptable if it was not flagged as an issue.

Ms. Goya stated she was unfamiliar with the concern mentioned and asked which document was being reviewed so she could clarify. Ms. Pang responded that it was a review sheet that Kaiser had completed comparing the submitted plan against the prevalent plan. Ms. Goya stated she did not have access to the office-use-only comments added to the form. Mr. Graves explained that his question was about the information provided by Kaiser.

Ms. Iyomasa responded that if it had not been flagged, the benefit was sufficient. Ms. Pang explained that the office-use-only column would call out significant differences.

Mr. Kanehira stated the Council had asked for a revised version of the form to include deviations that had been previously approved.

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

1. Discontinuation letter(s) for the corresponding previously approved Added Choice plan are received; and
2. Written confirmation that the deductibles and out-of-maximums cross-accumulate between tiers is provided as was provided with the corresponding previously approved Added Choice plan.

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

Other Business

Kaiser Permanente Group Added Choice 80/20 Plan

Kaiser Permanente informed the Department of benefit changes and language clarifications made to the plan that would be effective January 1, 2024. The plan has an HMO component administered by Kaiser Permanente and a non-HMO component administer by KPIC. Kaiser Permanente and KPIC requested continued approval of the plan under Section 393-7(a).

Ms. Goya reviewed the changes and clarifications to the plan which included changes that had been reviewed at the previous meeting for other Kaiser plans. The changes for this plan included only language changes, no cost changes. The prostate specific antigen screening benefit moved out of the special services for men section to the preventive section. The pulmonary rehabilitation services were renamed to include all rehabilitation services including pulmonary and cardiac and a confusing exclusion was removed. Languages changes were made to comply with the No Surprises Act in chapters 3, 7, and 8. An additional change that was not in the document was made to comply with an increased maximum set by the Insurance Commissioner after the plan had been submitted. The staff had advised Kaiser Permanente to address this change verbally in the meeting. The maximum benefit for orthodontic care for the treatment of orofacial anomalies would increase from $5500 to $6898. This change was in chapter 3, page 50.

Mr. Graves asked Ms. Iyomasa if the staff would document the additional change. Ms. Iyomasa confirmed it would be documented.

Ms. Goya confirmed that after the prior meeting, staff had asked for revised documentation including the change and that she would provide the documentation for plan.

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

KP HI Platinum 0/15

Kaiser Permanente informed the Department of benefit changes and language clarifications made to the plan that would be effective upon the employer groups' contract renewal dates beginning January 1, 2024, and requested continued approval of the plan under Section 393-7(a).

Ms. Goya described the changes. The basic laboratory and general imaging benefit changed from $10 to $15 per day. The hearing aid member copay changed from 60% to 20%. The dependent child coverage outside the service area category had several changes: specialty visits were included as part of the first ten visits; a 50% benefit was added after the tenth visit; a 50% benefit was added after the tenth service for the combined category of basic lab, imaging, and testing; and a 50% benefit was added for drug prescriptions after the tenth prescription. The prostate specific antigen screening benefit moved out of the special services for men section. The rehabilitation services were clarified to cover all rehabilitation preauthorized by Kaiser. The No

Surprises Act language changes were made in chapters 3, 7 and 8. The maximum for orofacial orthodontic care for treatment of orofacial anomalies increased.

Ms. White left the meeting.

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

KP HI Platinum 0/20

Kaiser Permanente informed the Department of benefit changes and language clarifications made to the plan that would be effective upon the employer groups' contract renewal dates beginning January 1, 2024, and requested continued approval of the plan under Section 393-7(a).

Ms. Goya described the changes. The hearing aid member copay changed from 60% to 20%. The dependent child coverage outside the service area category had several changes: specialty visits were included as part of the first ten visits; a 50% benefit was added after the tenth visit; a 50% benefit was added after the tenth service for the combined category of basic lab, imaging, and testing; and a 50% benefit was added for drug prescriptions after the tenth prescription. The location of the prostate specific antigen screening benefit, the rehabilitation services, and the No Surprises Act language changes were made. The maximum for orofacial orthodontic care for treatment of orofacial anomalies increased.

In response to Mr. Graves' question, Ms. Iyomasa confirmed that the staff's review included the changes described and there were no staff questions aside from the documentation of the change to the orofacial orthodontic care limit.

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

KP HI Platinum 0/20 Rx Ded

Kaiser Permanente informed the Department of benefit changes and language clarifications made to the plan that would be effective upon the employer groups' contract renewal dates beginning January 1, 2024, and requested continued approval of the plan under Section 393-7(a).

Ms. Goya described the changes. The hearing aid member copay changed from 60% to 20%. The dependent child coverage outside the service area category had several changes: specialty visits were included as part of the first ten visits; a 50% benefit was added after the tenth visit; a 50% benefit was added after the tenth service for the combined category of basic lab, imaging, and testing; and a 50% benefit was added for drug prescriptions after the tenth prescription. The location of the prostate specific antigen screening benefit, the rehabilitation services, and the No Surprises Act language changes were made. The maximum for orofacial orthodontic care for treatment of orofacial anomalies increased.

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

KP HI Gold 300/20 – B

Kaiser Permanente informed the Department of benefit changes and language clarifications made to the plan that would be effective upon the employer groups' contract renewal dates beginning January 1, 2024, and requested continued approval of the plan under Section 393-7(b).

Ms. Goya described the changes. The dependent child coverage outside the service area category had several changes: specialty visits were included as part of the first ten visits; a 50% benefit was added after the tenth visit; a 50% benefit was added after the tenth service for the combined category of basic lab, imaging, and testing; and a 50% benefit was added for drug prescriptions after the tenth prescription. The location of the prostate specific antigen screening benefit, the rehabilitation services, and the No Surprises Act language changes were made. The maximum for orofacial orthodontic care for treatment of orofacial anomalies increased.

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

Ms. Pang deviated from the order of the agenda to allow a question from Mr. Hertzog. Mr. Hertzog requested clarification on the confirmation of the cross-accumulators for the KP Platinum Added Choice plan. He believed there was a disconnect between what was previously approved and the staff concerns. The approved plan was not administered with cross accumulation between the HMO product and the out-of-network product. Ms. Pang directed him to the staff and Director.

Mr. Graves interjected that he had a related question. He observed that the Kaiser representatives had submitted two PHC review forms for the Added Choice plan – one for the in-network and one for the out-of-network and asked if two review forms had been filed for the KP Platinum Added Choice plan. Mr. Hertzog confirmed. Mr. Graves stated he had questioned the KP Platinum Added Choice plan because the issues were the same in the Kaiser Permanente Group Added Choice Plan which the Council had deferred back to the Director. Mr. Graves asked if the difference was due to it being worded differently.

Ms. Iyomasa responded that the KP Platinum Added Choice - $20 plan was being renamed so the newly renamed KP Platinum Added Choice plan benefits were supposed to be the same. The cross accumulation of the deductible should be the same but had not been listed in the KP Platinum Added Choice - $20 plan. The PHC review forms looked different because one was for an existing plan and one was for a new plan. For the Kaiser Permanente Group Added Choice Plan there was nothing to compare it to, but the KP Platinum Added Choice plan had something to compare to.

Mr. Graves replied that although the Kaiser Permanente Group Added Choice Plan did not have a predecessor to compare to, if the two submitted plans were compared, many of the issues

flagged on the Kaiser Permanente Group Added Choice Plan were also disparities on KP Platinum Added Choice. Ms. Iyomasa agreed and clarified that it would just be a name change. Mr. Graves pointed out that there were concerns about so many deviations in the Kaiser Permanente Group Added Choice Plan but KP Platinum Added Choice out-of-network piece by KPIC had the same deviations. He requested confirmation that despite the deviations on KP Platinum Added Choice, the plan could be approved with a name change. Ms. Pang stated the plan with the name change had been filed and was an approved plan. She understood that Mr. Graves noticed the changes in the plans looked similar, but it was coded as a new plan. She felt that clarification of the protocols and best practices would be helpful to ensure the Council is looking at it correctly and making the best recommendation to the Director.

Ms. Sumida added that another difference between the plans is that the KP Platinum Added Choice had been reviewed as if the out-of-network tier was a comprehensive medical plan which would usually have an 80% benefit for a 7(a) plan. The Kaiser Permanente Group Added Choice Plan's second tier was not a comprehensive medical plan because it had different benefit levels for the contracted network and outside the contracted network. It had been compared against the PPO plans which had a 90% benefit in-network and a 70% or 80% out-of-network benefit.

Mr. Hertzog asked about the staff request for confirmation of cross-accumulation of out-of-pocket maximums. He noted that the minutes from the meeting when the predecessor of the KP Platinum Added Choice plan was initially approved, there were only questions about the cross-accumulation of the diabetic drug and insulin. Ms. Sumida said that it had been previously represented that the out-of-pocket maximum cross-accumulated between tiers. Ms. Pang recommended Kaiser Permanente work with the staff.

Ms. Pang welcomed Mr. Graves and suggested the Council enter executive session meeting. Ms. Iyomasa recommended a future meeting could be held to present an outside point of view and help understand the review. Mr. Marx suggested a discussion with the Director to review best practices.

Adjournment

Ms. Pang adjourned the meeting at 2:55 p.m. The next meeting may be scheduled for September 21 or September 28, 2023.