STATE OF CALIFORNIA

DEPARTMENT OF INSURANCE

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JUNE 22, 2012 ESSENTIAL HEALTH BENEFITS

PUBLIC HEARING

SACRAMENTO, CALIFORNIA

FRIDAY, JUNE 22, 2012

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TRANSCRIPT OF PROCEEDINGS, taken at 722 Capitol Mall, Auditorium, Sacramento, California, commencing at a.m., Friday, June 22, 2012, before Wendy Harrity, CSR No. 11494.

A P P E A R A N C E S

DAVE JONES, INSURANCE COMMISSIONER

BRUCE HINZE, DEPARTMENT OF INSURANCE

KIM MORIMOTO, HEALTH POLICY, APPROVAL BUREAU

CARL WITMARSH, HEALTH ACTUARIAL OFFICE

CHINO, HEALTH ACTUARIAL OFFICE

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P R O C E E D I N G S

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MR. JONES: My name is Dave Jones. I am the California Insurance Commissioner. I want to welcome everyone here to the Department of Insurance's hearing on essential health benefits.

Today we will be discussing the options available to the State, as California chooses its benchmark for essential health benefits. I have three purposes in holding this public hearing.

First is to provide information to stakeholders in California's healthcare system, as well as the broader public with regard to the options that are available to the State of California that makes this critical decision.

Second, to attain public input. I will have an opportunity to open the floor to testimony from healthcare, stakeholders, as well as advocacy groups and the general public to provide testimony about the decision that California has to make.

And third, in convening this public hearing in order to better inform me, as the California Insurance Commissioner, as I advise the Governor and legislature as they make the ultimate decision as to which of the ten healthcare health insurance products from which California will select, which will intend and serve as California's essential health benefits benchmark.

So I am looking forward to both information that we'll be hearing from the Department, as well as the testimony from stakeholders, and members of the public.

We are videotaping this, and we will make a copy of the videotape available on our website and also a broadly disseminated public notice about this hearing, and so we are eager to hear from as wide of a range of views as possible about this.

First, there has been a great deal attention paid to the Affordable Care Act, especially right now as we continue here in California to implement the reforms in the Federal law and we await the ruling by the United States Supreme Court.

The Affordable Care Act is one of the most significant Federal laws to pass in the last 50 years. Millions of Americans have already experienced benefits from the Act and millions of Californians have

experienced benefits from the Act, even as it is being implemented.

For example, the requirement that health insurers and healthcare plans put a larger percentage of the premium dollars they collect from us into actual healthcare, the so-called medical loss ratio requirement that 80 or 85 percent of premium dollars be spent on healthcare is already in effect and is already providing benefits to Californians.

In fact, even as I speak, the Department of Insurance is auditing health insurers to make sure they are meeting requirements of the Act and State law in this regard.

The Affordable Care Act also lifted lifetime and annual caps that existed in healthcare and health insurance policies that is provided in immediate benefit to literally millions of Californians who would have run up against those caps.

In addition, hundreds of thousands of young people have benefited in California from the requirement health insures and healthcare plans allow people to keep their dependants on their health insurance or healthcare plan policy until age 26.

We also derived immediate benefit from prohibition on discrimination against children who have

preexisting conditions. And as a result of the corporal care of preventative healthcare without copayment starting August 1st. That particular provision will include access to contraception.

So this is just a short list of the immediate benefit of Californians and all Americans enjoying from the Affordable Care Act.

As many of you know, non-grandfathered plans in the individual small group health market, both inside and outside the California health benefits change will all need to cover what is called the essential health benefits benchmark starting at 2014.

This will ensure someone has health insurance coverage, they have comprehensive health insurance coverage that provides coverage for service at least ten significant federally defined benefit categories.

This morning, the Department of Insurance staff will be walking us through information about the following issues: `

First, what essential health benefits are, information Federal Government insurance carriers have provided.

Second, the product which California may choose when selecting essential health benefits benchmark plan.

Third, a benefit and limitation where they

exist in those ten products from which we can choose.

Fourth, some information about the relative value associated with each of these ten plans.

California must take the selection from ten health insurance products. They must choose among them as to which concerns are essential health benefits benchmark for with 2014 and 2015. We have to the make that decision by the third quarter of this year.

Legislation has been introduced and authored by the Chairs of the Assembly and the Senate Health Care Committee respectively that serve as the vehicle for California selection.

So this decision is imminent. It is one we need to make soon, and it needs to introduce opportunities to gather more public input and stakeholder input.

My office received a number of requests for information about the ten health insurance and healthcare plan products from which California will choose its benchmark.

In conjunction with the hearing, we are posting documents on our website that provide information to public stakeholders about the products which California will choose, a summary of the significant benefits in the products, and as well as which plans cover them,

which plans have limits on coverage, and which exclude coverage for a particular benefit.

That will assist stakeholders and the public in having better understanding -- as much as we hoped this hearing will help stakeholders have better understanding -- of the content and limitation associated with each of the ten plans for which you will ultimately choose. We will be reviewing that information today.

We are joined by Bruce Hinze, Assistant Chief Counsel of the Departments Health Policy Approval Bureau and Kim Morimoto, the senior staff counsel for the Department of Insurance. They will walk us through this information in a moment.

Next we will hear from Karl Witmarsh, senior health actuary, from the department health actuarial office, and Carol Chio who is another actuary for the Department, about the relative values of the covered service provided by each of the products the State has before it based on an analysis that was performed by the Milliman Firm, which has also been made publically now.

Then we will take testimony from stakeholders and the public to hear from you as to your concerns, your suggestions, your ideas, and your input, as I consider what recommendation to make to the legislature

and the Governor.

I want to say at the offset, I approach this without any preconception or prejudgement as to which of the ten products which we must select will be most appropriate for California.

I do that because I want to hear from you first. I am interested in hearing from the medical provider community, the insurance company, planned community, the advocacy community, all of those -- and the general public -- all of those that have a stake in this decision, before I make recommendation to the legislation and Governor, which of the ten products will best serve California. So I am most eager to get your input. I am most eager to hear your testimony.

With that, I believe what we will do is turn the floor over to Mr. Hinze next who will provide us with an overview with regard to the essential health benefits, additional information about the option before the State of California.

Mr. HINZE.

MR. HINZE: Thank you very much.

Good morning. This morning I would like to provide you with an overview of the framework Federal Government has provided both statutory and through its regulatory process, which at this point has been by the

way of bulletins, which I have information provided and questions. And then proceed with respect to details especially the implementation of the Federal requirements.

The Affordable Care Act Section 1302 requires the Federal Department of Health and Human Services define essential health benefits. The statutory requirements were that the Department of Health and Human Services would have to set requirements so that the essential health benefits would cover ten specified categories of items and services. We have to be equal to benefits covered under a typical employer plan.

I would have to consider balance discrimination under healthcare needs of diverse centers of the population.

Next, I would like to discuss the statutory scope of the essential health benefits requirement, benefit required a certain type of plan, non-grandfathered health insurance plans, HMO, and the individual and small group market, and, of those two market segments is applied inside and outside the California health benefits exchange. Parenthetically, I would like to mention essential health benefits also applies the Medicaid benchmark and the equivalent of programs, but I ask you to set that mention of benchmark

aside. It has nothing to do with the benchmark we will be discussing.

The next I will discuss is the statutory framework for the ten categories of required items and services. I would like to read them. It is worth while hearing them.

First one is ambulatory patient services. I will mention the scope of that in a minute.

Emergency services, hospitalization, maternity, and new born care, mental health, and substance abuse disorder services. Including behavioral healthcare treatment, prescription drugs, rehabilitative and habilitative services and devices, laboratory services, preventative and wellness services, and chronic disease management, and pediatric services including oral and vision care.

Now the next line. There are categories with subcategories within a group of ten are not specified or defined by the Federal Government. That is a part from what the benchmark setting will establish.

Now, it turns out the structure of Federal guidance beyond the statute on the next slide, there is no formal Federal rule yet. We have been provided information from the Department of Human Services that rules will be forthcoming, but there is no specified

time.

We had two major written documents. One is a bulletin from the December 16th, 2001 -- 2011, thank you, that provides that each State shall choose a benchmark plan.

If a State does not choose, there is a default to the largest plan by enrollment in the larger product in that State's small group market.

Then the Federal Government issued a set of frequently asked questions on February 12th of this year. A rule is coming; but as of now, these two documents comprise the sum and substance of the formal written guidance provided to us.

As I go through the further discussion and mention some of the areas in which the Federal language, at this point, is not fully certain.

Before we move on, though, I would like the next line to mention a Federal terminological difference which differs somewhat from how some of us referred to insurance and managed care products in California in the past.

The Federal Bulletin continuing toward a Federal terminology used other circumstances in the Federal Government distinguishing between products, which is a larger umbrella term that describes services

covered as a package by various cost sharing and rider options. So product is the umbrella; the plan is subsidiary to product.

And there can be a number of plans with specified benefits and cost sharing provision within the larger scope of a product. It is something to keep in mind as we go forward today. Also, as you read the various Federal guidance that has been provided to us, you are going to know what they are talking about. Product is synonymous with plan; plan is a more granular level.

Now, the next line we have is the discussion of what is involved in selecting a benchmark plan.

Each State's essential health benefits benchmark plan must be chosen by the State or by default. As I mentioned, the default is the largest small group plan.

If there are -- if the benchmark plan chosen misses coverage of one of ten statutory categories that I mentioned, that has to be filled in, and I will describe that supplemental process in a few moment.

The benchmark plan will include coverage for State mandate enacted before December 31st, 2011, where applicable. As we will discuss in just a moment, there can be benchmark plans chosen by the State if they

choose to do so, that self-funded plans as much as a CalPERS plan, which may not be subject to certain restrictions.

Also, the State essential health benefits plan must comply with the Federal mental health parity and Addiction Equity Act of 2008, which include the treatment of substance abuse.

The next slide, an important thing to keep in mind, is that essential health benefits determine at least as far as the Federal Government articulated to date, may not include coverage provided by a rider to the benchmark policy.

I have a language here from frequently asked questions No. 6, for the purposes of identifying the benchmark plan we, the Federal Government, identify the plan as the benefits covered by the product excluding all riders.

Various insurance products and managed care products are structured differently and some provide some benefits of group riders that are frequently associated with the base product, but this information from the Federal Government makes it imperative that when evaluating the plan, the selected benchmark plan, that you want to be very careful to distinguish between coverage provided by the poor plan and coverage provided

by the rider.

Also the Affordable Care Act provided the State must defray the cost of any mandates that are not keeping within the benchmark plan.

If you read historical digression, there was implication from many people that the Federal Government would define essential health benefits nationally after the Affordable Care Act was enacted. The Federal Government and many of these in the country of health hearings, as a result of the hearings, they adopted instead of a national -- of what constitutes essential health benefits each State gets to choose a benchmark plan. In so doing, it decreases the likelihood the benchmark plan would not encompass the State mandates.

So this portion, the last bullet on the slide, is less of an issue that it might have been, but it is still significant. As I mentioned, not all of the candidate plans necessarily are required to have the State mandates.

Now, the State benchmark will define benefits but not co-pays. The benchmark plan selected set the minimum benefits and limits on the benefits for the 2014, 2015-year. This initial setting of the benchmark is only for those years because the benchmark can be reset by a method by the State.

Now, one benchmark plan will define the benefits for both the individual and small group market, only one selection. The plan does not set co-pays. That is a call that the cost sharing co-pays and deductibles will determine the actuarial guide or level, which are the so-called metal levels -- bronze, silver, gold, and platinum -- that the Affordable Care Act described will be provided for the individual small group plan.

Now, the next slide, what they needed in the State's essential health benefits benchmark, the frequently asked questions document from Federal HSS issued on February 17th had in response to Question 17 a description of what the State's essential health benefits plan would include.

The benefits included are the benefits offered in the benchmark plan. That is from the Federal FAQ. And it informed the viewer that in the text of the benchmark plan selected is what describes and defined the benchmark. It's not the regulatory number of that particular plan existing the text of the plan that is crucial.

As I mentioned, the audio technical plan, any supplemental benefits required to ensure coverage within all ten of the Federal statutory categories, must also

be included. Then any adjustments to recovery or applicable State mandate enacted before December of last year.

Now, the next slide I would like to discuss was the supplementation process that is involved. Remember, there are ten required categories of items and services required by the Affordable Care Act. If the benchmark plan selected does not cover one the ten categories, then the State must supplement the chosen benchmark plan by reference to another one of the candidate benchmark plans that covers the missing category.

By way of an example, that is an example based on use of the default plan, small group plan of the state. If that small group plan, say fails to offer laboratory services, just to pick one, then the state would look to, in this case the default. Federal Government would look to the second largest small group plan. And it if has a missing coverage, would pluck that out and put that as part of the benchmark.

And the third largest, again looking for that piece of missing coverage. And then failing that, the largest Federal health benefits program plan and to look, again, for that missing item of coverage from the Federal plan.

As mentioned, there is a third type of timeline

for selection of the benchmark plan. The plan selection has to be based on enrollment data from the first quarter of 2012. And the Federal destial (ph) has provided that in January and also is in the process of providing data this month to assist with that selection.

And the State must select, by the end of the third quarter of 2012, a benchmark plan. The benchmark has to be chosen this fall. The plan selected will define essential health benefits for 2014 and 2015. Thereafter, the State can define essential health benefits benchmark plans on an annual basis.

Now, the next line discusses the benchmark plan options that categories of plans that may be considered.

First, drawing on the State's small group market, the largest small group plans by enrollment from any of the three largest small group products.

Remember the description in between products and plan, you get three largest small group products, three umbrellas, then within those umbrellas, under those umbrellas, the State selected the benchmark both the largest small group plan within the cluster of three products.

The second choice the State can make to select from any of the top three State employee health benefit plan by enrollment or any of the three largest national

Federal employee health benefits program plan options by enrollment, or the largest commercial non Medicaid health maintenance organization in the State.

Now, the Department of Health and Human Services, in providing this information to the nation, provided for special consideration in terms of implementing and choosing a health benefits benchmark for some categories of services, it recognizes need for special supplemental approach for habilitative services, pediatric dental services, and pediatric services.

And the next slide regarding the habilitative services. Habilitative recognized that there is a definitional difference between the habilitative services, including concepts of maintaining function or creating and restoring function and the FAQ recognized in the Federal Government, there are varying definitions of habilitative services.

Then there is rehabilitative services, which are involved in restoring skill and function. And for many people, this is a type of therapy that often first comes to mind when thinking of these historical approaches.

For habilitative services, Question 5 of the frequently asked questions suggested that the Federal Government was contemplating a transitional approach and

I have the language on the slide here. And the language from the frequently asked question states that, we, the Federal Government, are considering proposing the following.

This reflects the fact that these are documents are subject to change and these plans of the Federal Government are subject to changes between now and the time that a rule is promulgated.

The transitional approach is twofold for habilitative services currently contemplated by the Federal HHS. One would be that the benchmark plan provide lab services could be required to offer the same services at parity for habilitative and rehabilitative needs.

The other option would be to decide what habilitative services to covers, and HHS would report to the Department of Health Human Services. After a period of information, HHS would evaluate what constituted habilitative services and provide further guidance.

Similarly, the next slide describes pediatric oral care. The Federal Government recognizes it is part of the process that it went through to develop the approach to selecting the benchmark, essential health benefits plans, that many plans would be candidates might not provide pediatric oral care.

Again, here, frequently asked Question 5, again the Federal Government, we are considering proposing the most definitive information we have from the Federal Government. At this point, that for pediatric oral care, if the select benchmark plan did not provide us the required benefit, could be provided by supplementing the benefits by the Federal employees dental and vision insurance plan, dental plan, with the highest national enrollment or the State's children health insurance program, SCHIPS, healthy families.

Similarly with regard to pediatric vision care, same frequently asked question with the same caveat, it is an approach the Federal Government was considering proposing. Considered proposing that the benchmark plan could be supplemented with the benefit from the vision plan of the Federal employee dental and vision insurance plan with the highest national enrollment.

Now, on our website there are, as mentioned, a benefit comparison chart and an explanation of coverage for the plans discussed on the benefit chart. If you can show the chart, we are not going to ask anyone to read this with one eye closed.

A similarly dense and small chart available at the front desk, again, we are not going to read it together. This is somewhat by way to wet your appetite

so that you can look at it on our website. There is a lot of information here and present this chart to you at this moment to emphasize that there are a lot of factors involved, a lot of different kinds of coverage for each of the canidate plans California has an opportunity to look at. And so to emphasize the selection is complex and difficult and requires thought, and is the reason we are here today to get information from you as to what factors should be considered in developing recommendations. The chart available on the website, this chart, is preliminary based on our evaluation to date as available to us. It may change as our understanding of information, as we progress through the process together.

I do have a couple of illustrations of these differences that I would like to discuss with you. And I would like to go over that at this time.

The first benchmark illustration is comparing by way of selecting group plans and, at this moment, solutions 2500 PPO plans and HMO group HMO 30 plans.

You will notice that many things are simply covered; and as you go through the very dense chart that has been prepared, the coverage is very similar through much of the coverage categories required and provided. It is like the human gene. We all share much of the

same DNA but the subtle difference makes the difference between us.

Here, for example, are primary care visits, specialist visits, and acupuncture are relatively similarly covered in both plans.

The chiropractic services are different. The Anthem small group 2500 PPO plan, chiropractic services are covered with a limit. In the Kaiser HMO small group plan, they are not to covered, although they are available for purchase as a rider.

Keep in mind, however, the Federal information that we have been provided, that selection of the benchmark plan has a general rule, riders don't count.

On the next slide, this is continuing with comparison of the same two plans, again showing that broadly many of the same categories are covered.

With all that I mentioned, that ambulatory services is that the scope of that is not designed by the Federal Government. We are looking to the benchmark plans to see what services are provided on consistent the basis.

Here, the State dental procedures and outpatient surgery services, for general care services are covered by the two.

On the next slide, there are differences with

regard to assistive reproductive technology.

The middle column, the Anthem plan covered with limits. The Kaiser HMO plan does not cover it. Similarly for non assisted reproductive technology infertility is the same coverage, just the Anthem coverage on this plan, does not.

Moving to a different benchmark illustration. The second one compares the same Anthem plan small group solution 2500 PPO with PERS Choice, PERS from CalPERS.

The Anthem plan covers treatments for substance abuse and alcoholism treatment. Treatment for severe mental illness and serious emotional disturbance and abuse for a child.

Coverage required by insurance 1014.5 covered by both. Although, PERS Choice is not an insurance product.

The next slide, the same comparison regarding substance abuse. Covered in both, although with limits on the Anthem plan. And it is alcoholism abuse. I know I said double coverage.

Let's go to the one you are looking at, which deals with treatment for mental illnesses other than severe emotional illness for serious emotional disturbance as a child.

The Anthem small group product covered it with

limits. The PERS Choice does not specify coverage for those conditions outside the scope of the insurance code 101.075.

In terms of the difference in behavioral health treatment and ADA parity for appropriated disability disorder of autism, let me mention first as I earlier discussed of the slide, that from the insurance perspective, private behavior analysis therapy has been a negative benefit of 1010.5 and was inducted by 946, which requires treatment and provides coverage including behavior analysis therapy treatment for all products as of July 1st. With that, that would carry over because of SB 946 was enacted before December 1st -- excuse me -- December 31st of last year. But that is our understanding of the current Federal requirements. Should those requirements change, the difference in coverage, in particular, the Anthem small group product, that does provide coverage for the behavioral health, treatment is not covered in PERS Choice, PERS products. That is a consideration to have in mind moving forward.

Also, on the next slide on that note, that none of the Kaiser HMO plans has covered any therapy without limiting coverage to a wide group of professionals within the scope of their license.

Again, the effectiveness of SB 946 addresses

the issue, but it is a technical issue present in the document itself.

Now, at this point, I would like to provide an opportunity for actuaries to provide additional information. And that additional information will be provided by Carl Witmarsh, the president of Kaiser of Los Angles, to speak with us.

Take a brief moment while Ed comes to see if the microphone is working.

Thank you, Bruce.

Have you heard anything we said? Can you hear us in the back? Can you hear us? Speak up, please. Can you hear us? Speak into the microphone. I hate to make Bruce do that again.

MR. WITMARSH: Okay. Thank you, Bruce.

Can we have the slide of all of the numbers on it? Thank you.

As Bruce said, this is not an eye test. I will try to explain the numbers best I can from this chart. This chart as mentioned is available at the website of the benefits exchange.

And with that, first of all, I would like to mention that as Bruce has pointed out, there's distinction between products and plans. That distinction, which address essential health benefits, is

that a plan involved cost share. How the total cost of a benefit is shared between the insured individual and the plan itself.

Now, this chart -- all benefits charts have to do with product costs. In other words, they do not involve cost share. These numbers refer to the total aggregate cost of the benefits. That being said, as Bruce said, we pretty much have the same DNA. About 95 percent of the cost of benchmark plans is for the same set of covered services. And those are in the ten categories.

These services that we see listed here, we have a few of them. We have, for example, acupuncture, assisted reproductive technology, chiropractic, et cetera. These are services not covered in the ten categories, and that would be the focus of our conversation here.

Now, if you can read this, you could see that the total overall, these I call supplemental coverages, among these ten plans actually falls within a fairly narrow range. And the extra cost ranges from less than two percent for the CalPERS Choice Plan to a little over four percent for the small group PPO, under the Department of Insurance. So a spread of about two percent. Although, that is a significant spread, I

think it shows the need for us or the State, as we make the decision about which of ten plans, ought to be chosen that cost is not the only issue. It is also a consideration, as Bruce has shown.

Now, let me tell you also about subject numbers. I apologize, I seem to be losing my voice. The numbers in the chart refer to these incremental numbers over the minimum requirement. I will give you an example here. You can go about seven lines down, you will see home health. And minimum requirement here is covered for two hours per day, 25 days per year.

What that means is that every single one of these candidate benchmark plans offers at least that amount of coverage for home health. And if it offers only that amount, it appears in the chart as zero.

And as a matter of fact, if you look at the second and third column under the Federal plan, you will note those are zero. We have a positive value. That means they are requiring more than minimum coverage.

So I would like to also just point out, as Bruce said, if you look at the two plans he was comparing, that would be the purple section there under the small group towards the right, you will see the Anthem Small Group PPO and the Kaiser, first and second column. Thank you. First and second column, go over to

the right more. There you go. Excellent. Thank you.

Now you can actually read it. You will see that.

MR. HINZE: I can read it. Everybody at the table can read it.

MR. WITMARSH: For the infertility services, about the seventh row down in purple, that represents about 0.13 percent of premium for Anthem. Is it not covered at all under Kaiser, and it's at zero.

What this means is when we add up all the numbers, although some plans would come out as appearing relatively rich, remember that it has to do with the way the services are distributing. There may be some benchmarks more comprehensive, which are actually a little less expensive than the benchmark that are not as provided.

And I think that should pretty much do it.

Back to Bruce.

MR. HINZE: Thank you.

At this point, we would like to hear from you. We would like to hear from people, members of the public. Our goal is to identify issues and concerns that should be considered in the developing the recommendation for regarding essential health benefits. I mentioned that we Federal Government has provided some

guidance of this preliminary and no one knows all the answers. We want to hear from you, what your issues and concerns are. Whereas we may not be able to provide answers, we are very eager to hear from you and learn from you.

So at this time, we will pass.

MR. JONES: We have a rostrum and a microphone. I think what I would like to propose we do is read initially and depends on the volume of folks that wish to be heard, limit the testimony to about five minutes each. If it turns out only two people want to testify, then we will listen to them longer, which may encourage others to want to come forward.

In any event, we are interested, as Bruce said, in trying to hear from the widest array of people here. I recognize a number of you here are representing medical providers, patient advocates. Representing those who have a particular illnesses or disease. Some of you represent health insurance companies or healthcare plans. Others are broader consumer representatives. We have a great cross-section of stakeholders, as well as members of the general public.

So what would help me would be to hear from you as to what you think we, as the insurance -- but other decision makers are considering as this decision is

made.

As stated a moment ago, earlier the decision to be made appears to be through a legislative vehicle, two of which have been introduced, one in each house by the Chairs respectively and the assembly health community.

Ultimately, the decision will be made a piece of legislation the Governor will sign. So what I plan to do is provide a recommendation to both the Governor and the Members based on my review of the ten products and plans from which to choose; but before doing so, I wanted to hear from you. That is what the purpose of this is.

And with that, I think what we will do is folks signed up. All right. Keep it to five minutes or so initially, play it by ear.

By show of hands, to give a sense of the testimony, how many folks would like to testify? Okay. Good.

We will probably have five minutes. Won't be entirely in the back. There are folks, we have time this morning. That's the whole plan of this. If you can identify yourself, if you are representing an organization or entity, in some way identify that organization entity, as well. Then we want to hear from you.

MR. HINZE: So, Commissioner, for a moment, I suggested those waiting in line take a seat in the front row, it might be a little more comfortable.

MR. JONES: That is fine. People are accustom to waiting a long time. If you wanted, that is great or if you want to lean against the wall, fine, which is the norm, we are okay with that, too. Very kind. A courtesy not extended on the other side. Whatever folks would you like to do.

THE WITNESS: Good morning. Shannon Smith-Crowely. I am representing the American Congress of Obstetricians and Gynecology in California and the American Society of Reproductions Medicine.

Our organizations works with a number of other organizations in coalition, particularly looking at issues related to reproductive health. Not surprising looking at the issues, the healthcare that we deliver.

We have not done our final analysis, but in terms or our thought process on some of looking at these Bills, the plans, there is a lot of process of elimination where we can cut some just off the top.

The Federal plan will not cover abortion. Those are out. There is a lot of things when we added mandates through the years, there is a lot of times when CalPERS has been exempted for cost. So that's out.

And there is an issue with which the Commissioner and staff are very familiar with, which we had to deal with five Bills over a seven year period. Where because the insurance code was -- when you look at insurance products and the insurance code was developed differently from the HMO Act, and it never initially drafted it, didn't put out what basic benefits were. Unlike the Knox-Keene Act, Blue Cross decided maternity was not a basic benefit and started selling health plans without maternity and it took seven years to get that basic benefit put back into the plan.

In the process of elimination right now, we are leaning toward the Kaiser small group HMO product. While we are disappointed it doesn't have any coverage for the fertility reproductive technology services, we will look at that from an actuarial perspective, it will save you in the long run. What happens with a lot of people doing IVF, for instance, if they mortgaged their home to do IVF, and they have a choice between one embryo and two, they are going to do two. IVF pregnancies have a great tendency of twinning. Conceivably -- no pun intended -- you could have implant four embryos.

MR. JONES: You never used that before, right?

THE WITNESS: You could implant two embryos and

have four babies and have a very high chance of increased premature birth resulting. Saving one severely preterm birth and ICU cost could pay for a of IVF. We haven't figured out how to put this into otherwise acceptability.

MR. JONES: Follow-up question. I appreciate testimony about the struggle to make sure that the insurance product that you identified, the Blue Cross product. As of December 31st, it did include those services, did it not?

HE WITNESS: Yes, sir, which?

MR. JONES: You mentioned, your testimony said Blue Cross did not include originally certain benefits, then you fought for seven years to get it in. As of the operative date for purposes of looking at the contents of the products and plans for purposes of selecting essential health benefits, are the benefits in that regard you were concerned about in that plan and product?

THE WITNESS: Yes. I am sorry. I was using that as an illustration of the kind of things that might get left and fall through the cracks. We were able to get maternity. Maternity is now implemented, but there may be other areas like that that we have not discovered yet.

MR. JONES: Okay. If you do, I would like to know. I think the ones we are aware of are the elements left out of the Kaiser small group HMO that we described here, but if there are others in any of the other plans left out, putting aside the ones you already knocked out, please let us know.

Thank you.

THE WITNESS: Good morning. Dr. Catherine Donohue from California Chiropractic Association.

We are here because the benchmark listed chiropractic benefit is included in seven of them. We believe that it is important that benchmark California needed includes chiropractic benefits. We have numerous studies that show we are cost saving to the system, that we get patients better faster with higher patient satisfaction rate.

We are a profession that has always been worried about preventive care. It is not being included is a huge problems for the occupation of the public access.

That is pretty much all I have to say.

MR. JONES: Great. Have you had -- or the chiropractors had a chance to look through each of the ten -- we identified that is not included in the --

THE WITNESS: We are not included in the Kaiser

plans.

MR. JONES: Pardon me?

THE WITNESS: We are only not included in the Kaiser plan.

MR. JONES: In all of the rest except for the Kaiser HMO small group?

THE WITNESS: Yes. Well, any of the three Kaiser plans.

MR. JONES: Any of the three Kaiser, you are not in any of the three Kaiser?

Great. Thank you very much.

THE WITNESS: Thank you.

THE WITNESS: Good morning, Commissioner Jones and colleagues at the Department of Insurance.

My name is Debra Kelch (ph) with the Kelch Policy Group. I am here today based on work we are doing in the Health Insurance Alignment Project, which is funded by the California Healthcare Foundation. I appreciate your masterful job at giving us the context. I think that's hard to do and I thought it was well done.

For me, as I was thinking about coming here today, I have EOCs open, and statute open, and all the charts, which I had blown up at Kinko's, so I could read them. I tried to think what, you know, in two to

five minutes, what could I offer here that would be helpful. I passed out my written testimony and I will shorten that.

Fundamentally, what I really came to late yesterday, actually, is that essential health benefits in the Federal law is basically a promise to consumers. The promise is every policy they look at, every contract they consider, will have the same services covered as a minimum regardless of type of health plan, HMO or PPO. In a great delivery system, contract and network of providers, fee for service, capitation, inside and outside of the exchange. This frees consumers to look at other aspect in their choice. They can look at what is my cost share. What is the delivery system or network that will work for me. Is my doctor, my pharmacist, my hospital included. What is additional benefits above the minimum am I willing to pay for.

In California, to get to this uniformity we have to do so using two very different statutory and regulatory framework under department managed healthcare and Department of Insurance. Our message here today is that given this unique California challenge we must all work together to make sure we can deliver on this promise.

Essential health benefits should meet the same

minimum services for every contractor policy whether it is overseen by DMHC or CDI. We have these charts. We have covered limits, some cost estimates. For those us of who may have made a poor decision to actually read all the coverage documents, what we know that it is much more complex than the list of benefits.

For example, health plans regulated by DMHC must provide many essential health benefits as basic healthcare services, which are further defined as medically necessary and detailed and regulation.

For a DMHC plan impatient hospital coverage must include, among other elements all medically necessary lab and X-ray services, medication, therapies, diagnostic services provided during the hospital stay regardless of the number of days subject to their cost share.

Outdated insurance code regulations consider hospital benefit based on whether it is a real economic value. Defined as an amount that is at least $30 per day for at least 60 days and a benefit for, quote, miscellaneous hospital services of at least five times that.

These are different approaches to hospital coverage and not even possible to do much of an apples and oranges kind of comparison.

If policy makers, for example, choose a CDI policy as the benchmark, unless basic healthcare services in the heath and safety is repealed, DMHC plans would still have to cover basic healthcare services as defined in that law.

CDI insureds would have to cover benefits in the benchmark but would not be subject to the definition of basic healthcare services.

So questions, would basic healthcare services under DMHC be a State mandate? Presumably because it has been in place since before 12-31 of '11, that is not a problem.

But there are many questions here for us to consider, both policymakers and regulators. Maybe the federal guidance coming will help us.

Conversely, if policy makers choose a DMHC benchmark plan such as Kaiser or small employer HMO plan in proposed impending legislation, there will be three elements to essential health benefits.

First, basic healthcare services as designed in Knox-Keene for Knox-Keene plans, Federal essential health benefits that are not basic healthcare services, such as prescription drugs and oral and vision care.

Then third, benefits that are in the benchmark but not either basic healthcare services or Federal

benefits but they are covered like acupuncture, for example. So an implementation, we still have the issue of definition. These are just a couple of examples. I convinced myself to do that, just a couple examples.

Basically, Affordable Care Act has given us an entirely new context, it has created a new expectation for how health insurance that would be marketed, priced and sold. This is an enormous opportunity to eliminate the differences and the complexity that is rooted in the past. To do this, we will need to consider, work through and revise, as needed, complex provisions of existing law; and in some cases, leave behind old terminology and inconsistent approaches.

Again, our message here today, while it may be complicated, we can simplify how we think about it if we focus on the goal and the promise to consumers that California will choose a benchmark and an implementation approach, so they will not have to worry about the minimum essential health benefits. Because regardless which product they choose, they will get coverage for the same minimum services.

We look forward to working collaboratively with all of you to continue our work on this to accomplish this goal. I would like to say in a non prepared -- sort of think about, we need to say, as policy makers,

regulators, and interested persons, we need to say to consumers, don't worry, we got this. Behind the scene we will take care of making sure however complex it is, these are the same. Then you do your analysis based on the other factors which matter to you. That is what the challenge is.

Those are my remarks today. Thank you for this opportunity.

MR. JONES: Thank you, Debra.

Just a question. Earlier in the presentation, one of the slides that Mr. Hinze and Bruce shared was that Federal Bulletin and the Federal frequently asked questions indicate that we are to look at the actual verbiage and each product and plan as opposed to the regulatory numbers that surrounds it.

You are asserting a slightly different view, I think, in these comments, which is that in evaluating the relative merits of products and plans, we need to consider the regulatory number that surrounds insurance products versus managed care products. What I am trying to figure out is, does that mean that you disagree with interpretation of Federal Bulletin of frequently asked questions that suggest that we need to look at the content of the plan themselves, product language.

THE WITNESS: Right.

MR. JONES: Policy form, if you will, versus looking at the surrounding regulations?

THE WITNESS: No.

MR. JONES: Okay.

THE WITNESS: It is the two things. The first is, once you pick a list, which is what the Federal Bulletin contemplates, then look on the contract, which is what the Federal Bulletin contemplates, regardless of that unless we repeal a whole bunch of existing law that, for example, using Knox-Keene basic healthcare services, the Knox-Keen will not just have to do that list of essential health benefits in whatever contract. They will still be legally obligated to cover basic healthcare services in all the meaning under their law.

MR. JONES: If that goes in --

THE WITNESS: Exactly my point.

MR. JONES: If those Knox-Keene requirements are in excess of the language, say the actual healthcare plan we might select --

THE WITNESS: Right.

MR. JONES: This could be an HMO product, which would normally be covered by Knox-Keene.

THE WITNESS: I know Knox-Keene would be less than basic healthcare services.

MR. JONES: I think the question is, what is in

the policy.

THE WITNESS: Right.

MR. JONES: Because the regulations you cite to, may or may not be expressly contemplated in the policy form.

THE WITNESS: Right.

MR. JONES: It may be certain services are identified and then under the current scheme, we look to the regulations to decide how, in fact, those are effectuated.

The point I am trying to make, at least one interpretation of Federal Bulletin and frequently asked questions, is that you got to just stick to what is in the policy form. Once you go to the regulations, even it has been our practice to use those to inform how we go about implementing the policy form, you end up, as a State, having to pick up the additional costs.

So I think, while it is helpful to remind us of differences in the codes, if, for example, the Kaiser Small Group Policy Form doesn't pick up explicitly all of the things you talked about or any other things in Knox-Keene, then the extent we continue to require that, the State of California is on the hook to pay for that. I don't know how we would do that.

THE WITNESS: I think what is the point we are

trying to make. It is one thing for a Knox-Keene plan to be dealing with a Knox-Keene contract. But it is even more problematic if the CDI plan, which has none of the underlying requirements and State law, is following to the letter of a contract that may or may not give the detail of all of the definitions of the Knox-Keene.

I will say, in addition, having read the EOCs small group Kaiser, small group Anthem, the list of what is covered for hospitalization is different. The list in the Knox-Keene plan provides their statutory regulatory definition.

So issue by issue, service by service, that is the situation we find ourself in. And also you need to be clear, are we in some way pulling away from the repealing basic healthcare services. What does that mean?

I am not suggesting that the Federal Bulletin is wrong. I am saying, beyond that, once we get the list and comply with the Federal Bulletin, there is still a body of State law we have to sit down and work through and deal with.

MR. JONES: Right. I think what I take away from this is that in addition to analyzing what coverage is in the plans, we need to do an analysis as to each of the ten -- how the actual language in the policy form is

consistent with or differs from what is in regulations and statute. Because if there are the differences and if we want to maintain those differences, if, for example, in the Knox-Keene Act and the regulation under Knox-Keene, there are things called for that are actually not spelled out explicitly in the Kaiser Small Group Policy Form.

THE WITNESS: Uh-huh.

MR. JONES: And to the extent we want to maintain those things, we have to pick up the cost. We need to do the cost analysis.

Let me continue.

THE WITNESS: Okay.

MR. JONES: Then I will be happy to hear a response.

What occurs to me then, we need to figure that out because making this choice and then if we think in making the choice to any of the products automatically sweep in the entirety of the law and the regulations associated with that product, it depends what is in the policy form; and if we want to continue to maintain those legal requirements, there may be a cost in the general fund associated with that. I think we need to know that. I don't know that analysis has been done. I am not aware that the legislature has done that analysis

and I am not aware if anyone else did the analysis.

THE WITNESS: I think it is true. I think the last thing I would say, hopefully, that is not to the case because basic healthcare services were mandated before December. It shouldn't be a problem, but if we were, for example, to say to the CDI plans, maybe, that we will add to that list, I think we have to figure it out at that point.

MR. JONES: I think what you are selling me, though. We have to drill down and look at what is actually in the policy.

THE WITNESS: And to conclude, with the same goal, right? We don't want the consumers to have to do that later.

MR. JONES: Thank you. Great.

THE WITNESS: Thank you.

MR. JONES: Thanks.

THE WITNESS: I am the ultimate stakeholder. I am a human being, consumer of health services in California. I am with Kaiser. I am happy with Kaiser, but I am not here to tell you Kaiser is great.

MR. JONES: Can you tell us your name?

THE WITNESS: Carl Yench.

MR. JONES: Thank you.

THE WITNESS: I am here to tell you that or to

say with the comment is that I wonder to what extent, what you are doing is being done from a human medical care need, rather than from the standpoint of what plans provide and what plans don't provide.

It seems to me like the departure point needs to be was accepted practice. Keeping people healthy and helping them to overcome medical problems.

Do you have the medical -- a physician -- is there physician on here today? Why isn't there a physician out there?

If you are going to talk about essential health benefits, you need to have a physician involved in that discussion. Or physicians involved in that discussion.

I don't know how many people here are stakeholders that are speaking from insurance perspectives or legal perspectives. I am afraid most of them are that sort, rather than speaking from what the human body needs. I would encourage you to make sure that you include in your discussions considerations what the human body needs.

I also would like to support what the previous speaker said, please keep it simple. I am beyond the age of becoming covered with Medicare, but I continue to work. I do so because I enjoy working. I think it is good for mental health; but apart from that, I think

that I looked at Medicare plans when I was considering, just exploring what that would mean if I were become -- if Medicare were to be my medical insurance source.

It is incomprehensible what the consumers, especially us decrepit consumers, are faced with when we are asked to make choices, even from Medicare. I used to think Medicare would be the best example of what universal healthcare system would be. If it is like that, if it is as complicated as that, then it is really not a good way to serve people.

I urge you, please, talk to -- consider this from the standpoint of human needs, medical needs. Include some physicians in your considerations. Keep it simple.

MR. JONES: Thank you. I appreciate your testimony. We did send a notice of this hearing to all of the physician associations in the State of California for precisely that purpose, specifically California Medical Association and every other specialty group. I appreciate your suggestion. We will continue to do that outreach.

Let me hear from the next speaker.

THE WITNESS: What were the --

MR. JONES: Sir, I apologize. I am happy to talk to you off line. I am hoping some of them are here

and they will testify.

Go ahead.

THE WITNESS: Good morning. My name is Catherine Williams. I am here with the American Civil Liberties Union, a member of the California Coalition for Reproduction Freedom.

If you feel you believe that inflecting among benchmark options listed in the HHS bulletin that California must decide the Federal Employee Health Benefits Program is unacceptable because it excludes coverage for virtually all abortion services. Congress banned abortion funding for public employees, soldiers, Peace Core volunteers, women in Federal prisons, and women in the District of Columbia.

These restrictions have been placed in the Annual Appropriation Acts, most recently the consolidated Act of 2012. Federal policy on abortion services conflicts with California long standing constitutional principal and health policy and will have a serious adverse affect on the health of California women.

One in three will need -- women will need or have had an abortion by the age of 45. We are talking about the health of a lot of California women and girls.

In California, the State may not weigh a

pregnant woman's choice between abortion and child birth by discriminatory funding of healthcare options. Our public policy codified in the Reproductive Privacy Act states every woman has the choice to bear a child or to choose to obtain an abortion.

Thus, California public and private insurance programs currently include abortion coverage. Despite restrictions, our Medi-Cal system had provided benefits to indigent pregnant women for both child birth and abortion for over 30 years.

California must ensure women do not lose coverage for services currently available.

Thank you.

MR. JONES: Thank you.

THE WITNESS: Hi. Karen Cecil, (ph), Autism Health Insurance Project.

I just want to say that autism is a condition that affects one in 88 children and becoming more and more prevalent. And the plans that you mentioned, my understanding is that the Federal plan, the speed plan, has a specific ABA exclusion. ABA is a treatment known to be effective in treating autism. It's one of the only treatments that is known to be effective, and it has a solid evidence base to support it.

So the Federal plan has a specific ABA

exclusion, and the CalPERS plan also has a specific ABA exclusion.

Now, that plan is also subject to the State Mental Health Parity Law. Whether or not that exclusion will hold up, is unknown at this time. But any of the State regulated plans on the table will include that mandate. So it is very important, in my mind, that that be included, that that be considered when you make your consideration.

MR. JONES: Thank you.

THE WITNESS: Thank you.

THE WITNESS: Good morning. How are you?

My name is Autumn Ogden Ogden. I am with California Coverage Health Initiative. We represent 24 member organizations and 19 outreach enrollment partners across California. I am here on behalf of the Children's Coverage Coalition. Comprised with Children's Defense Fund, Children Now, United Waive of California and PICO California.

We want to thank you for holding this hearing. We would like to first say it is important to recognize children's health care needs are considerably different than adults. Kids require a unique and tailored benefits package with broad and comprehensive benefits that will address all their health needs including

developmental screening, dental checkups, and behavioral health services.

The ACA emphasizes prevention and specifically identifies pediatric services including oral and vision care. As one of the ten broad categories of essential health benefits, we believe that the existing early periodic screening, diagnostic, and treatment framework in Medicaid is the gold standard to ensuring that children have access to medically necessary services they need. However, we acknowledge available Federal guidance does not explicitly allow for to be chosen as an essential health benefit benchmark. We are supportive of the efforts in current legislation AB 1453 and SB 951 to identify robust essential health benefit benchmark that built off the current Knox-Keene Act.

We think it is important to look closely at the benefits for kids to ensure they get -- make up comprehensive package. For example, kids should get eyeglasses, braces, hearing aids, if they need them.

Children should have coverage for full range of services and treatment that help prevent disease and improve quality of life including access to mental health services, as well as rehabilitative and habilitative services. We look forward to continuing to work closely with the legislature and the Department as

you move forward.

If you have any questions, you know where to reach me.

Thank you.

MR. JONES: Thank you.

THE WITNESS: Good morning, Commissioner and panelist. Thank you for the opportunity for the stakeholders input. I am Amy Bion (ph). I am vice-president of Public Affairs at California Family Health Counsel, CSHG Champions and promote quality and sexual reproductive healthcare for all. And it is with this mission that I stand here before you today to say that California has a long standing commitment in leadership in protecting and promoting access to comprehensive health services. We hope that this commitment is reflected in the benchmark plan that California selects. And we specifically want to ensure that all FDA approved contraceptive are covered in any benchmark plan. Counseling and family planning counseling, and education well woman exams, cancer screening and prenatal care are all covered. Also, to ensure all abortion services are covered as well.

We have put in an overall support position for the benchmark plan. That has been introduced by the legislature.

We do have a few areas of concerns. One is around the area of cost sharing.

One other area is around substitution of benefits. And also culture and linguistic confidence. We hope any benchmark plan selected would cover comprehensive reproductive health services without any burdensome of cost sharing that prohibits substitution of benefits that also has cultural and logistic confidence in mind.

Thank you very much.

MR. JONES: Thank you.

THE WITNESS: Good morning. I am Chris Weist (ph).

I am here on behalf coalition of woman's health groups who have been taking a look at what California is considering it wanted to register support for the process, support for the hearing today.

Specifically, I am here from the Jacob Institute for Women's Health, the National Research Center for Women and Family, and the National Women's Health Network.

We have more detailed comments we will be submitting to you. I want to take a moment today to point out the fact, while it is critically important the selection of benchmark claims in California takes into

account all of California families, women do experience a few unique health conditions we need to make sure there is coverage for.

One of the issues these groups have been looking at is certainly one of support. The comments of my colleagues spoken is full coverage for reproductive health services service. One of the issues they have been looking at is coverage for subsequent treatment relating to adverse health conditions or complications relating to device failure.

For example, many women who are breast cancer survivors receive breast implants as part of their reconstructive surgery treatment.

Many of the woman find out later, years later, if they have adverse health conditions or need subsequent treatment, not all of our insurance coverage is created equally. It is important that if looking at the coverage option, we make sure that women who are experiencing complications from devices, other related follow-up treatment, that they need, they are able to rely on California to have a benchmark plan that meets their needs, as well.

Again, we will be submitting more detailed comments to you for your record but wanted to get that on the radar screen, the issue in California. So we

look forward to working with you going forward.

MR. JONES: Thank you very much.

THE WITNESS: Commissioner, Mr. Jones, my name is David Peters. I am here on behalf of the California Association of Addiction Recovery Resources, CARR. We say CARR. Makes it nice and simple. Appreciate your attention to this process of holding this hearing today explaining things to us with a little more clarity than we have been able to dig out of this undertaking on our own.

I have one comment, I have a -- one really quick question first. I believe Bruce pointed out earlier that the States will all have to select a benchmark plan by the third quarter of this year.

Are we talking calendar quarter? Fiscal quarter?

MR. JONES: Calendar.

THE WITNESS: Calendar quarter, end of September. Bills are imperative.

MR. JONES: Yes. I think the intention of the legislative leadership and the Chairs of the two committees, as well as the administration, to make this decision through one or both have those legislative vehicles before, obviously, the close of this legislative session.

THE WITNESS: Perfect. Thank you for that clarification.

On behalf of CARR, I want to raise an issue that I think all of you involved in this, everyone in the legislature is going to have to reconcile at some point. Understanding Federal law, in the issue of mental health and substance abuse treatment, our understanding is, is that parity means parity. There is no distinguish between traditional medical procedure and the way insurance covers those types of things with assessed mental health or substance abuse treatment.

For example, the American Society of Addiction Medicine has a full layout of how to assess someone, their treatment assessment tools, and treatment follows assessment.

We would like to point out, while CARR currently among the benchmark plans under consideration, prefers the Kaiser model. It covers a great deal of the treatment and substance abuse in that field. However, nowhere any -- nobody anywhere, as far as we can tell, is talking truly about parity for mental health and substance abuse disorder treatment regimens would be considered.

Obviously, we think it is a very important component of societies and individuals' overall health.

Process treatment does work, and we just would like to urge you all to consider parity does mean parity. And these benchmark plans, at some point, will have to reconcile the Federal law on a Mental Health Parity Act that is attached at the top.

MR. JONES: Thank you.

THE WITNESS: Thank you for your time.

MR. JONES: Just note parenthetically, I agree. That is why filed an amicus brief and another reason is the Harlon case, which is a case that another issue was raised, is the issue of the application of Federal and State Parity Acts to a particular provision of health insurance and healthcare plans here in California. And I appreciate the issue, and I appreciate you bring it forward.

Thank you.

THE WITNESS: We are aware of your brief. We appreciate the fact you took the time and the energy to file it and get involved in that.

MR. JONES: Thank you.

THE WITNESS: Hi there. Christine Schultz representing California Optometric Association.

Just wanted to let you know that California Optometric Association is advocating for the essential benefit related to pediatric provision to default to the

Federal plan for Federal employees. That includes comprehensive eye examination and eyeglasses.

This is important, obviously, because children need to be able to see to learn. Without defaulting to the Federal plan, the small group HMO for Kaiser would not include eyeglasses.

We also advocate the State cover adult vision. We believe this is important because people need to be able to work, and it is hard to not be able to work if you can't see.

Additionally, there is evidence that shows you would actually save money. VSP did a study where they showed that they were able to say every dollar invested came back in a $1.25 that would -- because of lower cost.

That is because when you get eye examinations, you can often diagnosis really complicated chronic diseases like diabetes early and save money down the road.

Thank you for the opportunity to testify.

MR. JONES: I don't mean to put you on the spot. Do any of the ten that are under consideration include eyeglasses for kids?

THE WITNESS: Yes, several of them do.

MR. JONES: Which ones, if you can recall?

THE WITNESS: You know, I am not sure. It is listed in your documents.

MR. JONES: Great. Kaiser HMO small doesn't have it, but some do?

THE WITNESS: Yes.

MR. JONES: Okay. Thank you.

THE WITNESS: Good morning. Molly Bristle (ph) with California Mental Health Directors Association, and I am also here to represent the California Coalition for Whole Health. We are a collation of stake holders in the mental and substance abuse disorder field concerned with informing implementation of the Affordable Care Act in California. I will keep my comments this morning very brief because I am about to go back to my office and hit send on the written comment that we will be sending to all of you that will hopefully be helpful.

I think some of my colleagues noted this earlier, but our primarily concern is that ensuring whatever benchmark is selected will have the appropriate supplementation to make sure it is going to meet our Federal parity and equity laws.

The other thing I will mention, we will go into in more detail in written comments, I think regardless of the benchmark selected, the other important thing we

will be looking to the Department for is to ensure compliance with parity and equity laws. Even today, many mental health consumers who have coverage in the private market really struggle to sometimes know what the benefits are because of misinformation in the field. Often struggle to have timely access to services that are medically necessary. And not having timely access can often lead consumers to having more costly services down the road.

We want to really urge this group and all of you to consider what type of accountability and compliance protocols will be in place to ensure that whatever benefits are available that consumers have access to the benefits.

Thank you.

MR. JONES: Thank you very much.

Morning.

THE WITNESS: Morning. My name is John Dougherty. I am representing the United Health Group. United Health Group here represents more that 75 million Americans in the healthcare delivery system.

I wanted to thank, Mr. Commission, for having the hearing today. The essential health benefits is an extremely important topic and the more public light that shines on it, the better.

I think that Chairman Hernandez and Chairman Monty deserve a lot of encouragement and thanks for taking on the issue and being open to feed back on their decisions.

United will be sending in written comments. I will keep my comments brief. I want to point out as a company, we have not endorsed a particular benchmark, but I want to draw attention to the point the Institute of Medicine probably made best, which is that the function of the essential health benefits is to balance scope with affordability.

One of the interesting quirks when you look at this is that, especially in California, we have a lot of different models for delivering care. And the way the Affordable Care Act interacts with itself and with California laws is that choosing these plans will have different impacts on the different models.

One example of that is just how monetary limits that have been adopted in the past to, you know, kind of encourage affordability are not allowed; but other sorts of limits on, you know, the scope or the amount of doctors you can see, as long as they are actually equivalent, will be allowed.

So those are complicated decisions to see how picking one of these would impact the rest of the

market. We look forward to working with your office and the authors to try to work through those difficult decisions.

MR. JONES: I appreciate that. That point is almost compelling on its own. But it is a more acute issue in the face of potential Supreme Court action adverse to the Affordable Care Act, which I hope and pray the they do not do.

For example, one of the critical components of the health benefits exchange, in terms of affordability for those between 133 and 400 percent of the Federal poverty levels, you now have availability to affect the Federal tax credit. It is already challenging enough to make whatever products we select affordable even with the tax credit. In fact, I am not sure we will. But under existing law at any rate, be it as it may, if the Federal tax credit goes away, the issue of the cost associated with the choice of plan becomes even more acute. I appreciate there is an important balance to be struck between assessing coverage and benefits and limits and large of the conversation we had so far. But also the issue you raise, which is at the end of the day, what is it going to cost and how do we make sure that is affordable.

THE WITNESS: Your point is well taken,

especially when you look at you are trying to combine the small group with the individual and trying to eliminate some of the differences. The affordability gap there is pretty striking. If subsidies are not there, it is more glaring.

MR. JONES: Thank you.

THE WITNESS: Appreciate it.

MR. JONES: Thank you, Mr. Dougherty.

THE WITNESS: Morning, Commission Jones. I am representing the California Association of Alcohol and Drug Program Executives. The association is a Statewide association of community based nonprofit substance abuse treatments and disorder programs, and we operate at 300 different sites throughout California.

First, I would like to thank you for your ongoing support and interest in assuring that benefits are provided for substances abuse disorder. We, too, our association is concerned about implementation of FCA and needing of parity, Federal Parity Act, as California chooses essential health benefits.

In the bulletin, the February 17th bulletin, I believe one of the questions and one of the answers related to whether or not parity was going to be part of the implementation. And their -- the answer was in the response that the Federal Government intends to make

sure that parity is adhered to in ACA.

And we would look to you and your office to assure that the essential health benefits does meet the Federal parity requirements.

And I think that is about it.

MR. JONES: Thank you. Thank you very much.

THE WITNESS: Stephanie Watson on behalf of the Association of California Life and Health Insurance Company.

Our member companies are committed to affordable and choice as we evaluate the marketplace and move forward in implementing ACA and essential benefit benchmark plans.

As with many of the other stakeholders, we are actively engaged in the legislative process currently under way. And hope to implement through that process the importance of ensuring that consumers have a wide variety of choice; and, with that, we have the necessary flexibility to ensure PPOs have a place in the market place.

As we move forward, we will continue to keep open dialogue, and we hope that dialogue includes the CD9 legislature.

MR. JONES: Thank you. Thank you for coming.

THE WITNESS: Hi. Thank you. Melissa

Cortez-Ross. I am here today on behalf of Autism Speak.

First, I would like to thank your office for all you have done on behalf of children with autism. We worked very diligently last year on SB 946, which mandated coverage for ABA therapy.

It is already mentioned there are exclusions to that mandate. When making recommendation to the legislature or the Governor's office we would simply ask that you look to plans that do include ABA treatments.

Thank you.

MR. JONES: Thank you.

THE WITNESS: Thank you, Mr. Commissioner. Julianne Broils. I am here -- and members. I am here on behalf of the California Association of Health Underwriters, which are the independent health insurance agents.

Too, first of all, thank you very much for looking at this issue. We think it is important that a good essential benefit benchmark is selected for California. We have been actively looking at this issue since it was brought up as part of ACA back two years ago.

When you looked at this issue, probably the two big areas that we want to emphasize is affordability of whatever essential benefit package is eventually chosen

and to look at that, not just from the large employer but the small employer viewpoint, but also look at the multi-state employer viewpoint. When you have different packages here than from neighboring States or companies that have their benefits spread across the United States, look at some way to make sure it is easy to administer, that you don't have so many differences, and it is impossible to have the same plan in as many States as possible.

Health insurance agents hope employers choose these. We look closely on what the benefits are and what will make it affordable, an affordable reasonable choice for that employer.

So for that reason, we appreciate you looking at this as much as we can as it goes forward.

MR. JONES: Thank you very much.

We will take a quick tape break. We are building up the anticipation.

THE WITNESS: Morning, Commissioner. And illustrious CDI staff. My name it is Beth Abbott from Health Advocates of California.

In addition to that role as a consumer, public policy advocate, I am a funded national association of insurance commissioner consumer representatives. There are 28 of us nationally. Eighteen who work in health.

So let me say to you I am running as fast as I can to keep up with all of this. It was very beneficial for you to have such a forum today.

I have one comment that is not directly related to the hearing. I would like to say this publically what distinct pleasure it is to have our Insurance Commissioner take such an active role with his senior staff at the NAIC. That has not has been the case. He is a wonderful source of information and guidance and help to the consumer representative who represents American people, as well as Californians, obviously. So it is with extraordinary pleasure I come here to give testimony on this important topic.

Thank you, sir, for your involvement.

MR. JONES: Thank you. And the NAIC is a National Association of Insurance Commissioners that makes a lot of important decisions. Sometimes meetings are like watching paint dry. We both have the occupational hazard and pleasure of advocating. Thank you for your advocacy there, too.

THE WITNESS: This is my third year at it, so one would think I might be getting better, but maybe not.

At the last inning, just so you have some perspective, there were twenty-one hundred and ninety

people representing the industry. And probably some consumer friendly regulators there and there were about fifteen consumer representatives there. So we say that we are outnumbered but not outclassed.

MR. JONES: Indeed.

THE WITNESS: And I am sticking to it.

MR. JONES: Indeed.

THE WITNESS: Okay. Our comments today, I would say, are provisional and contingent upon further Federal guidance, which might eliminate some of the ambiguity and lack of clarity and might even change our position if we knew a little more about what was going to unfold.

Of course, it goes without saying the Supreme Court decision will probably influence much of this.

Health access supports the two Bills and the essential health benefit. Mr. Hernandez Bill SB 951 and Mr. Monty's Bill AB 1453.

I think our testimony would support and agree with several speakers this morning. We do not believe that the FEHBP plan, Federal Employees Insurance Plan should be a benchmark plan because of the lack of coverage for a very broad array of reproductive services.

We also do not believe that CalPERS or State a

benefit plan is a correct selection either because of exclusion of certain covered benefits that we think are particularly important.

California is ahead of the game in a lot of coverage issues, such as autism coverage. So we would not want this to be a step in, what we think, would be in the wrong direction.

We also have reservations about products that are licensed by the Department of Insurance as opposed the Department of Managed Healthcare.

We believe it is important to have a solid foundation. The precedent and protection of Knox-Keene Law as part of the essential benefits and so would lean towards a selection based on that.

We also believe since Ms. Kelch, who testified earlier her in depth study of the regulatory authorities and reproaches and the underling insurance law and the comparison between the Department of Managed Healthcare and the Department of Insurance, and even this year we have seen Ms. Rocco and Commissioner Jones undertake to the graces that they can do it as to align the consumer protection and regulatory approaches to be more in alignment.

We are the only State that has two regulatory bodies, which maybe that would be a comfort for the way

have more people watching what is going on and protecting consumers. But to some extent, it creates uncertainty for the industry and confusion for consumers. Commission Jones' interest in having those more aligned, we applaud him for that.

We think -- I have a long list here of, which I am not going to read, of the consumer protection that we -- that are inherent in the Knox-Keene law, which would create dysfunction or nonalignment Ms. Kelch spoke of. If a CDI product were selected, including balance billing for out of network emergency services, specific timely access to care, stipulation for both primary care, specialist care, dental care, mental health, was a long process to work to timely access to care. We would hate for those to be lost.

We also believe things like prior approval of marketing materials may strengthen by the Department of Managed Healthcare approach to this. Our position is that -- I will read this. This is very short.

Federal guidance provides if State selects a benchmark plan that incorporates benefit mandates enacted prior to December 31st, 2011, then the State faces no additional cost for the mandates.

The benchmark product selected needs identical measures meets this test, referring to the two Bills

before the California Legislature.

Therefore, we believe there will be no general found impact if the measures are enacted.

Also, since I have a large part of my work time spent listening to conversation with National Association of Insurance Commissioner staff and regulators and other HHS people. I find it interesting that a Federal HHS has asked the NAIC, we are not sure -- this is the Feds speaking -- we are not really sure exactly what would happen if a State mandate, we would have to make the State pay for that. We don't know how that would work. We don't know authority on that. We are not sure. Can you give us advice on that because we are not sure how that would all come together?

And speaking as a resident of California, we have plenty of demands on our general expenditure. I would like to see them have difficulty. I am a former Fed, too, but I would like to see them have more difficulty trying to collect more money from California. We will see how that is done, but I don't think the law and technical procedures have on that.

The main thing I would like to comment on, which several speakers have mentioned, is that this has all got to be completely transparent, clear, easy for

consumers. Consumers should not have to sort through this.

I applaud Debra Kelch's energy and intelligence in laying out evidence of coverage documents from one end of her house to the next to try to make comparisons. Technically, that is what consumers have to do. They are ill equipped to do it. Debra Kelch is a smart woman, lots of policy experience and she acknowledged how difficult it is. And the average consumer could not do that with any reliable, out of tone, in terms of their own best interest.

It is important that the regulators, the legislature work closely so this is a very easy choice to make. And it does not -- what it actually ends up devolving to a lot is the consumers throw up their hands and pick the cheapest plan.

We think there should be much more attention to value and content of the policy to make a value based purchasing decision.

So we thank you for your interest, sir, and your convening of this hearing. And thank you for letting me speak.

MR. JONES: Thank you. I think your testimony, like Ms. Kelch and some of the others, clarifies for me the importance of answering the following question,

which is, is it in fact, as seems to be the case based on two Federal bulletins, that the text or the plan and products themselves govern what would be the essential health benefits, or do you get to sweep in the regulatory conundrum around that.

If the answer to that is no, then issues raised at the hearing with regard to differences in the Knox-Keene Act and the Insurance Code Act have potentially cost implications to the extent we want to maintain those differences we think are positive and whatever the essential health benefits benchmark is going to be.

And so I think, while it is the case there are differences between the two codes, and I have to enforce the codes as are, I appreciate your acknowledgement of legislation that it sponsored this year to try to true up the two codes. Regrettably, the legislature has been so far disinclined to true up the code, as much as I think -- health access thinks would be beneficial. At the end of the day, I am governed by what the legislature does. And so I can only regulate within the ambit of whatever the legislature sets as the statutory basis for my regulations. We are trying to true up the codes. Unfortunately, our initial effort to do so has been somewhat reduced in scope as the Bill is moved

through the legislative process. Be that as it may, I think again, one of the essential takeaways from this hearing for me is this question of what exactly will define essential health benefits. Is it the text of product or plan, as the Federal Bulletin suggests or are we allowed to go beyond that and sweep in regulations under the Insurance Code or Knox-Keene, depending on what we pick. That has significant cost implications for the general fund. I appreciate Ms. Kelch's testimony that I don't think that analysis has been done yet, so it may be worth for us undertake that analysis.

Thank you.

THE WITNESS: Morning Brianna Hipman from Planned Parenthood. I will be brief.

I have similar comments to those that have been already expressed by other women health advocates and providers.

We believe whatever the benchmark California chooses needs to cover reproductive healthcare, including abortion, without restriction and a full range contraceptive methods at no cost, along with education and counseling to allow women the best method for their lifestyle.

I think Kaiser small group plan identified in the two pieces of legislation meets this requirement.

Our other concern is the substitutions raised. We would be concerned with substitutions that would allow plans to swap out benefits that would undermine women's healthcare protection.

Thank you so much.

MR. JONES: Do any of the other nine meet that standard from your perspective, the reproductive healthcare benefits?

THE WITNESS: Federal plan, I know it definitely doesn't not, the abortion restriction from the Federal level.

MR. JONES: Okay. Thanks.

Well, unless anyone else wishes to testify, I think that concludes the hearing. We want to thank you for taking the time to attend. We will put the slide shown earlier in the hearing up on the website. I know we had some handouts but those were all of the handouts that we're able to display. We will make sure folks have access to all the information here, and we will keep the record open in order to afford folks the opportunity to provide us with additional written testimony and encourage people to do so, particularly those who were unable to attend. But those that were in attendance, if there is anything else you would like to provide in writing to elaborate on the testimony you

provided us today, we would most welcome that.

I also wanted to thank you and acknowledge Chairman Hernandez and Chairman Monty, the Chairs of the Senate Health Committee and the Assembly Health Committee respectively for introducing legislation that will be the vehicle or vehicles to determine this question of what the essential health benefits will be. We appreciate their leadership, as well as the leadership of the other legislative leaders in continuing to move forward in implementation in California. I think we are all, at least all of us in all leadership positions, are committed to doing exactly that. The Brown Administration, Secretary Diana Duly (ph) has been extraordinary in her leadership, the members of the exchange board are partners at the Department of Managed Healthcare and the director, Brent Barnhart, our Federal partner, Secretary Sebelius, members of the Obama Administration. All of or us plan to keep moving forward.

And the good news is regardless what the Supreme Court decides, significant elements of the Affordable Care Act are already in State law. We touched on some of those earlier, the medical loss ratio provision, the requirement that ensures healthcare plans keep children on their policies until age 26, the

provisions dealing with maternity benefits are now in State law, prohibition on gender rating, discriminating against women in the pricing of health care plans health insurance in State law, the establishment in health benefits in State law, as well.

So I believe it is our intention to continue moving forward, even if the Supreme Court makes the decision adverse to the interest of Californians at the Federal level. And as a part of that, we need to move forward with determining what the essential health benefits benchmark is.

I want to thank Chairman Monty and Chairman Hernandez for doing exactly that. I fully anticipate that the Governor will welcome whatever legislation gets to his desk. And they are fully participating in the decision, as well.

This gives me an opportunity to hear from you. And, again, we welcome additional testimony in writing, if you wish to provide it, as I formulate my recommendation to the legislative leaders to the Chairs and to the Brown Administration.

And I think the hearing today raises a number of questions in my mind about interpretation and implementation of this particular decision. Some of those we had a chance to talk about in the course of the

dialogue here today.

So I have not yet made up my mind, but I will do so in short order. I appreciate your input in doing so.

So thank you. Thank you for taking the time to come participate.

I omitted to introduce Janice Rocco who is the Deputy Commissioner for Health Policy Healthcare Reform who has been the point person in my department on all these issues. I appreciate her leadership.

And assistants in putting this hearing today, I want to thank the members of the panel for their very helpful explanation of the information.

I want to think CDI staff who helped us with arranging the room.

I want to thank you of you for taking the time to come here today.

With that, we are adjourned.

Thank you very much.

(Adjourned at 11:48 a.m.)