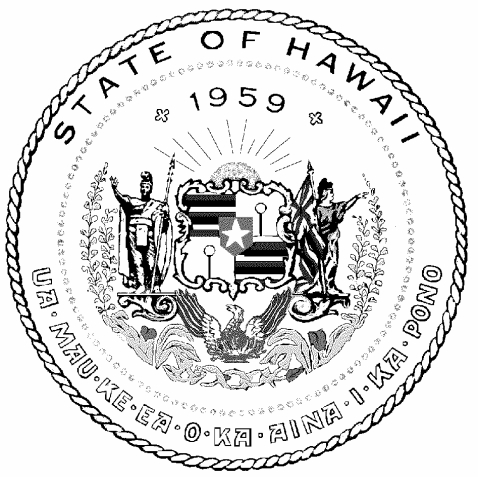

Report of the
Mandated Benefits Advisory Task Force

In Accordance with H.C.R. NO. 129, H.D.1, S.D.1, C.D.1
Adopted by the
Twenty-First Legislature of the State of Hawaii
Regular Session of 2001

Prepared by the

INSURANCE DIVISION
DEPARTMENT OF COMMERCE AND CONSUMER AFFAIRS
STATE OF HAWAII

December 2001

Executive Summary

House Concurrent Resolution No. 129, House Draft 1, Senate Draft 1, Conference Draft 1, which was adopted by the Twenty-First Legislature of the State of Hawaii, Regular Session of 2001, requested among other things, that the Insurance Commissioner establish a mandated benefits advisory task force (Task Force) to advise the 2002 Legislature on the problems surrounding Hawaii's mandated benefits and the legislative process enacting them. The concurrent resolution also instructed the Task Force to recommend legislation on the mandated benefit process as well as recommend legislation for the establishment of a permanent advisory panel to review mandated benefits.

H.C.R. NO. 129, H.D.1, S.D.1, C.D.1 directed the Insurance Commissioner to appoint the Task Force members and required that seven specific areas be represented on the Task Force:

- Licensed registered nurses;
- Licensed physicians;
- Alternate complementary care service providers;
- Professional medical associations;
- Health plans;
- Consumer advocate groups; and
- Members of the business community.

To facilitate the work of the Task Force, the Insurance Commissioner organized three subcommittees:

- Cost Utilization and Cost Avoidance Subcommittee;
- Appropriateness of Scope Subcommittee; and
- Healthcare Provider List Subcommittee.

The subcommittees' role was to gather information, review issues, and to identify, discuss, and develop specific recommendations for the full Task Force to consider.

The three subcommittees held several public meetings where they solicited input regarding the mandated health care benefits review and approval process from many stakeholders and interested parties. The subcommittees then reported their findings and recommendations to the full Task Force for its consideration. The full Task Force based its recommendations on the findings and recommendations of the three subcommittees.

Recommendations

The Mandated Benefits Advisory Task Force adopted the following recommendations:

1. Recommend that the Legislature adopt a concurrent resolution requesting the establishment of a task force to examine the effectiveness of the Prepaid Health Care Act and to consider the feasibility of amending or repealing it; and

2. Recommend that the Legislature replace the current review process to approve proposed mandated health care benefits with a new alternate process that is based on H.B. NO. 237, H.D.2, S.D.1 (2001) that incorporates appropriate elements from the models of the states of Washington, Pennsylvania, Virginia, and Maryland.

   The Legislature should also consider incorporating the following cost criteria:

   - Inclusion of the potential costs savings that may result from a proposed mandated health care benefit;

   - Inclusion of any increase in administrative and other "start-up" costs to health plans associated with providing the mandated health care benefit;

   - Require the review panel to consider broader social benefits when reviewing a proposed mandated health care benefit; and

   - Require the review panel to consider the potential additional costs that might result from the increased medical risks associated with providing the proposed mandated benefit.

When determining the composition of the review panel, the Legislature should also consider a balanced representation of stakeholders that includes providers and consumers.

The Legislature should also consider requiring that each mandated health care benefit undergo a sunset review every five years.

Insurance Division
Department of Commerce and Consumer Affairs
250 South King Street, 5th Floor
Honolulu, Hawaii 96813
PH: (808) 586-2790
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Foreword

This report was prepared in response to House Concurrent Resolution No. 129, House Draft 1, Senate Draft 1, Conference Draft 1, which was adopted by the Twenty-First Legislature of the State of Hawaii, Regular Session of 2001. In accordance with H.C.R. NO. 129, H.D.1, S.D.1, C.D.1, this report assesses the problems surrounding Hawaii's mandated benefits and the legislative process enacting them.

The Insurance Division wishes to acknowledge the cooperation and assistance of those state agencies, health plans, consumer advocates, health care providers, business representatives, and other interested organizations and individuals who took the time to participate in this endeavor. The Insurance Division also wishes to especially express its appreciation for the cooperation and assistance of the Task Force members. Without their total support, this report would not have been possible.

Wayne Metcalf
Insurance Commissioner
and Task Force Chair

Introduction

House Concurrent Resolution No. 129, House Draft 1, Senate Draft 1, Conference Draft 1, (Attachment 1) which was adopted by the Twenty-First Legislature of the State of Hawaii, Regular Session of 2001, requested among other things, that the Insurance Commissioner establish a mandated benefits advisory task force (Task Force) to advise the 2002 Legislature on the problems surrounding Hawaii's mandated benefits and the legislative process enacting them. The concurrent resolution also instructed the Task Force to recommend legislation on the mandated benefit process as well as recommend legislation for the establishment of a permanent advisory panel to review mandated benefits.

Organization, Structure, and Membership

H.C.R. No. 129, H.D.1, S.D.1, C.D.1, directed the Insurance Commissioner to appoint the Task Force members and required that seven specific areas be represented on the Task Force:

- Licensed registered nurses;
- Licensed physicians;
- Alternate complementary care service providers;
- Professional medical associations;
- Health plans;
- Consumer advocate groups; and
- Members of the business community.

Membership

In accordance with the membership specifications, the Insurance Commissioner appointed the following individuals to the Task Force:

- **Sharyn Stephani Monet, JD, RN**, from the Hawaii Nurses' Association, to represent licensed registered nurses;

- **Arlene Meyers, MD, JD**, to represent licensed physicians;

- **Lawrence Redmond, DC**, from PractiCare Hawaii, to represent alternate complementary care service providers;

- **Philip Hellreich, MD**, from the Hawaii Medical Association, to represent professional medical associations;

- **Paula Arcena**, from the Hawaii Medical Association, to represent professional medical associations;

- **Mike Cheng**, from the Hawaii Medical Service Association, to represent health plans;

- **Christopher Pablo, Esq.**, from Kaiser Permanente, representing health plans;

- **Ruth Ellen Lindenberg**, from the Kokua Council, to represent consumer advocate groups;

- **Laura Anderson, Esq.**, from Torkildson, Katz, Fonseca, Jaffe, Moore & Hetherington, designated by the Chamber of Commerce of Hawaii to represent members of the business community; and

- **Don Dawson**, from Dawson International, to represent members of the business community.

H.C.R. NO. 129, H.D.1, S.D.1, C.D.1 provided the Insurance Commissioner with flexibility in constituting the Task Force. The concurrent resolution specified that membership of the Task Force not be limited to the aforementioned areas. The Insurance Commissioner also appointed the following individuals:

- **The Honorable Kenneth Hiraki**, Chair of the House Committee on Consumer Protection and Commerce;

- **The Honorable Dennis Arakaki**, Chair of the House Committee on Health;
- **The Honorable Brian Taniguchi**, Chair of the Senate Committee on Ways and Means; and
- **Glenn Okihiro, DDS**, from the Hawaii Dental Association.

Subcommittees

To facilitate the work of the Task Force, the Insurance Commissioner organized three subcommittees:

- **The Cost Utilization and Cost Avoidance Subcommittee.** The Insurance Commissioner charged this subcommittee with the responsibility of gathering information on cost utilization and cost avoidance of mandated health care benefits. Mandating health care benefits can cause increases in utilization, which in turn may increase the direct costs to health plans. However, mandated benefits may also have been enacted to avoid potentially greater costs. For example, mandated diabetes coverage may have costs associated with utilization, but if the coverage is not provided, patients are thought to be less likely to avail themselves of the mandated preventive service. In these cases, the patient may experience much more serious and costly medical conditions as a result of not using the preventive services.

  Members:

  Senator Brian Taniguchi, Chair
  Laura Anderson, Esq.
  Mike Cheng
  Sharyn Stephani Monet, JD, RN
  Lawrence Redmond, DC

- **The Appropriateness of Scope Subcommittee.** The Insurance Commissioner charged this subcommittee with the responsibility of reviewing existing statutory mandated health care benefits as to their appropriateness of scope. Definitional changes or further clarification should be provided where determined to be

desirable. The costs/benefits of specific mandated health care benefits should be examined.

Members:

Representative Kenneth Hiraki, Chair
Mike Cheng
Don Dawson
Philip Hellreich, MD
Arlene Meyers, MD, JD
Sharyn Stephani Monet, JD, RN
Christopher Pablo, Esq.

- **Healthcare Provider List Subcommittee.** The Insurance Commissioner charged this subcommittee with the responsibility of reviewing the issues surrounding the historic expansion of the health care provider list to determine the continual appropriateness of existing providers and the cost effectiveness that can be realized by expanding or circumscribing the list.

  Members:

  Representative Dennis Arakaki, Chair
  Paula Arcena
  Don Dawson
  Ruth Ellen Lindenberg
  Glenn Okihiro, DDS
  Christopher Pablo, Esq.
  Lawrence Redmond, DC

Ground Rules

To ensure that the Task Force's and its subcommittees' deliberations maintained proper decorum, the Task Force adopted *Ground Rules for the Conduct of Business* (Attachment 2). The *Ground Rules* specified:

1. The voting rights of Task Force members and proxies;

2. The attendance policy; and

3. The applicability of the Public Meetings Law and the Uniform Information Practices Act (Modified).

Process

The Task Force and its subcommittees held several public meetings in the State Capitol Building and the Princess Victoria Kamamalu Building where they solicited input from many stakeholders and interested parties regarding the mandated health care benefits review and approval process. The members also discussed the appropriateness of the several suggestions to improving the current process. The Notice of Public Meetings (Attachments 3A to 6C) and the Minutes of the several meetings (Attachments 7A to 10C) are attached.

Based upon the content of their meetings, the subcommittees then reported their findings and recommendations to the full Task Force for its consideration (Attachments 11 to 13). The Task Force based its recommendations on the reports submitted by the subcommittees.

Background on Mandated Health Care Benefits

Since 1987, the Legislature has enacted several legislative measures mandating health insurance coverage for specific services, diseases, and health care service providers (see Attachment 14 for a summary of mandated health insurance coverages). That same year, the Legislature also established a process to review proposed mandated health care benefits. The review process enumerated in sections 23-51 and 23-52, Hawaii Revised Statutes (HRS) (Attachments 15 and 16), requires the Legislature to adopt concurrent resolutions requesting the State Auditor to study the social and financial effects of any proposed legislative measure that would mandate health insurance coverage for specific services, diseases, or providers.

The impetus for the law was legislative concern over the increasing number of these proposals and their impact on the costs of health care. The purpose of the assessment is to provide the Legislature with an independent review of the social and financial consequences of each proposal.

Specific Concerns

Based upon the information gathered, comments received, and resulting discussions, several concerns regarding the current review process were identified.

Impact Assessment Report

Notwithstanding the current law that requires the Legislature to request that the State Auditor prepare and submit a report that assesses the social and financial effects of proposed mandated health care benefits, one of the major concerns expressed about the current review process centered around the fact that the study has not always been conducted. The study has not always been conducted because the Legislature has not always adopted the required concurrent resolution.

Short of amending the Constitution of the State of Hawaii to require the Legislature to refrain from considering any legislative measure that mandates health care insurance coverage for specific health care benefits, the Legislature could continue to pass such bills without the benefit of the report. The Task Force chose not to specifically address this issue, leaving the development of a method to address this concern up to the wisdom and sound discretion of the Legislature.

Review Body and Review Process

The current review process specified in sections 23-51 and 23-52, HRS, identifies the State Auditor as the entity responsible for conducting the review study. However, the State Auditor has indicated that this review is not an audit function.

In its report to the full Task Force, the Appropriateness of Scope Subcommittee indicated that the State Auditor does not have the necessary resources to fulfill this responsibility. The Scope Subcommittee recommended that a new review process be established to determine which health care benefits should be mandated. Similarly, the Healthcare Provider List Subcommittee also recommended that an alternate process to approve proposed mandated health care benefits be supported.

Both of these subcommittees considered several alternate review bodies and processes, including the one proposed in H.B. NO. 237, H.D.2, S.D.1 (2001) (Attachment 17) and those contained in the models from the states of Washington, Pennsylvania, Virginia, and Maryland (Attachments 18 to 21).

Based upon these considerations, the Task Force recommended that the Legislature replace the current review process to approve proposed mandated health care benefits with a new alternate process based on H.B. NO. 237, H.D. 2, S.D.1 and that incorporates appropriate elements from the model of the states of Washington, Pennsylvania, Virginia, and Maryland.

Another concern that the Task Force discussed is the composition of the new alternate review panel. The Task Force believed that it is important that the panel have broad representation of stakeholders such as health care service providers and consumers.

Therefore, the Task Force recommended that the Legislature consider a balanced representation of stakeholders on the new alternate review panel, including a broad range of health care service providers and consumers.

Sunset Review

Both the Appropriateness of Scope Subcommittee and the Healthcare Provider List Subcommittee considered the value of a periodic sunset review of each mandated health care benefit and found that this kind of review merits further consideration by the Legislature.

A sunset review would provide a means to determine if there is a continued need for specific mandated health care benefits. A sunset review could also help determine if the benefit is being adequately provided and if statutory amendments are appropriate.

In response to these considerations, the Task Force recommended that the Legislature also consider requiring that each mandated health care benefit undergo a sunset review every five years.

Cost Criteria

The Cost Utilization and Cost Avoidance Subcommittee use the in vitro fertilization procedure mandated benefit and the mental health and alcohol and drug abuse treatment mandated benefit as case studies to base its recommendation on.

The Cost Subcommittee recommended that when reviewing a mandated health care benefit, the review panel should review not only direct and indirect costs associated with providing the benefit, but also any potential cost savings that may result from preventing future treatments. As an example, early substance abuse treatment may prevent patients from requiring more costly medical treatment in the future.

The Cost Subcommittee also recognized that the review panel needs to review any increase in administrative and other "start-up" costs to health plans associated with providing the mandated health care benefit.

The Cost Subcommittee found that it is also appropriate that the review panel consider broader social benefits when conducting the review of a proposed mandated benefit.

Additionally, as many medical procedures have some risks associated with them, to strike a balance, the review panel should also consider the potential additional costs that might result from the increased medical risk in providing the benefit.

The Cost Subcommittee also considered whether the review panel should include in its cost analysis, savings not only attributed to the patient, but also to others that may be impacted by the patient. For example, a person suffering from an untreated mental illness might harm others. However, due to the difficulty in quantifying this kind of savings, the Subcommittee decided that this is a public policy issue best left to the sound discretion of the Legislature.

Prepaid Health Care Act

In 1974, in an effort to ensure that the working people of Hawaii had access to adequate health care, the Legislature

extended prepaid health care insurance to workers who did not have that kind of protection or who had only inadequate prepaid health care insurance. This was accomplished by the enactment of the Hawaii Prepaid Health Care Act (Act), which has been codified as chapter 393, HRS.

Since its enactment, the Act has accomplished a great deal in terms of health care coverage for the working people of Hawaii – it has set a floor below which no person in Hawaii working more than twenty hours a week would be allowed to fall; it defined a basic health care coverage benefits package long before that idea was fashionable; and it enfranchised thousands of people.

However, just three months after the Act was passed, mandatory employee health care coverage in Hawaii soon found itself on a collision course with federal law with the enactment of the federal Employee Retirement Income Security Act of 1974, which is better known as ERISA.

In 1977, a suit was filed in federal court essentially questioning whether self-insured employers were subject to state regulation of employee benefits. The court held that ERISA preempted the Act. Consequently, the State ceased administering the Act.

However, in 1983, with the hard work of Hawaii's Congressional Delegation, the State successfully obtained a waiver that exempted the Act from the ERISA preemption.

Although the waiver exempted the act from ERISA, it also specifically prohibited the exemption of any changes to the act after September 2, 1974, other than those that might improve "effective administration" of the Act. This essentially has "frozen" the Act in the form it was passed in 1974.

It is this "frozen" state of the Act that has generated certain problems and controversy, where some argue that the waiver language does not allow the Act to evolve with the times.

Notwithstanding the concerns regarding the Act, H.C.R. NO. 129, H.D.1, S.D.1, C.D.1 charged the Task Force with the responsibility of advising the 2002 Legislature on the problems surrounding Hawaii's mandated benefits and the legislative process enacting them. It was determined that

this limited the scope of the Task Force's duties and responsibilities to reviewing the process of mandating specific individual health care benefits, such as those that have been enacted periodically by the Legislature since 1987.

It was also determined that a review of the Act was beyond the Task Force's scope of responsibility. However, despite this determination, the Task Force and its subcommittees believed that the problems associated with the Act merit review.

Consequently, the Task Force recommended that the Legislature adopt a concurrent resolution requesting the establishment of a task force to examine the effectiveness of the Prepaid Health Care Act and to consider the feasibility of amending or repealing it. The Task Force also adopted a proposed concurrent resolution (Attachment 22). Proposed committee report language is also attached (Attachment 23).

Conclusions and Recommendations

Although the current procedure to assess the social and financial impacts of proposed mandated health care benefits will benefit from modifications, the primary fault lies with the process and not the specific criteria enumerated in the law.

The current process requires the Legislature to adopt a concurrent resolution requesting the State Auditor to prepare and submit a report that assesses both the social and financial effects of the proposed mandated coverage. If the Legislature does not adopt such a concurrent resolution, the State Auditor does not prepare such a report. This has too often been the case in the past.

Additionally, the State Auditor has indicated that this type of review is not an audit function. The Task Force also believes that it would be appropriate to replace the State Auditor with an alternate review panel to conduct this type of review.

Therefore, the Task Force recommends that the current State Auditor review process be replaced with an alternate process based on H.B. NO. 237, H.D.2, S.D.1, and that

incorporates appropriate elements from the models utilized by the states of Washington, Pennsylvania, Virginia, and Maryland.

The Legislature should also consider incorporating the following cost criteria:

- Inclusion of the potential costs savings that may result from a proposed mandated health care benefit;

- Inclusion of any increase in administrative and other "start-up" costs to health plans associated with providing the mandated health care benefit;

- Require the review panel to consider broader social benefits when reviewing a proposed mandated health care benefit; and

- Require the review panel to consider the potential additional costs that might result from the increased medical risks associated with providing the proposed mandated health care benefit.

The Task Force also recommends that the Legislature consider a balanced representation of stakeholders on the panel that includes providers of health care services, the business community, and consumers.

To ensure that each mandated benefit continues to be appropriate or it modifications are needed, the Task Force suggests that the Legislature consider requiring that each mandated health care benefit undergo a sunset review every five years.

Finally, an in-depth review of the underlying "mandated health care benefit" is appropriate. Therefore, the Task Force recommends that the Legislature establish a new task force to examine the effectiveness of the Prepaid Health Care Act and to consider the feasibility of amending or repealing it.

Attachments

Attachment 2

MANDATED BENEFITS ADVISORY TASK FORCE

GROUND RULES FOR CONDUCT OF BUSINESS

I. VOTING

A. When votes are needed to be taken on any matter, only the "official" members of the task force shall have the right to vote on the task force. "Proxies" shall be allowed to vote on the subcommittee for which they are holding the proxy of the member of the subcommittee.

B. To ensure continuity in the task force's discussions and avoid the necessity of constantly having to revisit matters when a "substitute" attends a task force meeting in place of a member, voting by "proxies" shall not be recognized on the task force. However, voting by "proxies" on the subcommittee level shall be permitted.

C. "Substitutes" shall not be permitted to sit at the table or engage in the discussions at the task force level. The function of "substitutes" on the task force level shall be to act as observers, take notes, and report back to the member of the task force.

D. Participation by telephone shall be permitted; provided that the appropriate equipment is available.

II. ATTENDANCE

A. Since continuity and sustained effort are critical to the task force's success, two consecutive unexcused absences from task force meetings will result in automatic removal from the task force. The chair shall exercise reasonable discretion in determining what is an excusable absence.

B. Although a strong policy on absences from meetings is recommended, the subcommittees shall be given the discretion to determine their own policies on absences from meetings.

III. APPLICABILITY OF THE PUBLIC MEETINGS LAW AND THE UNIFORM INFORMATION PRACTICES ACT (MODIFIED)

Members are advised that the requirements of chapters 92 and 92F, Hawaii Revised Statutes apply to the task force's deliberations, including discussions at the subcommittee level. All decision-making, as well as discussions that could lead to decision-making, shall be held in public and in places accessible to the public.

Attachment 3A

MANDATED BENEFITS ADVISORY TASK FORCE

Wayne Metcalf, Chair

Members:

Laura Anderson, Esq.	Arlene Meyer, MD
Rep. Dennis Arakaki	Sharyn Stephani Monet, JD, RN
Mike Cheng	Glenn Okihiro
Philip Hellreich, MD	Christopher Pablo, Esq.
Rep. Kenneth Hiraki	Lawrence Redmond, DC
Ruth Ellen Lindenberg	Sen. Brian Taniguchi

NOTICE OF PUBLIC MEETING

DATE: Tuesday, July 31, 2001

TIME: 10:00 a.m.

PLACE: Princess Victoria Kamamalu Bldg., Kapuaiwa Room
250 S. King Street, 2nd Floor
Honolulu, HI 96813

A G E N D A

The Mandated Benefits Advisory Task Force was established pursuant to H.C.R. NO. 129, H.D.1, S.D.1, C.D.1, which was adopted by the Twenty-First Legislature of the State of Hawaii, Regular Session of 2001. The Task Force will be conducting its first meeting on the above date, time, and location.

The purpose of this meeting is to introduce the members of the Task Force, discuss the Ground Rules for the Conduct of Business, review the Task Force's responsibilities, to discuss the expectations of the Chair and Task Force members, and to discuss the Task Force's organization.

Members of the public are invited to participate in the discussion by submitting 30 copies of their testimony in writing at least 48 hours prior to the meeting to Garett Kashimoto at the Insurance Division, 250 S. King St., 5th Floor, Hon., HI 96813. Copies should be printed on one side of 8-1/2" by 11" paper. For further information, please contact Garett Kashimoto at 586-2790.

If you require special assistance or auxiliary aids or services to attend this public meeting (e.g., sign language interpreter, large print, taped materials, wheelchair access, parking for the disabled, etc.), please call Lani Nakazawa at 586-2790 at least 48 hours prior to the meeting so that arrangements can be made.

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Wayne Metcalf, Chair

Attachment 3B

MANDATED BENEFITS ADVISORY TASK FORCE

Wayne Metcalf, Chair

Members:
Laura Anderson, Esq.
Rep. Dennis Arakaki
Paula Arcena
Mike Cheng
Philip Hellreich, MD
Rep. Kenneth Hiraki
Ruth Ellen Lindenberg
Arlene Meyers, MD, JD
Sharyn Stephani Monet, JD, RN
Glenn Okihiro, DDS
Christopher Pablo, Esq.
Lawrence Redmond, DC
Sen. Brian Taniguchi

NOTICE OF PUBLIC MEETING

DATE: Monday, November 19, 2001

TIME: 1:00 p.m.

PLACE: Princess Victoria Kamamalu Bldg., Kapuaiwa Room
250 S. King Street, 2nd Floor
Honolulu, HI 96813

A G E N D A

I. Call to Order
II. Approval of Minutes (07/31/01 Meeting)
III. Discuss The Three Subcommittees' Recommendations
IV. Public Comment
V. Next Meeting
VI. Announcements
VII. Adjournment

Members of the public are invited to participate in the discussion by submitting 30 copies of their testimony in writing at least 48 hours prior to the meeting to Garett Kashimoto at the Insurance Division, 250 S. King St., 5th Floor, Hon., HI 96813. Copies should be printed on one side of 8-1/2" by 11" paper. For further information, please contact Garett Kashimoto at 586-2790.

If you require special assistance or auxiliary aids or services to attend this public meeting (e.g., sign language interpreter, large print, taped materials, wheelchair access, parking for the disabled, etc.), please call Lani Nakazawa at 586-2790 at least 48 hours prior to the meeting so that arrangements can be made.

_____
Wayne Metcalf, Chair

Attachment 3C

MANDATED BENEFITS ADVISORY TASK FORCE

Wayne Metcalf, Chair

Members:

Laura Anderson, Esq.	Ruth Ellen Lindenberg
Rep. Dennis Arakaki	Arlene Meyers, MD, JD
Paula Arcena	Sharyn Stephani Monet, JD, RN
Mike Cheng	Glenn Okihiro, DDS
Don Dawson	Christopher Pablo, Esq.
Philip Hellreich, MD	Lawrence Redmond, DC
Rep. Kenneth Hiraki	Sen. Brian Taniguchi

NOTICE OF PUBLIC MEETING

DATE: Monday, November 26, 2001

TIME: 10:00 a.m.

PLACE: Princess Victoria Kamamalu Bldg., Kapuaiwa Room
250 S. King Street, 2nd Floor
Honolulu, HI 96813

A G E N D A

I. Call to Order
II. Approval of Minutes (11/19/01 Meeting)
III. Discuss The Task Force's Proposed Recommendations
IV. Public Comment
V. Next Meeting
VI. Announcements
VII. Adjournment

Members of the public are invited to participate in the discussion by submitting 25 copies of their testimony in writing at least 48 hours prior to the meeting to Garett Kashimoto at the Insurance Division, 250 S. King St., 5th Floor, Hon., HI 96813. Copies should be printed on one side of 8-1/2" by 11" paper. For further information, please contact Garett Kashimoto at 586-2790.

If you require special assistance or auxiliary aids or services to attend this public meeting (e.g., sign language interpreter, large print, taped materials, wheelchair access, parking for the disabled, etc.), please call Lani Nakazawa at 586-2790 at least 48 hours prior to the meeting so that arrangements can be made.

_____
Wayne Metcalf, Chair

Attachment 4A

MANDATED BENEFITS ADVISORY TASK FORCE

Wayne Metcalf, Chair

Appropriateness of Scope Subcommittee

Rep. Kenneth Hiraki, Chair

Members: Mike Cheng, Don Dawson, Philip Hellreich, MD, Arlene Meyers, MD, JD, Sharyn Stephani Monet, JD, RN, Christopher Pablo, Esq.

NOTICE OF PUBLIC MEETING

DATE: Thursday, August 23, 2001

TIME: 9:30 a.m.

PLACE: State Capitol Building, Room 312
415 South Beretania Street
Honolulu, Hawaii 96813

A G E N D A

I. Call to Order
II. Ground Rules
III. Plan of Action – Develop a plan of action to review existing statutory mandated benefits as to their appropriateness of scope. Definitional changes or further clarification should be provided where determined to be desirable. The cost/benefit of specific mandated benefits should be examined.
IV. Public Comment
V. Next Meeting
VI. Announcements
VII. Adjournment

Members of the public are invited to participate in the discussion by submitting 15 copies of their testimony in writing at least 48 hours prior to the meeting to Garett Kashimoto at the Insurance Division, 250 S. King St., 5th Floor, Hon., HI 96813. Copies should be printed on one side of 8-1/2" by 11" paper. For further information, please contact Garett Kashimoto at 586-2790.

If you require special assistance or auxiliary aids or services to attend this public meeting (e.g., sign language interpreter, large print, taped materials, wheel chair access, parking for the disabled, etc.), please call Lani Nakazawa at 586-2790 at least 48 hours prior to the meeting so that arrangements can be made.

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Wayne Metcalf, Chair

Attachment 4B

MANDATED BENEFITS ADVISORY TASK FORCE

Wayne Metcalf, Chair

Appropriateness of Scope Subcommittee

Rep. Kenneth Hiraki, Chair

Members: Mike Cheng, Don Dawson, Philip Hellreich, MD, Arlene Meyers, MD, JD, Sharyn Stephani Monet, JD, RN, Christopher Pablo, Esq.

NOTICE OF PUBLIC MEETING

DATE: Friday, August 31, 2001

TIME: 9:30 a.m.

PLACE: State Capitol Building, Room 329
415 South Beretania Street
Honolulu, Hawaii 96813

A G E N D A

I. Call to Order
II. Approval of Minutes (08/23/01 Meeting)
III. Identify Appropriate Policy Bases for Mandated Benefits
- What is a Mandated Benefit?
  A Panel Will Provide the Subcommittee with Information on Mandating Benefits.

IV. Public Comment
V. Next Meeting
VI. Announcements
VII. Adjournment

Members of the public are invited to participate in the discussion by submitting 15 copies of their testimony in writing at least 48 hours prior to the meeting to Garett Kashimoto at the Insurance Division, 250 S. King St., 5th Floor, Hon., HI 96813. Copies should be printed on one side of 8-1/2" by 11" paper. For further information, please contact Garett Kashimoto at 586-2790.

If you require special assistance or auxiliary aids or services to attend this public meeting (e.g., sign language interpreter, large print, taped materials, wheel chair access, parking for the disabled, etc.), please call Lani Nakazawa at 586-2790 at least 48 hours prior to the meeting so that arrangements can be made.

_____
Wayne Metcalf, Chair

Attachment 4C

MANDATED BENEFITS ADVISORY TASK FORCE

Wayne Metcalf, Chair

Appropriateness of Scope Subcommittee

Rep. Kenneth Hiraki, Chair

Members: Mike Cheng, Don Dawson, Philip Hellreich, MD, Arlene Meyers, MD, JD, Sharyn Stephani Monet, JD, RN, Christopher Pablo, Esq.

NOTICE OF PUBLIC MEETING

DATE: Friday, September 7, 2001

TIME: 9:30 a.m.

PLACE: State Capitol Building, Room 329
415 South Beretania Street
Honolulu, Hawaii 96813

A G E N D A

I. Call to Order
II. Approval of Minutes (08/31/01 Meeting)
III. Identify Appropriate Policy Bases for Mandated Benefits
- Scope of Interests Affected when Benefits are Mandated Under Article 10A of the Insurance Code and HRS Chapters 432 and 432D.
  A Panel Will Provide the Subcommittee with Information on the Scope of Interest.

IV. Public Comment
V. Next Meeting
VI. Announcements
VII. Adjournment

Members of the public are invited to participate in the discussion by submitting 15 copies of their testimony in writing at least 48 hours prior to the meeting to Garett Kashimoto at the Insurance Division, 250 S. King St., 5th Floor, Hon., HI 96813. Copies should be printed on one side of 8-1/2" by 11" paper. For further information, please contact Garett Kashimoto at 586-2790.

If you require special assistance or auxiliary aids or services to attend this public meeting (e.g., sign language interpreter, large print, taped materials, wheel chair access, parking for the disabled, etc.), please call Lani Nakazawa at 586-2790 at least 48 hours prior to the meeting so that arrangements can be made.

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Wayne Metcalf, Chair

Attachment 4D

MANDATED BENEFITS ADVISORY TASK FORCE

Wayne Metcalf, Chair

Appropriateness of Scope Subcommittee

Rep. Kenneth Hiraki, Chair

Members: Mike Cheng, Don Dawson, Philip Hellreich, MD, Arlene Meyers, MD, JD, Sharyn Stephani Monet, JD, RN, Christopher Pablo, Esq.

NOTICE OF PUBLIC MEETING

DATE: Friday, September 14, 2001

TIME: 9:30 a.m.

PLACE: State Capitol Building, Room 329
415 South Beretania Street
Honolulu, Hawaii 96813

A G E N D A

I. Call to Order
II. Approval of Minutes (09/07/01 Meeting)
III. Identify Appropriate Policy Bases for Mandated Benefits
- Scope of Interests Affected when Benefits are Mandated Under Article 10A of the Insurance Code and HRS Chapters 432 and 432D.
  A Panel Will Provide the Subcommittee with Information on the Scope of Interest.

IV. Public Comment
V. Next Meeting
VI. Announcements
VII. Adjournment

Members of the public are invited to participate in the discussion by submitting 15 copies of their testimony in writing at least 48 hours prior to the meeting to Garett Kashimoto at the Insurance Division, 250 S. King St., 5th Floor, Hon., HI 96813. Copies should be printed on one side of 8-1/2" by 11" paper. For further information, please contact Garett Kashimoto at 586-2790.

If you require special assistance or auxiliary aids or services to attend this public meeting (e.g., sign language interpreter, large print, taped materials, wheel chair access, parking for the disabled, etc.), please call Lani Nakazawa at 586-2790 at least 48 hours prior to the meeting so that arrangements can be made.

_____
Wayne Metcalf, Chair

Attachment 4E

MANDATED BENEFITS ADVISORY TASK FORCE

Wayne Metcalf, Chair

Appropriateness of Scope Subcommittee

Rep. Kenneth Hiraki, Chair

Members: Mike Cheng, Don Dawson, Philip Hellreich, MD, Arlene Meyers, MD, JD, Sharyn Stephani Monet, JD, RN, Christopher Pablo, Esq.

NOTICE OF PUBLIC MEETING

DATE: Friday, September 21, 2001

TIME: 9:30 a.m.

PLACE: State Capitol Building, Room 329
415 South Beretania Street
Honolulu, Hawaii 96813

A G E N D A

I. Call to Order
II. Approval of Minutes (09/14/01 Meeting)
III. Identify Appropriate Policy Bases for Mandated Benefits
- Scope of Interests Affected when Benefits are Mandated Under Article 10A of the Insurance Code and HRS Chapters 432 and 432D.
  A Panel Will Provide the Subcommittee with Information on the Scope of Interest.

IV. Public Comment
V. Next Meeting
VI. Announcements
VII. Adjournment

Members of the public are invited to participate in the discussion by submitting 15 copies of their testimony in writing at least 48 hours prior to the meeting to Garett Kashimoto at the Insurance Division, 250 S. King St., 5th Floor, Hon., HI 96813. Copies should be printed on one side of 8-1/2" by 11" paper. For further information, please contact Garett Kashimoto at 586-2790.

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_____
Wayne Metcalf, Chair

Attachment 4F

MANDATED BENEFITS ADVISORY TASK FORCE

Wayne Metcalf, Chair

Appropriateness of Scope Subcommittee

Rep. Kenneth Hiraki, Chair

Members: Mike Cheng, Don Dawson, Philip Hellreich, MD, Arlene Meyers, MD, JD, Sharyn Stephani Monet, JD, RN, Christopher Pablo, Esq.

NOTICE OF PUBLIC MEETING

DATE: Friday, September 28, 2001

TIME: 9:30 a.m.

PLACE: State Capitol Building, Room 329
415 South Beretania Street
Honolulu, Hawaii 96813

A G E N D A

I. Call to Order
II. Approval of Minutes (09/21/01 Meeting)
III. Identify Appropriate Policy Basis for Mandated Benefits
- Scope of Interests Affected when Benefits are Mandated Under Article 10A of the Insurance Code and HRS Chapters 432 and 432D.
  A Panel Will Provide the Subcommittee with Information on the Scope of Interest.

IV. Public Comment
V. Next Meeting
VI. Announcements
VII. Adjournment

Members of the public are invited to participate in the discussion by submitting 15 copies of their testimony in writing at least 48 hours prior to the meeting to Garett Kashimoto at the Insurance Division, 250 S. King St., 5th Floor, Hon., HI 96813. Copies should be printed on one side of 8-1/2" by 11" paper. For further information, please contact Garett Kashimoto at 586-2790.

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_____
Wayne Metcalf, Chair

Attachment 4G

MANDATED BENEFITS ADVISORY TASK FORCE

Wayne Metcalf, Chair

Appropriateness of Scope Subcommittee

Rep. Kenneth Hiraki, Chair

Members: Mike Cheng, Don Dawson, Philip Hellreich, MD, Arlene Meyers, MD, JD, Sharyn Stephani Monet, JD, RN, Christopher Pablo, Esq.

NOTICE OF PUBLIC MEETING

DATE: Friday, October 5, 2001

TIME: 9:30 a.m.

PLACE: State Capitol Building, Room 329
415 South Beretania Street
Honolulu, Hawaii 96813

A G E N D A

I. Call to Order
II. Approval of Minutes (09/28/01 Meeting)
III. Identify Appropriate Policy Basis for Mandated Benefits
- Criteria to be Considered in Mandating Benefits.
  A Panel Will Provide the Subcommittee with Information on Policy Basis for Considering Mandated Benefits.

IV. Public Comment
V. Next Meeting
VI. Announcements
VII. Adjournment

Members of the public are invited to participate in the discussion by submitting 15 copies of their testimony in writing at least 48 hours prior to the meeting to Garett Kashimoto at the Insurance Division, 250 S. King St., 5th Floor, Hon., HI 96813. Copies should be printed on one side of 8-1/2" by 11" paper. For further information, please contact Garett Kashimoto at 586-2790.

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_____
Wayne Metcalf, Chair

Attachment 4H

MANDATED BENEFITS ADVISORY TASK FORCE

Wayne Metcalf, Chair

Appropriateness of Scope Subcommittee

Rep. Kenneth Hiraki, Chair

Members: Mike Cheng, Don Dawson, Philip Hellreich, MD, Arlene Meyers, MD, JD, Sharyn Stephani Monet, JD, RN, Christopher Pablo, Esq.

NOTICE OF PUBLIC MEETING

DATE: Friday, October 12, 2001

TIME: 9:30 a.m.

PLACE: State Capitol Building, Room 329
415 South Beretania Street
Honolulu, Hawaii 96813

A G E N D A

I. Call to Order
II. Approval of Minutes (10/05/01 Meeting)
III. Identify Appropriate Policy Basis for Mandated Benefits
- Criteria to be Considered in Mandating Benefits.
  A Panel Will Provide the Subcommittee with Information on Policy Basis for Considering Mandated Benefits.

IV. Public Comment
V. Next Meeting
VI. Announcements
VII. Adjournment

Members of the public are invited to participate in the discussion by submitting 15 copies of their testimony in writing at least 48 hours prior to the meeting to Garett Kashimoto at the Insurance Division, 250 S. King St., 5th Floor, Hon., HI 96813. Copies should be printed on one side of 8-1/2" by 11" paper. For further information, please contact Garett Kashimoto at 586-2790.

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_____
Wayne Metcalf, Chair

Attachment 4I

MANDATED BENEFITS ADVISORY TASK FORCE

Wayne Metcalf, Chair

Appropriateness of Scope Subcommittee

Rep. Kenneth Hiraki, Chair

Members: Mike Cheng, Don Dawson, Philip Hellreich, MD, Arlene Meyers, MD, JD, Sharyn Stephani Monet, JD, RN, Christopher Pablo, Esq.

NOTICE OF PUBLIC MEETING

DATE: Friday, November 2, 2001

TIME: 9:30 a.m.

PLACE: State Capitol Building, Room 329
415 South Beretania Street
Honolulu, Hawaii 96813

A G E N D A

I. Call to Order
II. Approval of Minutes (10/12/01 Meeting)
III. Discuss The Subcommittee's Draft Recommendations to the Full Task Force
IV. Public Comment
V. Next Meeting
VI. Announcements
VII. Adjournment

Members of the public are invited to participate in the discussion by submitting 15 copies of their testimony in writing at least 48 hours prior to the meeting to Garett Kashimoto at the Insurance Division, 250 S. King St., 5th Floor, Hon., HI 96813. Copies should be printed on one side of 8-1/2" by 11" paper. For further information, please contact Garett Kashimoto at 586-2790.

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Wayne Metcalf, Chair

Attachment 4J

MANDATED BENEFITS ADVISORY TASK FORCE

Wayne Metcalf, Chair

Appropriateness of Scope Subcommittee

Rep. Kenneth Hiraki, Chair

Members: Mike Cheng, Don Dawson, Philip Hellreich, MD, Arlene Meyers, MD, JD, Sharyn Stephani Monet, JD, RN, Christopher Pablo, Esq.

NOTICE OF PUBLIC MEETING

DATE: Friday, November 9, 2001

TIME: 9:30 a.m.

PLACE: State Capitol Building, Room 309
415 South Beretania Street
Honolulu, Hawaii 96813

A G E N D A

I. Call to Order
II. Approval of Minutes (11/02/01 Meeting)
III. Discuss The Redraft of the Subcommittee's Recommendations to the Full Task Force
IV. Public Comment
V. Next Meeting
VI. Announcements
VII. Adjournment

Members of the public are invited to participate in the discussion by submitting 15 copies of their testimony in writing at least 48 hours prior to the meeting to Garett Kashimoto at the Insurance Division, 250 S. King St., 5th Floor, Hon., HI 96813. Copies should be printed on one side of 8-1/2" by 11" paper. For further information, please contact Garett Kashimoto at 586-2790.

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_____
Wayne Metcalf, Chair

Attachment 5A

MANDATED BENEFITS ADVISORY TASK FORCE

Wayne Metcalf, Chair

Healthcare Provider List Subcommittee

Rep. Dennis Arakaki, Chair

Members:	Paula Arcena, MD	Glenn Okihira, DDS
	Don Dawson	Christopher Pablo, Esq.
	Ruth Ellen Lindenberg	Lawrence Redmond, DC

NOTICE OF PUBLIC MEETING

DATE: Thursday, August 9, 2001

TIME: 11:00 a.m.

PLACE: State Capitol Building, Room 437
415 South Beretania Street
Honolulu, Hawaii 96813

A G E N D A

I. Call to Order
II. Ground Rules
III. Plan of Action – Develop a plan of action to review issues surrounding the historic expansion of the healthcare provider list to determine the continual appropriateness of existing providers and the cost effectiveness that can be realized by expanding or circumscribing the list.
IV. Public Comment
V. Next Meeting
VI. Announcements
VII. Adjournment

Members of the public are invited to participate in the discussion by submitting 15 copies of their testimony in writing at least 48 hours prior to the meeting to Garett Kashimoto at the Insurance Division, 250 S. King St., 5th Floor, Hon., HI 96813. Copies should be printed on one side of 8-1/2" by 11" paper. For further information, please contact Garett Kashimoto at 586-2790.

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Wayne Metcalf, Chair

Attachment 5B

MANDATED BENEFITS ADVISORY TASK FORCE

Wayne Metcalf, Chair
Healthcare Provider List Subcommittee

Rep. Dennis Arakaki, Chair

Members:	Paula Arcena	Glenn Okihira, DDS
	Don Dawson	Christopher Pablo, Esq.
	Ruth Ellen Lindenberg	Lawrence Redmond, DC

NOTICE OF PUBLIC MEETING

DATE: Thursday, August 23, 2001

TIME: 11:00 a.m.

PLACE: State Capitol Building, Room 437
415 South Beretania Street
Honolulu, Hawaii 96813

A G E N D A

I. Call to Order
II. Approval of Minutes (08/09/01 Meeting)
III. Continue the review of issues surrounding the historic expansion of the healthcare provider list to determine the continual appropriateness of existing providers and the cost effectiveness that can be realized by expanding or circumscribing the list. What is the problem?
IV. Identify the current eligible providers and examine other states' process of mandating new healthcare benefits
V. Public Comment
VI. Next Meeting: Tentatively set for Thursday, September 6, 2001
VII. Announcements
VIII. Adjournment

Members of the public are invited to participate in the discussion by submitting 15 copies of their testimony in writing at least 48 hours prior to the meeting to Garett Kashimoto at the Insurance Division, 250 S. King St., 5th Floor, Hon., HI 96813. Copies should be printed on one side of 8-1/2" by 11" paper. For further information, please contact Garett Kashimoto at 586-2790.

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_____
Wayne Metcalf, Chair

Attachment 5C

MANDATED BENEFITS ADVISORY TASK FORCE

Wayne Metcalf, Chair

Healthcare Provider List Subcommittee

Rep. Dennis Arakaki, Chair

Members:

Paula Arcena	Glenn Okihiro, DDS
Don Dawson	Christopher Pablo, Esq.
Ruth Ellen Lindenberg	Lawrence Redmond, DC

NOTICE OF PUBLIC MEETING

DATE: Thursday, September 20, 2001

TIME: 11:00 a.m.

PLACE: State Capitol Building, Room 437
415 South Beretania Street
Honolulu, Hawaii 96813

A G E N D A

I. Call to Order
II. Approval of Minutes (08/23/01 Meeting)
III. Continue the review of issues surrounding the historic expansion of the healthcare provider list to determine the continual appropriateness of existing providers and the cost effectiveness that can be realized by expanding or circumscribing the list.
IV. Public Comment
V. Next Meeting: Tentatively set for Thursday, September 20, 2001
VI. Announcements
VII. Adjournment

Members of the public are invited to participate in the discussion by submitting 15 copies of their testimony in writing at least 48 hours prior to the meeting to Garett Kashimoto at the Insurance Division, 250 S. King St., 5th Floor, Hon., HI 96813. Copies should be printed on one side of 8-1/2" by 11" paper. For further information, please contact Garett Kashimoto at 586-2790.

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_____
Wayne Metcalf, Chair

Attachment 5D

MANDATED BENEFITS ADVISORY TASK FORCE

Wayne Metcalf, Chair

Healthcare Provider List Subcommittee

Rep. Dennis Arakaki, Chair

Members:	Paula Arcena	Glenn Okihiro, DDS
	Don Dawson	Christopher Pablo, Esq.
	Ruth Ellen Lindenberg	Lawrence Redmond, DC

NOTICE OF PUBLIC MEETING

DATE: Thursday, October 4, 2001

TIME: 11:00 a.m.

PLACE: State Capitol Building, Room 437
415 South Beretania Street
Honolulu, Hawaii 96813

A G E N D A

I. Call to Order
II. Approval of Minutes (09/20/01 Meeting)
III. Continue the review of issues surrounding the historic expansion of the healthcare provider list to determine the continual appropriateness of existing providers and the cost effectiveness that can be realized by expanding or circumscribing the list.
IV. Public Comment
V. Next Meeting
VI. Announcements
VII. Adjournment

Members of the public are invited to participate in the discussion by submitting 15 copies of their testimony in writing at least 48 hours prior to the meeting to Garett Kashimoto at the Insurance Division, 250 S. King St., 5th Floor, Hon., HI 96813. Copies should be printed on one side of 8-1/2" by 11" paper. For further information, please contact Garett Kashimoto at 586-2790.

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_____
Wayne Metcalf, Chair

Attachment 5E

MANDATED BENEFITS ADVISORY TASK FORCE

Wayne Metcalf, Chair

Healthcare Provider List Subcommittee

Rep. Dennis Arakaki, Chair

Members:

Paula Arcena	Glenn Okihiro, DDS
Don Dawson	Christopher Pablo, Esq.
Ruth Ellen Lindenberg	Lawrence Redmond, DC

NOTICE OF PUBLIC MEETING

DATE: Thursday, October 11, 2001

TIME: 11:00 a.m.

PLACE: State Capitol Building, Room 437
415 South Beretania Street
Honolulu, Hawaii 96813

A G E N D A

I. Call to Order
II. Approval of Minutes (10/04/01 Meeting)
III. Continue the review of issues surrounding the historic expansion of the healthcare provider list to determine the continual appropriateness of existing providers and the cost effectiveness that can be realized by expanding or circumscribing the list.
IV. Public Comment
V. Next Meeting
VI. Announcements
VII. Adjournment

Members of the public are invited to participate in the discussion by submitting 15 copies of their testimony in writing at least 48 hours prior to the meeting to Garett Kashimoto at the Insurance Division, 250 S. King St., 5th Floor, Hon., HI 96813. Copies should be printed on one side of 8-1/2" by 11" paper. For further information, please contact Garett Kashimoto at 586-2790.

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Wayne Metcalf, Chair

Attachment 5F

MANDATED BENEFITS ADVISORY TASK FORCE

Wayne Metcalf, Chair

Healthcare Provider List Subcommittee

Rep. Dennis Arakaki, Chair

Members:	Paula Arcena	Glenn Okihiro, DDS
	Don Dawson	Christopher Pablo, Esq.
	Ruth Ellen Lindenberg	Lawrence Redmond, DC

NOTICE OF PUBLIC MEETING

DATE: Tuesday, October 23, 2001

TIME: 1:00 p.m.

PLACE: State Capitol Building, Room 437
415 South Beretania Street
Honolulu, Hawaii 96813

A G E N D A

I. Call to Order
II. Approval of Minutes (10/11/01 Meeting)
III. Discuss Proposed Recommendations of the Subcommittee to the full Task Force.
IV. Public Comment
V. Next Meeting
VI. Announcements
VII. Adjournment

Members of the public are invited to participate in the discussion by submitting 15 copies of their testimony in writing at least 48 hours prior to the meeting to Garett Kashimoto at the Insurance Division, 250 S. King St., 5th Floor, Hon., HI 96813. Copies should be printed on one side of 8-1/2" by 11" paper. For further information, please contact Garett Kashimoto at 586-2790.

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_____
Wayne Metcalf, Chair

Attachment 5G

MANDATED BENEFITS ADVISORY TASK FORCE

Wayne Metcalf, Chair

Healthcare Provider List Subcommittee

Rep. Dennis Arakaki, Chair

Members:	Paula Arcena	Glenn Okihiro, DDS
	Don Dawson	Christopher Pablo, Esq.
	Ruth Ellen Lindenberg	Lawrence Redmond, DC

NOTICE OF PUBLIC MEETING

DATE: Thursday, November 15, 2001

TIME: 11:00 a.m.

PLACE: State Capitol Building, Room 437
415 South Beretania Street
Honolulu, Hawaii 96813

A G E N D A

I. Call to Order
II. Approval of Minutes (10/11/01 and 10/23/01 Meetings)
III. Subcommittee's Recommendations
IV. Public Comment
V. Next Meeting
VI. Announcements
VII. Adjournment

Members of the public are invited to participate in the discussion by submitting 15 copies of their testimony in writing at least 48 hours prior to the meeting to Garett Kashimoto at the Insurance Division, 250 S. King St., 5th Floor, Hon., HI 96813. Copies should be printed on one side of 8-1/2" by 11" paper. For further information, please contact Garett Kashimoto at 586-2790.

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_____
Wayne Metcalf, Chair

Attachment 6A

MANDATED BENEFITS ADVISORY TASK FORCE

Wayne Metcalf, Chair

Cost Utilization and Cost Avoidance Subcommittee

Sen. Brian Taniguchi, Chair

Members:	Laura Anderson, Esq.	Sharyn Stephani Monet, JD, RN
	Mike Cheng	Lawrence Redmond, DC

NOTICE OF PUBLIC MEETING

DATE: Monday, September 10, 2001

TIME: 9:30 a.m.

PLACE: State Capitol Building, Room 211
415 South Beretania Street
Honolulu, Hawaii 96813

A G E N D A

I. Call to Order
II. Ground Rules for the Conduct of Business
III. Potential Cost Avoidance and Patient Benefits of Mandated Benefits
IV. Public Comment
V. Next Meeting
VI. Announcements
VII. Adjournment

Members of the public are invited to participate in the discussion by submitting 15 copies of their testimony in writing at least 48 hours prior to the meeting to Garett Kashimoto at the Insurance Division, 250 S. King St., 5th Floor, Hon., HI 96813. Copies should be printed on one side of 8-1/2" by 11" paper. For further information, please contact Garett Kashimoto at 586-2790.

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_____
Wayne Metcalf, Chair

Attachment 6B

MANDATED BENEFITS ADVISORY TASK FORCE

Wayne Metcalf, Chair

Cost Utilization and Cost Avoidance Subcommittee

Sen. Brian Taniguchi, Chair

Members:	Laura Anderson, Esq.	Sharyn Stephani Monet, JD, RN
	Mike Cheng	Lawrence Redmond, DC

NOTICE OF PUBLIC MEETING

DATE: Wednesday, October 17, 2001

TIME: 10:00 a.m.

PLACE: State Capitol Building, Room 211
415 South Beretania Street
Honolulu, Hawaii 96813

A G E N D A

I. Call to Order
II. Approval of Minutes
III. Potential Cost (Utilization and Avoidance) and Patient Benefits of Mandated Benefits
IV. Public Comment
V. Next Meeting
VI. Announcements
VII. Adjournment

Members of the public are invited to participate in the discussion by submitting 15 copies of their testimony in writing at least 48 hours prior to the meeting to Garett Kashimoto at the Insurance Division, 250 S. King St., 5th Floor, Hon., HI 96813. Copies should be printed on one side of 8-1/2" by 11" paper. For further information, please contact Garett Kashimoto at 586-2790.

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Wayne Metcalf, Chair

Attachment 6C

MANDATED BENEFITS ADVISORY TASK FORCE

Wayne Metcalf, Chair

Cost Utilization and Cost Avoidance Subcommittee

Sen. Brian Taniguchi, Chair

Members:	Laura Anderson, Esq.	Sharyn Stephani Monet, JD, RN
	Mike Cheng	Lawrence Redmond, DC

NOTICE OF PUBLIC MEETING

DATE: Friday, November 16, 2001

TIME: 10:00 a.m.

PLACE: State Capitol Building, Room 211
415 South Beretania Street
Honolulu, Hawaii 96813

A G E N D A

I. Call to Order
II. Approval of Minutes
III. Discuss the Subcommittee's Proposed Recommendations to the Full Task Force
IV. Public Comment
V. Next Meeting
VI. Announcements
VII. Adjournment

Members of the public are invited to participate in the discussion by submitting 15 copies of their testimony in writing at least 48 hours prior to the meeting to Garett Kashimoto at the Insurance Division, 250 S. King St., 5th Floor, Hon., HI 96813. Copies should be printed on one side of 8-1/2" by 11" paper. For further information, please contact Garett Kashimoto at 586-2790.

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Wayne Metcalf, Chair

MANDATED BENEFITS ADVISORY TASK FORCE
MINUTES OF PUBLIC MEETING
JULY 31, 2001

The meeting was convened at the Kapuaiwa Room, Second Floor, Princess Victoria Kamamalu Building, on July 31, 2001, at approximately 10:05 a.m.

PRESENT

Wayne Metcalf, Chair; Laura Anderson, Rep. Dennis Arakaki, Mike Cheng, Don Dawson, Dr. Philip Hellreich, Rep. Kenneth Hiraki, Ruth Ellen Lindenberg, Dr. Arlene Meyers, Sharyn Stephani Monet, Dr. Glenn Okihiro, Christopher Pablo, and Dr. Lawrence Redmond, members. Absent: Sen. Brian Taniguchi. Also present: Terrance Aratani, Sen. Brian Taniguchi's Office; Jennifer Diesman, HMSA; and Loren Liebling, HDA.

INTRODUCTION OF MEMBERS

Chair Metcalf introduced the members of the Task Force and the sector that they represent as follows:

- **Sharyn Stephani Monet, JD, RN,** representing licensed registered nurses;
- **Arlene Meyers, MD, JD,** representing licensed physicians;
- **Lawrence Redmond, DC,** representing alternate complementary care service providers;
- **Philip Hellreich, MD,** from the Hawaii Medical Association, representing professional medical associations;
- **Paula Arcena,** from the Hawaii Medical Association, representing professional medical associations;
- **Mike Cheng,** from the Hawaii Medical Service Association, representing health plans;
- **Christopher Pablo, Esq.,** from Kaiser Permanente, representing health plans;
- **Ruth Ellen Lindenberg,** from the Kokua Council, representing consumer advocate groups;
- **Laura Anderson, Esq.,** designated by the Chamber of Commerce of Hawaii, representing members of the business community;
- **Don Dawson,** from Dawson International and designated by the National Federation of Independent Businesses of Hawaii, representing members of the business community.

The Insurance Commissioner also appointed the following:

- **The Honorable Kenneth Hiraki;**
- **The Honorable Dennis Arakaki;**

- **The Honorable Brian Taniguchi; and**
- **Glenn Okihiro, DDS.**

GROUND RULES FOR THE CONDUCT OF BUSINESS

Copies of the Ground Rules for the Conduct of Business were transmitted to the members in advance of the meeting for review and comment. Chair Metcalf indicated that the Ground Rules track those of the Patient Rights and Responsibilities Task Force. Mr. Pablo moved, seconded by Dr. Hellreich to adopt the minutes as circulated. The motion passed unanimously.

TASK FORCE STRUCTURE

Chair Metcalf established three subcommittees that are intended to gather information, review issues, and make recommendations to the full Task Force, which will consider the information and recommendations in developing its recommendations to the Legislature. Chair Metcalf then appointed members of the Task Force to the subcommittees. The Chair indicated that he would consider changes to the subcommittee membership provided that the odd number configuration is maintained.

The subcommittee descriptions and membership are as follows:

Cost Utilization and Cost Avoidance Subcommittee

This subcommittee will gather information on cost utilization and cost avoidance of mandated benefits. Mandating healthcare benefits can cause increases in utilization, which in turn may increase direct costs. However, mandated benefits may have been enacted to avoid potentially greater costs. For example, mandated diabetes coverage may have costs associated with utilization, but if the coverage is not provided, patients are thought to be less likely to avail themselves of the preventive service. In these cases, the patient may experience even more serious and costly medical conditions as a result of not using preventive services.

Members:
Sen. Brian Taniguchi, Chair
Laura Anderson, Esq.
Mike Cheng
Sharyn Stephani Monet, JD, RN
Lawrence Redmond, DC

Appropriateness of Scope Subcommittee

This subcommittee will review existing statutory mandated benefits as to their appropriateness of scope. Definitional changes or further clarification should be provided where determined to be desirable. The costs/benefits of specific mandated benefits should be examined.

Members:
Rep. Kenneth Hiraki, Chair
Mike Cheng
Don Dawson
Philip Hellreich, MD
Arlene Meyers, MD, JD
Sharyn Stephani Monet, JD, RN
Christopher Pablo, Esq.

Healthcare Provider List Subcommittee

This subcommittee will review issues surrounding the historic expansion of the healthcare provider list to determine the continual appropriateness of existing providers and the cost effectiveness that can be realized by expanding or circumscribing the list.

Members:
Rep. Dennis Arakaki, Chair
Paula Arcena
Don Dawson
Ruth Ellen Lindenberg
Glenn Okihiro, DDS
Christopher Pablo, Esq.
Lawrence Redmond, DC

Ms. Monet moved, seconded by Mr. Cheng that the subcommittees and membership be adopted. Without objection, the motion was adopted.

Chair Metcalf stressed that the subcommittee chairs can call upon the Insurance Division Staff for support and assistance.

TIMETABLE

Chair Metcalf established a timetable to help ensure that the Task Force is able to submit its report and findings to the Legislature on time. The timetable is as follows:

- **Monday, November 19, 2001: Subcommittees to report their findings to the full Task Force.** The full Task Force will need time to consider the findings of the subcommittees and to develop its recommendations.

- **Monday, December 3, 2001: Task Force to complete its work.** Staff will need sufficient time to perform an adequate job in drafting the report and proposed legislation, if any.

- **Monday, December 10, 2001: Drafts of the report and proposed legislation to be completed.** The report and proposed legislation will have

to be reviewed and approved by: (1) the full Task Force, (2) the Insurance Commissioner, (3) the Director of Commerce and Consumer Affairs, and (4) the Governor. This will occur during the Holiday Season.

- **Thursday, December 27, 2001: Deadline to submit the report and proposed legislation to the Legislature.** H.C.R. NO. 129, H.D.1, S.D.1, C.D.1 specifies that the Task Force is to report its findings to the Legislature no later than 20 days prior to the convening of the Regular Session of 2002, which is December 27, 2001.

Chair Metcalf indicated that the Task Force and its subcommittees would work toward consensus when making any decision. However, if consensus is not possible, then decisions would be made by majority vote.

PUBLIC COMMENT

The Task Force did not receive any public comment.

NEXT MEETING

None scheduled. Members will be notified when the next meeting is scheduled.

ANNOUNCEMENTS

Mr. Pablo announced that he brought copies of information he obtained from the Internet and that interested members were welcome to take copies.

ADJOURNMENT

The meeting was adjourned at approximately 10:28 a.m.

Respectfully submitted:

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WAYNE METCALF, Chair
Mandated Benefits Advisory Task Force

MANDATED BENEFITS ADVISORY TASK FORCE
MINUTES OF PUBLIC MEETING
NOVEMBER 19, 2001

CALL TO ORDER

The meeting was convened at the Kapuaiwa Room, Second Floor, Princess Victoria Kamamalu Building, on November 19, 2001, at approximately 1:15 p.m.

PRESENT

Wayne Metcalf, Chair; Laura Anderson, Esq.; Rep. Dennis Arakaki; Paula Arcena; Mike Cheng; Don Dawson; Philip Hellreich, MD; Ruth Ellen Lindenberg; Arlene Meyers, MD, JD; Sharyn Stephani Monet, JD, RN; Christopher Pablo, Esq.; Lawrence Redmond, DC; and
Sen. Brian Taniguchi; members. Absent: Rep. Kenneth Hiraki (excused). Also present: Tom Smyth, DBEDT; Phil McNamee, MD, Pacific In Vitro Institute; Dot Shigemura and Brit Bozanic, RESOLVE of Hawaii; Richard Miller, Esq., Suzanne Gelb, PhD, and Rafael del Castillo, Esq.; Hawaii Coalition for Health; Don Kopf, PhD.

REPORT OF SUBCOMMITTEES

Chair Metcalf indicated that the Task Force received the reports of the subcommittees and copies were distributed to the members. Chair Metcalf then briefly summarized the recommendations of the subcommittees as follows:

Healthcare Provider List Subcommittee. This Subcommittee recommended that the Legislature: 1) adopt a resolution to examine the Prepaid Health Care Act; 2) enact a provision to automatically sunset all mandated benefits on a five-year cycle; 3) repeal the current process of reviewing proposed mandated benefits; and 4) support an alternate process to approve proposed mandated benefits.

Cost Utilization and Cost Avoidance Subcommittee. This subcommittee recommended that: 1) when reviewing a proposed mandated benefit, the panel should review not only the direct and indirect costs associated with providing the benefit, but also any potential cost savings that may result; 2) the panel also review any increase in administrative and other "start-up" costs to health plans associated with providing the benefit; 3) the statutory language is concise so that there is no broad construction of the benefit; 4) the panel consider broader social benefits when reviewing a proposed mandated benefit; and 5) the panel also consider the potential additional costs that might result from the increase of medical risks associated with providing the benefit.

Appropriateness of Scope Subcommittee. This subcommittee recommended the following: 1) request that the Legislature establish a task force to review the

effectiveness of the Prepaid Health Care Act; 2) further discussion is needed on whether existing mandated benefits should continue; and 3) establish a new review process to determine which benefits should be mandated.

Chair Metcalf indicated that he would offer proposals based on the subcommittees' recommendation for the Task Force's consideration at the next Task Force meeting. Therefore, the members would be given a week to review the subcommittees' recommendations.

PUBLIC COMMENT

Chair Metcalf indicated that the Task Force received written comments from several individuals. Dot Shigemura highlighted and summarized her written comments. Ms. Shigemura's comments basically indicated that although RESOLVE of Hawaii understands the need to periodically review mandated benefits, all benefits should go through the same review…specific benefits should not be singled out.

NEXT MEETING

Chair Metcalf indicated that the meeting schedule for the Task Force would be as follows:

- Monday, November 26, 2001, at 10:00 a.m. in the Kapuaiwa Room. The Chair plans to offer proposed recommendations. Members will be able to discuss the proposals. If consensus is reached, the Task Force will adopt the proposals.

- If necessary, Monday, December 3, 2001, at 10:30 a.m. in the Kapuaiwa Room. If the Task Force does not adopt the proposals at the November 26th meeting, the discussion will continue on this date. If the Task Force is in agreement, the proposals will be adopted.

- As a back up, Friday, December 14, 2001 at 12:00 noon in the Kuhina Nui Room. If the Task Force does not complete its work by December 3rd, this date has been reserved to facilitate the Task Force's ability to finish.

ANNOUNCEMENTS

None.

ADJOURNMENT

Ms. Monet moved, seconded by Ms. Lindenberg, to adjourn the meeting. Without objection, the meeting was adjourned at approximately 1:28 p.m.

Respectfully submitted:

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WAYNE METCALF, Chair
Mandated Benefits Advisory Task Force

MANDATED BENEFITS ADVISORY TASK FORCE
MINUTES OF PUBLIC MEETING
NOVEMBER 26, 2001

CALL TO ORDER

The meeting was convened at the Kapuaiwa Room, Second Floor, Princess Victoria Kamamalu Building, on November 26, 2001, at approximately 10:16 p.m.

PRESENT

Wayne Metcalf, Chair; Paula Arcena; Mike Cheng; Don Dawson; Philip Hellreich, MD; Rep. Kennth Hiraki; Ruth Ellen Lindenberg; Arlene Meyers, MD, JD; Sharyn Stephani Monet, JD, RN; Christopher Pablo, Esq.; and Lawrence Redmond, DC; members. Absent: Laura Anderson, Esq.; Rep. Dennis Arakaki; Glenn Okihiro, DDS; and Sen. Brian Taniguchi. Also present: Tom Smyth, DBEDT; Donald Kopf, PhD, and Martin Johnson, PsyD, Hawaii Psychological Association; Jennifer Diesman, HMSA; Terrence Aratani, Esq., of Sen. Taniguchi's office; and Bev Harbin, Chamber of Commerce of Hawaii.

APPROVAL OF MINUTES (11/19/01 MEETING)

Draft copies of the minutes were transmitted to the members prior to the meeting for review. Dr. Hellreich moved, seconded by Rep. Hiraki, that the minutes of the November 19, 2001 meeting be approved and adopted. Without objections, the minutes were adopted.

PROPOSED RECOMMENDATIONS OF THE TASK FORCE

Based upon the recommendations of the three subcommittees, Chair Metcalf offered two recommendations to the Task Force for consideration:

- Recommend that the Legislature adopt a concurrent resolution requesting that establishment of a task force to examine the effectiveness of the Prepaid Health Care Act and to consider the feasibility of amending or repealing it.

  Chair Metcalf also presented a draft concurrent resolution.

- Recommend that the Legislature approve a revised version of H.B. NO. 237, H.D.2, S.D.1 that incorporates appropriate elements from the models of the states of Washington, Pennsylvania, Virginia, and Maryland. Incorporation of the cost criteria recommendations of the Cost Utilization and Cost Avoidance Subcommittee should also be considered. These include:

- Inclusion of the potential costs savings that may result from a proposed mandated health care benefit;

- Inclusion of any increase in administrative and other "start-up" costs to health plans associated with providing the mandated health care benefit;

- That the review panel/commission consider broader social benefits when reviewing a proposed mandated health care benefit; and

- That the review panel/commission also consider the potential additional costs that might result from the increased medical risks associated with providing the proposed mandated health care benefit.

Mr. Pablo moved, seconded by Rep. Hiraki, to approve and adopt the first recommendation and the draft concurrent resolution. Dr. Meyers offered an amendment to the draft concurrent resolution to reorder the issues the task force is being requested to examine. Dr. Meyers' amendment was adopted. Dr. Hellreich and Mr. Dawson offered an amendment to place the Insurance Commissioner in charge of the task force rather than the Director of Labor and Industrial Relations. This amendment was also adopted. Mr. Cheng offered technical, nonsubstantive amendments that were also adopted.

Mr. Dawson inquired about using 20 employees as the demarcation between small businesses and larger ones. Chair Metcalf indicated that the federal government uses 20 employees as the threshold between small business and larger ones. Mr. Pablo asked about congressional representation on the task force. Chair Metcalf indicated that the task force could invite congressional representation at the appropriate time.

Mr. Pablo suggested that it would be beneficial to have a discussion, or at least acknowledge the seven basic principles for mandatory prepaid employee coverage that were developed by Stefan A. Riesenfeld, who as a law professor at the University of California at Berkeley, was commissioned to conduct a study on prepaid employee health insurance. Chair Metcalf indicated that the Insurance Division staff would draft proposed committee report language that would be part of the Task Force's report to the Legislature.

Hearing no further discussion on the motion, Chair Metcalf called for the vote. The motion carried. The first recommendation and the draft concurrent resolution, as amended, were approved.

Mr. Pablo moved, seconded by Mr. Dawson, to approve and adopt the second recommendation. Dr. Hellreich indicated that he objected to the language in H.B. NO. 237, H.D.2, S.D.1, that requires the panel to recommend a cap of the total cost of mandated health insurance services may not exceed. Dr. Hellreich further indicated that caps would result in rationing of health care services. Dr. Hellreich offered an

amendment to the motion to have the cap provision removed. Dr. Hellreich's amendment was voted down and therefore failed to carry.

Dr. Meyers expressed concerns in having the plans on the panel vote, as there could be conflicts of interests. She also indicated that by allowing the plans to vote, she was concerned that the panel would be viewed in an unflattering light, similar to the Prepaid Health Care Advisory Council. Dr. Meyers offered an amendment that would make the plans ex-officio, non-voting members of the panel. Dr. Meyers' amendment was voted down and therefore failed to carry.

Rep. Hiraki mentioned that the Healthcare Provider List Subcommittee recommended that each mandated benefit go through a sunset review every five years. Rep. Hiraki offered an amendment to include the sunset review. Rep. Hiraki's amendment was approved.

Dr. Redmond indicated that alternative complementary care providers are not represented on the panel. Chair Metcalf suggested that the recommendation be amended to request the Legislature to consider a balanced membership on the panel. Dr. Meyers offered an amendment to request the Legislature to consider a balanced representation of stakeholder such as providers and consumers on the panel. Dr. Meyers' amendment was approved.

Hearing no further discussion on the motion, Chair Metcalf called for the vote. The motion carried. The second recommendation, as amended, was approved.

PUBLIC COMMENT

The Task Force did not receive any written comments from the public.

NEXT MEETING

None scheduled.

ANNOUNCEMENTS

None.

ADJOURNMENT

Dr. Hellreich moved, seconded by Dr. Meyers, to adjourn the meeting. Without objection, the meeting was adjourned at approximately 11:24 a.m.

Respectfully submitted:

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WAYNE METCALF, Chair
Mandated Benefits Advisory Task Force

MANDATED BENEFITS ADVISORY TASK FORCE
APPROPRIATENESS OF SCOPE SUBCOMMITTEE
MINUTES OF PUBLIC MEETING
August 23, 2001

The meeting was convened in the State Capitol Building, Room 312, on August 23, 2001, at approximately 9:33 a.m.

PRESENT

Rep. Kenneth Hiraki, Chair; Mike Cheng; Don Dawson; Philip Hellreich, MD; Arlene Meyers, MD, JD; Sharyn Stephani Monet, JD, RN; and Phyllis Dendle, proxy for Christopher Pablo, Esq.; members. Absent: None. Also present: Rafael del Castillo, Hawaii Coalition for Health; and Jennifer Diesman, HMSA.

GROUND RULES FOR THE CONDUCT OF BUSINESS

To encourage a free exchange of ideas, Chair Hiraki indicated that the meetings of the Subcommittee would be run in an informal manner. As with the full Task Force, the Subcommittee would work towards consensus. However, if consensus is not achieved, then a majority vote will determine the Subcommittee's actions. Deference will be given to Subcommittee members over non-members.

PLAN OF ACTION

Chair Hiraki proposed a plan of action (see attachment) to the Subcommittee members. The plan calls for panels of knowledgeable persons to brief the Subcommittee on the following:

- What is a mandated benefit?
- The scope of interests affected when benefits are mandated.
- Criteria to consider in mandating benefits.

Mr. Dawson indicated that he liked the questions contained in the proposed plan. He continued by asking what would happen if there was no Prepaid Health Care Act? According to his experience, Mr. Dawson indicated that employers are refusing to hire people for more than 20 hours a week to avoid the requirements of the Act. The Act is too narrow and inhibits competition.

Dr. Meyers offered that it was not realistic to work on the Prepaid Health Care Act. She added that if there were no Act, would people still be insured? She indicated that it would be prudent to assess the impact of repealing the Act.

Mr. Cheng indicated that HMSA experience a slight increase in the number of insureds after the enactment of the Prepaid Health Care Act. Whereas, Dr. Hellreich indicated that 10% of the population was uninsured before the enactment of the Act, and today it is still about the same.

Because the plan of action is ambitious, Chair Hiraki suggested meeting weekly, every Friday. No one objected to the plan, or to meeting every Friday. Chair Hiraki then solicited suggestions on who should be invited to make presentations to the Subcommittee. Several names were offered. Staff was tasked with contacting the suggested panel members for the next meeting of the Subcommittee.

PUBLIC COMMENT

The Subcommittee did not receive any public comment.

NEXT MEETING

Friday, August 31, 2001, at 9:30 a.m. at the State Capitol Building, Room 329.

ANNOUNCEMENTS

There were no announcements.

ADJOURNMENT

Mr. Cheng moved, seconded by Dr. Meyers, that the meeting be adjourned. The meeting was adjourned at approximately 10:08 a.m.

Respectfully submitted:

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Rep. Kenneth Hiraki, Chair
Appropriateness of Scope Subcommittee
Mandated Benefits Advisory Task Force

MANDATED BENEFITS ADVISORY TASK FORCE
APPROPRIATENESS OF SCOPE SUBCOMMITTEE
MINUTES OF PUBLIC MEETING
August 31, 2001

The meeting was convened in the State Capitol Building, Room 329, on August 31, 2001, at approximately 9:44 a.m.

PRESENT

Rep. Kenneth Hiraki, Chair; Mike Cheng; Don Dawson; Philip Hellreich, MD; Arlene Meyers, MD, JD; Sharyn Stephani Monet, JD, RN; and Phyllis Dendle, proxy for Christopher Pablo, Esq.; members. Absent: None. Also present: Noraine Ichikawa and Audrey Hidano, DLIR; Paula Arcena, HMA; Bill Donahue, Hawaii Independent Physicians Association; Rafael del Castillo, Suzanne Yelb, and Richard Miller, Hawaii Coalition for Health; Connie Hastert, Hawaii Employers Council; Jennifer Diesman, HMSA; Valisa Saunders, HNA; Louis Darnell, Bev Harbin, and Wes Lum, Chamber of Commerce; Lawrence Redmond, DC, PratiCare Hawaii.

APPROVAL OF MINUTES (08/23/01 MEETING)

Ms. Monet moved, seconded by Mr. Dawson, to approve the minutes of the August 23, 2001 meeting. Without objection, the minutes were approved.

IDENTIFY APPROPRIATE POLICY BASES FOR MANDATED BENEFITS

Chair Hiraki briefly explained the history and purpose of the mandated benefit process, the Mandated Benefits Advisory Task Force, and the Subcommittee. The Subcommittee then proceeded to receive comments regarding the question "what is a mandated benefit?" The following summarizes the comments received by the Subcommittee and is not intended to be a verbatim transcription.

Richard E. Chard, Ph.D., M.P.A. Professor Chard submitted written comments but was not able to attend. Professor Chard's comments indicated that *"Overall, mandated benefits are a good idea given the nature of health care and the inability of markets to fairly and efficiently supply health care."* Professor Chard also concluded that *"mandating preventative health care benefits will serve two purposes. First, it will reduce current acute care costs because there will be greater access to basic care. Second, in the long run, mandating preventative health care benefits ensures a healthier society and thereby reduces health care costs and concerns for generations into the future."*

Department of Labor and Industrial Relations (Leonard Agor, Director of Labor and Industrial Relations). Mr. Agor submitted written comments and was

represented by Ms. Audrey Hidano, Deputy Director. Mr. Agor's comments indicated that the Hawaii Prepaid Health Care Act (Act) was enacted to provide protection for all employees against the cost of medical care in case of sudden need that may consume all or an excessive part of a person's resources. Mr. Agor's written comments also indicated that the Act established a level of mandated benefits that include *"sound basic hospital, surgical, medical and other health care benefits,"* and that the benefits are established by the "prevalent plan" or plan with the largest number of subscribers.

Mr. Agor further explained that under the conditions of Hawaii's ERISA (the federal Employees Retirement Income Security Act of 1974) exemption, which allows Hawaii to continue to administer the Act, no substantive changes to the Act as passed in 1974 are allowed. However, through amendments in the Insurance Code, mutual benefit societies (e.g. HMSA), HMOs (e.g. Kaiser), and insurance companies, are required to provide specific mandated benefits. Mr. Agor's written comments indicated that if the Act were to be repealed, the number of uninsured would increase and insurance premiums may also increase.

HMSA (Mike Cheng, Vice President of Underwriting and Statistics). Mr. Cheng's written comments indicated that government mandated benefits force health care plans to cover specific diseases, conditions, and services and pay for the services of certain types of providers, and that mandated health benefits have been enacted at both the state and federal levels. The written comments further indicated that health plans along with input from purchasers of these products are in the best position to determine what specific benefits should be included in a health care plan. The employer marketplace should drive what additional benefits are offered to their employees. However, government mandates may require employers to provide benefits that their employees may not want or need.

Mr. Cheng's written comments continued by indicating that allowing health plans along with employer purchasers to design benefit packages is particularly salient in Hawaii given that the Prepaid Health Care Act mandates a 1.5% annual gross wage cap on the employee's cost share for the health plan benefit. However, employers are picking up 100% of the tab for their employees' health benefits, and therefore should be allowed to decide which additional benefits to include in the health plan package. Mr. Cheng verbally indicated that 1.5% of the median monthly salary is approximately $40.

Mr. Cheng's written comments concluded by stating that HMSA opposes mandated health benefits.

Kaiser Permanente (Phyllis Dendle, Director of Government Affairs). Ms. Dendle's written comments indicated that if there were no specific state laws regarding health benefits in Hawaii, *"we would still have comprehensive health plans available to our citizens. This is because there is substantial federal legislation that provides regulation on benefits in a variety of areas."* Ms. Dendle's comments further indicated that beyond these requirements, purchasers of health plans frequently shape the benefits offered in ways that addresses consumer needs. In the U.S. and particularly in

Hawaii, the purchasers of health plans are mainly employers and the consumers are these purchasers and their employees. In Hawaii, employees generally pay little if anything for their coverage or care. This means that they do not act like consumers…they experience health care as virtually "free" – an entitlement.

Ms. Dendle's comments also indicated that many of the single mandated benefits enacted via special legislation meet the needs of relatively few people. She also stated *"if the Legislature curtailed mandating benefits, I think that we would continue to see many services covered in excess of what might be basic health care largely because of demand."*

PractiCare Hawaii, Inc. (Lawrence A. Redmond, DC, President). Dr. Redmond's written comments indicated that under the Prepaid Health Care Act, benefits for chiropractic, acupuncture, massage therapy, and other types of complementary alternative medicine (CAM) are not mandated and that these benefits are available only through benefit riders that are an added cost to employers and limits consumers to a predetermined number of visits regardless of the type or severity of their health condition.

Dr. Redmond noted the federal legislation H.R. 4205, which mandates that chiropractic care be made available to all active duty personnel in the U.S. armed forces. A cost analysis developed by the chiropractic members of the CHCDP oversight advisory committee with the assistance of ACA and ACC's consulting firm, concluded that the integration of chiropractic care into the military would produce a net dollar savings of $25 million a year for the DOD.

Dr. Redmond also noted the Illinois experience. Using Doctors of Chiropractic as primary care physicians with oversight and co-management by its medical director, Alternative Medicine, Inc. (AMI) imbedded chiropractic and other CAM therapies into its core services offered through its fully integrated delivery system for BlueCross/BlueShield of Illinois' HMO of Illinois. The results are a 66% reduction of total health care costs achieved through significantly decreasing the need for expensive and invasive diagnostics, preventing the health crises that drive hospitalization and length of stay and reducing the reliance on pharmaceuticals.

Hawaii Medical Association (Gerald McKenna, MD, President-Elect). Dr. McKenna submitted written comments and was represented by Dr. Hellreich. Dr. McKenna's written comments indicated that general medical and surgical benefits would be mandated if there were no mandated benefits and that the alternative to mandating specific benefits is to provide sufficiently broad basic benefits as part of health insurance policies. Enrollees could elect special treatments not covered under core benefits in any specific insurance plan. The market would work to provide consumer benefits if all insurance companies agreed to a broadly defined core benefit package.

Dr. McKenna's comments further indicated that *"it is necessary to mandate benefits that are life-saving, but are not usually included in core surgical benefits.*

These include mental health benefits since there is a high morbidity and mortality due to untreated major psychiatric disorders. Also, untreated addiction carries a high morbidity and mortality." Dr. McKenna expressed concern if these benefits were not mandated because insurance companies may choose to severely restrict reimbursement for mental health and addiction medicine.

Dr. McKenna explained that the *"main reason to limit the mandated benefit, is the tendency for special interests groups to lobby for particular procedures in medicine which may apply to a relatively few number of people."*

Dr. Hellreich added that 10% of the population was uninsured before the enactment of the Prepaid Health Care Act (Act), and 10% of the population is uninsured now. He also pointed out that the State exempted itself from the Act because it could not afford it. Dr. Hellreich also indicated that HMA supports medical savings accounts.

Valisa Saunders, MSN, APRN, GNP. Ms. Saunders' written comments indicated that health insurance benefits tend to be based on a model that emphasizes allopathic medicine in acute care facilities and physician's offices over preventive care and public health measures. Ms. Saunders continued by offering that the alternative to mandating benefits is accepting what the insurance market is willing to provide. Generally, those will be services that are desired by the population at large in order to increase the risk pool. Ms. Saunders further indicated that the most efficient way of using funds would be to provide preventive services. *"It is far less expensive to pay for treatment of diabetes in the early stages than it is to pay for dialysis, which may be needed at a later time, if the disease is left untreated."*

Chamber of Commerce of Hawaii (Louis Darnell). Mr. Darnell did not submit written comments, but indicated that he would reduce his remarks into writing. Basically, Mr. Darnell indicated that businesses cannot afford additional increases in health coverage costs and that employees should share a greater responsibility of the benefits that they enjoy.

Questions.

Dr. Meyers ask Dr. Redmond if the population that uses CAM services is mistrusting of traditional services. Dr. Redmond indicated that a minority may be mistrusting of traditional medicine, however, most that use CAM services have use traditional services first, and not received the results they expect, and therefore seek relief from CAM services.

Mr. Dawson indicated that employees should have a greater sense of the costs of the benefits they enjoy and should pay a greater share of the premiums. Dr. Meyers indicated that it must be determined if mandated benefits serve the public good.

PUBLIC COMMENT

The Subcommittee received comment from Bill Donahue of the Hawaii Independent Physicians Association. Mr. Donahue indicated that although the Prepaid Health Care Act (Act) was good legislation that was ahead of its time when it was enacted in 1974, it has not evolved to keep up with the current environment and needs of the consumers. Mr. Donahue suggested that it is time to rethink the Act and that Hawaii's ERISA exemption should not be a roadblock to improving Hawaii's situation.

NEXT MEETING

Friday, September 7, 2001, at 9:30 a.m. at the State Capitol Building, Room 329. Chair Hiraki indicated that he plans to extend invitations to the parties that participated in this meeting and also invite other parties who could provide meaningful information.

ANNOUNCEMENTS

There were no announcements.

ADJOURNMENT

The meeting was adjourned at approximately 11:16 a.m.

Respectfully submitted:

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Rep. Kenneth Hiraki, Chair
Appropriateness of Scope Subcommittee
Mandated Benefits Advisory Task Force

MANDATED BENEFITS ADVISORY TASK FORCE
APPROPRIATENESS OF SCOPE SUBCOMMITTEE
MINUTES OF PUBLIC MEETING
September 7, 2001

The meeting was convened in the State Capitol Building, Room 329, on September 7, 2001, at approximately 9:38 a.m.

PRESENT

Rep. Kenneth Hiraki, Chair; Jennifer Diesman, proxy for Mike Cheng; Don Dawson; Paula Arcena, proxy for Philip Hellreich, MD; Arlene Meyers, MD, JD; Sharyn Stephani Monet, JD, RN; Christopher Pablo, Esq.; members. Absent: None. Also present: Noraine Ichikawa, DLIR; Connie Hastert, Hawaii Employers Council; Cynthia Nakamura, Law office of Linda Takayama; Rafael del Castillo and Suzanne Yelb, Hawaii Coalition for Health; William Donahue, Hawaii Independent Physicians Association; Sandra Stone-Conway and Mitchell Hall, HMAA; Bob Toyofuku, Advocates-Aloha Care; and Bev Harbin, Chamber of Commerce of Hawaii.

APPROVAL OF MINUTES (08/31/01 MEETING)

Ms. Monet moved, seconded by Dr. Meyers, to approve the minutes of the August 31, 2001 meeting. Without objection, the minutes were approved.

IDENTIFY APPROPRIATE POLICY BASES FOR MANDATED BENEFITS

Chair Hiraki informed the Subcommittee that the purpose of this meeting was to hear from the health plans regarding their perspective on the scope of interests affected when benefits are mandated. Chair Hiraki indicated that HMAA, HMSA, Kaiser Permanente, and Aloha Care were invited to provide the Subcommittee with health plan perspectives on this issue. Chair Hiraki also indicated that Aloha Care declined to participate because they serviced a different population and did not feel that their experience applied in this particular situation.

HMSA (Jennifer Diesman, Manager of Government Relations). Ms. Diesman's written comments briefly described how HMSA responds to a mandated benefit. This includes trying to understand the law and its intent, determining if there are any short falls in the current benefits that need to be covered, calculating the cost and dues impact, updating the written benefit information, providing adequate notice to employees, and redesigning the claims processing system to comply with the mandates. Ms. Diesman's written comments also indicated that individual, limited-benefit, government, and Medicare-related plans are excluded from mandates.

Employer groups with at least one employee, union trust funds, government employees and retirees, conversion plan members, self-employed individuals, full-time students, and individual members are plan customers identified by HMSA. Additionally, Ms. Diesman's comments indicated that everyone pays more whether they utilize mandated benefits because the increased liability for the mandated benefit is estimated across all affected populations equally. HMSA also indicated that mandates result in a reduction in coverage as employers may discontinue dental, vision, drug, and/or dependent coverage, which are not required under the Prepaid Health Care Act.

HMSA indicated that factors such as expanding rather than adding new benefits and increases in utilization make it difficult to measure the actual cost of a mandated benefit. Ms. Diesman reiterated HMSA's opposition to mandated benefits.

HMAA (Sandra Storm-Conway, Manager, Government & Regulatory Affairs). Ms. Storm-Conway indicated in her written comments that mandated benefits increase costs to health plans and that mandated benefits provide both positive and negative impacts to HMAA's customers (i.e. guaranteed coverage and potential increase in costs to the employer). Ms. Storm-Conway also indicated that HMAA utilizes a nationally accepted standard rating model, which includes adjustments necessary to accommodate increases in coverage, to determine its rates.

Ms. Storm-Conway further indicated that HMAA was not necessarily opposed to mandated benefits, as it is in the best interests of the community to have certain health care benefits mandated (e.g. disease management programs and catastrophic thresholds). She noted that the timeframe to implement a mandated benefit is important to a plan. With reasonable notification of a new mandated benefit, the plan will be better able to analyze the potential costs associated with the benefit and would allow appropriate communication with employers and subscribers regarding the benefit.

Kaiser Permanente (Christopher Pablo, Esq., Manager, Public, Government & Community Affairs). Mr. Pablo indicated that he would submit his written remarks at a later date. Mr. Pablo verbally indicated that mandated benefits interfere with the ability of health plans to design their benefits package and their system of delivering services. Mr. Pablo further indicated that economic interests drive many of the mandated benefits and that Kaiser is opposed to this kind of micromanagement.

Questions.

Kaiser and HMSA have indicated that mandated benefits are not necessary. In response to that, Dr. Meyers inquired if the two plans would provide "well child" and immunization coverage if they were not mandated. Mr. Pablo indicated that Kaiser's clinicians recommend the kinds of services that should be included in their plans. Dr. Meyers indicated that HMSA did not provide the coverage until it was mandated. She also indicated that she feels great anxiety in leaving this type of social policy decision up to the health plans.

Chair Hiraki asked if all health insurance mandated benefits were repealed, would premiums decrease? Ms. Diesman indicated that because of the administrative systems costs involved, premiums might not be reduced. Mr. Pablo also indicated that premiums might not necessarily be reduced. Ms. Diesman further indicated that there would be very few currently mandated benefits that they would not provide. Ms. Storm-Conway indicated that it takes about a year to assess the cost impact of a particular mandated benefit. Mr. Pablo suggested that if the Legislature feels it must mandate benefits, it should look carefully at the effective date (to provide health plans sufficient time to implement the mandate) or use a case study group such as state employees.

Mr. Dawson inquired if the health plans opposed the Prepaid Health Care Act (Act)? If we got rid of mandated benefits, what would happen? Mr. Pablo indicated that Kaiser is not opposed to the Act, however, consumers should share a more equal portion of the risks. Mr. Pablo continued by indicating that the Act is not within the scope of the Task Force. He also indicated that the Act was not intended to be static, but rather evolve with the time. However, as a result of Hawaii's ERISA exemption for the Prepaid Health Care Act, the Act's requirements are frozen in time.

Ms. Monet asked the plans how prescription drugs impact costs. Mr. Pablo indicated that pharmaceuticals are the fastest growing component of the health care delivery system. Factors that impact costs are demand and expectation, research, intellectual property, and advertisement. Ms. Diesman indicated that currently, prescription drugs account for approximately 17% of the total cost, whereas ten years ago, it was only about 5%.

PUBLIC COMMENT

The Subcommittee did not receive any public comment.

NEXT MEETING

Friday, September 14, 2001, at 9:30 a.m. at the State Capitol Building, Room 329.

ANNOUNCEMENTS

There were no announcements.

ADJOURNMENT

The meeting was adjourned at approximately 10:47 a.m.

Respectfully submitted:

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Rep. Kenneth Hiraki, Chair
Appropriateness of Scope Subcommittee
Mandated Benefits Advisory Task Force

MANDATED BENEFITS ADVISORY TASK FORCE
APPROPRIATENESS OF SCOPE SUBCOMMITTEE
MINUTES OF PUBLIC MEETING
September 14, 2001

CALL TO ORDER

The meeting was convened in the State Capitol Building, Room 329, on September 14, 2001, at approximately 9:34 a.m.

In recognition of President Bush declaring today as a day of prayer and remembrance, Chair Hiraki requested everyone to stand for a moment of silence.

PRESENT

Rep. Kenneth Hiraki, Chair; Jennifer Diesman, proxy for Mike Cheng; Don Dawson; Paula Arcena, proxy for Philip Hellreich, MD; Arlene Meyers, MD, JD; Sharyn Stephani Monet, JD, RN; Christopher Pablo, Esq.; members. Absent: None. Also present: Noraine Ichikawa, DLIR; Connie Hastert, Hawaii Employers Council; Suzanne Gelb, Hawaii Coalition for Health; Bev Harbin and Christine Camp, Chamber of Commerce of Hawaii; Dick Botti, Legislative Information Services of Hawaii; Bette Tatum and Marcia Anderson, National Federation of Independent Business; Lokelani Laybon and Carina Tagupa, Senate Minority; and Melvin Ah Ching, Sen. Slom's Office.

APPROVAL OF MINUTES (09/07/01 MEETING)

Mr. Pablo requested a correction to the minutes regarding the requirements of the Hawaii Prepaid Health Care Act being frozen in time. Ms. Diesman clarified that although the minutes accurately reflects Dr. Meyers' comment that HMSA did not provide "well child" and immunization coverage until it was mandated, HMSA did indeed provide the coverage prior to the mandate. Dr. Meyers stood by her statement, indicating that practicing physicians disagree with HMSA's statement that they did provide coverage prior to the mandate. Ms. Diesman indicated that she would provide documentation that HMSA did provide the coverage prior to the mandate.

Mr. Dawson moved, seconded by Ms. Monet, to approve the minutes as amended by Mr. Pablo. Without objection, the minutes were approved as amended.

IDENTIFY APPROPRIATE POLICY BASES FOR MANDATED BENEFITS

Chair Hiraki informed the Subcommittee that the purpose of this meeting was to hear from employers regarding their perspective on the scope of interests affected when benefits are mandated. Chair Hiraki indicated that Small Business Hawaii (SBH), Legislative Information Services of Hawaii (LISH), the National Federation of

Independent Business (NFIB), and the Chamber of Commerce of Hawaii were invited to provide the Subcommittee with employer perspectives on this issue.

SBH (Senator Sam Slom, President and Executive Director) Sen. Slom submitted written comments indicating that because of a previous speaking engagement, he would not be able to attend the Subcommittee meeting.

Sen. Slom indicated in his written comments that the pattern under Hawaii's Prepaid Health Care Act during the past 25 years has been higher premiums, lower benefits, and discrimination among small businesses. The Act is for employees, not employers and their families, as the law requires providers to make plans available to employees, but does not require providers to make comparable plans available for entrepreneurs, sole proprietors, or independent contractors.

Sen. Slom further indicated that over the years, there have been more than a dozen companies that came into – and left – the Hawaii market. Numerous potential providers were discouraged or denied entry into the market by the "hoops" set by the Prepaid Health Care Advisory Council.

Sen. Slom identified the problem as a systemic problem that affects more than just mandated costs. He suggested that the Prepaid Health Care Act be changed if the goal is universal coverage.

LISH (Dick Botti). Mr. Botti indicated that because of the size of their program, LISH is experienced rated, meaning that their fees are based on their experience. He further indicated that independent contractors are finding it difficult obtaining medical coverage because they are not defined under the Prepaid Health Care Act (Act) as an employee, therefore exempted from the requirements of the Act. Mr. Botti indicated that both HMSA and Kaiser have advised LISH that they do not want them accepting independent contractors, or any firm that does not have a DOL Number.

Mr. Botti further indicated that the entire Act is a mandate. The cost is equivalent to upwards to $1.20 per hour for a forty-hour a week employee. He also indicated that although the effect of the Act was good at one time, because of the limitations on employee financial participation, the law has become counterproductive.

Mr. Botti suggested encouraging individuals to establish medical savings accounts to allow for medical necessity reserves paid for with pre-tax dollars. Mr. Botti stated that he believes that HMSA has a monopoly that stifles competition because of their prohibition from allowing LISH to offer any other fee for service plan. If they cannot offer any other fee for service plan, there is little likelihood of competition in the future. He also suggested creating an entity similar to HEMIC for the purpose of providing major medical supplemental health care coverage.

NFIB (Bette Tatum, State Director). Ms. Tatum indicated in her written comments that small business owners have named the skyrocketing costs of providing

quality, effective health care benefit as a major problem. Small businesses outside of Hawaii can opt to not cover employees or increase employee contribution when health care insurance proves too costly for them. However, small businesses in Hawaii do not have the same options.

Ms. Tatum further indicated that Hawaii's Prepaid Health Care Act mandates employers to provide health coverage for employees. On top of this, over the years, mandate after mandate have been added. This represents a huge problem for small businesses. She also indicated that based upon experience, small business owners have indicated that mandates can drive up the cost of providing insurance by as much as 8% per mandate. These additional costs require small businesses to cut non-mandated benefits such as not being able to increase wages, letting employees go, or shutting down completely.

Ms. Tatum stated that supporters of the Prepaid Health Care Act insisted that without a mandate, employers would drop health care coverage for their employees. She contends that that did not happen. She is not aware of any business that dropped health care coverage for employees after the Legislature refused to re-impose the Act.

Ms. Tatum noted the Washington State experience. She indicated that the lessons learned from Washington State include:

- States should not get involved in mandating a uniform package of insurance benefits, as such mandates restrict consumer choice and control, and ultimately increases costs.
- States should not mandate insurance coverage of specific conditions or medical services, as such mandates force people to purchase medical services or treatment coverages that they may not want.
- States should not impose employer mandates requiring the provision of health insurance, as the costs to employers are ultimately passed on to workers through lost wages and jobs.
- Medical Savings Accounts are effective in controlling costs.

The Chamber of Commerce of Hawaii (Christine Camp, Chair of the Small Business Council). Ms. Camp indicated that mandates create additional administrative costs to health plans and that these costs are passed onto businesses. She further indicated that independent contractors find it difficult and expensive to find health care. This particularly affects small business owners as many of them start out as independent contractors. As health care benefits become more and more expensive for small business owners, they opt not to provide dependent coverage to their employees.

Ms. Camp also indicated that it is estimated that 10% of the population is uninsured, and the number is rising as the cost of medical plans increase. Because of the Prepaid Health Care Act, some employers keep their employees at a part-time level to avoid the requirements of the Act. Also, more and more, the dependents of full-time

employees find themselves without coverage. The more premiums increase, more small business owners decide not to offer dependent coverage.

Ms. Camp's written comments indicated that using an average premium of $200/month, in order for an employer to pass on $100 per month of the premiums to employees, the employee would have to make more than $80,000 per year.

Ms. Camp suggested that all mandated benefits be repealed. They believe that would be the first step to provide the basic medical needs of the majority of the population, as was originally intended by the Prepaid Health Care Act.

Questions.

Dr. Meyers asked Ms. Camp where she got the 10% uninsured estimate from? Ms. Camp responded that it came from a state agency. Dr. Meyers follow by inquiring if the 10% uninsured was because of mandates? Ms. Camp indicated that if costs were not high, the number of uninsured would decrease.

Ms. Monet asked Ms. Camp if she had data on the actual costs of mandates? Ms. Camp indicated that she did not have specific information. Ms. Harbin suggested that the Auditor conduct research on the costs of mandates. Chair Hiraki indicated that that was a good idea.

Mr. Dawson inquired how much would the 1.5% cap be? Ms. Camp indicated that based upon a gross salary of $30,000, it would be approximately $18. Ms. Arcena asked if mandated benefits are only one component of the problem, what are the other components? Mr. Botti agreed that mandates are only a small part of the problem. Ms. Camp indicated that employees do not pay, therefore they do not know what the costs are. They need to understand what the costs are.

Ms. Diesman asked who were the supporters of the Prepaid Health Care Act? Mr. Pablo indicated that union leaders were the driving force, but it is interesting to note that collective bargaining is exempt from the Act. He further indicated that HRS sections 23-51 and 23-52 created a greater rational basis in mandating benefits. However, Mr. Pablo believes that the system is broken because the Legislature does not always request the Auditor to conduct a study on proposed mandates, as in the case of the diabetes mandate.

Mr. Pablo also indicated that the 1.5% cap on gross wages was not intended to be frozen in time, but to be a more equitable sharing of premium costs. Ms. Tatum suggested that the 1.5% cap be changed to reflect a better balance and sharing of costs between employers and employees. Ms. Camp suggested that existing mandates sunset. Proponents would then have to defend and justify the mandates.

Chair Hiraki reminded the members that the scope and authority of the Task Force and Subcommittee is limited to the concurrent resolution.

PUBLIC COMMENT

The Subcommittee did not receive any public comment.

NEXT MEETING

Friday, September 21, 2001, at 9:30 a.m. at the State Capitol Building, Room 329.

ANNOUNCEMENTS

There were no announcements.

ADJOURNMENT

The meeting was adjourned at approximately 10:51 a.m.

Respectfully submitted:

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Rep. Kenneth Hiraki, Chair
Appropriateness of Scope Subcommittee
Mandated Benefits Advisory Task Force

MANDATED BENEFITS ADVISORY TASK FORCE
APPROPRIATENESS OF SCOPE SUBCOMMITTEE
MINUTES OF PUBLIC MEETING
SEPTEMBER 21, 2001

CALL TO ORDER

The meeting was convened in the State Capitol Building, Room 329, on September 21, 2001, at approximately 9:39 a.m.

PRESENT

Rep. Kenneth Hiraki, Chair; Mike Cheng; Don Dawson; Paula Arcena, proxy for Philip Hellreich, MD; Arlene Meyers, MD, JD; Sharyn Stephani Monet, JD, RN; Christopher Pablo, Esq.; members. Absent: None. Also present: Audrey Hidano, Noraine Ichikawa, and Edward Wang, DLIR; Connie Hastert, Hawaii Employers Council; Suzanne Gelb and Rafael del Castillo, Hawaii Coalition for Health; Bev Harbin, Chamber of Commerce of Hawaii; Nancy Smith, Hawaii Nurses' Association; Jennifer Diesman, HMSA; Bill Donahue, Hawaii Independent Physicians Association; Philip McNamee, MD, Pacific In Vitro Fertilization Institute; Lydia Hardie, Hawaii Psychiatric Medical Association; and Carol Parker, Hawaii Psychological Association.

APPROVAL OF MINUTES (09/14/01 MEETING)

Chair Hiraki requested a correction to the spelling to Ms. Gelb's name. Mr. Pablo requested a revision regarding his statement that an Auditor's study is not always conducted for proposed mandated benefits.

Mr. Dawson moved, seconded by Mr. Cheng, to approve the minutes as amended. Without objection, the minutes were approved as amended.

Mr. Cheng informed the Chair that he distributed a memorandum clarifying that HMSA did provide coverage for well baby care and childhood immunizations before the state mandate was enacted. Mr. Cheng's memo indicated that HMSA's prevalent plan, Plan 4, provided coverage for both Well Baby Care Visits and Immunizations. However, Dr. Meyers indicated that the coverage described in Mr. Cheng's memo is different from the current mandate.

IDENTIFY APPROPRIATE POLICY BASES FOR MANDATED BENEFITS

Chair Hiraki informed the Subcommittee that the purpose of this meeting was to hear from providers of health care services regarding their perspective on the scope of interests affected when benefits are mandated. Chair Hiraki indicated that the Hawaii Independent Physicians Association (HIPA), the Pacific In Vitro Fertilization Institute,

the Hawaii Medical Association (HMA), PractiCare Hawaii, Inc., and the Hawaii Nurses' Association (HNA) were invited to provide the Subcommittee with provider perspectives on this issue.

HIPA (Bill Donahue). Mr. Donahue indicated that HIPA endorses the concept of state mandated benefits when they are the product of the elected officials of Hawaii, and when applied judiciously with proper oversight.

Mr. Donahue further indicated that a mandated health benefit is some health care service that a government decides is socially necessary, or at least socially desirable. Almost by definition, it is a health insurance benefit that the marketplace is unable or unwilling to provide to a significant percentage of the population. He continued by categorizing these mandated benefits into four categories.

Those that health insurance companies have determined to be too expensive. This usually means that if the benefit is added to the health insurance package, it will address the needs of only a small section of the population, but increase premiums across the board to the point where an unacceptable amount of subscribers will drop the coverage. However, unless, as a society, we are willing to accept that a certain group of people who have a particular medical problem that is not covered by insurance must fend for themselves, then government intervention by means of mandated benefits is necessary.

Those benefits that traditionally have not been part of the average health insurance package. As an example, Mr. Donahue used special foods needed by children who suffer from PKU. Traditionally, health insurance did not pay for food. However, as a society, we decided that health insurance needed to expand beyond its traditional boundaries.

Those benefits that are in the nature of "public health" measures. For example, screening tests like pap smears. This is not strictly speaking a diagnostic test, but a screening test. Typically, a physician orders a diagnostic procedure when a patient presents certain symptoms. By contrast, screening tests are administered even if the patient does not present any symptoms, but rather falls into a category of people (e.g. women over a certain age). As a society, we have decided to spread the cost of this early intervention technique over the entire insured population.

A catch-all category that includes treatments or pharmaceuticals that are only emerging from the experimental stage but have garnered a political advocacy group that has successfully lobbied lawmakers.

HIPA recommended that mandated benefits be utilized only when government intervention is required to provide the health insurance coverage necessary to produce the greatest good for the greatest number of citizens. Specifically, HIPA recommended that new mandated benefits be reviewed by an expert panel. Several other states have created this type of panel.

Another recommendation is to mandate that health insurers be required to offer certain benefits, but allow groups to "opt-out" of the mandate. This would spread the costs of the mandates over only those groups that elect the mandated benefit, resulting in a higher premium for those groups, but allowing groups that cannot afford the higher premium to keep the less comprehensive coverage in place.

Another recommendation is to have the Legislature as the sole entity that mandates health insurance benefits. Mr. Donahue indicated that Kaiser and HMSA decide most of the health insurance benefits that will be provided in Hawaii by way of the "prevailing plan" provision of the Prepaid Health Care Act. Mr. Donahue also indicated that HIPA considers the prevailing plan provision to be detrimental to competition and consumer choice.

Pacific In Vitro Fertilization Institute (Philip McNamee, MD, Program Director). Dr. McNamee indicated that the U.S. Supreme Court, in Bragdon v. Abbot, deemed reproduction as a "major life function", and the inability to reproduce has been identified as a disability protected under the Americans with Disabilities Act.

Dr. McNamee indicated that he believes the mandate for in vitro fertilization (IVF) is good legislation, not only because it serves the public well, but also because it has many safeguards. The mandate allows for a one-time benefit from the insurance policy involved and defines various diagnoses that qualify for coverage. This prevents over utilization. The mandate also requires that the facility meet the minimum standards for IVF as published by the American Society for Reproductive Medicine.

Dr. McNamee further indicated that the cost of covering IVF is approximately $0.15 per subscriber per month and that 13 other states have mandated IVF coverage. For women under age 40, the success rate is 50%. As a result, fewer surgeries, which are less effective than IVF, are being performed. Once a couple has a child, IVF is no longer needed. Consequently, there is an ongoing decrease in less cost-effective surgeries.

HMA (Paula Arcena, Director of Legislative and Government Affairs). Ms. Arcena indicated that HMA favors consumer driven health insurance options that allow patients, rather than government, to decide how their needs are met. The patient-physician relationship has deteriorated because parties outside that relationship are allowed to make decisions. Consumers should be allowed to design a health plan that best meets their individual needs.

Ms. Arcena indicated that HMA supports consumer options such as medical savings accounts and supplemental insurance.

PractiCare Hawaii, Inc. (Lawrence Redmond, DC, President). Dr. Redmond was not present, but submitted written comments. His comments indicated that the self-employed often do not qualify for the major coverage that the larger groups have

because they do not have the "economies of scale" on their side to bring down costs. The effect of mandated benefits is that the excluded population would gain access to types of care not now available to them.

Dr. Redmond further indicated that if there were no major mandates, both consumer demand and competition would result in a more innovative product line. He also indicated that the scope of providers is limited to the mandated benefits. This type of process artificially tries to match a particular type of provider to a specific mandate.

Dr. Redmond indicated that the scope of interest affected by mandated benefits needs to change. He suggested that a new wellness paradigm be incrementally instituted to replace the old disease oriented model. If a wellness model is adopted, the future health of the people of Hawaii will improve over time.

HNA (Nancy Smith, PhD, APRN, CS, FAANP). Dr. Smith indicated that lower costs could be achieved by increasing efficiency in the supply of services such as reducing barriers to entry and the promotion of market competition among providers and insurers through a system of economic incentives. In this type of system, the effect of increasing the part of the costs paid directly by users will be to reduce the quantities of health care services demanded.

Dr. Smith further indicated that the uninsured are more likely to delay obtaining necessary, even life-saving care and those without health insurance are more likely to have had hospitalization that could have been prevented and to have received a diagnosis of cancer at an advanced stage. It has also been determined that increasing risk for out-of-pocket expenditures in catastrophic illness is associated with increased subsequent mortality among elderly Americans.

Dr. Smith also indicated that the lack of health care insurance coverage has been associated with decreased use of preventive health services and decline in health status when compared to the insured population. Evidence also points to the risks associated with being uninsured may result in substantial increases in the number of people with chronic conditions.

Questions.

Mr. Dawson wanted to ask Mr. Donahue a few questions, however, Mr. Donahue was not available. Consequently, Mr. Dawson indicated that he liked Mr. Donahue's suggestion of an expert panel to review proposed mandated benefits. Mr. Dawson wanted to find out if the suggested expert panel would also review existing mandates. Mr. Pablo also indicated that he found Mr. Donahue's comments to be interesting and was looking forward to future discussions with Mr. Donahue.

Ms. Monet asked Dr. McNamee if unmarried couples were excluded from the IVF mandate. Dr. McNamee indicated that unmarried couples were excluded. Mr. Pablo indicated that he disagreed with the Insurance Commissioner's interpretation that the

IVF benefit was one-time per plan. Mr. Pablo indicated that he believes the benefit is one-time per person and not per plan. Mr. Pablo asked what was the intent when the benefit was mandated? Dr. McNamee indicated that the law was copied from a Maryland law and that he did not recall any discussion of the issue. Dr. McNamee indicated that Maryland was the first to mandate IVF and that Hawaii was the second state to mandate it.

Dr. Meyers asked how did HMA decide its position? Was the membership polled? Ms. Arcena indicated that HMA's legislative committee developed the position. Dr. Meyers inquired if the position could be that of only a few? Ms. Arcena indicated that all members can participate.

Mr. Dawson asked if Hawaii could use the Internet to provide health information in a manner similar to Montreal. Dr. Smith indicated that technologies can be used, however, the segment of the population that would be in the greatest need does not have access to the Internet.

Chair Hiraki asked if IVF procedure results in cost savings. Mr. Cheng indicated that IVF procedures increase costs and that successful births also increase costs. Chair Hiraki inquired if the IVF mandate was repealed, would it still be included in health care coverage. Mr. Cheng indicated that purchasers would determine if the benefit would be included. Mr. Pablo indicated that IVF is not a treatment for a condition that would deteriorate if left untreated. Therefore, it should be left up to the marketplace.

Dr. Meyers indicated that it is not true that employees do not pay for their health care coverage. She indicated that employees pay through lower wages.

PUBLIC COMMENT

Lydia Hardie from the Hawaii Psychiatric Medical Association indicated that the HMA position is not the position of all its members. She also indicated that because of the five-year infertility requirement before IVF can be covered by the mandate, cost is probably high because of the long and drawn-out nature of the mandate requirement. As a way to decrease costs, she suggested allowing couples to access the IVF benefit sooner than the five-year wait required by the mandate.

NEXT MEETING

Friday, September 28, 2001, at 9:30 a.m. at the State Capitol Building, Room 329. Chair Hiraki set forth a meeting calendar that will enable the Subcommittee to submit a recommendation to the full Task Force by the November 19, 2001 deadline. The calendar is as follows:

- 09/28 – Consumers (including unions) and government agencies
- 10/05 – Auditor, consumers (including unions), Rep. Lee, and government agencies

- 10/12 – Providers, employers, and health plans
- 10/19 and 10/26 – No meetings. The time will be used to draft a recommendation
- 11/02 – Discuss the draft recommendation
- 11/09 – Discuss the redraft if necessary

ANNOUNCEMENTS

There were no announcements.

ADJOURNMENT

The meeting was adjourned at approximately 10:58 a.m.

Respectfully submitted:

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Rep. Kenneth Hiraki, Chair
Appropriateness of Scope Subcommittee
Mandated Benefits Advisory Task Force

MANDATED BENEFITS ADVISORY TASK FORCE
APPROPRIATENESS OF SCOPE SUBCOMMITTEE
MINUTES OF PUBLIC MEETING
SEPTEMBER 28, 2001

CALL TO ORDER

The meeting was convened in the State Capitol Building, Room 329, on September 28, 2001, at approximately 9:36 a.m.

PRESENT

Rep. Kenneth Hiraki, Chair; Jennifer Diesman, proxy for Mike Cheng; Don Dawson; Paula Arcena, proxy for Philip Hellreich, MD; Arlene Meyers, MD, JD; Nancy Smith, PhD, proxy for Sharyn Stephani Monet, JD, RN; Christopher Pablo, Esq.; members. Absent: None. Also present: Audrey Hidano, Noraine Ichikawa, and Edward Wang, DLIR; Connie Hastert, Hawaii Employers Council; Suzanne Gelb, Rafael del Castillo, and Richard Miller, Hawaii Coalition for Health; Bev Harbin, Chamber of Commerce of Hawaii; Lydia Hardie, Hawaii Psychiatric Medical Association; and Carol Parker, Hawaii Psychological Association.

APPROVAL OF MINUTES (09/21/01 MEETING)

Dr. Meyers moved, seconded by Mr. Dawson, to approve the minutes. Without objection, the minutes were approved.

Ms. Arcena noted that HMA submitted a letter to the Chair regarding how HMA formulated its positions. The letter indicated that HMA's Legislative Committee is open to participation by all members and that HMA's current officers were elected with a greater than 60% of the vote of its membership. The letter also indicated that HMA supports parity for all medical specialties.

IDENTIFY APPROPRIATE POLICY BASES FOR MANDATED BENEFITS

Chair Hiraki informed the Subcommittee that the purpose of this meeting was to hear from consumer groups, unions, and government, regarding their perspective on the scope of interests affected when benefits are mandated. Chair Hiraki indicated that the Kokua Council, the Department of Labor and Industrial Relations (DLIR), and the Hawaii Coalition for Health (HCFH) submitted written comments. The Chair also indicated that the American Association of Retired Persons (AARP), the Department of Health, and the AFL-CIO were also invited to submit comments but declined.

Kokua Council (Ruth Ellen Lindenberg). Ms. Lindenberg's written comments indicated that the Kokua Council lauds the Prepaid Health Care Act, but they are

concerned about those who are not covered by the Act. She also indicated that since 1996, there has been a steady decline in the number of people with health care insurance and the number of uninsured will increase as welfare clients reach their 5-year limit of financial assistance under Temporary Assistance for Families.

Ms. Lindenberg continued by noting that those individuals without health care coverage, over the long haul, cost the community more as neglected problems ultimately result in more serious conditions that require more costly care.

DLIR (Leonard Agor, Director of Labor and Industrial Relations, presented by Audrey Hidano, Deputy Director). Mr. Agor indicated that DLIR has no jurisdiction over health care plans that cover government employees as government groups are excluded from the Prepaid Health Care Act and are covered under collectively bargained health care plans.

Mr. Agor indicated that the Act provides Hawaii employees protection from catastrophic medical costs. Although the Act does not mandate specific benefits, it does require certain benefit types. The specificity of benefits is established by the "prevalent plan," the plan with the largest number of subscribers in the State. The "prevalent plan" must also comply with the Insurance Code, which mandates specific benefits. Benefits mandated under the Insurance Code and the Mutual Benefits Society and HMO chapters are applicable to health care insurers, not employers.

Mr. Agor also indicated that whenever benefits are mandated, the cost to the employee and employer increases, and therefore, we must carefully evaluate the necessity and cost of mandated benefits.

HCFH (Suzanne Gelb, PhD, Chair, Mental Health Division). Dr. Gelb's written comments indicted that the HCFH has data that strongly suggests that at least a quarter of the population is not presently covered by mandates. She continued that some consumers are entitled to charity care by hospitals because federal anti-dumping laws require that emergency rooms treat patients, regardless of whether the patient is covered by insurance. However, this does not resolve their inability to access care.

Dr. Gelb continued by indicating that mandates might or might not translate into increased premiums. If the mandated benefit were to reduce total health costs, as by avoiding expensive procedures that may be needed by those who do not received the mandated benefit, there would be a favorable effect on premiums. If on the other hand, the mandated benefit were to increase total health costs, then this might have an adverse impact on business in Hawaii. She also indicated that failure to cover expensive diagnostic or treatment services for serious illnesses could have severe negative effects on the affected patient and family. These are social costs involving human dignity that must also be factored into any decision about mandated benefits.

Dr. Gelb indicated that HCFH is seeking that decisions be made by an impartial decision-making mechanism that is informed by knowledgeable individuals with the aim

of maximizing society's values. HCFH preferred role for the Legislature is only to approve or disapprove decisions made by an expert panel.

Dr. Gelb also indicated that the overarching value to be promoted by the expert panel should be Human Dignity in Health Care. HCFH recommended the following values: (1) Economic productivity; (2) Treatment that meets the appropriate professional legal standard of care for providers; (3) Relief from, and alleviation of suffering; (4) Availability and use of the most up-to-date diagnostic and treatment modalities; (5) Promoting medical education; (6) Promoting research and advances in care delivery; (7) Protecting and conserving existing resources; (8) Improving access to care; (9) Compliance with advance directives duly executed by patients; (10) Death with dignity; (11) Admission of patients to, and support for participation in clinical studies where innovative modalities of treatment do not meet "medical necessity" criteria; (12) Economic Efficiency; (13) Prolongation of life for the seriously ill or aged where minimum reasonable quality of life is possible; and (14) Community expectations.

Questions.

Mr. Dawson indicated that he believed that HCFH's recommendations were far too broad. Dr. Meyers indicated that the factors in HCFH's recommendations are important, especially as they relate to societal values. Mr. del Castillo indicated that HCFH's recommendations are consistent with what the Subcommittee considered during its last meeting.

Mr. Pablo commended HCFH for its efforts and indicated that he liked their comprehensive approach. However, Mr. Pablo indicated that there would be little accountability if an expert panel made the decisions. The Legislature can be voted out of office. The panel should be advisory in nature. Mr. Pablo supports having the process and dialog occur outside the legislative session, where decision can be made in a calmer atmosphere.

Dr. Gelb indicated that the experts will be able to balance societal values and personal conflicts. Mr. Pablo indicated that the members of the panel should have a broad depth of knowledge and not just interests. Dr. Meyers indicated that the panel would not be the place for providers or plans, just the experts.

Mr. Miller indicated that it is difficult to develop well-fashioned, well-reasoned decisions of this type during the hustle and bustle of the legislative session. He also indicated that it may not be necessary for the panel members to be compensated, however, they should have a paid professional staff that possesses an understanding of the health system and the economic system. The Legislature should confine itself to either approving the recommendation, or remanding it back to the panel.

Chair Hiraki indicated that he believed the session was a good one – a thought provoking session. He asked HCFH to submit a more formal proposal.

PUBLIC COMMENT

No public comment was received.

NEXT MEETING

Friday, October 5, at 9:30 a.m. at the State Capitol Building, Room 329.

ANNOUNCEMENTS

There were no announcements.

ADJOURNMENT

The meeting was adjourned at approximately 10:50 a.m.

Respectfully submitted:

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Rep. Kenneth Hiraki, Chair
Appropriateness of Scope Subcommittee
Mandated Benefits Advisory Task Force

MANDATED BENEFITS ADVISORY TASK FORCE
APPROPRIATENESS OF SCOPE SUBCOMMITTEE
MINUTES OF PUBLIC MEETING
OCTOBER 5, 2001

CALL TO ORDER

The meeting was convened in the State Capitol Building, Room 329, on October 5, 2001, at approximately 9:35 a.m.

PRESENT

Rep. Kenneth Hiraki, Chair; Mike Cheng; Don Dawson; Philip Hellreich, MD; Arlene Meyers, MD, JD; Sharyn Stephani Monet, JD, RN; Christopher Pablo, Esq.; members. Absent: None. Also present: Paula Arcena, Hawaii Medical Association; Connie Hastert, Hawaii Employers Council; Suzanne Gelb, PhD, Rafael del Castillo, and Richard Miller, Hawaii Coalition for Health; Sherry Hayashi, Jim McMahon, and Jan Taylor, Office of the Auditor; Terry Lau, Hawaii State AFL-CIO; Audrey Hidano, Edward Wang, and Noraine Ichikawa, Department of Labor and Industrial Relations; Bev Harbin, Chamber of Commerce of Hawaii; Carol Parker, Hawaii Psychological Association; Stacy Evensen and Jennifer Diesman, HMSA; Lydia Hardie, Hawaii Psychiatric Medical Association; and Ruth Ellen Lindenberg, Kokua Council.

APPROVAL OF MINUTES (09/28/01 MEETING)

Mr. Dawson moved, seconded by Mr. Cheng, to approve the minutes. Without objection, the minutes were approved.

IDENTIFY APPROPRIATE POLICY BASES FOR MANDATED BENEFITS

Chair Hiraki informed the Subcommittee that the purpose of this meeting was to hear from consumer groups, unions, and government, regarding their perspective on the criteria to be considered in mandating benefits. Chair Hiraki indicated that the Kokua Council, the Department of Labor and Industrial Relations (DLIR), the Hawaii Coalition for Health (HCFH), and the Office of the Auditor submitted written comments. The Chair also indicated that Rep. Marilyn Lee was invited to speak about the proposed alternate process in mandating benefits contained in H.B. NO. 237, which she introduced. Unfortunately, she had a scheduling conflict and could not attend.

State Auditor (Marion Higa, State Auditor, presented by Jim McMahon). Ms. Higa's written comments indicated that since 1988, her office has conducted close to 20 studies of the social and financial impact of proposed measures to mandate certain health insurance benefits. She indicated that ultimately, deciding whether to mandate certain health insurance coverages requires determining what is best for the public

good. Some of the issues that could be considered are the extent of the need and demand for a particular coverage, the impact of the coverage on health, how much the coverage will cost, and who will bear the costs.

Ms. Higa indicated that the criteria reflected in section 23-52, Hawaii Revised Statutes (HRS), is both specific and comprehensive, covering 14 issues of social or financial impact. The section provides them the flexibility to focus on what they believe to be most important within each of the 14 areas. It does not force them to recommend for or against the proposed coverage. She did not have any amendments to the criteria to suggest. However, Ms. Higa indicated that she has testified that this activity consumes valuable audit resources and leads to inconclusive results. The studies did not yield the answers legislators needed because data on utilization and cost were generally not available, and this would probably continue to be the case no matter who conducts the studies.

Ms. Higa clarified that contrary to H.C.R. NO. 129, H.D. 1, S.D. 1, C.D. 1, the Office of the Auditor does gather input from others in the health care industry. In their most recent study, they mailed a detailed set of questions to key individuals at the employer groups, private insurers, HMOs, providers and their associations, unions, academic institutions, state agencies, and a consumer association. Ms. Higa also noted a potential legal problem, indicating that it is possible that any mandated benefit law passed after 1974 could be challenged as bypassing the limitations placed on the Prepaid Health Care Act.

Kokua Council (Ruth Ellen Lindenberg). Ms. Lindenberg's written comments indicated that in addition to assessing the social and financial impacts of new mandates, there should also be an efficacy component. She noted that the State of Washington includes this third standard.

Ms. Lindenberg indicated that we must learn how to use expert opinion more wisely. However, she also indicated that we should involve all those who might be affected by these decisions, not just the experts. She mentioned her experience in working on committees and task forces where favorable outcomes were achieved by bringing together as many of those who would ultimately have to live with what was proposed.

Ms. Lindenberg further indicated she would prefer a small community task force with an expert component to support them to make these types of decisions.

DLIR (Leonard Agor, Director of Labor and Industrial Relations, presented by Audrey Hidano, Deputy Director). Mr. Agor's written comments indicated that the proponents of a request to mandate a particular benefit should provide the pros and cons of the proposal. The gathering of expert advice and input from the community should also be the work of the proponents. The Auditor or some kind of review board could then act as the overseeing agency.

HCFH (Suzanne Gelb, PhD, Chair, Mental Health Division). Dr. Gelb's written comments set forth HCFH's proposal for a forum for making decisions regarding mandated benefits. HCFH proposed that the decisions be made by an impartial decision-making mechanism that is informed by knowledgeable individuals with the aim of maximizing society's values. In this mechanism, input may be provided by an advisory panel. This advisory panel would hold hearings to solicit wide public opinion. The expert panel would then report its finding to the Legislature, which would either approve the recommendations or remand it back to the panel. The Governor would appoint the expert panel and its powers would be specifically defined by legislation.

Questions.

Mr. Pablo commended Ms. Lindenberg on her insights. He indicated that he sees the role of experts as advisors to the decision-makers, and not become the decision-makers. He prefers the structure described by Ms. Lindenberg. Mr. Pablo then asked Dr. Gelb what are the differences between HCFH's proposal and Rep. Lee's bill. Dr. Gelb indicated that the bill was more democratic and HCFH's proposal, more autocratic.

Dr. Meyers indicated that providers and insurers should not be part of the panel, as it needs to be impartial. Mr. Pablo indicated that stakeholders should be at the table and that the experts should advise them. Dr. Meyers expressed concerns that if stakeholders like providers and insurers are included on the panel, we might have another Prepaid Health Care Advisory Council. Mr. Pablo indicated that every member of the Council has only one vote, and that they all have equal opportunity to influence the other members of the Council. Dr. Hellreich indicated that the health plans that currently have representation on the Council have access to information about potential competitors when they submit their proposed plan to the Council.

Dr. Meyers indicated that HCFH's proposal is not an attempt to shut out insurers, rather, it is to make the process a more reasoned one. Mr. Cheng suggested that the stakeholders could abstain from voting but still be at the table.

Mr. Dawson asked where the funding to implement HCFH's proposal would come from. He indicated that the proposal should be structured so that the Legislature will accept it. Mr. Donahue indicated that stakeholders should be able to lobby the proposed panel and that the Legislature should be able to "tinker" with the recommendation. Mr. Donahue used zoning boards in Massachusetts to illustrate his point. He indicated that the Massachusetts Legislature can only vote up or down the recommendation of the zoning boards. Many zoning board members are led-off in handcuffs for unethical behavior.

Mr. Pablo indicated that he believed that they were not too far apart. He saw the issue of the composition and power of the panel as the deal breaker.

PUBLIC COMMENT

No public comment was received.

NEXT MEETING

Friday, October 12, at 9:30 a.m. at the State Capitol Building, Room 329.

ANNOUNCEMENTS

There were no announcements.

ADJOURNMENT

The meeting was adjourned at approximately 10:57 a.m.

Respectfully submitted:

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Rep. Kenneth Hiraki, Chair
Appropriateness of Scope Subcommittee
Mandated Benefits Advisory Task Force

MANDATED BENEFITS ADVISORY TASK FORCE
APPROPRIATENESS OF SCOPE SUBCOMMITTEE
MINUTES OF PUBLIC MEETING
OCTOBER 12, 2001

CALL TO ORDER

The meeting was convened in the State Capitol Building, Room 329, on October 12, 2001, at approximately 9:37 a.m.

PRESENT

Rep. Kenneth Hiraki, Chair; Mike Cheng; Don Dawson; Philip Hellreich, MD; Arlene Meyers, MD, JD; Nancy Smith, PhD, proxy for Sharyn Stephani Monet, JD, RN; Christopher Pablo, Esq.; members. Absent: None. Also present: Lydia Hardie, Hawaii Psychiatric Medical Association; Paula Arcena, Hawaii Medical Association; Connie Hastert, Hawaii Employers Council; Suzanne Gelb, PhD and Rafael del Castillo, JD, Hawaii Coalition for Health; Edward Wang, and Noraine Ichikawa, Department of Labor and Industrial Relations; Bev Harbin, Christine Camp, and Wes Lum, Chamber of Commerce of Hawaii; Jennifer Diesman, HMSA; Carolina Jobbagyi, HMAA; Bette Tatum, National Federation of Independent Business – Hawaii; Philip McNamee, MD, Pacific In Vitro Fertilization Institute; .Robyn Wong, Department of Health; Tim Lyons, Hawaii Business League; Paula Heim, Mental Health Association; Martin Johnson, PsyD, Hawaii Psychological Association; and Britain Washburn-Bonnie, Resolve of Hawaii.

APPROVAL OF MINUTES (10/05/01 MEETING)

Mr. Dawson moved, seconded by Mr. Cheng, to approve the minutes. Without objection, the minutes were approved.

IDENTIFY APPROPRIATE POLICY BASES FOR MANDATED BENEFITS

Chair Hiraki informed the Subcommittee that several parties were invited to provide insight as to what they believed were criteria that should be considered in mandating benefits.

National Federation of Independent Business – Hawaii (Bette Tatum and Tim Lyons). Ms. Tatum provided a brief history of the sunrise review requirements, indicating that the legislation was passed in 1987 in recognition of, and to address, some of the problems small business was experiencing with the rising costs of health care. She also indicated that the law is clear, but has not always been followed. More and more additional mandates have been passed but the required concurrent resolution

requesting the Auditor to conduct a study to assess the social and financial effects of the mandate has not always been adopted.

In her written comments, Ms. Tatum recommended that the 2002 Legislature place a moratorium on any additional health care mandates for at least one year.

PractiCare Hawaii, Inc. (Lawrence Redmond, DC, President). Dr. Redmond was not able to appear in person, however, he submitted written comments.

Dr. Redmond indicated that the main criteria for a good foundational policy are already generally in the statutes. However, he also indicated that the primary policy basis should be: 1) keeping up with the needs of the community served. The law should reflect the general population it serves (e.g. "blue collar" union plans may have a need for coverage that emphasizes care of musculoskeletal conditions), 2) keeping up with the latest technology. Laws should be flexible enough to be proactive. We should look beyond our own community, 3) efficacy and cost effectiveness. We should review all mandated benefits, as there may now be better alternatives.

Dr. Redmond further indicated that we should look outside our community and state to see what is working or not working elsewhere.

Legislative Information Services of Hawaii (Dick Botti, President). Mr. Botti indicated that the only acceptable policy to determine whether coverage should be mandated is whether the coverage is needed. If it is something that we cannot do without for basic life support, then it should be covered. Mr. Botti suggested that the State reestablish the coverages that should be required, simplifying it to the basic needs. In this system, supplemental insurance could be made available to allow employees the option of purchasing additional coverage. If insurers are not willing to offer such programs, the State should enter the insurance business of providing such coverage until the voluntary market provides such a program.

Mr. Botti clarified that the only mandated benefit they have ever supported was parity on psychiatric care.

Hawaii Management Alliance Association (Carolina Jobbagyi, Manager, Compliance). Ms. Jobbagyi indicated that good policy basis for deciding whether to mandate certain coverages are: a) the extent to which the treatment or service is generally utilized by a significant portion of the population, b) the level of public demand for individual or group insurance coverage of the treatment or service, c) consideration of the financial impact on the population, the insurance industry, and the employer, and d) evaluation of the extent to which the mandated treatment or service might serve as an alternative for more expensive treatment or service.

Ms. Jobbagyi also indicated that the statutory criteria in section 23-52, HRS, could be revised to add more steps to better assist the Auditor's and legislators' analyses.

Hawaii Medical Service Association (Mike Cheng). Mr. Cheng indicated that HMSA generally opposes legislatively mandated benefits because they believe that it is the employer who should be helping determine what to include in the benefit package.

Mr. Cheng also indicated that generally speaking, the criteria in section 23-52, HRS, serve as a good foundation for deciding whether to mandate certain coverages. However, they recommend the following additional questions: 1) if coverage is currently offered on an optional rider basis, how many employers have chosen to purchase it? 2) would the new benefit expand current coverage for these services? 3) is there medical evidence to support the necessity of this type of benefit? 4) what is the rationale for mandating services for a new provider type? 5) will the mandate serve to lower the overall cost of medical care by the savings that will be achieved with the new benefit? 6) what are the administrative impacts or burdens on providers and their staff? 7) how does it conflict or duplicate what is already federally regulated? 8) can there be abuse or over-utilization of services? 9) are there similar mandates in other states, and what were the outcomes and impacts to healthcare coverage, quality of care, and costs? and 10) will the mandated coverage withstand the test of time as treatment changes with new techniques and technology?

Mr. Cheng recommended that an independent review commission be established to analyze any new mandated benefit. He also recommended that there should be an objective, quantitative method of evaluating the proposals with a requirement that it meet a minimal rating score before it can move forward.

The Chamber of Commerce of Hawaii (Christine Camp, Chair, Small Business Council). Ms. Camp indicated that to have good policy basis for determining mandated benefits, there must be data gathered on the cost and utilization of each present and future mandated benefit. She also suggested that the statute be amended to mandate that the Auditor conduct the study of the social and financial effects of the proposed mandated coverage. Ms. Camp also indicated that the law should be modified to require the Auditor, when investigating the social and financial impacts of proposed mandated benefits, to solicit input from business organizations.

Ms. Camp indicated that the Chamber suggests that before a benefit is mandated, the mandate be implemented on a pilot basis for one year in the State employee health benefits program. The Chamber also recommended that the law be amended to require the Auditor to conduct a study on each proposed mandated benefit. The Auditor should also be required to reassess the financial, social, and efficacy impacts of all mandated benefits every five years.

Department of Health (Robyn Wong, MPH, Public Health Nutritionist). Ms. Wong submitted written comments regarding medical foods for individuals with inborn errors of metabolism. She indicated that in Hawaii, there are currently 24 children and three adults with inborn errors of metabolism who require treatment with medical foods.

Ms. Wong indicated that compliance with the standard of practice in the medical treatment of a disorder or disease is a good basis for deciding whether to mandate certain coverages. She also indicated that because very few individuals have inborn errors of metabolism, utilization, public demand, and interest in coverage of medical foods has come from a small group of affected individuals and health care providers. However, this should not be used to suggest that coverage of medical foods is of reduced importance and benefit.

Kaiser Permanente (Chris Pablo, Director, Public, Government & Community Affairs). Mr. Pablo suggested an additional set of criteria be added to the existing ones to address the questions of medical efficacy. He provided examples from Washington State and Virginia. He also urged consideration of methods used by other states and provided models from Washington, Pennsylvania, Virginia, and Maryland.

Mr. Pablo offered his preference of the features of the model that Hawaii should consider: a) entity. A commission or panel that is attached to a state agency, b) analyses. To be conducted by the staff of the agency. The agency should be given resources to hire experts or consultants and to conduct public hearings, c) membership. Should be appointed by the Governor and/or leaders of the House and Senate. No more than 17 members who represent health plans, health care providers, small and large business, and consumers, d) reports. Reports of findings and recommendations should be submitted to the Legislature. Recommendation is to be non-binding upon the Legislature, e) legislation. Prohibit hearing bills that propose to mandate a benefit until an analysis is completed, and f) pilot. New benefit mandates should be implemented on a pilot basis for one year in the state employee health benefits program.

Hawaii Medical Association (Philip Hellreich, MD, President). Dr. Hellreich indicated that HMA strongly believes that a core group of medical and surgical benefits, which include psychiatry and addiction medicine, be the base. Over and above this core group of benefits, HMA generally favors free market solutions and opposes mandated benefits because they significantly increase the cost of health care.

Dr. Hellreich also indicated that HMA believes that the best way to contain costs and provide high quality care is to establish a free and competitive medical market place. Also, every citizen should be offered the choices available by statute to all federal workers. They should be provided with a wide variety of healthcare options, including HMOs, PPOs, non-deductible and high deductible plans as well as medical savings accounts.

Dr. Hellreich further indicated that the fault lies not with the current criteria, but with the process as many mandates have been enacted without an Auditor's study as required by the law.

Pacific In Vitro Fertilization Institute (Philip McNamee, MD, Program Director). Dr. McNamee suggested the following questions to consider when considering the mandating of specific benefits: 1) should the condition or disease be

covered under health insurance when viewed by a reasonable person? 2) is the condition or disease currently covered adequately by health insurance? 3) are there qualified medical professionals to treat this condition or disease? and, 4) can safeguards be included to provide some cost control or to prevent overutilization of the benefit?

Dr. McNamee cautioned against using the criterion of the extent to which the treatment or service is generally utilized by a significant portion of the population. In some cases, the reason the service or treatment is not covered is that a small number of people need the service. The service may be very important, but these small number of patients have little choice. Dr. McNamee prefers: the extent to which the treatment or service is generally utilized by a significant portion of the **affected** population. Similarly, he cautioned against using the criteria of the level of public demand for the treatment or service and the level of public demand for individual or group insurance coverage of the treatment or service.

Hawaii Nurses' Association (Nancy Smith, PhD). Dr. Smith indicated that when considering good policy basis for deciding whether to mandate certain coverages, it should be in the context of, and in response to, an evaluation of the current policy. Evaluation can ask: 1) did mandating this benefit make a difference? 2) how can the effect be measured? 3) what were the outcomes when compared to the intent? 4) did this mandate alter the health status of the people? 5) what is the cost-benefit of the mandate? 6) should termination of the policy be considered? and, 7) should adjustment and revision of the policy be considered?

Dr. Smith also indicated that the criteria should be considered as a component part of policy evaluation – not only prior to adoption of a mandate. State health goals develop by the Department of Health and whether the mandate would have any impact on these goals are not currently criteria.

Hawaii Psychiatric Medical Association (Lydia Hardie, Executive Director). Ms. Hardie indicated that HPMA's position is that psychiatry and addiction medicine should be part of the core medical and surgical health benefits. She also indicated that mental health benefits, which include addictions, is one benefit you are really going to need when you need it.

Although HPMA does not have specific recommendations of how to carry out the Task Force's mission, they support the committee's endeavor to consider different review panel scenarios. HPMA agrees that the review panel process be democratic with ultimate legislative authority.

Hawaii Psychological Association (Martin Johnson, PsyD, Chairperson, Legislative Affairs Committee). Dr. Johnson offered four policy areas for considering appropriate policy basis for mandating health benefits: 1) impact on public health. The overall impact on the public health and wellbeing should be a guiding principle, 2) cost impact of both having the mandate and not having the mandate. Consideration should

be given both to cost of not providing the mandate and any potential cost offsets that the mandate might provide, 3) efficacy of treatment. When individuals are not able to access care and effective treatments are available, mandates should be considered, and, 4) presence of stigma. Social stigma can be a barrier to receiving health care. When social stigma presents a barrier to providing, paying for, or receiving care, the state should consider mandates to assure the public health.

Questions.

Dr. Meyers inquired if small business premiums are more than larger companies? Ms Camp indicated that all small business are pooled and are not rated by individual small business. Dr. Meyers ask about community rating – if everyone were in the same pool, would premiums be reduced? Ms. Harbin indicated that it is difficult to place everyone into one pool. Dr. Meyers clarified that she did not question HMA's authority to represent doctors, rather, she questioned whether it represents the sentiments of the doctors. Dr. Hellreich invited Dr. Meyers to rejoin the HMA, as they would welcome her input.

Chair Hiraki ask if the standard of greatest good for the greatest number of people were used, how would it impact current benefits such as in vitro and medical foods? Dr. McNamee indicated that with respect to in vitro, one of six in the State would be affected. He further indicated that by mandating in vitro, the cost is spread to many so that a few can receive the service, which is what insurance is all about. Dr. Meyers indicated that with respect to medical foods, ordinary people with inborn errors of metabolism cannot afford it, and without medical food, these people will experience gross mental retardation.

Mr. Dawson suggested a major medical policy with medical savings account. Patients would have the choice on how to use the money.

PUBLIC COMMENT

The Hawaii Coalition for Health suggested that part of the discussion seemed to be regarding premium cost and health care cost. Mr. Pablo indicated that premiums are related to the cost of health care. Mr. Cheng indicated that HMSA's dues are determined by health care cost and administrative cost.

NEXT MEETING

Chair Hiraki indicated that this concluded the fact-finding stage of the Subcommittee. He will contact members to discuss the Subcommittee's recommendation to the full Task Force. He also indicated that the calendar for November will be as follows: November 2 – discuss the initial draft of the proposed recommendation; November 9 – discuss the redraft if necessary; and November 16 – discuss the final draft if necessary.

ANNOUNCEMENTS

There were no announcements.

ADJOURNMENT

The meeting was adjourned at approximately 11:29 a.m.

Respectfully submitted:

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Rep. Kenneth Hiraki, Chair
Appropriateness of Scope Subcommittee
Mandated Benefits Advisory Task Force

MANDATED BENEFITS ADVISORY TASK FORCE
APPROPRIATENESS OF SCOPE SUBCOMMITTEE
MINUTES OF PUBLIC MEETING
NOVEMBER 2, 2001

CALL TO ORDER

The meeting was convened in the State Capitol Building, Room 309, on November 2, 2001, at approximately 9:40 a.m.

PRESENT

Rep. Kenneth Hiraki, Chair; Mike Cheng; Don Dawson; Philip Hellreich, MD; Arlene Meyers, MD, JD; Sharyn Stephani Monet, JD, RN; Christopher Pablo, Esq.; members. Absent: None. Also present: Jennifer Diesman, HMSA; Paula Arcena, HMA; Suzanne Gelb, HCFH; and Connie Hastart, Hawaii Employers Council

APPROVAL OF MINUTES (10/12/01 MEETING)

Mr. Pablo moved, seconded by Dr. Hellreich, to approve the minutes. Without objection, the minutes were approved.

DISCUSS THE SUBCOMMITTEE'S DRAFT RECOMMENDATIONS TO THE FULL TASK FORCE

Chair Hiraki began by indicating that the work of the Subcommittee exceeded his expectations. He then briefly describing the draft report document and explained the development process of the recommendations.

A new review process should be established. Although there currently is a review process, it has limitations. The new process should be conducted by a new panel, not the Auditor. The Legislature should remain involved but it should respect the review process. We should use H.B. NO. 237, the bill introduced by Rep. Lee as a starting point on developing a new review process. However, more discussion is needed to work out the specific details.

We should **review the existing mandated health care benefits and determine whether they should continue**. Again, further discussion on this issue is needed.

A new task force should be establish to **examine the effectiveness of the Prepaid Health Care Act**.

Chair Hiraki indicated that he will allow members to submit additional comments regarding their reservations, clarification, and dissenting opinions, which will be attached to the recommendations.

Questions.

Dr. Hellreich indicated that the members need to report back to their respective organizations for comment.

Dr. Meyers indicated that before the existing mandates are considered for repeal, they should go through the same review process that is eventually developed and adopted by the Legislature.

Mr. Cheng indicated that if any of the existing mandates are repealed, it should be left up to the employers to decide whether to remove it from their plans.

Mr. Pablo expressed concerns with the language in the recommendation section of the draft that referred to the relationship of any reduction in health premiums and the repeal of existing mandates. He indicated that if all mandates were repealed, there would be a reduction in premiums, although it is difficult to quantify cost of new benefits or the repeal of existing ones.

Chair Hiraki asked Mr. Pablo and Mr. Cheng to develop language to address their concerns regarding the relationship of any reduction in health premiums and the repeal of existing mandates. Chair Hiraki asked the members to submit any material that they would want to be added to the report.

PUBLIC COMMENT

There was none.

NEXT MEETING

November 9 – discuss the redraft and November 16 – discuss the final draft. Chair Hiraki informed the members of a change in venue. Future Subcommittee meetings will be held in Room 309 until further notice.

ANNOUNCEMENTS

There were no announcements.

ADJOURNMENT

The meeting was adjourned at approximately 10:10 a.m.

Respectfully submitted:

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Rep. Kenneth Hiraki, Chair
Appropriateness of Scope Subcommittee
Mandated Benefits Advisory Task Force

MANDATED BENEFITS ADVISORY TASK FORCE
APPROPRIATENESS OF SCOPE SUBCOMMITTEE
MINUTES OF PUBLIC MEETING
NOVEMBER 9, 2001

CALL TO ORDER

The meeting was convened in the State Capitol Building, Room 309, on November 9, 2001, at approximately 9:38 a.m.

PRESENT

Rep. Kenneth Hiraki, Chair; Mike Cheng; Don Dawson; Philip Hellreich, MD; Rafael del Castillo (proxy for Arlene Meyers, MD, JD); Sharyn Stephani Monet, JD, RN; Christopher Pablo, Esq.; members. Absent: None. Also present: Jennifer Diesman, HMSA; Paula Arcena, HMA; Lydia Hardie, and Beadie Dawson.

APPROVAL OF MINUTES (10/12/01 MEETING)

Ms. Monet moved, seconded by Mr. Cheng, to approve the minutes. Without objection, the minutes were approved.

DISCUSS THE REDRAFT OF SUBCOMMITTEE'S RECOMMENDATIONS TO THE FULL TASK FORCE

Chair Hiraki began by referencing the final draft of the subcommittee's report, which was distributed to the members along with an attachment. The attachment, filed in green paper, described the amendments made to the draft and included additional comments by members of the subcommittee. Chair Hiraki asked Mr. Cheng to discuss the amendments suggested by HMSA.

Mr. Cheng commented on HMSA's suggested amendments. The concern raised was that any repeal of mandated benefits would be dependent on the willingness of the employer to reduce benefits. Mr. Cheng further stated that it is unlikely an employer would discontinue benefits like well-baby visits and immunizations. Chair Hiraki referred to the attachments that illustrated the amendments in ramseyer format.

Mr. Pablo interjected by stating that the State would continue to be subject to any Federal mandated benefits. Chair Hiraki clarified that the subcommittee's recommendations refer to State mandates only. Chair Hiraki then asked each member who submitted comments to give a brief statement.

Mr. Dawson began by stating his comments from the consumer and small business perspective. Mr. Dawson suggested that a task force review the whole spectrum of healthcare in Hawaii. He stated that consumers are unaware of what they

are getting, and do not have a choice in spending their healthcare dollars. Mr. Dawson further commented that he would like to see a medical savings account promoted in Hawaii, and greater discretionary power in consumer spending. Mr. Dawson also stated that he would like to continue as an ad hoc committee.

Mr. del Castillo commented on Dr. Meyers' suggestions. Mr. del Castillo stated that any mandated benefits should not be repealed with out a review.

Dr. Hellreich agreed that mandated benefits should be reviewed. Dr. Hellreich also commented on the subcommittee's report by stating that HMA does not support the cap review every five years in Rep. Lee's bill, HB237.

Ms. Monet commented on behalf of the Hawaii Nurses' Association. Ms. Monet stated that the Association supports the subcommittee's report and suggests that any review panel on mandated benefits should include one representative from each of the healthcare provider groups.

Chair Hiraki then stated that the subcommittee's report would be circulated for signatures. The members could sign, write with reservations, or write descent. The subcommittee's report will be submitted to the full task force for discussion. The Chair adjourned the meeting and there was no announcement of any future subcommittee meetings.

PUBLIC COMMENT

There was none.

NEXT MEETING

There are no meetings scheduled for the subcommittee.

ANNOUNCEMENTS

There were no announcements.

ADJOURNMENT

The meeting was adjourned at approximately 10:01 a.m.

Respectfully submitted:

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Rep. Kenneth Hiraki, Chair
Appropriateness of Scope Subcommittee
Mandated Benefits Advisory Task Force

MANDATED BENEFITS ADVISORY TASK FORCE
HEALTHCARE PROVIDER LIST SUBCOMMITTEE
MINUTES OF PUBLIC MEETING
August 9, 2001

The meeting was convened in the State Capitol Building, Room 437, on August 9, 2001, at approximately 11:09 a.m.

PRESENT

Rep. Dennis Arakaki, Chair; Paula Arcena, Don Dawson, Ruth Ellen Lindenberg, Christopher Pablo, Esq., and Lawrence Redmond, DC, members. Absent: Glenn Okihiro, DDS. Also present: Mike Cheng and Jennifer Diesman, HMSA.

GROUND RULES FOR THE CONDUCT OF BUSINESS

Without objection, Chair Arakaki stated that the Subcommittee would follow the same Ground Rules that were adopted by the Task Force.

PLAN OF ACTION

Chair Arakaki solicited input from those present as to a game plan that the Subcommittee could follow in planning its activities in gathering information and reporting its findings and recommendations to the full Task Force. Suggestions were made that the subcommittee should identify:

- The current list of eligible providers;
- Potential providers, if it is determined that is the direction the Subcommittee should go; and
- Issues relating to the expansion or circumscribing of the list.

Mr. Dawson suggested that the Pre-Paid Health Care Act should be reviewed as it is considered by many in the small business community to be the root of the problem. Mr. Pablo stated that the Legislature micro-manages health plans when it does not have adequate knowledge about the delivery of healthcare services.

When asked what the Legislature is looking for, Chair Arakaki responded by saying that they are looking for a rational way to make these decisions.

Mr. Pablo indicated that perhaps the Subcommittee should ask “what’s broken?” and the answer will better enable the Subcommittee to develop a solution to the problem. Chair Arakaki concurred saying that the Subcommittee should identify what is wrong with the process.

Responding to Mr. Pablo and Chair Arakaki, Mr. Dawson indicated that he saw two problems: reciprocity between different jurisdictions regarding licensing of professionals who provide healthcare services, and health plan products. Mr. Cheng indicated that the problem is that we have no criteria—is there a need for a benefit? Mr. Cheng also indicated that it appears that a vocal few are successful in getting the benefits mandated without enough consideration of who will have to foot the bill. Dr. Redmond indicated that the State of Washington has very strict and tough criteria. Ms. Arcena added that the Task Force should develop criteria that will withstand political pressure.

Mr. Pablo stated that at least one state requires every mandated benefit to "sunset" after six years unless the evidence/data indicates that it should continue. Mr. Dawson indicated that small business is looking for something similar to the State Public Employees Health Fund. Mr. Dawson continued by adding that if employees are willing to pay a greater portion of the premiums, then that would be a win-win situation.

Chair Arakaki suggested that the Task Force examine the "whole" package—including the Pre-Paid Health Care Act.

The Subcommittee requested that the Insurance Division provide the Subcommittee members with copies of the following:

- H.B. NO. 237 as introduced;
- A roster of the Task Force members;
- The Pre-Paid Health Care Act;
- A listing of the current eligible providers;
- A summary of how other states are addressing this issue; and
- A summary of the Act that established the Auditor's review of mandated benefits.

PUBLIC COMMENT

Aside from the comments of those nonmembers present, the Subcommittee did not receive any other public comment.

NEXT MEETING

Thursday, August 23, 2001 in the State Capitol Room 437, at 11:00 a.m. The Subcommittee plans to meet every second Thursday after that.

ANNOUNCEMENTS

There were no announcements.

ADJOURNMENT

Mr. Pablo moved, seconded by Ms. Arcena, that the meeting be adjourned. The meeting was adjourned at approximately 12:15 p.m.

Respectfully submitted:

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Rep. Dennis Arakaki, Chair
Healthcare Provider List Subcommittee
Mandated Benefits Advisory Task Force

MANDATED BENEFITS ADVISORY TASK FORCE
HEALTHCARE PROVIDER LIST SUBCOMMITTEE
MINUTES OF PUBLIC MEETING
August 23, 2001

The meeting was convened in the State Capitol Building, Room 437, on August 23, 2001, at approximately 11:08 a.m.

PRESENT

Rep. Dennis Arakaki, Chair; Paula Arcena; Don Dawson; Ruth Ellen Lindenberg; Lawrence Redmond, DC; and Phyllis Dendle, proxy for Christopher Pablo, Esq.; members. Absent: Glenn Okihiro, DDS. Also present: Jennifer Diesman, HMSA.

APPROVAL OF MINUTES (08/09/01 MEETING)

Mr. Dawson moved, seconded by Ms. Lindenberg, that the minutes be approved. Without objection, the minutes of the August 9, 2001 meeting were approved.

REVIEW OF ISSUES SURROUNDING THE EXPANSION OF THE ELIGIBLE PROVIDER LIST

HB237. Chair Arakaki indicated that the Subcommittee was attempting to identify the best mechanism in developing mandated benefits process and suggested that HB237 be used as a base for further discussion. Dr. Redmond indicated that the State of Washington has criteria to assess the social and financial impacts of mandating benefits. However, Washington also has efficacy criteria.

Prepaid Health Care Act (PPHCA). Mr. Dawson indicated that he sees three options regarding the PPHCA, 1) leave it alone, 2) revise it, or 3) repeal it. He continued by asking what would happen if the PPHCA was repealed. Mr. Dawson indicated that as a small businessman, he would continue coverage for his employees, however, the employees would probably have to pay a greater share of the premiums. He also indicated that he probably would be able to obtain broader coverage (e.g. dental coverage) for his employees.

Chair Arakaki inquired if the limitation that the employees' share not exceed 1.5% of their wages was a problem. Ms. Dendle indicated that the 1.5% limit is seen as an administrative burden for businesses, therefore, most employers pay 100% of the premiums. She went on to explain that the PPHCA is basically frozen in time as it was enacted in 1974, that is the reason the Legislature amends the Insurance Code and other laws, rather than the PPHCA. As a way of amending the PPHCA and still maintain Hawaii's exemption from the federal Employee Retirement Income Security Act of 1974 (ERISA), Ms. Dendle suggested a process in which a draft of desirable

amendments to the PPHCA were presented to Congress with a request to continue Hawaii's ERISA exemption. Following up on Ms. Dendle's suggestion, Mr. Dawson asked if an exemption to the PPHCA for small businesses could be drafted.

In response to the discussion, several members inquired if the State could amend the PPHCA with approval from the administration rather than an Act of Congress. The Insurance Division staff was requested to obtain an opinion.

After a discussion in which it was clarified that the PPHCA allowed for collective bargaining agreements for different prepaid health care coverage if the negotiated plan is more favorable to the employees than the PPHCA, Chair Arakaki inquired if the Insurance Division staff could obtain copies of the current plans under the Public Employees Health Fund.

Prepaid Health Care Advisory Council. Mr. Dawson indicated that he saw a conflict of interest in having representatives from Kaiser and HMSA as members of the Council and felt that consumer interests should have greater representation. Chair Arakaki requested the Insurance Division staff to inquire with the Director of Labor and Industrial Relations as to the membership of the Council, who the current Council members represent, and the process in which the members were selected.

IDENTIFY THE CURRENT ELIGIBLE PROVIDERS AND EXAMINE OTHER STATES' PROCESS

The Insurance Division identified the following as the current eligible providers:

- Licensed Physicians
- Licensed Optometrists
- Licensed Dentists
- Licensed Psychologists
- Advance Practice Registered Nurses

The Insurance Division also indicated that with respect to mental health and alcohol and drug abuse treatment, clinical social workers are also eligible providers.

Ms. Dendle suggested that Auditor's reports on other providers that may have been considered for inclusion, but are not currently eligible providers, be identified.

It was also suggested that the states that have sunset provisions regarding their mandated benefits be identified to determine whether the sunset provisions also apply to eligible providers.

PUBLIC COMMENT

Aside from the comments of those nonmembers present, the Subcommittee did not receive any other public comment.

NEXT MEETING

Thursday, September 6, 2001.

ANNOUNCEMENTS

There were no announcements.

ADJOURNMENT

Mr. Dawson moved, seconded by Dr. Redmond, that the meeting be adjourned. The meeting was adjourned at approximately 12:20 p.m.

Respectfully submitted:

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Rep. Dennis Arakaki, Chair
Healthcare Provider List Subcommittee
Mandated Benefits Advisory Task Force

MANDATED BENEFITS ADVISORY TASK FORCE
HEALTHCARE PROVIDER LIST SUBCOMMITTEE
MINUTES OF PUBLIC MEETING
SEPTEMBER 20, 2001

CALL TO ORDER

The meeting was convened in the State Capitol Building, Room 437, on September 20, 2001 at approximately 11:10 a.m.

PRESENT

Rep. Dennis Arakaki, Chair; Don Dawson; Ruth Ellen Lindenberg; Lawrence Redmond, DC; and Christopher Pablo, Esq.; members. Absent: Paula Arcena and Glenn Okihiro, DDS. Also present: Jennifer Diesman, HMSA and Martin Johnson, Hawaii Psychological Association.

APPROVAL OF MINUTES (08/23/01 MEETING)

Ms. Lindenberg moved, seconded by Mr. Dawson, that the minutes be approved. Without objection, the minutes of the August 23, 2001 meeting were approved.

REVIEW OF ISSUES SURROUNDING THE EXPANSION OF THE ELIGIBLE PROVIDER LIST

Mr. Pablo indicated that with respect to the scope of providers, Kaiser is based on western medicine and does not specify which provider is to render the service – they are concerned with getting the job done. Chair Arakaki asked if the criteria in sections 23-51 and 23-52, HRS, also apply to providers. It was indicated that section 23-51 specified that before any legislative measure that mandates health insurance coverage for specific health services, specific diseases, or "certain providers of health care services" can be considered, a concurrent resolution must be adopted requesting the Auditor to prepare a report that assesses both the social and financial effects of the proposed mandated coverage.

Ms. Diesman indicated that providers are not tied to a specific treatment service. Dr. Redmond inquired why chiropractic and other alternative care providers not been included as mandated providers. Mr. Pablo indicated that it was a financing issue. Health plans decide when to incorporate alternative care providers. Ms. Lindenberg asked if alternative care providers were add-ons. Mr. Pablo indicated that it is not a consumer demand item, however, physicians could prescribe it.

Chair Arakaki asked if the Legislature were to mandate chiropractors, would Kaiser have to have at least one chiropractor on staff? Are there any mandated providers that Kaiser had to hire because of the mandate? Mr. Pablo indicated that Kaiser would oppose all provider mandates.

Dr. Redmond indicated that both Kaiser and HMSA have riders for alternative care. However, visits are limited and the patient may not be stable even though they used all the allowable visits. Dr. Redmond referenced evidence that complementary and alternative medicine (CAM) produce savings of 60%. Ms. Diesman asked if Kaiser and HMSA could save 60% by utilizing CAM, why would not they voluntarily include CAM?

Mr. Dawson indicated that he believed that the Prepaid Health Care Advisory Council is the underlying problem, because of the conflict of interest. He wants competition but two major players dominate the market. Mr. Pablo indicated that the Council is there to advise the Department of Labor and Industrial Relations on the law.

Mr. Pablo indicated that he prefers a pure market, where those who pay have a greater say in determining the product. Mr. Dawson indicated that he believes that employees should pay more, as they currently have no concept of the costs involved. He also indicated that he understands the limited responsibility of the Task Force, but believes the Subcommittee should mention that the Prepaid Health Care Act is the underlying problem.

Chair Arakaki asked how the members felt about automatic sunset of mandates. Mr. Pablo indicated that he was in favor of it. Chair Arakaki indicated that he felt that the Subcommittee should discuss the Prepaid Health Care Advisory Council, long-term care services, and a single payer system, at the next meeting. Mr. Pablo indicated that he opposes a single payer system – he prefers an open market.

PUBLIC COMMENT

The Subcommittee did not receive any public comment.

NEXT MEETING

Thursday, October 4, 2001.

ANNOUNCEMENTS

There were no announcements.

ADJOURNMENT

The meeting was adjourned at approximately 12:16 p.m.

Respectfully submitted:

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Rep. Dennis Arakaki, Chair
Healthcare Provider List Subcommittee
Mandated Benefits Advisory Task Force

MANDATED BENEFITS ADVISORY TASK FORCE
HEALTHCARE PROVIDER LIST SUBCOMMITTEE
MINUTES OF PUBLIC MEETING
OCTOBER 4, 2001

CALL TO ORDER

The meeting was convened in the State Capitol Building, Room 437, on October 4, 2001 at approximately 11:03 a.m.

PRESENT

Rep. Dennis Arakaki, Chair; Paula Arcena; Don Dawson; Lawrence Redmond, DC; and Christopher Pablo, Esq.; members. Absent: Ruth Ellen Lindenberg and Glenn Okihiro, DDS. Also present: Jennifer Diesman, HMSA.

APPROVAL OF MINUTES (09/20/01 MEETING)

Mr. Pablo moved, seconded by Mr. Dawson, that the minutes be approved. Without objection, the minutes of the September 20, 2001 meeting were approved.

REVIEW OF ISSUES SURROUNDING THE EXPANSION OF THE ELIGIBLE PROVIDER LIST

Copies of two Auditor's reports regarding the study of proposed mandated health insurance (for Acupuncture Services and Chiropractic Services) were distributed along with copies of H.B. NO. 237, H.D. 2, S.D. 1; H.C.R. NO. 129, H.D. 1, S.D. 1; and an NCSL report on ERISA.

Dr. Redmond summarized the report on chiropractic services saying that the Auditor's report was inconclusive because the current market is not on a level playing field. Chair Arakaki asked if other professions perform chiropractic services. Ms. Arcena indicated that osteopaths perform chiropractic services. Dr. Redmond noted that the treatment that chiropractors perform is based on the nervous system whereas the treatment that osteopaths perform is based on the muscular system. He also indicated that 97% of chiropractic services are performed by chiropractors.

Chair Arakaki asked if providers are mandated when the Legislature mandates specific benefits. Mr. Pablo indicated that if the treatment service is within a profession's scope of practice, then they would be able to provide the services. As an example, Mr. Pablo indicated that physiatrists could perform spinal manipulation. Chair Arakaki then asked if the Legislature could mandate the services of a particular provider. Mr. Pablo indicated that generally, mandates start with specific benefits.

Chair Arakaki indicated that he plans to invite Rep. Marilyn Lee and State Auditor Marion Higa to the next meeting to discuss the process and criteria involved in mandating health insurance benefits, and to discuss H.B. NO. 237 (introduced by Rep. Lee), which proposed an alternate process in mandating benefits. Chair Arakaki asked the members to review the bill and be prepared to discuss it. Several members indicated that they would not be able to attend the next meeting. Chair Arakaki indicated that they would be able to submit written comments.

Chair Arakaki also indicated that the Subcommittee may propose to the full Task Force that the Legislature adopt a concurrent resolution to establish a task force to review the Prepaid Health Care Act.

Chair Arakaki indicated that the Subcommittee would meet again on October 11 and October 23.

PUBLIC COMMENT

The Subcommittee did not receive any public comment.

NEXT MEETING

Thursday, October 11, 2001.

ANNOUNCEMENTS

There were no announcements.

ADJOURNMENT

Mr. Pablo moved, seconded by Dr. Redmond, that the meeting be adjourned. The meeting was adjourned at approximately 11:32 a.m.

Respectfully submitted:

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Rep. Dennis Arakaki, Chair
Healthcare Provider List Subcommittee
Mandated Benefits Advisory Task Force

MANDATED BENEFITS ADVISORY TASK FORCE
HEALTHCARE PROVIDER LIST SUBCOMMITTEE
MINUTES OF PUBLIC MEETING
OCTOBER 11, 2001

CALL TO ORDER

The meeting was convened in the State Capitol Building, Room 437, on October 11, 2001 at approximately 11:02 a.m.

PRESENT

Rep. Dennis Arakaki, Chair; Paula Arcena; Don Dawson; Ruth Ellen Lindenberg; Glenn Okihiro, DDS; and Christopher Pablo, Esq.; members. Absent: Lawrence Redmond, DC. Also present: Rep. Marilyn Lee; Paula Heim, Mental Health Association in Hawaii; Gary Hamada and Noraine Ichikawa, Dept. of Labor and Industrial Relations; and Lydia Hardie, Hawaii Psychiatric Medical Association.

APPROVAL OF MINUTES (10/04/01 MEETING)

Dr. Okihiro moved, seconded by Ms. Lindenberg, that the minutes be approved. Without objection, the minutes of the October 4, 2001 meeting were approved.

REVIEW OF ISSUES SURROUNDING THE EXPANSION OF THE ELIGIBLE PROVIDER LIST

Chair Arakaki informed the members that the Subcommittee received written comments regarding H.B. NO. 237 from Lawrence Redmond, DC, President of PractiCare Hawaii and Paula Arcena, Director of Legislative and Government Affairs, Hawaii Medical Association. The Subcommittee also received written comments from Chris Pablo, JD, Director Public, Government & Community Affairs, Kaiser Permanente regarding criteria and models for consideration when mandating health care benefits. Marion Higa, the State Auditor, submitted written comments regarding the process involved in mandating health care benefits. Leonard Agor, Director of Labor and Industrial Relations submitted written comments regarding the Hawaii Prepaid Health Care Act and its exemption under ERISA.

Rep. Lee began by briefly describing the history behind H.B. NO. 237, the bill she introduced to help the Legislature make reasoned decisions in mandating health care benefits. She indicated that the bill passed the House but died in the Senate. She also indicated that her bill was based on similar legislation that passed in Maryland.

Chair Arakaki asked if the bill would prevent the Legislature from circumventing the sunrise analysis? Rep. Lee indicated that it would be more difficult for the Legislature to ignore recommendations from a broad community panel.

Ms. Lindenberg asked if consumers would be part of the broad-based panel. Rep. Lee responded by indicating that consumers were not included in the original bill but were added as the bill proceeded through the legislative process.

Mr. Pablo briefly described his written comments, indicating that he attached models from four different states. Ms. Arcena also briefly explained HMA's written comments. She indicated that they support an alternative panel with the final decision remaining with the Legislature.

Mr. Pablo indicated that an administrative body is needed to support the panel. The panel should be broad based and should hold public hearings. The Legislature should be prohibited from acting upon any proposal to mandate additional health care benefits until the panel submits its recommendations.

Mr. Hamada briefly described the history of the Prepaid Health Care Act. He indicated that the Act took effect in 1975 and was intended to provide protection for employees against the cost of medical care in case of sudden that may consume all or an excessive part of a person's resources. Most large companies were providing health coverage but smaller ones did not. He also indicated that the Act provides that the prevalent plan sets the standard. Standard Oil filed suit contending that ERISA superceded the Act. From 1981 to 1983, as a result of the Standard Oil suit, the State could not administer the Act. In 1983, Congress exempted the Act with the condition that substantive changes could not be made to the Act as enacted in 1974. The Act has no authority over collective bargained contracts.

Mr. Dawson asked if the 1.5% ceiling could be adjusted without jeopardizing the ERISA exemption? Mr. Hamada indicated that it would be considered a substantive change. Mr. Hamada suggested that Hawaii's congressional delegation could lobby to allow Hawaii to change the Act without losing the ERISA exemption.

Mr. Hamada briefly explained the purpose of the Prepaid Health Care Advisory Council. He indicated that the Council analyzes new proposals. Dr. Okihiro asked if HMSA reviews the proposals of other health plans. Mr. Hamada indicated that the plan representatives usually abstain and do not comment. Mr. Dawson asked how Hawaii could get more competition? Mr. Hamada indicated that because Hawaii is such a small state, large insurers do not find Hawaii to be an attractive market. Dr. Okihiro asked why Hawaii has only two major health plans? Mr. Hamada invited Dr. Okihiro and the other Subcommittee members to attend the next Council meeting.

Chair Arakaki indicated that he would like the Subcommittee to consider and vote on the following recommendations for submittal to the full Task Force at the next meeting:

- A resolution to examine the Prepaid Health Care Act;
- Provision to automatically sunset all mandated health care benefits;
- Retain or revise the current process found in sections 23-51 and 23-52, HRS;
- Passage of HB237; and
- Require mandates to identify the providers of the service.

PUBLIC COMMENT

The Subcommittee did not receive any public comment.

NEXT MEETINGS

Tuesday, October 23, 2001 at 1:00 p.m. and Thursday, November 15, 2001 at 11:00 a.m.

ANNOUNCEMENTS

There were no announcements.

ADJOURNMENT

The meeting was adjourned at approximately 12:38 p.m.

Respectfully submitted:

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Rep. Dennis Arakaki, Chair
Healthcare Provider List Subcommittee
Mandated Benefits Advisory Task Force

MANDATED BENEFITS ADVISORY TASK FORCE
HEALTHCARE PROVIDER LIST SUBCOMMITTEE
MINUTES OF PUBLIC MEETING
OCTOBER 23, 2001

CALL TO ORDER

The meeting was convened in the State Capitol Building, Room 437, on October 23, 2001 at approximately 1:17 p.m.

PRESENT

Rep. Dennis Arakaki, Chair; Paula Arcena; Don Dawson; Lawrence Redmond, DC; and Christopher Pablo, Esq., Ruth Ellen Lindenberg and Glenn Okihiro, DDS; members. Also present: Martin Johnson, Hawaii Psychological Assoc.; Marion Poirier, NAMI Oahu; Debbie Shimizu, NASW.

APPROVAL OF MINUTES (10/11/01 MEETING)

The minutes of the 10/11/01 meeting were not available for approval.

DISCUSS PROPOSED RECOMMENDATIONS OF THE SUBCOMMITTEE TO THE FULL TASK FORCE

Chair Arakaki stated the five recommendations the subcommittee is proposing. The recommendations included: 1) a resolution to create a task force to review the Pre-Paid Health Care Act, 2) propose legislation that would require an automatic sunset for all mandated benefits, 3) retain or revise HRS § 23-51 and HRS § 23-52, 4) recommend passage of HB237 of the regular session of the 2001 Legislature, and 5) require mandated proposals to identify the providers of service. Chair Arakaki then asked the subcommittee to discuss each of the recommendations separately.

Ms. Poirier asked if the task force in the first recommendation would study the ERISA issues of the Pre-Paid Health Care Act. Chair Arakaki clarified that the task force's review would include recommending changes, alternatives or repeal. Mr. Johnson questioned the makeup of the panel or task force. Mr. Dawson also expressed concern over how long the task force would have to complete the review and who would appoint the members. The members agreed that the appointing authority should be the Insurance Commissioner. The subcommittee also suggested that the membership of the task force include representatives from the following groups: 1) Consumers, 2) Health Care Providers, 3) Big & Small Business, 4) Hospitals, 5) Health Plans, 6) Labor, 7) Congressional Delegation, 8) Department of Labor, 9) Insurance Division, and 10)

Education or Youth Representative. Chair Arakaki recommended that the specifics of this recommendation be left to the full task force.

The members agreed that the second recommendation should include a sunset review. Mr. Dawson asked how much do mandated benefits actually cost. Ms. Arcena commented that not all mandates are created equal. Mr. Pablo also commented on the complexity of measuring these benefits. Chair Arakaki reminded the members that they could not mandate a Legislature to follow a certain process unless you change the State Constitution. The members decided that the recommendation should include a sunset review five years after the effective date of the mandated benefit.

For the third recommendation the members agreed the criteria set forth in HRS § 23-51 and HRS § 23-52 should not be repealed, but another body needs to be identified to administer the criteria.

Under the fourth recommendation the members agreed that the latest draft of HB237 be considered with features from the states of Washington, Virginia, Maryland, and Pennsylvania.

The members agreed that the fifth recommendation be withdrawn because they did not see any benefits from this proposal.

Chair Arakaki asked the members to vote on each of the recommendations. There were no objections to the first and second recommendations. There were no objections to the third recommendation with two caveats. Ms. Arcena suggested deleting the capping mechanism on page 5, section 4. Mr. Johnson suggested that additional subject matter legislators, consumers, and health care providers be equally represented on the review panel. There were no objections to the fourth recommendation.

Chair Arakaki indicated that the Subcommittee would meet again on November 15.

PUBLIC COMMENT

The Subcommittee did not receive any public comment.

NEXT MEETING

Thursday, November 15, 2001 at 11:00 a.m.

ANNOUNCEMENTS

There were no announcements.

ADJOURNMENT

Mr. Pablo moved, seconded by Dr. Redmond, that the meeting be adjourned. The meeting was adjourned at approximately 2:53 p.m.

Respectfully submitted:

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Rep. Dennis Arakaki, Chair
Healthcare Provider List Subcommittee
Mandated Benefits Advisory Task Force

MANDATED BENEFITS ADVISORY TASK FORCE
HEALTHCARE PROVIDER LIST SUBCOMMITTEE
MINUTES OF PUBLIC MEETING
NOVEMBER 15, 2001

CALL TO ORDER

The meeting was convened in the State Capitol Building, Room 437, on November 15, 2001 at approximately 11:08 a.m.

PRESENT

Rep. Dennis Arakaki, Chair; Paula Arcena; Don Dawson; Ruth Ellen Lindenberg; and Phyllis Dendle, proxy for Christopher Pablo, Esq.; members. Absent: Glenn Okihiro, DDS. Also present: Debbie Shimizu, National Association of Social Workers; and Carol Parker, Hawaii Psychological Association.

APPROVAL OF MINUTES (10/11/01 and 10/23/01 MEETINGS)

Mr. Dawson moved, seconded by Dr. Redmond, that the minutes be approved. Without objection, the minutes of the October 11, 2001 and October 23, 2001 meetings were approved.

SUBCOMMITTEE'S RECOMMENDATIONS

Chair Arakaki distributed copies of a draft document that formalized the recommendations the Subcommittee adopted during the October 23, 2001 meeting. The Subcommittee considered the specific language of the draft document and recommended several revisions.

With respect to the recommendation that a resolution be adopted requesting that the Prepaid Health Care Act be examined, Mr. Dawson indicated that the language was too narrow. The review should not only be confined to options within the ERISA exemption, but all other options, including the possibility of repealing the Act. The members were in agreement.

Regarding the automatic sunset recommendation, Chair Arakaki asked if the sunset review should continue every five years or should the mandated benefit be considered "permanent" at some point in time, thereby making the sunset review unnecessary after a period of time. After discussing the matter, it was agreed that the mandates must stand the test of time. Therefore, the sunset reviews should continue every five years indefinitely.

With respect to the repeal of the current review process, suggestions were made to tighten the draft language so that it is clear that the Subcommittee intends to

recommend that the current process be repealed and be replaced with a that establishes a new alternate body to conduct the reviews. The members agreed to the revisions.

As for the recommendation that HB237 be passed in its latest version, the Subcommittee suggested several revisions to the draft language. The language will be reworked to indicate that the Subcommittee supports an alternate process. Some of the models to consider include those from the states of Pennsylvania, Virginia, Maryland, and Washington, from other jurisdictions and organizations, and the one proposed in HB237.

Upon further consideration, the Subcommittee agreed to also include in the alternate process recommendation, that the alternate commission also identify the appropriate providers who should be able to provide the specific mandated benefit.

Chair Arakaki indicated that he would make the revisions and forward the revised language of the Subcommittee's recommendations to the members prior to the forthcoming meeting of the full Task Force.

PUBLIC COMMENT

The Subcommittee did not receive any written public comment.

NEXT MEETINGS

No other meetings are planned.

ANNOUNCEMENTS

The meeting of the full Task Force is Monday, November 19, 2001 at 1:00 p.m.

ADJOURNMENT

The meeting was adjourned at approximately 12:14 p.m.

Respectfully submitted:

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Rep. Dennis Arakaki, Chair
Healthcare Provider List Subcommittee
Mandated Benefits Advisory Task Force

MANDATED BENEFITS ADVISORY TASK FORCE
COST UTILIZATION AND COST AVOIDANCE SUBCOMMITTEE
MINUTES OF PUBLIC MEETING
September 10, 2001

CALL TO ORDER

The meeting was convened in the State Capitol Building, Room 211, on September 10, 2001, at approximately 9:32 a.m.

Chair Taniguchi began by having the Subcommittee members introduce themselves.

PRESENT

Sen. Brian Taniguchi, Chair; Laura Anderson, Esq.; Jennifer Diesman, proxy for Mike Cheng; and Lawrence Redmond, DC; members. Absent: Sharyn Stephani Monet, JD, RN. Also present: Carl Morton, MD, Pacific In Vitro Fertilization Institute; Chris Yamamoto, Mike Wylie, and Anita Swanson, DOH; Martin Johnson, PsyD, Hawaii Psychological Association; and Nicole Masukawa, Mental Health Association.

GROUND RULES FOR THE CONDUCT OF BUSINESS

Chair Taniguchi suggested the Subcommittee adopt the same Ground Rules that the full Task Force adopted. Ms. Anderson moved, seconded by Dr. Redmond, to adopt the Ground Rules. Without objection, the Ground Rules were adopted.

POTENTIAL COST (UTILIZATION AND AVOIDANCE) AND PATIENT BENEFITS OF MANDATED BENEFITS

The Subcommittee will be using in vitro fertilization procedure and mental health and alcohol and drug abuse treatment as case studies to review the potential cost (both utilization and avoidance) and patient benefits of mandated benefits.

Chair Taniguchi invited Carl Morton, MD, from the Pacific In Vitro Fertilization Institute was invited to provide the Subcommittee with the perspective of providers of in vitro fertilization procedures.

Dr. Morton provided a brief history of the in vitro fertilization mandated benefit. Dr. Morton indicated that in the last year of the Ariyoshi administration, the Legislature passed a bill that would have mandated in vitro fertilization coverage. However, Governor Ariyoshi vetoed the bill. The following year, in the first year of the Waihee

administration, the Legislature again passed a bill mandating in vitro fertilization coverage. This time, Governor Waihee signed the bill.

Dr. Morton also provided general information about the procedure. He indicated that the chance of success for women 35 years of age or under is 50%. The cost for the procedure for someone without insurance is $15,000 to $16,000. For those with insurance, their out-of-pocket expense is about $2,000 to $3,000. Dr. Morton also indicated that the cost for the coverage to HMSA subscribers was $0.18 per subscriber per year. He further indicated that HMSA said that the cost was $0.14 per subscriber per year.

Ms. Diesman ask Dr. Morton if the benefit is per individual or per plan. Dr. Morton indicated that his understanding is that it is per plan. Ms. Anderson inquired if utilization increased, would there be an increase in cost also. Dr. Morton indicated that the increase would be less than a straight-line increase. Ms. Anderson then asked what percent of Dr. Morton's patients is from out-of-state. Dr. Morton indicated that 5% is from out-of-state and that about 80% are covered by insurance.

Chair Taniguchi invited representatives from the Department of Health to provide the Subcommittee with information regarding mental health and alcohol and drug abuse treatment. Anita Swanson, Deputy Director for Behavioral Health Administration, Chris Yamamoto, Alcohol and Drug Abuse Division, and Mike Wylie, Adult Mental Health Division, represented the Department.

The Department indicated that approximately 23.9% of the population has some kind of mental illness with 2.6% having serious mental illness. The Department also estimated that of those that have private health insurance, only 4% of the covered population received mental health treatment. The Department further indicated that the cost to society for these kinds of services include prison detainees, those on probation and parole, and those incarcerated.

Ms. Swanson indicated that there was an access problem—people are not obtaining the needed services. Ms. Anderson asked what should insurers do to improve access. Ms. Swanson indicated that barriers should be broken down and that people who seek treatment should receive it immediately, not weeks later after checking on insurance coverage.

PUBLIC COMMENT

Martin Johnson, PsyD, from the Hawaii Psychological Association, noted employer assistance programs, which national surveys indicate save employers money.

NEXT MEETING

Wednesday, September 26, 2001, at 9:30 a.m. in State Capitol Room 211. Chair Taniguchi indicated that the health plans would be invited to participate in the next meeting.

ANNOUNCEMENTS

There were no announcements.

ADJOURNMENT

Ms. Anderson moved, seconded by Dr. Redmond, to adjourn the meeting. Without objection, the meeting was adjourned at approximately 10:27 a.m.

Respectfully submitted:

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Sen. Brian Taniguchi, Chair
Cost Utilization and Cost Avoidance Subcommittee
Mandated Benefits Advisory Task Force

MANDATED BENEFITS ADVISORY TASK FORCE
COST UTILIZATION AND COST AVOIDANCE SUBCOMMITTEE
MINUTES OF PUBLIC MEETING
October 17, 2001

CALL TO ORDER

The meeting convened in the State Capitol Building, Room 211, on October 17, 2001, at approximately 10:00 a.m.

PRESENT

Sen. Brian Taniguchi, Chair; Laura Anderson, Esq.; Jennifer Diesman, proxy for Mike Cheng; and Sharyn Stephani Monet; JD, RN, members. Absent: Lawrence Redmond, DC. Also present: Paula Heim, Mental Health Association; and Phyllis Dendle, Kaiser Permanente.

APPROVAL OF MINUTES (09/10/01 MEETING)

Copies of the aforementioned minutes were transmitted to the Subcommittee members prior to the meeting for review and comment. Ms. Monet moved, seconded by Ms. Diesman, that the minutes be approved and adopted. The minutes were adopted by unanimous vote.

POTENTIAL COST (UTILIZATION AND AVOIDANCE) AND PATIENT BENEFITS OF MANDATED BENEFITS

The subcommittee was briefed by representatives from HMAA, HMSA, and Kaiser Permanente. No one from HMAA was present.

Jennifer Diesman from HMSA provided the subcommittee with testimony addressing HMSA's cost and utilization experiences for the mental health and in-vitro fertilization mandated benefits. HMSA has seen an increase in utilization for both in-vitro fertilization and mental health benefits since being mandated. Utilization of these costs would most probably decrease if these benefits were no longer mandated. No other costs have been avoided through the mandates of these benefits. The member avoids the cost of having to pay out-of-pocket for in-vitro fertilization and since health plans already covered mental health services prior to enactment of the insurance code mandate, it is unlikely that other costs would have been avoided.

Member Monet asked whether utilization of inpatient mental health visits decreased since mental health outpatient visits increased. Ms. Diesman said she would get the information.

Chair Taniguchi asked if the increase in in-vitro fertilization utilization increased due to technology and/or advertising of the procedure? Ms. Diesman responded that it was probably a combination of both although she has heard of local clinics advertising in-vitro fertilization procedures. Chair Taniguchi then asked if there were other infertility procedures that HMSA provided. Diesman's response was that HMSA does not cover infertility treatments. Ms. Diesman also suggested that requesting pre-mandate data information from Dr. Morton of the Pacific In-Vitro Fertilization Institute might be helpful in determining increased utilization benefits.

PUBLIC COMMENT

Paula Heim from the Mental Health Association stated that it is important to continue to mandate mental health benefits and that the task force should continue to look into the needs of mental health patients. There is a lot of informative data that was collected by the Mental Health Task Force last year, but unfortunately the task force was not able to properly identify and address those concerns due to the limited time frame in which the Task Force existed. Ms. Heim also suggested that the Insurance Division conduct an actuarial report.

NEXT MEETING

The next meeting is pending informational data from Dr. Morton of the Pacific In-Vitro Fertilization Institute.

ANNOUNCEMENTS

There were no announcements.

ADJOURNMENT

Ms. Anderson moved, seconded by Ms. Monet, to adjourn the meeting. Without objection, the meeting was adjourned at approximately 10:40 a.m.

Respectfully submitted:

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Sen. Brian Taniguchi, Chair
Cost Utilization and Cost Avoidance Subcommittee
Mandated Benefits Advisory Task Force

MANDATED BENEFITS ADVISORY TASK FORCE
COST UTILIZATION AND COST AVOIDANCE SUBCOMMITTEE
MINUTES OF PUBLIC MEETING
November 16, 2001

CALL TO ORDER

The meeting was convened in the State Capitol Building, Room 211, on November 16, 2001, at approximately 10:06 a.m.

PRESENT

Sen. Brian Taniguchi, Chair; Laura Anderson, Esq.; Jennifer Diesman, proxy for Mike Cheng; and Sharyn Stephani Monet; JD, RN, members. Absent: Lawrence Redmond, DC. Also present: Don Kopf, Hawaii Psychological Association and Tom Smyth, DBEDT.

APPROVAL OF MINUTES (10/16/01 MEETING)

Copies of the minutes were transmitted to the Subcommittee members prior to the meeting for review and comment. Ms. Diesman moved, seconded by Ms. Anderson, that the minutes be approved and adopted. Without object, the minutes were adopted.

DISCUSSION AND ADOPTION OF THE SUBCOMMITTEE'S PROPOSED RECOMMENDATION

Copies of the proposed recommendations were distributed. After reviewing the proposed recommendations, Chair Taniguchi opened the floor for discussion.

Ms. Anderson expressed reservations with the last paragraph of the proposed recommendations, indicating that the purpose of mandates is not to fund research. Agreeing with Ms. Anderson, Ms. Diesman indicated that it would be very difficult for the panel to consider social and moral implications. Ms. Diesman also questioned whether the panel was the appropriate body to consider who will be eligible for specific benefits. Chair Taniguchi indicated that the language was intended to avoid ambiguities such as those associated with in vitro fertilization procedure – whether the intent was one procedure per plan or per individual.

Ms. Diesman indicated that it is very difficult for the health plans to perform a cost analysis of any potential cost savings that may result from preventing future treatments. She also indicated that cost savings is difficult to determine. Ms. Anderson indicated that the language regarding violent behavior of those receiving mental health treatment may raise privacy concerns. She also indicated that some mandated benefits may be

placing those who utilize the benefit at greater medical risk. These costs should also be examined.

PUBLIC COMMENT

Don Kopf suggested an example to illustrate the potential cost savings of preventative measures. Tom Smyth indicated that data on potential cost savings is available from other groups.

NEXT MEETING

This is the last Subcommittee meeting.

ANNOUNCEMENTS

Ms. Diesman distributed material that responds to Ms. Monet's question from the last Subcommittee meeting regarding whether utilization of inpatient mental health visits decreased since mental health outpatient visits have increased. Ms. Diesman's material indicated that although there was an initial decrease in acute care hospitalizations immediately following the enactment of the mental health mandated benefit, the decrease did not hold. She also indicated that they did not have any explanation for what happened.

ADJOURNMENT

Ms. Diesman moved, seconded by Ms. Monet, to adjourn the meeting. Without objection, the meeting was adjourned at approximately 10:38 a.m.

Respectfully submitted:

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Sen. Brian Taniguchi, Chair
Cost Utilization and Cost Avoidance Subcommittee
Mandated Benefits Advisory Task Force

Report of the Appropriateness of Scope Subcommittee
Mandated Benefits Advisory Task Force
November 2001

Appropriateness of Scope Subcommittee

Pursuant to H.C.R. No. 129, 2001, the Insurance Commissioner convened the Mandated Benefits Advisory Task Force (Task Force) to advise the Legislature on problems relating to Hawaii's mandated health insurance benefits and the legislative process enacting them. To facilitate the work of the Task Force, the Insurance Commissioner organized three subcommittees:

1. Cost Utilization and Cost Avoidance Subcommittee;

2. Healthcare Provider List Subcommittee; and

3. Appropriateness of Scope Subcommittee.

The Appropriateness of Scope Subcommittee (Scope Subcommittee) was charged with investigating the appropriateness of the scope of mandated benefits, including the costs and benefits. The Insurance Commissioner appointed the following to be members of the Scope Subcommittee:

Representative Kenneth Hiraki, Chair
Mike Cheng, Hawaii Medical Services Association
Don Dawson, Dawson International
Philip Hellreich, M.D., Hawaii Medical Association
Arlene Meyers, M.D., J.D.
Sharyn Stephani Monet, J.D., R.N.
Christopher Pablo, Esq., Kaiser Permanente

The Scope Subcommittee met each Friday for approximately two hours a meeting from August 23, 2001 through October 12, 2001 to gather information from invited speakers to consider the following:

1. What is a mandated benefit?

2. What is the scope of interests affected when benefits are mandated?

3. What criteria should be considered in mandating benefits?

The meeting agenda (attachment A), minutes (attachment B), and a list of all invited organizations and individuals (attachment C) are attached.

Summary of Findings

1. What is a mandated benefit?

A health insurance mandate is a requirement that an insurance company offer specified benefits in an insurance plan.[1] According to the Council for Affordable Health Insurance (CAHI), mandates have proliferated from only seven state-mandated benefits in 1965 to over 1,000 nationwide by January 1, 1997.[2]

The Hawaii Independent Physicians Association (HIPA) suggested that there are four categories of mandated benefits:

1. **Benefits that the health care insurance companies have determined to be too expensive.** "Too expensive" usually means that if the benefit is added to the health insurance package, it will address the needs of only a small section of the population, but will increase premiums across the board to an (unacceptable) amount where an insurance company's subscribers will drop coverage.

2. **Those health care services that traditionally have not been part of the average health insurance package.** An example is the mandate requiring health insurers to cover the cost of special foods needed by children who suffer from a condition known as phenylketonuria (PKU). Food was not considered a diagnostic procedure or therapeutic treatment and fell outside the usual scope of benefits provided under a health insurance policy.

3. **"Public health" measures.** These would be mandates that require health insurers to pay for screening tests, such as PAP smears and PSA tests. These are not diagnostic tests. A physician orders a diagnostic procedure when a particular patient has certain symptoms and the diagnostic procedures are needed to differentiate the diagnosis. By contrast, screening tests are administered even if the patient does not present any symptoms at all, but rather falls into a category of people, who may be vulnerable to a particular medical problem that is best treated in its early stages. Preventative or health maintenance measures, such as "well baby" visits also fall into this category.

4. **"Catch-all" category.** This category includes certain medical treatments or pharmaceuticals that are only emerging from the experimental state, but nonetheless have garnered a political advocacy group that has successfully lobbied lawmakers to mandate that particular treatment.

Within these categories of potential mandated benefits, HIPA recommended that mandated benefits should be used only when government intervention is required to provide the health insurance coverage needed to produce the greatest good for the

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1 Council for Affordable Health Insurance (CAHI), *CAHI Policy Brief: Mandated Health Insurance Benefits*, Volume I, Number 6, p. 1 (August 4, 1997).

2 Ibid.

greatest number of our citizens, while at the same time keeping health insurance affordable.

Tables 1-2 outline a sampling of the various positions presented to the Scope Subcommittee on what a mandated benefit is, as presented by Professor Richard E. Chard, the Hawaii Medical Association, PractiCare, Inc., the Hawaii Medical Services Association, Kaiser Permanente, and the Department of Labor and Industrial Relations.

2. What is the scope of interests affected when benefits are mandated?

The Scope Subcommittee considered the scope of interests described by various groups during its series of meetings. These groups included insurers, providers, employers, government, and consumer groups. A sampling of the varying positions are outlined in Tables 3-5.

3. What criteria should be considered in mandating benefits?

The **Children with Special Health Needs Branch of the Department of Health** suggested that "compliance with the standard of practice in the medical treatment of the disorder or disease" is a good basis.

The **Hawaii Coalition for Health** suggested that the criteria for considering mandated benefits should have the aim of maximizing society's values. The overarching value should be human dignity in health care and should include:

- Economic productivity;
- Treatment meeting the appropriate professional legal standard of care for providers;
- Relief from and alleviation of suffering;
- Availability and use of up-to-date diagnostic and treatment modalities, as well as approved drugs, where cost-effective;
- Promoting medical education;
- Promoting research and advances in care delivery;
- Protecting and conserving existing resources;
- Improving access to care;
- Compliance with advance directives duly executed by patients;
- Death with dignity;
- Admission of patients to and support for participation in clinical studies where innovative modalities of treatment or new drugs do not meet "medical necessity" criteria;
- Economic efficiency;
- Prolongation of healthy, productive life; and
- Community expectations.

Hawaii Management Alliance Association suggested the following policy bases:

1. The extent to which the treatment or service is generally utilized by a significant portion of the population.

2. The level of public demand for individual or group insurance coverage of the treatment or service.

3. Consideration of the financial impact on the population, the insurance industry, and employer.

4. Evaluation of the extent to which the mandated treatment or service might serve as an alternative for more expensive treatment or service.

Hawaii Medical Service Association stated that there should be an objective, quantitative method for evaluating mandated benefit proposals with a requirement that it meet a minimal rating score before it can move forward. A litmus test should be developed based on the criteria set forth in section 23-52, Hawaii Revised Statutes (HRS), along with the following considerations:

1. If coverage is currently offered on an optional rider basis, how many employers have chosen to purchase it?

2. Would the new benefit expand current coverage for these services? If so, why would it be necessary to mandate a higher level of benefits if there is already a minimum level of coverage?

3. Is there medical evidence to support the necessity of this type of benefit? Will it provide better quality of care and improve the effectiveness of treatment currently covered?

4. What is the rationale for mandating services for a new provider type?

5. Will the mandate serve to lower the overall cost of medical care by the savings that will be achieved with the new benefit? Can that be proven through demonstration projects in other states?

6. What are the administrative impacts or burdens on providers and their staff? What is the administrative impact to Hawaii's health plans?

7. How does it conflict or duplicate what is already federally regulated?

8. Can there be abuse or overuse of services? For example, by removing or increasing a benefit maximum, does it promote overuse and make if difficult to manage care?

9. Are there similar mandates in other states, and what were the outcomes and impacts to health care coverage, quality of care, and costs?

10. Will the mandated coverage withstand the test of time as treatment changes with new techniques or technology?

Hawaii Nurses' Association suggested considering the following:

1. Did mandating this benefit make a difference?

2. How can the effect be measured?

3. What were the outcomes when compared to the intent?

4. Did this mandate alter the health status of the people?

5. What is the cost-benefit of the mandate?

6. Should termination of the policy be considered?

7. Should adjustment and revision of the policy be considered?

Hawaii Psychological Association suggested four policy considerations:

1. Impact on public health;

2. Cost impact of both having the mandate and not having the mandate;

3. Efficacy of treatment; and

4. Presence of stigma.

Both **Kaiser Permanente** and **Kokua Council** suggested that while assessment of the SOCIAL and FINANCIAL impacts of new mandates are already required in Hawaii[3], a third area is needed. The State of Washington requires this third standard: that of EFFICACY. Specifically, this standard measures the extent to which a proposed mandate would enhance the general health status of the state's residents and the degree to which there are studies that demonstrate the health consequences of the mandate.

Section 48.47.030, Revised Code of Washington (RCW), requires the consideration of:

> *(c) Evidence of health care service efficacy:*
> *(i) If a mandatory benefit of a specific service is sought, to what extent has there been conducted professionally accepted controlled trials demonstrating the health consequences of that service compared to no service or an alternative service?*
> *(ii) If a mandated benefit of a category of health care provider is sought, to what extent has there been conducted professionally accepted controlled trials demonstrating the health consequences achieved by the mandated benefit of this category of health care provider?*
> *(iii) To what extent will the mandated benefit enhance the general health status of the state residents?*

Kaiser Permanente also recommended looking at the laws of Pennsylvania, Virginia, and Maryland.

Legislative Information Services of Hawaii made the following suggestions:

[3] Section 23-52, HRS.

1. The only acceptable policy that must be established to determine whether coverage should be mandated is whether the coverage is needed. In addition to repealing the Prepaid Health Care Act, they suggested that the State reestablish what coverage should be required and simplifying it to meet basic needs. For example, faculty from the University of Hawaii School of Medicine could help determine these core services, and the costs for the services could be determined by actuaries.

2. Statutes should be simplified to require employers to provide **basic coverage** only. Supplemental insurance should be made available to allow employees the option of purchasing additional coverage.

3. If insurers are not willing to offer affordable basic coverage, the State should enter the insurance business until such time as competition enters the market.

Pacific InVitro Fertilization Institute suggested the consideration of the following common sense principles:

1. Should the condition or disease being considered for a mandate be covered under health insurance when viewed by a reasonable person? Is the disease or condition recognized by the diagnostic codes used almost universally by the medical profession and the insurance industry?

2. Is the condition or disease currently covered adequately by health insurance?

3. Are there qualified medical professionals to treat this condition or disease? Can this qualification be codified in the mandate to assure quality of care?

4. Can safeguards be written into the mandate to provide some cost control or prevent overuse of these services or treatments?

Each mandated coverage should act as a reminder to the insurance companies that they should continually evaluate their positions on denial of coverage. If insurance companies could become more responsive to these changes, there would be fewer requests for mandated coverage.

PractiCare Hawaii Inc. suggested three primary policy bases:

1. Keeping up with the needs of the community served;

2. Keeping up with the latest technology; and

3. Efficacy and cost-effectiveness.

Recommendations

During the course of its meetings, the Scope Subcommittee heard diverse points of view and engaged in thought-provoking discussions on mandated benefits. At the initial meeting, some members expressed frustration with the limited scope of study as outlined in H.C.R. No. 129. Excluded from study was a detailed review of other state mandates such as the Prepaid Health Care Act (PHCA) and other related factors that contribute to the overall cost of health care premiums.

The Scope Subcommittee also looked at the correlation between the repeal of all or some of the mandated benefits and their potential for reductions in health premiums. Based on feedback from the two largest health plans in the state, a repeal of all current mandated benefits would result in a reduction in health plan dues. However, the amount of that reduction would be dependent on the willingness of employers to proactively discontinue benefits which had already been made available to their employees. In the health plan's estimation, some of the preventive care benefits such as well-baby visits, mammography screening, and immunizations would unlikely be discontinued.

There was a general agreement among Subcommittee members that there is a need to strengthen the current process of reviewing proposed mandates. Under the present system, the Legislature is allowed to disregard the findings of an Auditor's recommendations and has even enacted mandates without ever conducting the required Auditor's review. In an attempt to bring reason and uniform standards to this process, the Subcommittee strongly endorses that the Task Force considers a change to the present review process.

As requested by H.C.R. No. 129, the Scope Subcommittee offers several recommendations for further consideration. While the Subcommittee has attempted to resolve all the details of its proposals, some of the specifics are too complex to resolve immediately and require additional discussion.

The Scope Subcommittee makes the following recommendations to the Task Force:

1. **The Task Force should request the Legislature to establish a task force to examine the effectiveness of the Prepaid Health Care Act of 1974 (PHCA).**

   Problems associated with PHCA were often raised during the Scope Subcommittee's meetings. Many recognized that PHCA was instrumental in establishing Hawaii's reputation as the "Health State" in the 1970s and 1980s. However, because any amendment to the law would risk Hawaii's exemption from the federal Employee Retirement Income Security Act (ERISA), the law has remained unchanged despite societal changes and medical advances that have occurred since PHCA's inception almost 30 years ago.

   Although PHCA plays a significant role in Hawaii's health care situation, the Scope Subcommittee can also understand the position of those who advocated the repeal of the PHCA because its "time has passed." At the

same time, the Scope Subcommittee recognizes that the consideration of the PHCA is beyond the scope of what it was assigned to study.

In recognition that the complex issues associated with amending or repealing the PHCA merits further study, the Scope Subcommittee recommends that the Legislature establish a task force to examine the effectiveness of PHCA and to consider the feasibility of amending or repealing PHCA.

2. Further discussion is needed on whether existing mandated health benefits shall continue.

Until such time as standards for establishing mandated benefits in Hawaii are developed, the merits of certain existing mandated health insurance benefits need to be examined. Factors to consider include whether the mandate: 1) provides a benefit to a large segment of the population; 2) is cost efficient; and, 3) addresses a medical "need" as opposed to a "want."

Judged in this light, the subcommittee supports further discussion on whether in vitro fertilization should continue as a mandated benefit.

3. A new review process should be established to determine which benefits are mandated.

Sections 23-51 and 23-52, HRS, require the Legislative Auditor to study the social and financial impacts of measures that propose to mandate health insurance benefits. Many expressed disappointment that so many mandates have been enacted without a Legislative Auditor report, as required by law. Most agreed, aside from making a few modifications, the fault lies with the process and not with the criteria.

Although there already is a review process in place, there are limitations to this process. To begin with, the Legislative Auditor does not have the resources needed to fulfill this responsibility. The Legislative Auditor has stated that it does not want to take on the role of studying mandated benefits as this function does not relate to its constitutionally-defined role. This responsibility also makes it difficult for the Auditor to maintain its independence in fulfilling its auditory functions.

The following are suggestions to be considered in establishing the review process:

Chamber of Commerce of Hawaii

Chamber of Commerce of Hawaii would like to mandate the Legislative Auditor to conduct assessments on any proposed mandated benefits without the need for a concurrent resolution. However, if periodic assessment must be conducted by an entity other than the Legislative Auditor, a Review Panel on Mandated Health Insurance Services should be established. The Review Panel should be composed of representatives from a cross section of small business associations, larger business associations, a health plan, a nurse, an economist, and one legislator from each chamber. Businesses should occupy at least one-third of the panel.

The **Chamber of Commerce of Hawaii** also recommended that the Legislative Auditor or Review Panel revisit mandates every five years to determine the cost, utilization, and efficiency. Sunset reviews are required in Oregon. Section 743.700, Oregon Revised Statutes, provides for the automatic repeal of mandated health insurance benefits six years after the enactment of the benefit, unless the legislature specifically provides otherwise. Note that the repeal of a benefit does not apply to any insurance policy in effect on the effective date of the repeal. However, the repeal of the benefit will apply to a renewal or extension of an existing insurance policy on or after the effective date of the repeal as well as to a new policy issued on or after the effective date of the repeal.

The **Chamber of Commerce of Hawaii** also suggested that before a mandate is required, the mandate should first be implemented on a pilot basis for one year in the State employee health benefits program. According to the **Chamber of Commerce**, this is required in the State of Kansas.

Hawaii Coalition For Health

A suitable and credible forum for making decisions regarding mandated benefits must be devised.

1. Decisions must be made by an impartial decision-making mechanism or panel (Panel). Persons with potential conflicts of interest should not be appointed. Members of the Panel should include knowledgeable individuals capable of evaluating benefits to the community as a whole including:

    - An expert on health insurance;
    - A health economist;
    - A medical expert, preferably an academic from the University of Hawaii;
    - The chair of Senate Committee on Ways and Means; and
    - The chair of House Committee on Finance.

2. Input may be provided from an advisory panel that has no decision-making power. It is difficult for a panel of people who have special interests to prioritize criteria needed for impartial decision-making. The final decision must be made by the Panel.

3. The Panel must hold hearings to elicit wide public opinion.

4. The Panel must report its findings to the Legislature. The Legislature would then either:

    - Pass the legislation, approving that particular mandate if that is what the Panel recommended; or
    - If the Legislature's decision is inconsistent with the Panel's recommendation, they would remand it for further investigation.

5. The Panel must be appointed by the Governor. It should be under the direction of the Insurance Commissioner. The Panel must be compensated.

6. The Panel's power must be specifically defined by legislation. More negotiation needs to occur because the law must be specific about:

   - Who is on the Panel;
   - How they make decision; and
   - What factors they have to consider in making the decisions.

Hawaii Independent Physicians Association

1. Require any proposed legislation for new mandated health benefits to be reviewed by an Expert Panel of physicians and insurance professionals (such as underwriters and actuaries) before consideration. This Expert Panel should provide a report to the Legislature that would include an assessment of medical efficacy of the proposed mandated benefit, the expected improvement in the health of the population that will follow from its implementation, and an estimate of financial impact the proposed mandated benefit would have on insurance premiums.

2. Consider taking a bounded mandate approach to any legislation proposing new mandated health insurance benefits.

3. Specify that the Legislature is the sole entity mandating health insurance benefits in Hawaii.

Hawaii Medical Association

Hawaii Medical Association suggested that a panel should be appointed by the Governor to evaluate any proposed mandates and then make recommendations to the Legislature. The panel should include health care providers, health plan representatives, consumer groups, small business groups, key legislative chairs, the Legislative Auditor, Insurance Commissioner, and Director of Commerce and Consumer Affairs. The panel should be required to obtain input from individuals capable of evaluating benefits to the community as a whole, including health economists, academic medical experts, actuaries, and public health experts. The panel should be given adequate staff support and funds to carry out its responsibilities and obtain expert opinions and analyses required to make informed decisions.

Hawaii Medical Services Association

An independent review commission should be established to analyze any new mandated benefit. The commission should be limited to a small group to include a small business representative, a physician, a health plan representative, a health economist, a nurse, a representative from a large business organization, and a legislator. The commission should meet throughout the year and report to the Legislature on a semiannual basis, or as needed.

Hawaii Nurses' Association

Hawaii Nurses' Association suggested seeking consultation with an academic program such as the Public Administration Program or Department of Public Health Services at the University of Hawaii to provide assistance in the evaluation of existing law and included criteria. Policy analysis/design is a time-consuming and detailed process. Seeking this kind of consultation can provide a strategic advantage in accomplishing this mission in a timely and effective manner.

Hawaii Psychiatric Medical Association

The review panel process must be democratic with ultimate legislative authority. The review panel should be provided with staff support, member compensation, if deemed appropriate, and adequate resources for research. Guidelines should be well-developed to provide integrity to the process and provide a public forum.

Kaiser Permanente

Kaiser Permanente suggested that:

- The entity should be attached to the Insurance Commission or Health Department for administrative purposes.

- Analyses should be conducted by the staff of the agency or department. The agency should be given resources and funding to hire experts or consultants, as needed, to conduct public hearings and prepare reports for the Legislature.

- Membership be appointed by the Governor or House/Senate leadership. Membership should consist of no more than 17 members and include representatives of health plans, health care providers, small and large business, and consumers.

- No bill proposing a mandate should be heard by a legislative committee until an analysis has been done by the entity. The recommendation of the entity should be nonbinding upon the Legislature.

- Before a mandate is required, the mandate should first be implemented on a pilot basis for one year in the State employee health benefits program.

Kokua Council

The **Kokua Council** suggested the following:

- There should be no more than 16 people on the group/panel reviewing the need for mandated benefits.

- The group would need to be backed up by a group of experts with the capability of fact gathering, data analysis, developing options, laying out costs, and implications for the state. The experts should include:

    - Health economists;
    - Health policy analysts;

- Statisticians;
- Health care providers; and
- Recognized community planners.

- Experts would be expected to add the expertise of others, local and national, for their research.

- Given the small community task force mentioned to carry the ball in marketing and decision-making, and an agreed upon expert component to fortify them, it would then be necessary to structure a process allowing time together for study, deliberation, and ongoing cross fertilization.

- Experts and planners with a measure of humility, able to understand the complexities of community planning, and expediters, whose role would be to market the final product, are essential components of broad-based planning.

National Federation of Independent Business

The **National Federation of Independent Business** suggested that the Legislature place a moratorium on any additional health care mandates for at least one year.

Pacific InVitro Fertilization Institute

Pacific InVitro Fertilization Institute suggested changing section 23-52(1)(A), HRS, to read:

> *(A) The extent to which the treatment or service is generally utilized by a significant portion of the affected population;*

Concerns were also raised about the requirements in section 23-52(1)(E) and (F).

The State of Washington: Sunrise Review

As mentioned earlier, **Kaiser Permanente** and **Kokua Council** recommended adding a third standard of EFFICACY to the criteria already required in section 23-52, HRS, for evaluating the need for mandated health benefits. The State of Washington requires the consideration of health care service efficacy.

In 1997, the Washington State Legislature passed HB 1191, which established a procedure for the proposal, review, and determination of the need for proposed mandated health insurance benefits. According to section 48.47.005, RCW, the purpose of this systematic sunrise review, which explores all the ramifications of proposed legislation, was to "assist the legislature in determining whether mandating a particular coverage or offering is in the public interest."

Under Washington law, the proponent of a mandate must provide specific information to the Legislature at least 90 days before the regular session. Upon the Legislature's request, and if funds are available, the Washington Department of Health makes recommendations on the proposal using the criteria set forth in section 48.47.030, RCW. The Department of Health must report its

recommendations on the appropriateness of adoption no later than 30 days before the legislative session during which the proposal is to be considered.

In addition to examining the social and financial impacts of the proposed mandated benefits, section 48.47.030, RCW, also requires the consideration of health care service efficacy. Further, section 48.47.030, RCW, provides that:

> *(2) The department shall consider the availability of relevant information in assessing the completeness of the proposal.*
> *(3) The department may supplement these criteria to reflect new relevant information or additional significant issues.*
> *(4) The department shall establish, where appropriate, ad hoc panels composed of related experts, and representatives of carriers, consumers, providers, and purchasers to assist in the proposal review process. Ad hoc panel members shall serve without compensation.*
> *5) The health care authority shall evaluate the reasonableness and accuracy of cost estimates associated with the proposed mandated benefit that are provided to the department by the proposer or other interested parties, and shall provide comment to the department. Interested parties may, in addition, submit data directly to the department.*

Representative Marilyn Lee – HB 237 HD2 SD1 "Relating to Mandated Health Coverage Review"

During the 2001 Legislature, Representative Marilyn Lee introduced HB 237 HD2 SD1, "Relating to Mandated Health Coverage Review", which:

1. Creates a mandated health insurance service review panel within the Department of Commerce and Consumer Affairs to assess social, medical, and financial impacts of mandated health insurance coverage;
    - Membership in this review panel will be composed of fourteen members. The Insurance Commissioner, the Auditor, and the Director of Health shall be ex-officio voting members. The Insurance Commissioner shall serve as chairperson. The Governor will appoint the following eleven members:
        1) the Chairperson of the Senate Committee on Ways and Means, or designee;
        2) the Chairperson of the House Committee on Finance, or designee;
        3) one member who is a licensed registered nurse;
        4) one member who is a licensed physician;
        5) three members who represent health plan insurers, including
        6)
            (a) one representing an insurer under Hawaii Revised Statutes (HRS) chapter 431, article 10A;
            (b) one representing mutual benefit societies under HRS chapter 432; and
            (c) one representing health maintenance organizations under HRS chapter 432D
        7) one member who is a health economist; and

8) three members who represent the business community.

2. Recommends a cap on the cost of mandated health insurance coverage in terms of percentage of average annual state wage; and

3. Repeals the State Auditor's duty to review such proposals.

This bill did not pass the Legislature, however, in order to facilitate discussion on this matter, the Legislature adopted HCR 129, HD1 SD1 CD1, "Requesting the Insurance Commissioner to convene a mandated benefit taskforce and requesting the Legislative Reference Bureau to conduct a study on the feasibility of a state pharmaceutical assistance program."

The work conducted by the Subcommittee is a direct result of this resolution.

The Subcommittee could not resolve in the time allowed all the issue raised by the various recommended changes contained in the public testimony. As a result, the Subcommittee endorses the approach contained in H.B. 237 HD2 SD1 (Attachment D) authored by Rep. Marilyn Lee as a starting point for further thoughtful debate by the full Task Force. The Subcommittee also strongly supports the recommendation of the Chamber of Commerce that requires each mandated benefit be reviewed at least once every five years to determine whether there is still a need to continue or amend the mandated benefit.

As affirmed by the record of votes of the members of the Appropriateness of Scope Subcommittee, the Subcommittee is in accord with the intent and purpose of this report.

November 9, 2001

REP. KENNETH T. HIRAKI, CHAIR

MIKE CHENG, MEMBER

DON DAWSON, MEMBER

PHILIP HELLREICH, MD, MEMBER

ARLENE MEYERS, MD, JD, MEMBER

SHARYN STEPHANI MONET, JD,RN, MEMBER

CHRISTOPHER PABLO, ESQ., MEMBER

MANDATED BENEFITS ADVISORY TASK FORCE
Cost Utilization and Cost Avoidance Subcommittee Recommendations

Based upon the testimonies received on the mandated benefits that the subcommittee reviewed, in vitro services and mental health, alcohol and substance abuse treatment, the subcommittee makes the following recommendations for a mandated benefit review process.

When reviewing a mandated benefit the panel should review not only direct and indirect costs associated with providing the benefit but also any potential cost savings that may result from preventing future treatments. For example, early substance abuse treatment may prevent patients from requiring more costly medical treatment in the future.

The subcommittee considered whether the panel should include in its cost savings analysis savings not only attributed to the patient but also to others that may be impacted by the patient**.** For example, a person suffering from an untreated mental illness may do harm to others. Due to the difficulty of this assessment, the subcommittee believes this aspect is best left to the discretion of the Legislature.

The subcommittee also recognizes that the panel needs to review any increase in administrative and other “start-up” costs to health plans associated with providing the mandated benefit.

When a mandated benefit is proposed, the statutory language needs to be concise so that there is no broad construction of the benefit. The panel should identify any ambiguities in the proposed law. The in vitro services mandated benefit is a good example. Testimony indicated that it is not clear whether the

benefit is to be provided once per lifetime or once per plan. This recommendation is related to costs because if a broad interpretation is permitted, unknown additional costs may arise after the mandated benefit becomes law.

Notwithstanding any cost impacts to the consumer, the panel should consider broader social benefits when reviewing a mandated benefit. Additionally, medical procedures have some risks associated with them. To strike a balance, the panel should also consider the potential additional costs that might result from the increase of medical risks in providing the benefit.

SUMMARY OF MANDATED
HEALTH INSURANCE COVERAGES **Attachment 14**

STATUTORY AUTHORITY	MANDATED COVERAGE	ENACTED	NOTES
431:10A-115 432:1-602 432D-23	NEWBORN CHILDREN	1987	This coverage mandates that benefits applicable for children shall be payable for newborn infants from the moment of birth; provided that the coverage for the newly born children shall be limited to the necessary care and treatment of medically diagnosed congenital defects and birth abnormalities. There is no Legislative Auditors Report for this mandated coverage.
431:10A-116 432D-23	REIMBURSEMENT OF LICENSED OPTOMETRIST	1987	This coverage mandates that policies offer reimbursement for vision services provided by a licensed optometrist. There is no Legislative Auditor's Report for this mandated coverage.
431:10A-116 432D-23	REIMBURSEMENT OF DENTIST FOR DENTAL SURGERY OR EMERGENCY SERVICES	1987	This coverage mandates that policies offer reimbursement for dental services provided by a licensed dentist. There is no Legislative Auditor's Report for this mandated coverage.
431:10A-116 432:1-603 432D-23	REIMBURSEMENT FOR PSYCHOLOGICAL SERVICES	1987	This coverage mandates that policies offer reimbursement for psychological services provided by a licensed physician or licensed psychologist. There is no Legislative Auditor's Report for this mandated coverage.
431:10A-116.5 432:1-604 432D-23	IN VITRO FERTILIZATION PROCEDURE	1987	This coverage mandates that all policies that offer pregnancy related benefits shall include in addition to any other benefits for treating infertility, a one-time only benefit for outpatient expenses arising from in vitro fertilization procedures. There is no Legislative Auditor's Report for this mandated coverage.
431:10A-115.5 432:1-602.5 432D-23	CHILD HEALTH SUPERVISON SERVICES	1988	This coverage mandates that policies offer well baby services. Legislative Auditor's Report – **Study of Proposed Mandatory Health Insurance for Well Baby Services**.

SUMMARY OF MANDATED HEALTH INSURANCE COVERAGES

431M-4 432D-23	MENTAL ILLNESS, ALCOHOL AND DRUG DEPENDENCE REIMBURSEMENT OF CLINICAL SOCIAL WORKERS	1988	This coverage mandates that policies offer mental health benefits. It was enacted in 1988, but has been amended in 1994, 1997, 1998, and 1999 to broaden the scope of the coverage. A Legislative Auditor's Report – **Study of Proposed Mandated Additional Mental Health and Alcohol and Drug Abuse Insurance Benefits** was released in December of 1997.
431M-5 432D-23	NONDISCRIMINA-TION IN DEDUCTIBLES, COPAYMENT PLANS, AND OTHER LIMITATIONS ON PAYMENT	1988	This coverage mandates that the deductibles and copayments of a policy shall be not greater than those of comparable physical illness generally requiring a comparable level of care. There is no Legislative Auditor's Report for this mandated coverage.
431:10A-116 432:1-605 432D-23	MAMMOGRAPHY	1990	This coverage mandates that policies offer mammography screening for women over thirty-five. There is no Legislative Auditor's Report for this mandated coverage.
431:10A-116 432:1-602.6 432D-23	COVERAGE FOR NEWBORN CHILDREN	1991	This coverage mandates that if a policy covers the children of the insured, the coverage shall extend to the birth of any adopted newborn of the insured. There is no Legislative Auditor's Report for this mandated coverage.
431:10A-116.6 431:10A-116.7 432:1-604.5 432D-23	CONTRCEPTIVE SERVICES	1993	This coverage mandates that policies cease to exclude contraceptive services for subscribers or their dependents. A Legislative Auditor's Report – **Study of Proposed Mandatory Health Insurance Coverage for Contraceptive Services** was released in February of 1998. The mandate was amended in 1999 to exempt certain employers who conflicted with their religious tenets.

SUMMARY OF MANDATED HEALTH INSURANCE COVERAGES

431:10A-116.3 432:1-601.5 432E-23.5	TELEHEALTH	1998	This coverage mandates that policies recognize telehealth as reimbursable benefit. There is no Legislative Auditor's Repot for this mandated coverage.
431:10A-119 432:1-608 432D-23	HOSPICE CARE	1999	This coverage mandates that policies, which offer hospice care shall reimburse hospice care providers for each hospice room and board expense or referral visit. There is no Legislative Auditor's Report for this mandated coverage.
431:10A-120 432:1-609 432D-23	MEDICAL FOODS AND LOW-PROTEIN MODIFIED FOOD PRODUCTS	1999	This coverage mandates that policies offering family coverage shall contain a provision for the coverage of Medical foods and low-protein modified food products for treatment of inborn error metabolism. A Legislative Auditor's Report – **Study of Proposed Mandatory Health Insurance Coverage for Medical Foods in the Treatment of Inherited Metabolic Diseases** was released in January of 1999.
431:10A-121 432:1-612 432D-23	DIABETES COVERAGE	2000	This coverage mandates that a policy shall provide coverage for outpatient diabetes self-management training, education, equipment, and supplies, if medically necessary and prescribed by a health care professional. There is no Legislative Auditor's Repot for this mandate coverage.

S.C.R. NO. _____

SENATE CONCURRENT RESOLUTION

REQUESTING THE CONVENING OF A TASK FORCE TO EXAMINE THE EFFECTIVENESS OF THE PREPAID HEATLH CARE ACT (ACT), CHAPTER 393, HAWAII REVISED STATUTES, AND TO CONSIDER THE FEASIBILITY OF AMENDING OR REPEALING THE ACT.

WHEREAS, in 1974, in an effort to ensure that the working people of Hawaii had access to adequate health care, the Legislature extended prepaid health care insurance to workers who did not have that kind of protection or who had only inadequate prepaid health care insurance by passing S.B. NO. 14, S.D.1, H.D.2, C.D.1, better known as the Hawaii Prepaid Health Care Act (Act), which has since been codified as chapter 393, Hawaii Revised Statutes; and

WHEREAS, since its enactment, the Act has accomplished a great deal in terms of health care coverage for the working people of Hawaii – it has set a floor below which no person in Hawaii working more than twenty hours a week would be allowed to fall; it defined a basic health care coverage benefits package long before that idea was fashionable; and it enfranchised thousands of people; and

WHEREAS, notwithstanding its accomplishments, the history of the Act has not always been filled with universal enthusiastic support; and

WHEREAS, an example of this problem is when Congress, only three month after the Act was passed, enacted the Employee Retirement Income Security Act of 1974, which is better known as ERISA; and

WHEREAS, with the enactment of ERISA, mandatory employee health care coverage in Hawaii soon found itself on a collision course with federal law; and

WHEREAS, in 1977, Standard Oil Company of California, a self-insured employer with workers in Hawaii, filed suit in federal court, essentially questioning whether self-insured employers were subject to state regulation of employee benefits; and

WHEREAS, the court found in favor of Standard Oil and held that ERISA preempted the Hawaii Act; and

WHEREAS, Hawaii sought and successfully obtained a waiver that exempted the Act from the ERISA preemption when in 1983, President Ronald Reagan signed a bill into law that contained the waiver language; and

WHEREAS, although the waiver exempted the Act from ERISA, it also specifically prohibited the exemption of any changes to the Act after September 2, 1974, other than those that might improve "effective administration" of the Act, which essentially has "frozen" the Act in the form it was passed in 1974; and

WHEREAS, it is this "frozen" state of the Act that has generated certain problems and controversy, where some argue that the waiver language does not allow the Act to evolve with the times; and

WHEREAS, the Mandated Benefits Advisory Task Force (Task Force), which was convened in accordance with H.C.R. NO. 129, H.D.1, S.D.1, C.D.1, which was adopted by the Twenty-First Legislature of the State of Hawaii, Regular Session of 2001, has heard in its public meetings that the problems associated with the Act and its "frozen" nature merit an in-depth examination and review; and

WHEREAS, some of the specific issues raised in the Task Force's deliberations regarding the Act were the fact that the employee contribution to pay for the health care coverage premiums is fixed at 1.5 percent of wages; the prevalent plan requirement; and the process that involves the Prepaid Health Care Advisory Council; now, therefore,

BE IT RESOLVED by the Senate of the Twenty-first Legislature of the State of Hawaii, Regular Session of 2002, the House of Representatives concurring, that the Insurance Commissioner is requested to convene a task force to review and

examine the effectiveness of Hawaii's Prepaid Health Care Act; and

BE IT FURTHER RESOLVED that the task force shall have a total membership not to exceed thirteen members and that the Insurance Commissioner shall be a member and serve as chair of the task force and appoint its remaining members; and

BE IT FURTHER RESOLVED that at least one representative from each of the following shall be appointed as a member; provided that members of other groups may also be appointed:

(1) The Department of Labor and Industrial Relations;

(2) A mutual benefit society that provides health insurance under chapter 432, Hawaii Revised Statutes;

(3) A health maintenance organization that holds a certificate of authority under chapter 432D, Hawaii Revised Statutes;

(4) A business organization that represents small businesses with twenty or less employees;

(5) A business organization that represents larger businesses with more than twenty employees;

(6) A labor union that represents public sector employees;

(7) A labor union that represents private sector employees;

(8) A consumer health advocacy organization;

(9) An organization that represents licensed physicians; and

(10) An organization that represents alternate complementary care service providers;

and

BE IT FURTHER RESOLVED that the task force also examine the feasibility of:

(1) Amending the Act and the possible effects that could have on Hawaii's ERISA exemption;

(2) Identifying or developing a process to ensure that any amendment to the Act does not jeopardize Hawaii's ERISA exemption (e.g. having a federal agency review any proposed amendment and certifying that it will not result in Hawaii losing its ERISA exemption); or

(3) Repealing the Act and alternatives for its replacement;

and

BE IT FURTHER RESOLVED that the task force submit a report of its findings and recommendations to the Legislature no later than twenty days prior to the convening of the Regular Session of 2003; and

BE IT FURTHER RESOLVED that certified copies of this Concurrent Resolution be transmitted to the Director of Labor and Industrial Relations and the Insurance Commissioner.

OFFERED BY:_____

Draft Language for Inclusion in a Committee Report for a Proposed Concurrent Resolution Requesting the Establishment of a Task Force to Examine the Prepaid Health Care Act

The purpose of this concurrent resolution is to establish a task force to examine the effectiveness of the Prepaid Health Care Act (Act) and to consider the feasibility of amending or repealing the Act. The task force would also examine the feasibility of:

1. Amending the Act and the possible effects that could have on Hawaii's exemption to the federal Employee Retirement Income Security Act of 1974 (ERISA);

2. Identifying or developing a process to ensure that any amendment to the act does not jeopardize Hawaii's ERISA exemption (e.g. having a federal agency review any proposed amendment and certifying that it will not result in Hawaii losing its ERISA exemption); and

3. Repealing the Act and alternatives for its replacement.

This concurrent resolution is based on the draft submitted and recommended by the Mandated Benefits Advisory Task Force (Task Force), which was established in accordance with H.C.R. NO. 129, H.D.1, S.D.1, C.D.1 (H.C.R. 129), which was adopted by the Twenty-First Legislature of the State of Hawaii, Regular Session of 2001.

The Task Force was charged with advising the 2002 Legislature on the problems surrounding Hawaii's mandated benefits and the legislative process enacting them. H.C.R. 129 limited the Task Force's scope of responsibility to reviewing the process of mandating specific individual health care benefits, such as those that have been enacted periodically by the Legislature since 1987. However, notwithstanding this, the Task Force believed that the problems associated with the Act merit an in-depth examination and review.

In 1967-68, legislation was passed to fund a study on prepaid employee health insurance. Stefan A. Riesenfeld, a law professor at the University of California at Berkeley was commissioned to conduct the study. In January 1971, Professor Riesenfeld submitted his report, *Prepaid Health Care in Hawaii*, to the Legislature.

Professor Riesenfeld's report discussed a full spectrum of options, from taking no action to "a total remodeling of the existing arrangements for the delivery and financing of medical care." However, it recommended "extension of the existing system of prepayment plan coverage to additional categories of employees on a contributory basis, with or without a premium supplementation scheme."

Professor Riesenfeld also recommended "basic principles" for mandatory prepaid employee coverage:

1. Every regular employee in private employment shall be protected by a prepaid plan providing for hospital, surgical, and medical benefits;

2. The level of benefits should conform with the prevailing community standards;

3. Unless a collective bargaining agreement or self-initiated employer's policy provides for an allocation of the costs more beneficial to the employee, the costs shall be shared equally by the employer and the employee;

4. The prescribed coverage may be provided with any of the existing prepayment plan operators, regardless of whether they provide services, such as Kaiser or other medical groups plans or reimbursement, either on a nonprofit principle, such as HMSA or similar organizations, or on the profit principle, as the commercial carriers;

5. The scheme does not intend to interfere with the collective bargaining process or interfere with the services provided pursuant to such collective agreements, as in the sugar industry;

6. The free choice of physician by the employee shall be protected; and

7. In order to avoid an oppressive burden on low-wage earners and their employers, the mandatory scheme should be coupled with a plan for premium supplementation from general revenues.