Good afternoon.

I'm Gary Sherwood, Communications Director for the National Alopecia Areata Foundation based in San Rafael.

As the voice of the alopecia areata community, NAAF serves the nearly 7 million Americans, including 800,000 Californians, affected by this autoimmune disease, which causes unpredictable, often sudden and severe hair loss. Frequently dismissed as a cosmetic condition, alopecia can be a deeply traumatic experience, resulting in emotional, economic, and social pain. It is not *just* hair. In addition to uncontrollable hair loss, alopecia areata creates feelings of isolation, and increases the risk of depression and self-harm.

It is only fair and just that California's alopecia community be provided with coverage for the cost of a wig, or cranial prosthetic. To deny these coverages is to deny multiple studies proving the psycho-social impacts of this serious autoimmune disease. NAAF and the alopecia community were greatly heartened by Assemblymember Berman's legislation, AB 2668, which would have fairly addressed this need. And we were saddened it did not go the Governor's desk, despite the warm reception it received when it went before and passed the Health Committee hearing. We fervently hope this can be redressed by approving wig coverages as essential health benefits.

Thank you.

| | |
|---|---|
| **From:** | Ann Cony |
| **To:** | DMHC Public Comments |
| **Subject:** | Essential health benefits and hearing aids |
| **Date:** | Tuesday, January 28, 2025 3:47:15 PM |



To the public servants managing hearing loss healthcare,

Both of my children were born with moderate to severe sensorineural hearing loss. I know firsthand the benefits of early intervention and the heartbreak and difficulties that result from delayed intervention.

Accordingly, I beseech you to include coverage for hearing aids in California's benchmark plan. This would benefit over 20,000 deaf and hard-of-hearing children. Currently, only one in ten health plans in California covers these devices. That is appalling.

Research shows that children who are deaf or hard of hearing need to access language by six months in order to develop at the same rate as their hearing peers. This intervention is crucial. Delaying it can lead to severe and permanent developmental consequences. Children must have hearing aids for that crucial access.

The cost of not providing early intervention is approximately $1.8 million per child, not including special education costs. In 2016, the state estimated that California spends over $400 million annually to educate around 14,000 deaf or hard-of-hearing students. The lack of coverage not only harms children but also costs taxpayers millions on an annual basis.

While 33 states have addressed this developmental emergency by mandating coverage, California has not. That is inexcusable.

Over the past two decades, numerous efforts to address this gap have gained significant legislative backing, underscoring the urgent need for action regarding this critical pediatric health issue in California.

Ann Cony

Sacramento, CA 95831

To: Department of Managed Health Care

Thank you for the opportunity to provide comments on the benefits that should be considered for inclusion in the state's new Essential Health Benefits benchmark plan. California Hands & Voices (CA-H&V) is the state-wide chapter of a parent driven support group serving families with children who are Deaf and Hard of Hearing . Hands & Voices itself is an international organization of parents, educators, and service providers united in serving those families. CA-H&V is writing to express our support for updating the California benchmark plan to include hearing aids and durable medical equipment, offering a policy solution that could permanently close coverage gaps and ensure that all children in California have access to affordable and comprehensive health insurance that meets the full range of their health needs.

Since the original Essential Health Benefits (EHB) benchmark was determined by California lawmakers more than a decade ago during the implementation of the historic Affordable Care Act (ACA), there have been numerous attempts to close the coverage gap that has been baked into California's insurance markets; specifically, there have been sustained efforts with strong legislative support to close the coverage gap for the more than 14,000 children and youth in the state who are Deaf and Hard of Hearing (DHH), of which a pronounced percentage would benefit from hearing aids, but unfortunately are not included in their private health coverage packages. In addition, according to pediatric experts, failure to provide appropriate early intervention to Deaf and Hard of Hearing children by three to six months of age, leads to serious delays in accessing language, and consequently delays in cognitive & educational development, in addition to a higher incidence of social-emotional deficits

Thirty-three states already require private individual and group health insurance plans to include coverage for children's hearing aids and services through a state insurance benefit mandate and/or by way of the state's EHB benchmark selection, but California is not one of them. California families with children who are Deaf and Hard of Hearing (DHH) are eager to ensure that they can access services for their children and be protected from the financial risk of uncovered benefits.

Over the past two decades there have been several advocacy attempts to close the hearing aid coverage gap for children. In 2023 our organizations were the proud supporters of SB 635 (Menjivar), the Let California Kids Hear Act, which passed through the Legislature with bipartisan support but was vetoed by Governor Newsom, who was concerned it would "set a new precedent by adding requirements that exceed the benchmark plan." The veto message also referred to the existing Hearing Aid Coverage for Children Program (HACCP), which has been subject to legislative budget oversight hearings for the past four years given low enrollment of children, limited participation by providers, and high administrative costs.

By having appropriate early access to language Deaf and Hard of Hearing children by the age of six months can develop at the same rate as their hearing peers. Many of those children would benefit specifically from hearing aids for that crucial access, which if achieved, reduces the state's long-term mitigation costs compared to those children that didn't receive appropriate early intervention.

Consequently, this presents an opportunity to maintain care in a child's medical home by including hearing aids (as appropriate) in the rehabilitative and habilitative services category. Researchers estimate that the mitigation cost for a child who is Deaf or Hard of Hearing who does not receive early intervention is $1.8 million per child in 2023. In 2016, the Legislative Analyst Office estimated that California spends more than $400 million a year to educate approximately 14,000 students who are Deaf or Hard- of-Hearing. The lack of access for the percentage of those children who could receive suitable assist from hearing aids is costing the state and its taxpayers hundreds of millions of dollars, and the relatively low cost of adding hearing aids (0.11%-0.21% of total costs) calculated by the Wakely actuarial analysis makes a clear case for adding this benefit.

It is also crucial that children and families have access to durable medical equipment (DME). Many Californians do not have access to the wheelchairs, augmentation communication devices, hearing aids, oxygen equipment, and other DME that they need. Private health plans offered in California's individual and small group markets regularly exclude or severely limit coverage of this equipment. Faced with out-of-pocket costs up to $50,000, many people go without medically necessary devices or obtain inferior ones that put their health and safety at risk.

Under the EHB benchmarking approach, California will not have to defray any additional premium costs associated with new required benefits. According to the National Health Law Program, seven states have recently added/improved benefits with minimal actuarial impact and minimal effect on premiums.

It is critical that the department and administration move quickly, as a DHH child is a potential developmental emergency which has preventable and far-reaching consequences, and California's kids have waited long enough for affordable and accessible care and devices.

Thank you, and we look forward to future conversations about updating the state's benchmark.

Kasey Cain

Kasey Cain
Board President, CA Hands & Voices

Submitted to: publiccomments@dmhc.ca.gov

Subject: California's Essential Health Benefits and Hearing Aids

Thank you for the opportunity to provide comments on the benefits that should be considered for inclusion in the state's new Essential Health Benefits benchmark plan. Children Now and Let California Kids Hear are writing to express our support for updating the California benchmark plan to include hearing aids and durable medical equipment, offering a policy solution that could permanently close coverage gaps and ensure that all children in California have access to affordable and comprehensive health insurance that meets the full range of their health needs.

Since the original Essential Health Benefits (EHB) benchmark was determined by California lawmakers more than a decade ago during the implementation of the historic Affordable Care Act (ACA), there have been numerous attempts to close the coverage gap that has been baked into California's insurance markets; specifically, there have been sustained efforts with strong legislative support to close the coverage gap for the more than 20,000 children and youth in the state who need hearing aids, which are not included in their private health coverage packages. According to pediatric experts, failure to provide appropriate intervention to deaf and hard-of-hearing children by three to six months of age leads to speech, language, cognitive, educational, and social-emotional deficits and permanent delays.

Thirty-three states already require private individual and group health insurance plans to include coverage for children's hearing aids and services through a state insurance benefit mandate and/or by way of the state's EHB benchmark selection, but California is not one of them. California families with children who are deaf and hard-of-hearing are eager for solutions that will ensure they can access services for their children and be protected from the financial risk of uncovered benefits.

Over the past two decades there have been several advocacy attempts to close the hearing aid coverage gap for children. In 2023 our organizations were the proud co-sponsors of SB 635 (Menjivar), the Let California Kids Hear Act, which passed out of the Legislature with bipartisan support but was vetoed by Governor Newsom, who was concerned it would "set a new precedent by adding requirements that exceed the benchmark plan." The veto message also referred to the existing Hearing Aid Coverage for Children Program (HACCP), which has been subject to legislative budget oversight hearings for the past four years given low enrollment of children, limited participation by providers, and high administrative costs.

With early access to hearing aids, deaf and hard-of-hearing children who are aided by the age of six months can develop at the same rate as their hearing peers and attend mainstream schools, reducing the state's long-term costs of supporting these children. This presents an opportunity to address the cost of untreated newborn hearing loss and special education while maintaining care in a child's medical home by including hearing aids in the rehabilitative and habilitative services category. Researchers estimate that the cost for untreated newborn hearing loss is $1.8 million per child in 2023, without factoring in the cost of special education, other medical complications, and loss of productivity when a child who is deaf or hard-of-hearing does not receive early intervention. In 2016, the Legislative Analyst Office estimated that California spends more than $400 million a year to educate approximately 14,000 students who are deaf or hard- of-hearing (DHH). The lack of a permanent solution is costing the state and its taxpayers hundreds of millions of dollars, and the relatively low cost of adding hearing aids (0.11%-0.21% of total costs) calculated by the Wakely actuarial analysis makes a clear case for adding this benefit.

It is also crucial that children and families have access to durable medical equipment. Many Californians do not have access to the wheelchairs, augmentation communication devices, hearing aids, oxygen equipment, and other DME that they need. Private health plans offered in California's individual and small group markets regularly exclude or severely limit coverage of this equipment. Faced with out-of-pocket costs up to $50,000, many people go without medically necessary devices or obtain inferior ones that put their health and safety at risk.

Under the EHB benchmarking approach, California will not have to defray any additional premium costs associated with new required benefits. According to the National Health Law Program, seven states have recently added/improved benefits with minimal actuarial impact and minimal effect on premiums.

It is critical that the department and administration move quickly, as hearing loss is a developmental emergency that has preventable and permanent consequences, and California's kids have waited long enough for affordable and accessible care and devices.

Thank you, and we look forward to future conversations about updating the state's benchmark.

CHILDREN'S Specialty Care Coalition

*Putting California's Children First*


Children's Hospital Los Angeles
Medical Group

California Association
of Neonatologists

ChildNet/Specialty Medical Group
Valley Children's Hospital,
Madera

Sutter Children's Center
Sutter Medical Center, Sacramento

Children First Medical Group,
Emeryville

Rady Children's Specialists of
San Diego

Department of Pediatrics
California Pacific Medical Center
San Francisco

UCLA Mattel Children's Hospital
David Geffen School
of Medicine at UCLA

Department of Pediatrics
UC San Diego School of Medicine

Stanford Children's Health
Stanford University School
of Medicine

Department of Pediatrics
UC Davis Children's Hospital

Department of Pediatrics
UCSF Benioff Children's Hospital
UC San Francisco School of Medicine

Department of Pediatrics
UC Irvine Medical Center

Department of Pediatrics
Loma Linda University Faculty
Medical Group, Inc.

Miller Children's and Women's
Hospital Long Beach

CHOC Children's Specialists, Orange
County

Cottage Children's Medical Center -
Santa Barbara

Shriners Hospitals for Children -
Northern California

Community Regional Medical Center,
Fresno

Cedars-Sinai Guerin Children's


January 31, 2025

Department of Managed Health Care
980 9th Street, Suite 500
Sacramento, CA 95814

Submitted via email to: publiccomments@dmhc.ca.gov

**Subject: California's Essential Health Benefits and Hearing Aids**

On behalf of the Children's Specialty Care Coalition, we are advocating for an update to California's benchmark plan to include coverage for hearing aids. This would benefit over 20,000 deaf and hard-of-hearing children. Currently, only one in ten health plans in California covers these devices.

Research shows that children who are deaf or hard of hearing must access language by six months in order to develop at the same rate as their hearing peers. This intervention is crucial, and delaying it can lead to severe and permanent developmental consequences.

Lack of hearing aid coverage not only harms the children who need them, but also costs taxpayers millions of dollars on an annual basis due to special education costs and other interventions that become necessary when kids do not get receive hearing aids in a timely manner.

While 33 states have addressed this developmental emergency by mandating coverage, California has not. Over the last decade, numerous efforts to address this gap have gained significant legislative backing, including the unanimous passage of AB 598 (Bloom) in 2019, that would have required commercial insurance to cover children's hearing aids and services.

In lieu of signing the mandate into law at that time, Governor Newsom offered funding for an alternative program administered by the Department of Health Care Services (DHCS). On July 1, 2021, DHCS launched the Hearing Aid Coverage for Children Program (HACCP) to help families in California with incomes under 600% of the federal poverty level afford hearing aids for their children.

Unfortunately, HACCP has not solved the problem. After over three years of operation, and millions of dollars spent, only 251 children have successfully gotten hearing aids through the program, which has struggled from high administrative burdens and low provider enrollment.

We urge the addition of hearing aids to California's benchmark plan, as it is the best solution to ensure children who need hearing aids are able to access and afford them.

CSCC represents over 3,000 pediatric subspecialty care physicians throughout California, and our mission is to ensure that children and youth with complex health care needs have access to equitable, timely and high quality care, provided by pediatric subspecialists who are able to thrive in California's health care environment, through strong leadership, education and advocacy.

Sincerely,

Katie Layton

Katie Layton
Director of Government Affairs and Programs
Children's Specialty Care Coalition

**From:** Jennifer Isensee
**To:** DMHC Public Comments
**Subject:** California's Essential Health Benefits and Hearing Aids
**Date:** Wednesday, January 29, 2025 2:40:25 PM



To the public servants managing hearing loss healthcare,

I am advocating for an update to California's benchmark plan to include coverage for hearing aids. This would benefit over 20,000 deaf and hard-of-hearing children. Currently, only one in ten health plans in California covers these devices.

***Research shows that children who deaf or hard of hearing need to be able to access language by six months in order to develop at the same rate as their hearing peers. This intervention is crucial, delaying it can lead to severe and permanent developmental consequences.***

***Many of these children rely on hearing aids for that crucial access,***

The cost of not providing early intervention is approximately $1.8 million per child, not including special education costs. In 2016, the state estimated that California spends over $400 million annually to educate around 14,000 deaf or hard-of-hearing students. The lack of coverage not only harms children but also costs taxpayers millions on an annual basis.

While 33 states have addressed this developmental emergency by mandating coverage, California has not.

Over the past two decades, numerous efforts to address this gap have gained significant legislative backing, underscoring the urgent need for action regarding this critical pediatric health issue in California.

Jennifer Isensee

Teacher of the Deaf/Hard of Hearing, retired

**From:** Jim Lang
**To:** DMHC Public Comments
**Subject:** Support Hearing Aids for CA's Kids
**Date:** Tuesday, February 4, 2025 3:19:24 PM

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To the Leaders of the Department of Managed Health Care,

Children deserve comprehensive health coverage to meet all their developmental needs. Over 20,000 children in California need hearing aids, yet their health insurance does not cover them. This coverage gap has created a developmental emergency. Our kids can't wait any longer for essential hearing aids to be included as a health insurance benefit.

As an adult who who knows from experience the difficulties caused by hearing loss, I strongly urge California lawmakers to join over 30 other states in closing the coverage gap for hearing aids by modernizing our state's benchmark.

Sincerely,
Jim Lang
Los Altos, CA

California State Senate

SENATOR
SUZETTE MARTINEZ VALLADARES
TWENTY-THIRD SENATE DISTRICT

CAPITOL OFFICE
1021 O STREET
SUITE 7140
SACRAMENTO, CA 95814
TEL (916) 651-4023

DISTRICT OFFICES
848 WEST LANCASTER BOULEVARD
SUITE 101
LANCASTER, CA 93534
TEL (661) 729-6232

23920 VALENCIA BOULEVARD
SUITE 250
SANTA CLARITA, CA 91355
TEL (661) 286-1471

WWW.SENATE.CA.GOV/VALLADARES

VICE-CHAIR
GOVERNMENTAL ORGANIZATION
HEALTH
REVENUE & TAXATION

MEMBER
BUSINESS, PROFESSIONS & ECONOMIC DEVELOPMENT
JUDICIARY
TRANSPORTATION

February 3, 2025

Mary Watanabe, Director
California Department of Managed Health Care
980 9th Street, Suite 500
Sacramento, CA 95814-2725

Dear Director Watanabe:

As members of the Senate Health Committee, we are keenly interested in the process currently underway to update California's essential health benefits (EHB) benchmark plan. We understand the importance of this process and wish you and the department well as you make the difficult decisions that lie ahead.

Each of the new benefits proposed are undoubtedly deserving of inclusion to one degree or another, but we are aware that regulations, as well as limited resources, preclude the addition of every proposed benefit into the new benchmark plan. As previously mentioned, while tough decisions lie ahead, we believe one proposed benefit demands inclusion above all others – the Hearing Exam and Hearing Aids benefit. We urge you to include this benefit in the new benchmark plan, especially since this benefit includes hearing aids for children.

Senate Republicans have long advocated for improved children's access to hearing aids. In 2022, we demanded the State Department of Health Care Services improve the performance of the Hearing Aid Coverage for Children Program, which sadly is still underperforming (only 441 children have received hearing aids as of November 2024). We also supported SB 635 (Menjivar) of 2023, the Let California Kids Hear Act, which Governor Newsom vetoed. While not a silver bullet, we believe including the proposed hearing aid benefit in the new benchmark plan will improve hearing aid access for middle-class children. (As you know, low-income children already receive these services through Medi-Cal or the California Children's Services programs.)

Please know we do not make this request lightly. We realize adding benefits to a new benchmark plan has the potential to increase premiums paid by consumers, but we believe the price paid by hearing-impaired children who cannot access hearing aids will be even higher.

In summary, we again urge you to include a hearing aid benefit in the new benchmark plan, and thank you for your serious consideration of our request. Should you have any questions, please contact Joe Parra at (916) 651-1501.
Sincerely,

Suzette Martinez Valladares
Vice Chair, Senate Health Committee

Shannon Grove
Member, Senate Health Committee

**From:** Maggie Dietrick
**To:** DMHC Public Comments
**Date:** Monday, January 27, 2025 10:57:50 AM



I am advocating for an update to California's benchmark plan to include coverage for hearing aids. This would benefit over 20,000 deaf and hard-of-hearing children. Currently, only one in ten health plans in California covers these devices.

Research shows that children who receive hearing aids by six months can develop at the same rate as their hearing peers, while delaying intervention can lead to severe and permanent developmental consequences.

The cost of not providing early intervention is approximately $1.8 million per child, not including special education costs. In 2016, the state estimated that California spends over $400 million annually to educate around 14,000 deaf or hard-of-hearing students. The lack of coverage not only harms children but also costs taxpayers millions on an annual basis.

While 33 states have addressed this developmental emergency by mandating coverage, California has not.

Over the past two decades, numerous efforts to address this gap have gained significant legislative backing, underscoring the urgent need for action regarding this critical pediatric health issue in California.

Maggie Dietrick

CALIFORNIA CHILDREN'S HOSPITAL ASSOCIATION

1215 K STREET, SUITE 1930
SACRAMENTO, CA 95814
916.552.7111
www.ccha.org

January 31, 2025

Department of Managed Health Care
980 9th Street, Suite 500
Sacramento, CA 95814

Submitted via email: publiccomments@dmhc.ca.gov

**Subject: California's Essential Health Benefits and Hearing Aids**

On behalf of the California Children's Hospital Association (CCHA), I am writing to request that you update the state's benchmark plan to include hearing aid coverage for children as an Essential Health Benefit (EHB). This change will permanently close the coverage gap that exists for over 20,000 children and youth who need hearing aids that are not a covered benefit under their commercial insurance.

Currently, all children and adolescents enrolled in Medi-Cal and CalPERS plans have coverage for hearing aids, but only 10% of those with commercial coverage have coverage for this benefit. Because the cost of hearing aids can be prohibitive for families, children can miss critical educational milestones when they are unable to fully participate in the learning environment. According to the National Institute on Deafness and other Communication Disorders (NIDCD), 2-3 of every 1,000 children born in the United States are born with detectable levels of hearing loss in one or both ears. When children are not identified and do not receive early intervention, special education for a child with hearing loss costs schools an additional $420,000 and has a lifetime cost of approximately $1 million per individual. With early identification and appropriate services, children that are deaf and hard-of-hearing can develop communication skills at the same rate as their hearing peers.

California lawmakers have the opportunity to join thirty-two other states in updating their benchmark plans to include comprehensive coverage for hearing aids. We call on policy makers to seize this opportunity and prioritize hearing aid coverage as an EHB.

Sincerely,

Mira Morton
Vice President of Government Affairs

California Association of
Health Plans

1415 L Street, Suite 850
Sacramento, CA 95814
916.552.2910
www.calhealthplans.org

February 04, 2025

Mary Watanabe, Director
Department of Managed Health Care
980 9th Street, Suite 500
Sacramento, CA 95814-2725

*Via electronic submission:* Mary.Watanabe@dmhc.ca.gov
publiccomments@dmhc.ca.gov

Dear Director Watanabe:

On behalf of the California Association of Health Plans (CAHP), which represents 41 public, non-profit, and for-profit organizations in public programs and commercial markets, please accept this comment letter as you proceed with the critical task of updating California's Essential Health Benefits (EHBs) and benchmark plan.

California's health plans are committed to providing affordable health care coverage to consumers, and we acknowledge the complexities involved in making any changes to California's existing benefit package. To that end, CAHP applauds the Department of Managed Health Care (DMHC) for its dedication to transparency and its commitment to stakeholder engagement throughout this process. Building upon our prior comments at the June 2024 and January 2025 public meetings, we hope the DMHC will consider the following as it prepares to submit a proposal to the Centers for Medicare & Medicaid Services (CMS) this spring.

**Consider Impacts on Affordability and California's Efforts to Curb Health Care Cost Growth**
One of our top priorities is keeping health care as affordable as possible for consumers. This requires balancing the comprehensiveness of benefits against the associated cost increases stemming from this project. In other words, we need to recognize the direct link between affordability and access to care, which in turn means recognizing the significant work being done at the Office of Health Care Affordability (OHCA) within the Department of Health Care Access and Information (HCAI).

Starting this year, OHCA's newly adopted statewide health care spending target of 3.5% goes into effect, with required participation by payers and providers. CAHP supported the target because of its potential to positively impact the affordability of health care coverage. A new benchmark plan and a new set of EHBs will likely affect costs and increase premiums, which will hinder the ability of health care entities to meet that spending target threshold.

Additionally, it is our understanding that EHBs may not be subject to annual or lifetime limits. Some of the benefits included in the Wakely analysis are high-cost items (e.g., hearing aids, wigs, some DME items). The analysis does not appear to account for how the lack of limits on these items might impact the overall cost of the benefit, and the inability of plans to control costs associated with high-cost EHB is a vital consideration in how the proposed benefits could impact affordability.

Any discussion around EHBs should factor in and not conflict with the work that is being done by OHCA and its underlying mission of consumer affordability.

**Navigating Uncertainty Around Federal Funding and Covered California Subsidies**
Considering the everchanging landscape of our national government, there is widespread uncertainty regarding the continuation of enhanced federal premium tax credits for coverage at Covered California. If those subsidies expire at the end of this year, the cost of health care coverage will likely increase for many consumers. Covered California estimates that, on average, Covered California enrollees could see premiums increase by 63% and thousands could lose eligibility for premium tax credits entirely. Due to this uncertainty, we urge the state to move cautiously as it considers what a new benchmark plan could ultimately include.

**Encourage Consistency in Implementation Across Markets and More Defined Benefits**
During the January public meeting, Wakely staff acknowledged that none of the IVF options they presented align with Senate Bill (SB) 729, which applies to the large group market (and requires an offer of coverage in the small group market). While there are numerous outstanding questions related to the implementation of SB 729, to the extent that IVF is considered as an option in the benchmark plan, it would be beneficial to align coverage across markets rather than having to administer different coverage levels for different market sectors. We highly encourage interdepartmental coordination to assess how these differing coverage requirements could be aligned. This would help address ambiguities and alleviate confusion for health plans operating in multiple markets.

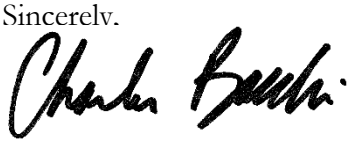
We also request that the state provide more context and more thorough definitions for what is included in some of the proposed benefit additions. For example, under the topic of artificial insemination within the IVF benefit, health plans need to understand the scope of what will be covered and if the benefits provide a limit on the number of inseminations or if there are any other clinical requirements or benefit limits. For another example, health plans would benefit from more specifics on what DME is being offered, especially on items that can range significantly in price (e.g., scooters, wheelchairs, and hospital beds).

**Account for Critical Gaps in Data Before Finalizing an EHB Benchmark Proposal**
It is our understanding that the California Health Benefits Review Program will release an analysis of potential premium impact in anticipation of a legislative hearing in February. This analysis is key. One of our key concerns following last week's meeting was that the Wakely analysis did not demonstrate the specific premium impact associated with the potential benefit additions to the benchmark plan, either cumulatively or individually. To ensure long-term sustainability of a new benchmark plan, the state needs to see the complete picture, which includes a look at premium impact.

Additionally, pent-up demand for services could drive consumption in the initial years of a potential new benchmark plan, but we were disappointed to see that an estimate for this was not incorporated in the Wakely analysis. In the spirit of thoroughness, we strongly recommend the state account for this crucial element in upcoming EHB discussions.

We appreciate the Department's consideration of the above factors as it prepares a benchmark proposal. Working together, we can ensure access to high-quality, affordable health care for all Californians. Health plans look forward to continuing participation in this conversation.

Sincerely,



Charles Bacchi
President & CEO

California Pan-Ethnic HEALTH NETWORK

February 4, 2025

Ms. Mary Watanabe, Director
Department of Managed Health Care
980 9th Street, Suite 500
Sacramento, CA 95814
Via email: publiccomments@dmhc.ca.gov

**Re: California's Essential Health Benefits and Updating the Benchmark Plan**

Dear Director Watanabe:

On behalf of the California Pan-Ethnic Health Network (CPEHN), we thank you for the opportunity to comment on DMHC's slide presentation and January 28th public meeting on California's Essential Health Benefits and Updating the Benchmark Plan.[1] CPEHN is a multicultural health advocacy organization, dedicated to advocating for policies that advance health equity and improve health outcomes for California's communities of color.

Under the 2025 NBPP Final Rule, states now can add additional benefits beyond the standard Essential Health Benefits (EHBs) through their state EHB benchmark plan, including benefits like routine adult dental services, effectively allowing for expanded coverage beyond the minimum EHB requirements; this means that states can include these added benefits as part of their EHBs without having to incur additional cost burdens due to state mandates enacted after 2011.[2] The new rule provides California with an unprecedented opportunity to expand access to key benefits such as adult dental benefits, Durable Medical Equipment (DME), hearing aids and infertility treatments, that have been shown to reduce health disparities and lead to more equitable health outcomes.

**Support for DME, Hearing Aides and Infertility Treatment:** We appreciate DMHC's proposal to add DME, hearing aids and infertility treatments to California's benchmark plan. Adding these benefits will make access to critical medical equipment and infertility services more affordable for millions of Californians, including low-income and communities of color. More specifically:

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[1] Public Meeting on California's Essential Health Benefits and Updating the Benchmark Plan January 28, 2025, https://www.dmhc.ca.gov/Portals/0/Docs/DO/EHB/EHBStakeholderMeetingPresentation01282025.pdf

[2] HHS Notice of Benefit and Payment Parameters for 2025 Final Rule, CMS, 2024: https://www.cms.gov/newsroom/fact-sheets/hhs-notice-benefit-and-payment-parameters-2025-final-rule#:~:text=Allowing%20States%20to%20Add%20Routine,or%20after%20January%201%2C%202027.

- ***Adding DME:*** Disparities in access to durable medical equipment (DME) in California can include racial and ethnic disparities, socioeconomic disparities, and barriers for people with disabilities. The current benchmark plan limits DME to a list of ten benefits and further limits coverage of DME to equipment for in-home use only. As a result, many plans in California fail to cover essential DME items such as wheelchairs, oxygen tanks, and blood glucose monitors, or have placed strict dollar limitations and/or high-cost sharing on the equipment they will cover, in addition to restrictions to in-home use only. Adding additional DME to the EHB benchmark plan will ensure all Californians can access these critical supports.
- ***Adding Hearing Aids:*** More than 20,000 children and youth who need access to hearing aids do not have them covered by their private health insurance cannot afford to purchase hearing aids.[3] The majority of states, (32) require private insurance to offer some level of coverage for kids' hearing aids, including 27 that mandate it as a benefit under the Affordable Care Act. California only offers coverage to very low-income families through public insurance like Medi-Cal or the program for kids with disabilities, setting the income cap for a family of four around $40,000. This proposal will ensure California raises the bar for all hearing impaired in the state.
- ***Adding Infertility Treatment:*** Adding infertility treatment as an EHB is critical to achieving full lived equality for LGBTQ+ people and advancing reproductive freedom for all Californians. The CDC's most recent National Survey of Family Growth reports that about 12% of women and nearly 9% of men under the age of 44 in the United States seek advice, testing, or treatment for infertility at some point in their life. Without insurance coverage for fertility care, the out-of-pocket costs for these treatments are simply insurmountable for most Californians. To date, 14 other states have already passed IVF insurance laws. Adding infertility treatments as an EHB will expand access to fertility care for all Californians, including coverage for IVF, and increase access to care, help reduce inequities in health and economic status, and bring existing law up to date on medical advancements in IVF and its uses.

While we are supportive of adding these additional three benefits, we think a more nuanced discussion regarding the scope of services to be added within each of these benefits is warranted so consumers can understand the cost implications as well as the trade-offs of adopting the different alternatives modeled. We note for example that the Wakely analysis modeled adding 11 additional DME benefits (Slide 17) and three potential pathways for IVF (slide 18) with differing levels of services, yet there was no discussion of the trade-offs of the various models on health equity or of the impact of choosing a more robust model for example, on the ability to add other services, including adult dental.

**We urge DMHC to ask Wakely to model a potential benchmark plan that includes DME, hearing aids, infertility treatment, and preventive oral services for adults**: We are very disappointed by DMHC and the Legislature's omission of adult dental, which is critical to eliminating health disparities and improving health outcomes for millions of Californians, from the

[3] Kids Can't Wait: Policymakers Must Include Hearing Aids in California's New Health Insurance Benchmark, Children Now. https://www.childrennow.org/portfolio-posts/kids-cant-wait-hearing-aids-factsheet/

list of proposed benefits to add to the current benchmark plan (slide 16).

- **Ensuring access to dental care will address broader health disparities and improve overall health and well-being:** Numerous studies have demonstrated that oral health is essential to overall health. Poor oral health is linked to a myriad of chronic health conditions - such as heart disease, difficulty managing diabetes, and an increased risk of cancer, creating a cycle of worsening health outcomes that can include death.[4] The lack of comprehensive adult dental benefits disproportionately affects low-income and communities of color who make up the majority of individuals enrolled in Covered California marketplace coverage. In California, close to 48% of adults 30 or older have periodontitis (gum disease), with even higher rates among low-income adults. Among adults with low-incomes in California, almost 50% of Latino adults did not have dental insurance in 2020, compared to 28% of White adults with low-incomes; Black adults are twice as likely to have untreated dental caries as White adults.[5]

- **Ensuring access to dental care will prevent economic hardship for low-income communities:** High costs are a major barrier to accessing dental care, especially for marginalized populations. National polling shows that 44% of LGBTQI individuals, 43% of mothers from communities of color, 42% of Latina women, and 43% of women under 50 report forgoing dental care due to cost.[6] About 4 in 10 Californians have medical debt, which includes dental debt.[7] This number is higher for marginalized groups, such as those who are low-income, Black, or Latino. In 2014, Covered California's Board decided to embed pediatric dental benefits into health plan offerings as it offered a better, more affordable type of coverage than stand-alone dental plans, which are not included in the calculation of a family's federal tax credits. Adding this benefit will make routine dental services more affordable for millions of Californians.

- **Adding an adult dental benefit to California's benchmark plan will strengthen consumer protections:** At the January 28th meeting, DMHC cited the fact that it could not count a separate dental offering or stand-alone dental plan as part of a typical dental plan, as the reason for not proposing to add dental benefits to the state's benchmark EHB. Unfortunately, stand-alone dental plans are exempt from many of the Knox-Keene consumer protections that apply to the other benefits included under the state's current benchmark plan. As a result, consumers can be denied coverage due to a health status or pre-existing condition or charged more for insurance based solely on their age and geographic region - essentially allowing insurers to deny coverage or charge higher rates to individuals with poorer health. Covered California's decision to embed pediatric dental

[4] "The Dental Divide: Oral Health Equity Challenges in Los Angeles County," the California Pan-Ethnic Health Network, December 2024. https://cpehn.org/assets/uploads/2024/12/2024_Report_OH-Disparities_Los-Angeles.pdf
[5] "Addressing the Root: Dismantling Systemic Barriers to Oral Health Equity," California Pan-Ethnic Health Network (CPEHN), September, 2022.
[6] Woodbury, Terrance, Erica Tebbs, Roshni Nedungafi, Ashley Aylward. "Health and Economic Justice Survey 2024." Community Catalyst & HIT strategies presentation, May 2024.
[7] The 2023 CHCF California Health Policy Survey, February 16, 2023. https://www.chcf.org/wp-content/uploads/2023/02/2023CHCFCAHealthPolicySurvey.pdf

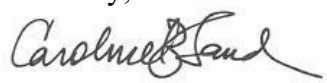
benefits into health plan offerings helped to strengthen consumer protections. Adding adult dental as a required EHB will allow Covered California to work more collaboratively with dental plans to improve oral health care access and quality for the millions of Californians who utilize these services while bringing dental services under the same consumer protections enacted for the individual and small group markets post-ACA.

- **California has the flexibility to define the benefits it chooses to add:** We understand there are important considerations policymakers must make when deciding which benefits to add to California's benchmark plan, including the costs of a benefit and whether it satisfies the typicality standard. Slide 15 shows the typicality range for adding additional benefits in California as being between 1.06%-2.23%. DMHC's Slide 16 shows the low end of adding a routine preventive dental benefit is 1.26% which is within range and would still allow the addition of other benefits such as DME, hearing aids and infertility treatment. The federal regulations allow states the flexibility to define "routine" dental services. We note for example, that California's benchmark plan, Kaiser, Small Group HMO 30, includes routine adult dental benefits and limited orthodontia and major dental care. We urge DMHC to ask Wakely to share the evaluation it conducted, including whether the Kaiser Small Group benchmark plan coverage was the plan they based their evaluation on and if the services provided are the most generous of the typicality range. Moving forward, we urge DMHC to ask Wakely to model whether adjusting the services that make up preventive dental care (e.g. frequency of oral health exams, x-rays, or prophylaxis) could lower the allowed cost of the proposed plan in order to bring it within the actuarial room to add other benefits including DME, hearing aids and infertility treatment. Concurrently, we would also be interested in analysis of whether there may be room to adjust any of the services included as part of the other proposed benefits to allow room for routine adult dental.

**We urge DMHC to ensure a more robust stakeholder process:** While we very much appreciate the time constraints DMHC faces, we request that there be sufficient time and opportunity to review any additional modeling and underlying analyses, including by broader stakeholders. Stakeholders only had a few weeks to respond to notice of the DMHC hearing and the analysis and underlying trade-offs that were presented at the January 28th meeting lacked a sufficient level of detail and explanation to ensure a more robust, comprehensive discussion. Moving forward, we urge DMHC to ensure there is ample time and opportunity for consumer groups to properly evaluate jointly the trade-offs of these different options and models on the ability of Californians to access these critical services.

Thank you for the opportunity to share our thoughts and recommendations. We look forward to additional modeling and public discussion on this important issue.

Sincerely,



Senior Policy Director/CPEHN

University of California
San Francisco

January 30, 2025

**Mitchell Rosen, MD, HCLD**
**Professor**
**UCSF Department of Obstetrics, Gynecology, and Reproductive Services**
**Director, Reproductive Laboratories**
**Director, Fertility Preservation Program**
Mitchell.Rosen@ucsf.edu

**UCSF Center for Reproductive Health**
499 Illinois Street, 6th Floor
San Francisco, CA 94158
Tel: 415/353-7475
Fax: 415/353-7744
TTY:415/885-3889
www.ucsfhealth.org
www.ucsfivf.org

University of California
San Francisco

Mary Watanabe
Director, Department of Managed Health Care
980 9th Street, Suite 500
Sacramento, CA 95814

Dear Ms. Watanabe,

As a reproductive endocrinologist and lab director for CRH Fertility at UCSF, I am deeply committed to ensuring that fertility care policies align with best medical practices and support patients' reproductive health needs. I appreciate the opportunity to provide input on the proposed updates to the benchmark plan for essential health benefits. While the inclusion of in vitro fertilization (IVF) coverage is a critical step forward, I am concerned that certain provisions particularly the proposed six-month limit for embryo cryopreservation introduce significant ethical, medical, and practical challenges. This restriction fails to account for the complexities of fertility care, placing unnecessary burdens on patients and potentially compromising their health and treatment outcomes.

The proposed six-month limit for embryo cryopreservation raises significant ethical, medical, and practical concerns, as it fails to consider the realities that many patients encounter during their fertility journeys and disregards the complexity of fertility care, while a longer timeframe would prioritize patient health, safety, and autonomy. Patients who have medical delays whether due to ongoing treatments, complications, or unforeseen health issues can easily extend the timeline beyond six months. The standard practice of Single Embryo Transfer (SET) also contradicts this restrictive timeline. SET is widely recommended to reduce the risks associated with multiple pregnancies, such as preterm birth or low birth weight. However, following SET often requires multiple transfer cycles over an extended period to achieve a successful pregnancy. A six-month limit would put undue pressure on patients, potentially forcing them to make rushed and unsafe decisions, such as transferring multiple embryos at once, which could lead to higher-risk pregnancies.

Moreover, current medical guidelines emphasize the importance of spacing pregnancies at least 18 months apart to optimize maternal and child health. A six-month cryopreservation limit directly conflicts with these recommendations, as it could force patients to attempt back-to-back

pregnancies to avoid the destruction of their remaining embryos. This rushed approach not only endangers the health of the parent but also compromises the success of future pregnancies.

A more reasonable and patient-centered policy, such as a five-year limit, would better reflect the diverse needs of individuals and align with medical best practices. It would provide patients with the time and flexibility necessary to make informed decisions about their family-building goals while reducing unnecessary risks. Extending the limit to five years would also account for the many uncertainties that can arise during fertility treatments and pregnancies, supporting both the physical and emotional well-being of patients.

Sincerely,

Mitchell Rosen, MD, HCLD
Director, UCSF Fertility Preservation Program
and Reproductive Endocrinology and Infertility
Center for Reproductive Health
Division of Reproductive Endocrinology

EQUALITY CALIFORNIA



February 4, 2025

Mary Watanabe
Director, California Department of Managed Health Care
980 9th Street, Suite 500
Sacramento, CA 95814

**Re: California's Essential Health Benefits and Updating the Benchmark Plan**

Dear Director Watanabe:

On behalf of Equality California, the nation's largest statewide LGBTQ+ civil rights organization, I am writing to share our comments following the recent stakeholder meeting on January 28th regarding California's Essential Health Benefits and the process for updating the benchmark plan. We are extremely pleased to see fertility and infertility services included among discussions about potential new benefits. We appreciate the opportunity to engage in this important dialogue and would like to emphasize two critical points at this stage that are particularly relevant to the LGBTQ+ community.

1. **For the purposes of the benchmark plan, infertility should be defined in an inclusive manner.**

DMHC's January 28th presentation did not explicitly address the importance of using an inclusive definition of infertility. This omission is concerning, as it could potentially exclude LGBTQ+ and single individuals from accessing this benefit. Equality California was a cosponsor of last year's SB 729 (Menjivar, Chapter 930, Codes of 2024), which mandated that large group health insurance plans cover infertility care in a non-discriminatory manner. It is crucial that the definition of infertility within the benchmark plan is similarly inclusive. We recommend using a definition that conforms with SB 729, which includes in the multipronged definition of infertility, "a person's inability to reproduce either as an individual or with their partner without medical intervention." This definition is consistent with the American Society for Reproductive Medicine's practice guidance[1] and is critical to meeting the federal requirement that a base benchmark plan must not include discriminatory benefit designs that contravene the non-discrimination standards defined in 45 CFR section 156.125.[2]

[1] Definition of Infertility: A Committee Opinion (2023) | American Society for Reproductive Medicine | ASRM
[2] 45 CFR section 156.111(v)

*Equality California*
*1150 S Olive Street, 10th Floor, Los Angeles, CA 90015*

**2. DMHC should further clarify surrogacy coverage.**

Regarding surrogacy, it is imperative to clarify that the health testing of the surrogate and related surrogacy coverage (including blood screening panels, medical evaluations, and psychiatric evaluations) should be covered under the intended parents' health insurance, not the gestational carrier's insurance. We recommend that all costs related to the embryo and associated infertility services, including any prescription medications and office visits required by the gestational carrier prior to embryo transfer, be covered by the intended parents' insurance. It seems appropriate for the gestational carrier's insurance to begin covering costs and claims upon confirmation of pregnancy.

Additionally, we would like to address a common point of discussion: insurers currently cover surrogate pregnancies, as they have since pregnancy care became a state mandate. However, issues arise when a gestational carrier is compensated for carrying a pregnancy. Insurers are permitted to seek subrogation of any funds received by an insured person that compensate for claims already paid by the insurer. This is similar to situations where individuals receive settlements for injuries, and the health insurer has already covered their healthcare costs. If a gestational carrier is not compensated for carrying a baby, the health insurer must cover all pregnancy-related costs without seeking subrogation. We understand that forthcoming legislation may address the ability of insurers to seek subrogation in surrogacy situations, and we look forward to reviewing and commenting on such legislation once it is introduced.

We appreciate your attention to these matters and urge you to ensure that the benchmark plan reflects these considerations to promote inclusivity and equity for members of the LGBTQ+ community. We look forward to providing additional input in the weeks and months ahead as DMHC works with the Legislature and other agencies to update the benchmark plan. If you have any questions, please do not hesitate to contact Equality California's Legislative Director, Craig Pulsipher, at craig@eqca.org or (916) 444-7807.

Sincerely,

Tony Hoang
Executive Director
Equality California

cc: Jessica Altman, Executive Director, Covered California
Ricardo Lara, Insurance Commissioner, California Department of Insurance
Members of the California Senate Health Committee
Members of the California Assembly Health Committee

February 4, 2025

Mary Watanabe, Director
California Department of Managed Health Care
980 9th Street, Suite 500
Sacramento, CA 95814

**Re: California's Essential Health Benefits and Updating the Benchmark Plan**

Dear Ms. Watanabe,

Health Access California, the statewide health care consumer advocacy coalition committed to quality, affordable health care for all Californians offers comments on Essential Health Benefits (EHBs) to be offered by health plans and insurers in the individual and small group markets in California.

In 2012, Health Access was involved in the development of the current standard for EHBs. We also recognize the many consumer protections that were included in the Knox-Keene Act prior to the enactment of the Affordable Care Act (ACA) such as the requirement to cover all medically necessary basic health services which included maternity care and newborn care as well as other requirements that if prescription drugs were covered, all medically necessary drugs would be covered. All these standards offer important consumer protections, some of which consumers won decades ago.

## 1. Existing Law is the Floor

Existing California law in Health and Safety Code 1367.005, and the parallel section in the Insurance Code, incorporates all of the benefit mandates and the important standards requiring coverage of all medically necessary basic health services and prescription drugs that predated the ACA. These are important consumer protections.

Health Access opposes use of self-insured public employee health plans offered by CalPERS or other state and local public employers because state law does not require these plans to meet the current floor for Essential Health Benefits. Health and Safety Code 1349.2 requires self-insured plans covering state or local public employees to provide basic health care services but exempts these plans from all other benefit mandates, including the requirement to cover medically necessary prescription drugs consistent with the Knox-Keene Act. Whether such benefit mandates are included in those plans is subject to the discretion of the CalPERS Board or the respective governing boards of the other self-insured plans. Current federal guidance permits use of such plans as the basis of a state's EHB: a CalPERS self-insured plan is likely to be one of the five largest large group plans. Health Access opposes any proposal to use a plan governed by Health and Safety Code

1349.2 because such a product is not required by law to meet current benefit mandates and standards.

**2. Adult Dental, Infertility Treatment, Durable Medical Equipment and More**

Health Access supports the inclusion of additional specific benefits to assure Californians have the benefits we need to get the care we need. We appreciate the recent actuarial analysis of the rate impacts of additional benefits. With the recognition of the limits on possible additional benefits, we support the following:

- *Hearing Exam and Hearing Aids:* Health Access supports the inclusion of hearing exams and hearing aids, including an annual hearing exam and hearing aids for each ear every three years. Thirty-three states already require private individual and group health insurance plans to include coverage for children's hearing aids and services through a state insurance benefit mandate and/or by way of the state's EHB benchmark selection, but California is not one of them. According to the World Health Organization, hearing challenges can result in delayed language development in children and social isolation among people of all ages[i]. We support hearing aids for consumers in their 50s and early 60s just as much as hearing aids for kids.
- *Durable Medical Equipment*: Health Access supports the inclusion of durable medical equipment (DME) for use in the home and outside the home. Many Californians do not have access to the wheelchairs, augmentation communication devices, hearing aids, oxygen equipment, and other DME that they need. Private health plans offered in California's individual and small group markets regularly exclude or severely limit coverage of this equipment. Faced with out-of-pocket costs up to $50,000, many people go without medically necessary devices or obtain inferior ones that put their health and safety at risk.
- *Infertility Treatment, including IVF:* As a matter of equity, the broad range of infertility treatment should be covered. Specific to the Department's recent presentation, we recommend consideration of Level B or Level C coverage. We would also encourage the Department to look into the costs of the recently passed SB 729 (Menjivar) as an option. This is an issue for equity for LGBTQ community as well as other persons seeking to be parents but facing challenges to conceiving, including single people. Like basic health services or medically necessary care, such benefits should be defined in a manner that allows evolution in what drugs, procedures or other interventions are most effective in achieving pregnancies that can be brought to term. California as a state is committed to reproductive rights: infertility treatment is as much part of that commitment as abortion.
- *Adult dental benefits:* We continue to support "embedded" adult dental benefits precisely because such benefits offered by full service plans are subject to all of the consumer protections added in ACA implementation, from outlawing pre-existing condition exclusions to requiring guaranteed issue and guaranteed renewal, providing benefits without annual or lifetime limits and more. Poor oral health is linked to a myriad of chronic health conditions, such as heart disease, diabetes and dementia[ii]. The lack of comprehensive adult dental benefits disproportionately affects low-income and communities of color[iii]. However, we also recognize the allowable cost range as stated in the Department's recent presentation for Preventive Dental Services Only and All Adult Dental Services and the limitations in what's reasonably possible for plans and consumers.



1127 11th Street | Suite 925 | Sacramento, CA 95814

In conclusion, we look forward to continuing to work with the Department and the Legislature in reconsidering the existing EHB standards which date to the initial implementation of the ACA. Much has changed in the dozen years since the EHB standard was initially adopted in California law: it is time and past time to update that standard.

Sincerely,

Christine Smith
Policy & Legislative Advocate

CC: Ricardo Lara, Insurance Commissioner, Department of Insurance
Senator Caroline Menjivar, Chair, Senate Health Committee
Assemblymember Mia Bonta, Chair, Assembly Health Committee
Jessica Altman, Director, Covered California

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[i] World Health Organization, "Deafness and Hearing Loss", https://www.who.int/health-topics/hearing-loss#tab=tab_1

[ii] National Institute of Dental and Craniofacial Research, "Healthy Mouth, Healthy Body", https://www.nidcr.nih.gov/news-events/nidcr-news/2024/healthy-mouth-healthy-body

[iii] Borrell LN, Williams DR. Racism and oral health equity in the United States: Identifying its effects and providing future directions. J Public Health Dent. 2022 Mar;82 Suppl 1(Suppl 1):8-11. doi: 10.1111/jphd.12501. Epub 2022 Jan 27. PMID: 35088413; PMCID: PMC9541355.



1127 11th Street | Suite 925 | Sacramento, CA 95814

February 2, 2025

Department of Managed Health Care
980 9th Street, Suite 500
Sacramento, CA 95814

RE: Comments on the Draft California "Essential Health Benefits and Updating the Benchmark Plan"

To Whom It May Concern:

The U.S. Pain Foundation (U.S. Pain) and its volunteer California Advocacy Team (CAT) are pleased to provide comments on the draft essential health benefits (EHB) following the presentation on January 28, 2025, that introduced potential updates to the California Benchmark plan (BMP).

U.S. Pain is a national non-profit 501(c)(3) organization created by people with pain for people with pain from various diseases, conditions, and serious injuries. The mission of the organization is to connect, support, educate, and advocate for those living with chronic pain, as well as their caregivers and healthcare providers.

**Impact of Chronic Pain**

**Pain is the most common reason Americans access the health care system.**

A study in the Centers for Disease Control and Prevention (CDC) *Morbidity and Mortality Weekly Report* dated April 14, 2023 reported that 51 million U.S. adults experienced chronic pain in 2021 and 17 million experienced high-impact chronic pain that interferes with a person's ability to function daily. **In California, this translates to approximately 5.06 million California residents with chronic pain and 1.67 million with high-impact chronic pain.** High-impact chronic pain devastates a person's quality of life, negatively affecting all aspects of daily functioning, including sleep, work, social activities, and relationships.

As described in the draft DMHC presentation all BMPs offered in the marketplace must cover 10 essential health benefits. Page five of the presentation lists Rehabilitative and habilitative services and devices. This EHB is described on Health.gov as services and devices to help people with injuries, disabilities, or chronic conditions gain or recover mental and physical skills. These services and devices are essential to Californians with chronic pain and other conditions so that they are fully employed, able to take care of their home and family and contribute to their community.

For these reasons, our organization provides both comments and questions about the proposed EHB for California's updated BMP that need clarity. It is our primary concern that all Californians receive the best care possible.

**The typicality test use of Kaiser as the BMP**

The California Department of Managed Health Care (DMHC) used the Kaiser Permanente for Small Business health plan to develop the 2014-2016 BMP. In the updated plan, the DMHC states it uses the

"best" Kaiser plan provided to University of California employees as the typicality test. Because Kaiser is an HMO (Health Maintenance Organization) with a closed network of providers patients may not get the services they need from outside providers

- In the January 2025 presentation, the DMHC listed only the new benefits that may be added to the BMP but did not provide any information about the EHB in the current California (2024-2016) BMP as to whether there would be any changes in quantitative limits of each of the services covered in the plan.
- Do any of the EHBs in the existing BMP change or improve because DMHC is now using the UC "Best" Kaiser health plan instead of the Kaiser small business plan for the typicality test?
- A detailed report identifying all EHBs in the new BMP should be available for a complete critique.

Our organization has the following concerns and questions about EHB and the updated BMP:

**Physical Therapy**

The California 2014-2016 BMP indicates that the Rehabilitative Occupational and Rehabilitative Physical Therapy in Column D has a "Qualitative Limit on Service" (limit) of none. However, the Kaiser small plan filed with CMS does not identify a limit of visits.

On the Covered California exchange website when researching a health plan and clicking on details there is no information about coverage for physical therapy. This lack of information about the number of visits the health insurance will cover makes it extremely difficult for patients to choose a health plan to meet their health needs.

Patients with chronic pain, many of whom need physical therapy, have no way of knowing what the plan covers either on Covered California, in the Kaiser Permanente documentation, or if they call Kaiser. Kaiser is more likely to cite their documentation.

**Mental/Behavioral Health**

1. The California 2014-2016 BMP indicates that the benefit for Mental/Behavioral Health for inpatients or outpatients in Column D has no quantitative limit.
2. Chronic pain is best understood and treated by a biopsychosocial model "as a multidimensional, dynamic integration among physiological, psychological, and social factors that reciprocally influence one another." (cite) Chronic pain patients frequently experience depression, anxiety, and emotional distress and need access to mental and behavioral health treatment.

**Acupuncture**

1. California BMP (2014-2016) Column D has no quantitative limit. Described as: Typically only to treat nausea or as part of a comprehensive pain management program. However, no documentation describes what is meant by a "comprehensive pain management program" at Kaiser. We would champion every insurance provider to provide documentation on their pain management programs in their health plans so that patients may choose the best health plan for their needs.

2. The UC Kaiser plan used by the DMHC as the typicality test lists chiropractic and acupuncture office visits (up to a combined total of 24 visits per 12-month period). Is the intention of the revised BMP to combine treatments with a limit of visits?
3. This plan describes acupuncture services as follows: Acupuncture Services: The stimulation of certain points on or near the surface of the body by the insertion of needles to prevent or modify the perception of pain or to normalize physiological functions and appropriate adjunctive therapies, such as hot/cold packs, infrared heat, or acupressure, when provided during the same course of treatment and in conjunction with acupuncture and when provided by an acupuncturist for the treatment of your Musculoskeletal and Related Disorder, nausea (such as nausea related to chemotherapy, post-surgery nausea, or nausea related to pregnancy), or joint pain (such as lower back, shoulder, or hip joint pain), and headaches.
4. Please provide greater detail on the updated BMP if there will continue to be a quantitative limit on the number of visits for chiropractic and a description of what treatments are covered.

**Chiropractic**

1. California BMP (2014-2016) EHB – None. California is one of only four states that does not include Chiropractic treatment as an essential health benefit.
2. In the presentation of the updated BMP, DMHC indicates the addition of 10 visits per year for Chiropractic care. We welcome the addition of this benefit to the updated BMP.
3. The UC Kaiser plan used by the DMHC as the typicality test lists chiropractic and acupuncture office visits (up to a combined total of 24 visits per 12-month period). Is the intention of the revised BMP to combine these treatments with a limit of visits, or does it provide for 10 additional visits listed in the updated presentation?
4. How does the updated BMP describe the treatments that will be covered for Chiropractic Services? The Kaiser "best" plan for UC describes those services as: Chiropractic Services: Chiropractic services include spinal and extremity manipulation and adjunctive therapies such as ultrasound, therapeutic exercise, or electrical muscle stimulation when provided during the same course of treatment and in conjunction with chiropractic manipulative services, and other services provided or prescribed by a chiropractor (including laboratory tests, X-rays, and chiropractic supports and appliances) for the treatment of your Musculoskeletal and Related Disorder.
5. Please provide greater detail on the updated BMP with a description of the treatments that will be covered.

**In vitro fertilization (IVF) and other Fertility Treatments**

IVF and other Fertility Treatments are wonderful treatments to allow individuals who are unable to conceive to have the blessing of having a child. In the presentation, the DMHC states that the budget or room to add new benefits is 2.23%. In the Supplemental presentation slides provided by Wakely, the data provided three pathways (or options) with costs of A (0.62%), B (0.68%), and C (0.87%). We are concerned that coverage of IVF may be so expensive as an EHB that other more basic health services utilized by a larger share of Californians would have to be severely limited in the updated BMP. Respectfully, Californians may need to rely on commercial plans outside the exchange to cover these treatments for Californians who choose to have them.

U.S. Pain Foundation and CAT thank the Department of Managed Health Care for considering our recommendations as the agency moves forward with this important work. We would be pleased to provide additional information and assist the Department's efforts in any way. Please feel free to contact Judy Chalmers at the e-mail address listed below.

Sincerely,


Judy Chalmers
Volunteer Advocate and Chronic Pain Patient
Sacramento, CA
judyannchalmers@gmail.com

Tom Norris
Volunteer Advocate and Chronic Pain Patient
Chronic Pain Support Group Facilitator, American Chronic Pain Association (ACPA)
Los Angeles, CA 90007
tomn482171@aol.com

Shelley Conger
Volunteer Advocate and Chronic Pain Patient
Los Angeles, CA
sconger123@gmail.com

Michele Rice
Patient Engagement Lead
U.S. Pain Foundation
Chronic Pain Support Group Leader
San Jose, CA
Michele@uspainfoundation.org

Victoria Killian
Volunteer Advocate and Chronic Pain Patient
Canoga Park, CA
victoria@victoriakillian.com

Cindy Steinberg
Advisor to the California Advocacy Team
National Director of Policy and Advocacy
U.S. Pain Foundation
cindy@uspainfoundation.org

**From:** Jason Gabhart
**To:** DMHC Public Comments
**Subject:** Health Net Comments on DMHC Essential Health Benefits (EHB)Thank
**Date:** Tuesday, February 4, 2025 5:38:49 PM
**Attachments:** image001.png

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Thank you for the opportunity to provide comments on the Essential Health Benefits benchmark plan. Health Net recommends adding Over the Counter (OTC) Blood Pressure Cuffs to the EHB benchmark plan. We believe this benefit will help address the QTI CBP measure as we have found that the cost to cover OTC blood pressure cuffs is less than the cost to distribute kits, and the premium impact is very small. This addition would include: A4663 (blood pressure cuff only) and A4670 (automatic blood pressure monitor).

If you have any questions, please contact me. Thank you!

**Jason Gabhart**
Government Affairs Advocate
Department of External Affairs

health net

Sacramento, CA – Remote
Preferred Contact – Teams or 916-833-0462
jason.gabhart@healthnet.com | healthnet.com

***Transforming the health of the communities we serve, one person at a time.***

REPRODUCTIVE FREEDOM FOR ALL CALIFORNIA

February 4, 2025

Mary Watanabe
Director
Department of Managed Health Care
980 9th Street, Suite 500
Sacramento, CA 95814

**Re: California's Essential Health Benefits and Updating the Benchmark Plan**

Dear Director Watanabe,

On behalf of Reproductive Freedom for All California (formerly NARAL Pro-Choice California), we write to comment the recently shared Essential Health Benefit (EHB) analysis and benefits that are being considered for inclusion in the new benchmark plan. Specifically, as you consider potential benefits for In vitro Fertilization (IVF), we encourage you to approve a benefit that conforms with SB 729 (Menjivar) Chapter 930, Statutes of 2024.

We are proud cosponsors of SB 729 (Menjivar), which Governor Newsom signed into law last year. SB 729 requires large group health plans to provide coverage for fertility and infertility care, including in vitro fertilization (IVF) and updates the definition of infertility to be inclusive of LGBTQ+ family planning experiences. SB 729 is an important and timely measure to advance reproductive freedom for all Californians and removing barriers that prevent LGBTQ+ people from accessing the care they need to start a family. As you consider updating the Benchmark Plan, we strongly urge DMHC to conform with the requirements of SB 729 as closely as possible, so all Californians have the same access to infertility treatment.

Reproductive Freedom for All is dedicated to protecting and expanding reproductive freedom for all people. For more than 50 years, Reproductive Freedom for All has fought to protect and advance reproductive freedom at the federal and state levels—including access to abortion care, birth control, pregnancy and post-partum care, and paid family leave—for everybody. Reproductive Freedom for All is powered by its more than 4 million members from every state and congressional district in the country, representing the 8 in 10 Americans who support legal abortion.

Without adequate insurance coverage for fertility care, the out-of-pocket costs for these treatments are simply insurmountable for most Californians. Hormone therapy alone can cost as much as $2,000 and intrauterine insemination can cost more than $5,000. IVF can run anywhere between $24,000 and $38,015 depending on the clinic and whether a patient needs donor eggs or sperm. For Californians struggling with infertility, the very existence of the family they hope to build can depend on income alone.

With attacks on IVF and reproductive health care on the rise, we must implement best practices for IVF treatment that is safe and effective. As a result, we urge DMHC to approve a Benchmark plan that is in line with the requirements of SB 729.

Sincerely,

Elizabeth Schoetz
Chief Campaigns & Advocacy Officer
Reproductive Freedom for All

cc: Jessica Altman, Executive Director, Covered California
Ricardo Lara, Insurance Commissioner, California Department of Insurance
The Honorable Senator Caroline Menjivar and Members of the Senate Health Committee
The Honorable Mia Bonta and Members of the Assembly Health Committee

February 4, 2025

Department of Managed Health Care
Mary Watanabe, Director
980 9th Street, Suite 500
Sacramento, California 95814-2725

Via email: publiccomments@dmhc.ca.gov

**Re: Essential Health Benefits and Updating the Benchmark Plan**

Dear Director Watanabe,

On behalf of the National Health Law Program (NHeLP), thank you for the opportunity to provide comments on the initial modeling of potential changes to California's Essential Health Benefits (EHB) base-benchmark plan. We reiterate our strong support for updating the benchmark plan in order to address current gaps in access to services for individuals in private individual and small-group market plans. As we have repeatedly said in the past, these existing gaps represent a significant barrier to achieving health equity across the State. We believe it is imperative that California join the growing list of states that have updated their benchmark plan in recent years by taking advantage of additional flexibilities that the federal EHB rules afford states.

Below you will find general comments regarding the benchmarking process, comments supporting the inclusion of durable medical equipment (DME), hearing aids, and infertility treatment given the initial modeling performed by Wakely, and a request to model a more limited set of preventive oral services for adults.

## I. Procedural Considerations

We deeply appreciate the various opportunities the Department of Managed Health Care (DMHC) has already provided for stakeholders and health advocates to submit feedback on potential changes to California's EHB benchmark plan and on the actuarial evaluation performed by Wakely. Given the limitations that the federal rules establish on states seeking to expand the number of benefits covered, a successful benchmarking process requires extensive stakeholder engagement so that policymakers can make an informed decision when prioritizing the benefits to be added. To that end, we commend both DMHC and the Legislature for holding meetings before the actuarial evaluation is concluded and for planning to hold additional meetings and comment periods before proposed changes are submitted to the Center for Consumer Information and Insurance Oversight (CCIIO) by the May deadline.

Stakeholder involvement is not only best practice for a successful benchmarking process, but it is also required by the federal EHB rules. Those rules require states to "provide reasonable public notice and an opportunity for public comment on the State's selection of an EHB–benchmark plan that includes posting a notice on its opportunity for public comment with associated information on a relevant State website."[1] While CCIIO has not provided further guidance as to what constitutes reasonable opportunity for comment, we believe that, at a minimum, states should provide stakeholders with all necessary materials to submit informed written or oral comments and provide sufficient time to review all relevant materials before formulating their comments.

To that end, we are concerned that neither Wakely or DMHC released a full-length actuarial analysis before the February 4 deadline to submit comments to DMHC. While the information contained in the meeting presentation and Wakely's discussion during that presentation provide some level of information that stakeholders can use to make a preliminary assessment, important unanswered questions remain and the answers to those questions are essential for stakeholders to take a position on the additional benefits being modeled for inclusion in the benchmark plan. For example, despite the fact that Wakely's initial conclusion about the allowed cost of benefits is defined in the presentation, stakeholders have no information about the actuarial methodology utilized

[1] 45 C.F.R. § 156.111(c).

to arrive at that conclusion. Moreover, it is unclear to us what factors Wakely utilized to select the Kaiser plan for the University of California as the most generous typical employer plan, a key decision in establishing the actuarial room to add benefits.

We also remain unclear about the extent to which DMHC has evaluated the current benchmark plan's compliance with federal nondiscrimination requirements including Section 1557 of the Affordable Care Act and the EHB nondiscrimination requirement. In particular, pursuant to the federal EHB rules, California must ensure that the State's EHB benchmark plan does "not include discriminatory benefit designs that contravene the non-discrimination standards" that prohibit issuers from discriminating based on an individual's age, expected length of life, present or predicted disability, degree of medical dependency, quality of life, or other health conditions.[2] We believe it is important that, as a preliminary matter, DMHC perform a legal assessment to evaluate whether there are gaps in the current benchmark plan that potentially contravene those nondiscrimination requirements. This step is vital because DMHC could either seek to address those gaps outside of the benchmarking process, leaving more actuarial space for other benefit priorities to be addressed through benchmarking, or prioritize those benefits needed for compliance with nondiscrimination requirements when proposing changes to the benchmark.

The lack of answers those these questions make our substantive comments below preliminary in nature and based on certain assumptions that may be disproven. Therefore, we urge DMHC not to interpret our comments as blindly endorsing Wakely's conclusion. We also urge DMHC to make available a full-length actuarial report from Wakely that explains, in detail, the process and methodology that led to the conclusions regarding allowable costs for each benefit and the actuarial room to expand benefits. We also urge the Department to explain whether an assessment has been conducted that concludes that the State's benchmark plan complies with benefit design nondiscrimination requirements. We believe such information would be instrumental for stakeholders to provide additional feedback, including during the February 11 Joint Legislative Hearing. By delaying access to this this information, DMHC risks falling out of compliance with the requirements to provide reasonable opportunity for public comment with associated information.

[2] 45 C.F.R. § 156.111(b)(2)(v). *See also* 45 C.F.R. § 156.125(a).

## II. Support for DME, Hearing Aids, and Infertility Treatment

Based on the information provided by Wakely during the January 28th meeting, we fully support the addition of DME, hearing aids, and infertility treatment services in California's EHB benchmark plan. The lack of coverage for these services leads to negative health consequences that disproportionately affect individuals with disabilities, Black, Indigenous, and People of Color (BIPOC), LGBTQI+ individuals, and other underserved populations. Therefore, California should ensure that plans are addressing these gaps in coverage as an additional tool in the State's fight towards achieving health equity.

The current benchmark plan limits DME to a list of ten benefits and further limits coverage of DME to equipment for in-home use only. As a result, many plans in California fail to cover essential DME items such as wheelchairs, oxygen tanks, and CPAP machines, or have placed strict dollar limitations and/or high-cost sharing on the equipment they will cover, in addition to restrictions to in-home use only. Because DME are predominantly used by individuals with disabilities, coverage restrictions have a severe discriminatory impact on this population. Without adequate coverage, the lives of adults and children with disabilities are severely impacted—many are unable to attend school, work, or participate in community life. Others face institutionalization because they cannot function in their own homes without needed equipment.

Based on this reality, we support the inclusion of all the DME being considered by DMHC (Wheelchairs, Portable Oxygen, CPAP Machines, Walkers, Scooters, Hospital Beds, Augmented Communication Devices, and Neuromodulators). We do, however, request that DMHC ask Wakley to model the actuarial impact of eliminating the current restriction limiting coverage to devices used exclusively in-home. Under the current "home use" rules, health plans will only cover devices an individual needs for use inside their home – to the exclusion of devices they may need to leave their homes, go to work, and participate in their communities.

For example, if a person with a mobility disability can move around their home with a walker, but needs a wheelchair to travel even ten feet outside their home, then only the walker would be covered. These policies perpetuate the segregation of disabled people and inhibit them from going to school, engaging in work, supporting their families, and doing anything else a person may want or need to do. In order for the addition of DME

to be effective in addressing this inequity, the Legislature should remove the in-home limitation that applies to currently covered DME and may, without a clear mandate, also apply to the DME being adopted through the benchmarking process.

Similarly, California's current benchmark plan is an outlier when it comes to coverage of hearing aids, a situation that disproportionately affects children with hearing loss for whom hearing aids are essential for their development. The vast majority of states already require, either through their EHB benchmark plans or through separate legislation, coverage of services and devices (with replacement at appropriate intervals) for children and adults with hearing loss. In California, only one out of ten minors with hearing loss have their hearing aids covered by their private health insurance plan. Several efforts have garnered the approval of legislators to expand access to hearing aids for minors. Those efforts have been derailed by concerns regarding the possibility of the State having to defray the costs of providing hearing aids outside of the benchmarking process. At such, it is time for the State to address this glaring gap in coverage and the benchmarking process presents an ideal opportunity to do so without additional costs to the State.

We also support the addition of infertility treatment services, including in-vitro fertilization (IVF), into the benchmark plan. Coverage exclusions of the broad range of infertility treatment options represent a barrier to California's commitment to health equity and the protection of reproductive and sexual health rights across the State. Until the passage of SB 729, most private plans in California excluded coverage for these services and individuals and families were left to bear the high cost of these services. These exorbitant fees not only have a disproportionate effect on low-income Californians, but also impact underserved communities such as LGBTQI+ individuals, BIPOC populations, and individuals with disabilities, who would disproportionally benefit from IVF and other infertility treatment to have children.[3] With the passing of SB 729,

[3] *See* Ashley Wiltshire et. al, Infertility Knowledge and Treatment Beliefs among African American Women in an Urban Community, 4 CONTRACEPT. REPROD. MED 16 (2019), https://pubmed.ncbi.nlm.nih.gov/31572616 (concluding that Black women between the ages of 33-44 are twice as likely to experience infertility as white women in the same age demographic). *See also*, Liz McCaman Taylor, Jennifer Lav, Abigail Coursolle & Fabiola De Liban, Nat'l Health Law Program, NHeLP Principles on Assisted Reproduction (Sept. 27, 2021), https://healthlaw.org/resource/nhelp-principles-on-assisted-reproduction/.

California already started closing this coverage gap by requiring coverage of infertility treatment among large-group plans. Similar fixes are now needed for individuals and families seeking infertility treatment through individual and small-group market plans.

We commend the listing of various services that take part of IVF, including embryo transfers, preservations, and storage. IVF is riddled with uncertainties where the odds are extremely difficult to assess. We are therefore encouraged that Wakely allowed for much flexibility when it broadly defined fertility drugs, extraction, and fertilization. The only point of clarification we seek is whether sperm and egg transfers include the patient's or partner's own egg and/or sperm since the implication in these charts is that the patient will seek donor eggs and sperms. Additionally, when donor eggs and sperm are used, the medical costs of the services associated with the retrieval should also be covered (including, without limitation, physical examination, laboratory screening, psychological screening, and prescription drugs).

Option C, which maximizes the number of IVF cycles and transfers, is more likely to result in a desired live birth experience.[4] This would of course result in three rounds of cryopreservation, which would make it consistent with the scope of SB 729. We highly discourage the limits on transfers, cycles, and storage found in Options A and B. Even in states where there are storage limits, they are a lot longer than six months.[5] Alternatively, some states limit storage to the duration of the policy term.[6] When it comes to transfers or retrievals, most states also go much beyond the limits prescribed under Options And B.[7] Finally, we want to make clear that this policy must be provided without discrimination on the basis of age, ancestry, disability, domestic partner status, gender, gender expression, gender identity, genetic information, marital status, national origin, race, religion, sex, or sexual orientation, consistent with state and federal law. Historically, LGBTQI+, non-partnered, and disabled people have been excluded from these benefits. We want to make sure they are accessed by anyone who needs them.

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[4] Other states, likes Maryland, also limit coverage to three IVF attempts per live birth. *See, e.g.*, Md. Insurance Code § 15-810 (2022).
[5] See, *e.g.*, Ky. Rev. Stat. § 304.17A-261 (limiting storage to one year).
[6] See, *e.g.*, N.H. Rev. Stat. § 417-G:2 (limiting cryopreservation storage to the duration of the policy term).
[7] *See, e.g.*, Code Me. R. tit. 02-031 Ch. 865 § 6 (limiting to four completed egg retrievals over the lifetime of the egg retrieval patient).

While we hope the addition of all DME, hearing aids, and Option C of infertility treatment will fit within the typicality room to add benefits, we are aware that DMHC is working within a very tight window. We will evaluate proposals to modify these three categories of benefits if needed for future comment opportunities. We reiterate that, if modifications to these three categories of benefits are needed, our future comments would greatly benefit from additional information regarding Wakely's methodology and regarding the benchmark plan's compliance with nondiscrimination requirements.

## III. Requesting Modeling of Preventive Oral Services for Adults

While we understand the difficult choices that DMHC and the Legislature must make given the typicality/generosity limit, we would like to see clear indication that no amount of preventive oral services for adults can be added together with all of the DME, hearing aids, and infertility treatment services, without exceeding the actuarial room available to the State. To that end, we urge DMHC to ask Wakely to model a potential benchmark plan that includes DME, hearing aids, infertility treatment, and preventive oral services for adults and evaluate whether adjusting the services that make up preventive oral care could lower the allowed cost of the proposed plan in order to bring it within the actuarial room to add benefits. Specifically, we would like to know whether reducing oral exams and prophylaxis to one per year lowers the allowable costs enough to bring the actuarial cost of the plan within the allowable range.

## IV. Conclusion

Thank you for considering our feedback. Please do not hesitate to contact me (hernandez-delgado@healthlaw.org) should you have any questions. We look forward to continue working with DMHC and the Legislature to make individual and small-group market coverage in California more comprehensive and equitable.

Sincerely,

Héctor Hernández-Delgado
Senior Attorney
National Health Law Program

Tuesday, February 4, 2025

Dear Members of the Department of Managed Health Care,

On behalf of the Occupational Therapy Association of California (OTAC), I appreciate the opportunity to provide comments following your recent analysis and cost estimates for California's Essential Health Benefits (EHB) benchmark plan. I am writing to advocate for the explicit and comprehensive inclusion of occupational therapy as an essential health benefit across multiple service categories in the areas of rehabilitation and preventative care.

OTAC is a not-for-profit professional organization representing the interests of the approximately 23,500 licensed occupational therapy practitioners throughout California. Under the California Occupational Therapy Practice Act, occupational therapists (OTs) and occupational therapy assistants (OTAs) are empowered to work with people of all ages experiencing physical, mental, and behavioral health conditions or disabilities to develop, improve, or restore functional daily living skills.

Occupational therapy is the only preventive and rehabilitative service that utilizes meaningful activities—or "occupations"—as therapeutic interventions, while addressing the holistic needs of individuals to promote functional independence, wellness, and recovery in essential life roles. Occupational therapy practitioners address simple yet complex occupations including activities of daily living, such as bathing, dressing, grooming, toileting, and eating. They also address instrumental activities of daily living, such as home management, grocery shopping, community mobility, and meal preparation. The scope of practice also includes work, education, leisure, social participation, health management, and sleep.

Occupational therapy (OT) plays a critical and irreplaceable role in health care, helping individuals regain, maintain, or enhance their ability to engage in meaningful daily activities. This therapeutic approach is crucial for aging in place, recovering after a hospitalization or life-changing health event, prevention and managing of chronic health conditions, and therapeutic intervention across the lifespan from babies through older adults.

**Why Occupational Therapy is Essential:**

1. **Ambulatory and Outpatient Services:**
   Occupational therapists provide personalized rehabilitation for individuals recovering from injuries, surgeries, and chronic conditions. They address functional challenges through pain management, adaptive equipment training, ergonomic modifications, and return-to-work strategies.
2. **Newborn Care:**
   In neonatal care, occupational therapists support the development of premature and medically fragile infants by addressing sensory regulation, feeding and oral motor skills, and educating parents and caregivers on optimal care strategies.

3. **Preventive and Wellness Services:**
   OT reduces risk factors for chronic conditions through fall prevention, joint protection strategies for arthritis, and lifestyle modifications for conditions like heart disease, hypertension, and diabetes.

4. **Rehabilitative and Habilitative Services:**
   Occupational therapists provide hands-on therapy, assistive technology training, and adaptive strategies to help individuals regain essential life skills and mobility. They are essential in training individuals and caregivers in the effective use of durable medical equipment (DME), ensuring proper selection, customization, and usability to maximize independence. This includes equipment like transfer tub benches, 3-in-1 commodes, ramps, wheelchairs, walkers, and other functional mobility devices and adaptive equipment used for feeding and dressing.

5. **Pediatric Services:**
   Occupational therapy practitioners play a key role in helping children develop motor, sensory, self-care, and social-emotional skills needed for school and daily life, addressing conditions such as autism, attention-deficit/hyperactivity disorder (ADHD), and motor delays.

6. **Hearing Aids and Communication Support:**
   While hearing aids restore auditory input, occupational therapy helps individuals navigate daily life by addressing sensory processing and communication barriers and modifying environments for meaningful participation in work and social activities.

7. **Fertility Care:**
   OT provides stress management, mental health support, and adaptive strategies for individuals undergoing fertility treatments, maternal mental health, postpartum recovery, and pelvic floor rehabilitation.

**The Comprehensive and Cost-Effective Nature of OT:**
Unlike many standalone treatments, occupational therapy offers long-term, functional solutions that reduce healthcare costs by preventing complications, avoiding hospital readmissions, and minimizing reliance on passive treatments. Occupational therapists analyze how a person's daily activities affect their health, recovery, and overall well-being—an approach that is both innovative and essential to comprehensive care.

We urge the Department of Managed Health Care to explicitly prioritize occupational therapy within California's EHB benchmark plan and request that Wavely incorporate an assessment of occupational therapy into their calculations (i.e. price out what it would cost to add occupational therapy as an essential benefit) for rehabilitative and preventative care. The inclusion of OT as a fully recognized service will enhance the health and well-being of Californians by supporting their ability to live life to its fullest, recover meaningfully after health events, and achieve lasting independence.

Thank you for your time and consideration. We are available to provide further information or participate in future discussions.

Sincerely,

Samia H. Rafeedie, OTD, OTR/L, BCPR, CBIS, FAOTA
President the Occupational Therapy Association of California

Stanford MEDICINE
Fertility and Reproductive Health

TO: Department Managed Health Care

FROM: Ruben Alvero, MD (Reproductive Endocrinologist/American Society for Reproductive Medicine Board of Directors (ASRM)/Executive Committee ASRM/Stanford Medical School Faculty)

February 5, 2025

SUBJECT: Response to Public Commentary for Essential Health Benefits (EHB)

1. It is my professional opinion that the Fertility EHB should closely mirror SB 729 by covering 3 eggs retrievals and an unlimited number of transfers. This is based on extensive US and international literature as well as professional consensus that supports this as the most cost-effective way to maximize an individual's chances for a healthy pregnancy and neonatal outcome. This standard is maintained by most of the mandated states and closely adheres to what commercial insurance companies do for their covered lives.
2. Specifically, Pathway C has the 3 egg retrievals and unlimited transfers as well as unlimited embryo storage. Embryo storage of this extended duration is important because in conventional practice the egg retrieval and subsequent embryo transfer are unlinked and the time interval between completion and recovery from an egg retrieval generally require several months due to coordination and consultation in the event that the first frozen embryo transfer is unsuccessful. The limited cryostorage time of six months in Pathways A and B are insufficient for safely completing this preparation.
3. In the event that donor sperm is needed, multiple insemination cycles are typically required, each with 2 vials for adequate sperm number and in the event that there are insufficient sperm number in just one vial. To maximize success rates, 6 insemination cycles are needed.
4. Four donor eggs, as seen in Pathway B, are inadequate to give a patient a good chance of obtain even a single blastocyst embryo. Embryos banks generally sell batches of at least 6-8 eggs and often more because of this. Therefore, Pathway C is the only one that meets the standard of care. This is especially important since this technique is especially used by same sex male couples to achieve a pregnancy.
5. I am concerned that calculations and assumptions have not been transparent in assigning the 0.87% of allowed benefit additions. Even in the breakdown received after the Public Meeting on January 28, 2025, the source data for arriving at the broken-out services is not available. Additionally, it appears to be out of line with prior assessments made by other agencies such as Fertility Dynamics in support of SB 729. For us to understand the Wakely cost estimate we would need to have the full back-up fiscal analysis that Wakely presumably developed to derive their bottom-line numbers. We need to know what services are included, what unit cost assumptions, what utilization assumptions, etc.
6. We would appreciate these additional data before we can understand if the estimate made by Wakely is acceptable.

Division of Reproductive Endocrinology and Infertility
1195 W. Fremont Avenue
Sunnyvale, CA 94087

Stanford
MEDICINE
Fertility and
Reproductive Health

DEPARTMENT OF OBSTETRICS AND GYNECOLOGY

Ruben Alvero, MD
Professor OB GYN
Department of Obstetrics and Gynecology
Stanford University

Division of Reproductive Endocrinology and Infertility
1195 W. Fremont Avenue
Sunnyvale, CA 94087

733 Third Avenue
Suite 510
New York, NY 10017

212-685-3440
info@crohnscolitisfoundation.org
www.crohnscolitisfoundation.org

February 4, 2024

Ms. Mary Watanabe, Director
California Department of Managed Health Care

RE: *CA Essential Health Benefits: Updating the Benchmark Plan – Inclusion of Oral Enteral Nutritional Formulas as Medically Necessary DME*

Dear Director Watanabe,

On behalf of the Crohn's & Colitis Foundation, I first would like to thank you for proposing updates to the existing benchmark to include coverages of treatments and durable medical equipment that reflect the current needs of patients. However, we were disappointed that the initial proposal did not include oral enteral nutritional formulas. Therefore, I am writing to urge the inclusion of **oral enteral nutritional formulas, including polymeric and semi-elemental formulas,** in the updated Essential Health Benefit Benchmark Plan. These formulas are medically necessary durable medical equipment (DME) for a broad range of patients with serious health conditions that impair their ability to obtain adequate nutrition from a standard diet.

**Oral enteral nutrition is a medical necessity.** Many individuals rely on enteral nutrition to sustain life, prevent malnutrition, and improve health outcomes. These formulas are critical for patients across a spectrum of medical conditions, including but not limited to the following:

**Gastrointestinal Disorders:**

- Crohn's disease and ulcerative colitis. Chronic inflammation can severely impact nutrient absorption, requiring enteral nutrition.
- Short bowel syndrome. Patients with surgically shortened intestines struggle to absorb sufficient nutrients from food.
- Gastroparesis. Delayed gastric emptying makes it difficult to digest solid foods, necessitating liquid nutritional formulas.
- Celiac disease (severe cases). Malabsorption may require enteral nutrition to prevent complications.

**Neurological and Neuromuscular Disorders**

- Amyotrophic lateral sclerosis, Parkinson's disease, stroke, multiple sclerosis. Dysphagia (swallowing difficulties) can lead to malnutrition without enteral support.

733 Third Avenue
Suite 510
New York, NY 10017

212-685-3440
info@crohnscolitisfoundation.org
www.crohnscolitisfoundation.org

**Cancer and Cancer Treatment-Related Conditions:**

- Head, neck, and esophageal cancers. Radiation and chemotherapy frequently cause swallowing impairments and severe weight loss.
- Cachexia (cancer-related wasting syndrome). Adequate nutrition is essential to maintaining strength during cancer treatment.

**Metabolic and Genetic Disorders:**

- Inborn errors of metabolism (e.g., phenylketonuria, maple syrup urine disease). Specialized enteral formulas provide essential nutrition while avoiding harmful metabolic byproducts.
- Cystic fibrosis. Malabsorption issues require high-calorie enteral formulas to maintain weight and support overall health.

**Chronic and Critical Illnesses:**

- Chronic kidney disease and congestive heart failure. Enteral nutrition supports overall health, hydration, and energy levels.
- Burn injuries and trauma recovery. High-protein and calorie-dense enteral nutrition aids in healing and immune function.

**Post-Surgical Recovery and Rehabilitation:**

- Gastrointestinal surgeries (e.g., bowel resection, bariatric surgery). Enteral nutrition is often required while the digestive system heals.
- Head and neck surgeries. Patients recovering from major procedures may require enteral nutrition to meet dietary needs.

**Pediatric Conditions:**

- Failure to thrive (FTT), cerebral palsy. Many children require enteral nutrition to prevent malnutrition and ensure proper growth and development.

Despite the critical importance of enteral nutrition, many health insurance policies exclude oral enteral formulas from coverage, forcing patients and families to bear excessive out-of-pocket costs. The current benchmark plan includes “elemental dietary enteral formulas” for the treatment of enteritis, but this limited language has created confusion and has failed to guarantee coverage for polymeric and semi-elemental formulas.

Expanding coverage for oral enteral nutrition is a practical and-cost effective solution that will prevent serious medical complications by ensuring that vulnerable patients receive proper nutrition and reduce overall healthcare costs by decreasing hospitalizations and avoiding the

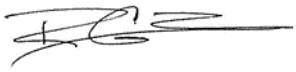
733 Third Avenue
Suite 510
New York, NY 10017

212-685-3440
info@crohnscolitisfoundation.org
www.crohnscolitisfoundation.org

need for costly medications or emergency interventions. Additionally, coverage will provide patients and families with much needed financial relief to afford medically necessary nutrition.

For all these reasons, the Crohn's & Colitis Foundation respectfully urges the Department of Managed Health Care to explicitly include oral enteral nutritional formulas—including polymeric and semi-elemental formulas—in the updated Essential Health Benefit Benchmark Plan. Doing so will align with California's commitment to equitable healthcare access and improve the lives of countless patients who depend on these formulas for survival. Thank you for your time and consideration.

Sincerely,



Ryan G. Spencer
Legislative Advocate

RICARDO LARA
CALIFORNIA INSURANCE COMMISSIONER

January 24, 2025

Director Mary Watanabe
California Department of Managed Health Care
980 9th Street, Suite 500
Sacramento, CA 95814

**Re: Updating California's Essential Health Benefits Benchmark Plan**

Dear Director Watanabe:

The Department is pleased that the Newsom Administration and the Legislature are reviewing California's benchmark plan. CDI has long been concerned that the lack of coverage for durable medical equipment (DME) and external prosthetic devices disproportionately and inequitably burdens people with disabilities and chronic illnesses who have individual or small group market coverage.

As you are aware, the current benchmark plan, the 2014 Kaiser small employer HMO "30 plan," was chosen in 2015 and codified by SB 43 (Hernandez, Ch. 648, 2015). During the legislative process, CDI provided analysis to the legislature regarding the benefits covered by the choices available for a new benchmark plan, especially regarding choices that would best benefit Californians with disabilities and chronic illnesses.

It is with those previous comments in mind that CDI offers the following recommendations when the Department of Managed Health Care (DMHC) considers adding benefits to the existing benchmark plan or choosing a new benchmark plan:

1. The current benchmark plan's coverage of DME is extremely limited.[1] The Department recommends that at a minimum, manual and power wheelchairs, walkers, hospital beds, respiratory equipment such as oxygen systems, and power operated scooters should be added to EHBs. These items have long been known to be essential to daily living for people with disabilities and are included in Medi-Cal coverage. California's previous failure to choose a benchmark plan that covered these items in 2015, when it had a clear opportunity to do so, can be rectified this year by adding a comprehensive DME benefit to the benchmark plan. DMHC can choose not to deprive Californians of the basic

[1] A list of the limited DME that is EHB can be found in 10 Cal. Code Regs. § 2594.3(a)(4).

right to leave their homes, access employment, and live full lives in their communities, and CDI strongly supports this choice.

2. The current benchmark plan's coverage of external prosthetic and orthotic devices is also meagre. CDI recommends that you consider adding external prosthetic and orthotic devices required to replace the function of all or part of an organ or extremity, rigid and semi-rigid orthotic devices required to support or correct a defective body part, and special footwear for foot disfigurement, to EHBs.

3. CDI recommends clarifying that birth doulas are covered benefits, consistent with Medi-Cal.

4. CDI recommends coverage of hearing aids and related services for insured people of all ages.

5. CDI recommends, consistent with the requirements set forth by SB 729 (Menjivar, Chapter 930, Statutes of 2024), coverage of the diagnosis and treatment of infertility, including but not limited to, services such as artificial insemination, in vitro fertilization, and fresh and frozen embryo transfer.

6. CDI recommends coverage for prescription eyeglasses or contact lenses following cataract surgery.

7. The current benchmark plan limits coverage of home health visits to 100 per year. CDI recommends the removal of this treatment limitation and instead cover all home health visits that are medically necessary.

Finally, the 2025 Notice of Benefit and Payment Parameters, finalized on April 3, 2024 by the Centers for Medicare & Medicaid Services, removed the regulatory prohibition on providing routine non-pediatric dental services. I strongly support including routine dental services for insured people of all ages in the next benchmark plan.

Good oral health is an essential component of an individual's overall health and well-being. Unfortunately, long-standing systemic inequities in our health care system have resulted in members of historically disadvantaged communities receiving inadequate access to dental care due to lack of coverage. Specifically, Black and Latino/x adults are more likely to have tooth decay, and moderate to severe periodontal disease than White adults.[2] A lack of access to dental care can have serious consequences for all aspects of overall health. Untreated periodontal disease and tooth loss are associated with cardiovascular disease, including atrial fibrillation and heart

[2] Borrell, Luisa, *Racism and oral health equity in the United States: Identifying its effects and providing future directions* (Spring 2022) Journal of Public Health Dentistry.

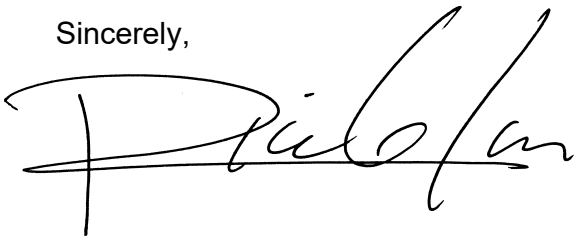
failure.[3] Moreover, studies have demonstrated that individuals who receive comprehensive oral care during substance use disorder treatment have improved treatment outcomes at discharge.[4]

Including routine dental care in the benchmark plan is critical to advancing overall health equity and increasing access to dental care. It will rectify long-standing disparities in this area and help address the mental health and substance use disorder crisis that the state is working so hard to alleviate.

The Affordable Care Act (ACA) and state law forbid health insurers and plans from employing benefit designs that discriminate based upon an individual's health status. Unfortunately, the current benchmark allows carriers to do just that. The current benchmark is based largely on pre-ACA era mandates and documents that were written prior to the ACA's prohibition on discriminatory plan design. We must do our part to eliminate the inequities in health coverage, especially those faced by historically disadvantaged communities. This is our chance to address the coverage gaps that promote inequities, to backfill gaps, and to incorporate advances in medical and behavioral health treatment.

We are pleased to be able to provide further input as you move through the process of examining and making recommendations on California's benchmark plan. Please contact me or Josephine Figueroa, Deputy Commissioner and Legislative Director, at (916) 917-7909 if you have any questions.

Sincerely,



**RICARDO LARA**
Insurance Commissioner

cc: Christine Aurre, Legislative Affairs Secretary, Office of the Governor
Christine Hemann, Deputy Director Legislative Affairs, California Department of Managed Health Care

[3] Webb, Dietrich, et. al., *Evidence summary: the relationship between oral and cardiovascular disease* (March 2017) British Dental Journal; Woo, Chang, et. al., *Improved oral hygiene care is associated with decreased risk for atrial fibrillation and heart failure: a nationwide population-based cohort study* (2020) European Journal of Preventive Cardiology.
[4] Hanson, G.R., et. al., *Comprehensive oral care improves treatment outcomes in male and female patients with high-severity and chronic substance abuse disorders* (2019) Journal of the American Dental Association.

California Association of Medical Product Suppliers
One Capitol Mall, Suite 800
Sacramento, CA 95814
Phone: (916) 443-2115
Fax: (916) 444-7464
www.campsone.org

February 4, 2024

Ms. Mary Watanabe, Director
California Department of Managed Health Care
980 9th St #500
Sacramento, CA 95814
publiccomments@dmhc.ca.gov

**RE:** ***CA Essential Health Benefits: Updating the Benchmark Plan***
**Medically Necessary Durable Medical Equipment: Enteral Nutrition, Glucose Monitors for Diabetes, & Blood Pressure Monitors.**

Dear Director Watanabe:

On behalf of the California Association of Medical Product Suppliers (CAMPS), I would like to express our gratitude for the inclusion of general durable medical equipment (DME), such as wheelchairs and portable oxygen, in the updated Essential Health Benefit Benchmark Plan. By covering these critical items, the Department of Managed Health Care is helping to alleviate financial burdens for patients and their families while improving access to necessary medical care and enhancing health outcomes.

While we appreciate the progress made in expanding coverage for certain DME, CAMPS respectfully requests additional consideration for other medically necessary DME, specifically enteral nutritional products, glucose monitors for diabetes, and blood pressure monitors. These essential items play a crucial role in the management of chronic health conditions and contribute to overall patient well-being, reducing hospitalizations and healthcare costs.

**Enteral Nutrition: A Lifeline for Patients with Medical Conditions.** Oral enteral nutrition formulas are essential for individuals who cannot meet their nutritional needs through regular diet alone due to medical conditions such as cancer, gastrointestinal disorders, or severe allergies. Despite their critical importance, many health insurance policies do not cover these medical necessities, forcing patients to bear substantial out-of-pocket expenses.

Including enteral nutrition as an essential health benefit is vital because:

- **It prevents malnutrition and life-threatening complications** for individuals who rely on these products for sustenance.
- **It reduces healthcare costs** by preventing hospitalizations and minimizing the need for intensive medical interventions.
- **It supports recovery and improves health outcomes**, particularly for patients recovering from illness or surgery.

**Glucose Monitors and Blood Pressure Monitors: Essential for Chronic Disease Management.** Devices such as glucose monitors for diabetes and blood pressure monitors for hypertension are indispensable for effective disease management. These tools empower patients to monitor their conditions at home, reducing the need for frequent doctor visits, emergency room visits, and hospital admissions. Without adequate coverage, many individuals forego essential monitoring, leading to severe complications and higher long-term healthcare costs.

## Ensuring Equitable Access to Essential DME

The financial burden of obtaining DME and medical supplies should not be a barrier to quality healthcare, and we appreciate the departments recognition by including such DME in the benchmark, but by including coverage of these additional durable medical equipment, we can better:

- **Reduce the burden on caregivers**, providing them with the necessary tools to care for loved ones safely and effectively.
- **Promote health equity and inclusivity**, ensuring vulnerable populations receive the care they need.
- **Align healthcare coverage with principles of compassion and dignity**, supporting individuals with disabilities and chronic conditions in leading independent lives.

For these reasons, CAMPS respectfully urges the Department of Managed Health Care to expand the Essential Health Benefit Benchmark Plan to include enteral nutritional products, glucose monitors, and blood pressure monitors. Doing so will not only improve patient outcomes but also reinforce California's commitment to equitable, accessible, and high-quality healthcare for all.

Thank you for your time and consideration. We look forward to your support in ensuring that these critical medical products are made available to those who need them most.

Sincerely,

Gloria Peterson
CA Association of Medical Product Suppliers, Executive Director

DELTA DENTAL®

deltadentalins.com

February 3, 2025

SUBMITTED ELECTRONICALLY
Ms. Mary Watanabe, Director
Department of Managed Health Care
980 9th Street, Suite 500
Sacramento, CA 95814.
Via electronic submission: publiccomments@dmhc.ca.gov

**Re: California's Essential Health Benefits and Updating the Benchmark Plan**

Dear Ms. Watanabe:

On behalf of Delta Dental of California ("Delta Dental"), which provides over 11.2 million Californians with quality dental coverage, thank you for the opportunity to provide input on California's Essential Health Benefits (EHBs) and the potential updates to the benchmark plan following the Wakely analysis.

Delta Dental appreciates the complexity that the California Department of Managed Health Care (DMHC), the Administration, and the Legislature faces in undergoing a joint effort in the review of California's EHBs Benchmark Plan, which establishes how small group and individual insurance plans can be offered both on and off the state's health exchange, Covered California. This process could result in recommendations for the California legislature to amend the current benchmark plans identified under H&S Code 1367.005, potentially impacting the markets in Plan Year 2027.

Due to recent changes to federal rules relating to a state's adoption of EHBs under the Affordable Care Act, the allowance for states to designate non-pediatric dental benefits as an EHB could result in unintended consequences unless carefully implemented. Delta Dental commends the thoughtful analysis overseen by the Department and the acknowledgement of the overall cost and market disruption that would occur if adult dental at any level was added to the benchmark.

Delta Dental appreciates this opportunity to provide comments on the proposed rule. Please contact me at (415) 972-8418 or jalbum@delta.org should you have any questions or concerns.

Sincerely,

Jeff Album

Jeff Album
Vice-President, Public and Government Affairs

Delta Dental Insurance Company
Telephone: 800-521-2651

Delta Dental of California
Telephone: 888-335-8227

Delta Dental Mid-Atlantic Region
Delta Dental of Delaware, Inc.
Delta Dental of the District of Columbia, Inc.
Delta Dental of Pennsylvania (Maryland)
Delta Dental of West Virginia
Delta Dental of New York, Inc.
Telephone: 800-932-0783

WESTERN CENTER
ON LAW & POVERTY
1107 Ninth Street, Suite 680
Sacramento, CA 95814
T 916.442.0753
www.wclp.org

Sacramento Office
Brandon L. Green, Director of Policy Advocacy
Linda Nguy, Associate Director of Policy Advocacy
Whitney Francis, Policy Advocate
Rebecca Gonzales, Policy Advocate
Benjamin Henderson, Policy Advocate
Keely O'Brien, Policy Advocate
Sandra O. Poole, Policy Advocate
Tina Rosales-Torres, Policy Advocate

February 3, 2025 Via email: publiccomments@dmhc.ca.gov

California Department of Managed Health Care
980 9th Street, Suite 500
Sacramento, CA 95814

**Re: California's Essential Health Benefits and Updating the Benchmark Plan**

To whom it may concern:

Thank you for the opportunity to provide comments regarding potential changes to California's Essential Health Benefits (EHB) base-benchmark plan. We appreciate the effort that the Department of Managed Health Care (DMHC), in partnership with the Legislature and the California Health and Human Services Agency (CalHHS), is undertaking towards achieving that goal.

For over fifty-six years, Western Center on Law and Poverty has advocated on behalf of Californians experiencing poverty in every branch of government—from the courts to the Legislature. Through the lens of economic and racial justice, we litigate, educate, and advocate around health care, housing, and public benefits policies and administration. Further, we believe health care is a human right, so we work to preserve and expand equitable health care for **all** Californians.

As previous co-sponsors of AB 2753 (Ortega)(2023-2024) and AB 1157 (Ortega) (2023-2024), Western Center on Law and Poverty has actively advocated for increased access to essential health services including the inclusion of Durable Medical Equipment (DME) as a covered EHB in California.

The current benchmark creates a significant gap in services due to its lack of coverage for DME. As a result, many Californians do not have access to the wheelchairs, hearing aids, oxygen equipment or other durable medical equipment that they need because private health plans in California's individual and small group markets regularly exclude or limit coverage of this equipment. Without adequate coverage, people go without medically necessary devices, obtain inferior ones that put their health and safety at risk, or turn to publicly-funded

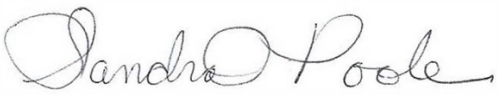
health care programs for help. This gap in private coverage occurs despite the Affordable Care Act's clear mandate to cover all essential health benefits, including rehabilitative and habilitative devices, in a nondiscriminatory way.

Western Center on Law and Poverty is pleased that the Essential Health Benefit Analysis and Benefit Options presented by Wakely at the public meeting on January 28, 2025 considers wheelchairs, portable oxygen, CPAP machines, hearing exams and hearing aids as potential benefit additions. A significant need currently exists for coverage of manual and power wheelchairs as well as hearing aids. Many of the concerns we heard from constituents regarding the gaps in coverage were related to these items. We also strongly support California's inclusion of In Vitro Fertilization (IVF) in the new benchmark plan.

In addition to the previously discussed EHBs, California would be remiss if it did not take this opportunity to also model adding preventive dental (or routine dental) as a benefit. Adding preventive dental would be an important step towards preventing chronic conditions and addressing health disparities in our state.

Finally, we caution that the resulting proposed benchmark plan should improve upon current benchmark coverage without cutting or reducing benefits. DMHC should only consider changes to the EHB benchmark plan that add benefits without cutting or reducing the scope of existing covered benefits. Any additional benefits or expansions in scope should be able to meet the generosity requirements without the need to reduce other benefits and should not be adopted at the expense of other currently covered services. The current benchmark plan and all services it extends to must be the baseline for any new benchmark plan.

Sincerely,



Sandra O. Poole
Policy Advocate

cc: Teri Boughton, Senate Health Committee
Lara Flynn, Assembly Health Committee