CALIFORNIA LEGISLATURE

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Joint Informational Hearing
Assembly and Senate Health Committees
2027 Essential Health Benefits Benchmark Options
Tuesday, February 11, 2025—1:30 p.m. 1021 O Street, Room 1100

PURPOSE OF THIS HEARING

The federal Patient Protection and Affordable Care Act (ACA) requires health plans sold in the individual and small group markets to offer a comprehensive package of items and services, known as essential health benefits (EHBs), with no dollar limits. Under the ACA, the federal government gave each state the authority to choose its "benchmark" EHB plan.

California's current EHB benchmark plan does not include coverage for hearing aids, infertility treatment, adult dental, chiropractic, wigs, optometry, nutritional counseling, dietary enteral formulas, or durable medical equipment (DME), among other benefits. The inclusion of any of these benefits in California's EHBs requires the state to update its existing benchmark plan through a stakeholder process and to notify the federal Centers for Medicare and Medicare Services (CMS), by May of 2025, in order for those benefits to be in place for the 2027 plan year. The introduction of SB 1290 (Roth) and AB 2914 (Bonta) in 2024 began a review process, which requires an actuarial analysis and a stakeholder process to inform policymakers about options, and ultimately to codify any changes to California's benchmark plan. Any added health insurance mandates outside of this process require the state to pay for or "defray" the added costs of health insurance mandates not included in the benchmark.

The purpose of this informational hearing is to provide the Assembly and Senate Health Committees with information about the analysis and options that may be considered for California's 2027 EHB benchmark plan. The hearing will also allow for stakeholder comment.

BACKGROUND

Prior to the enactment of the ACA in 2010, covered benefits under a health plan or insurance policy varied from policy to policy. For example, in California some state-required covered benefits (or coverage "mandates") applied only to health care service plan contracts offered by health plans regulated by the Department of Managed Health Care (DMHC) under the Knox-Keene Health Care Service Act of 1975, while others applied to health insurance policies offered by health insurers regulated by the Department of Insurance under the Insurance Code. Today,

most mandates apply to both health plan contracts and health insurance policies. However, there are three different market segments where carriers sell products that meet market-specific requirements: individual; small group; and, large group. In some cases, a mandate may apply to one, two, or all three market segments. In group products, there are also some mandates to "offer" coverage (for example, the offer of infertility services in the large group market). California has an expansive range of benefit mandates that includes basic health care services, cancer screenings and treatment, HIV prevention and treatment, diabetes education and treatment, behavioral health treatment for autism related disorders and severe mental illness, and hospice care.

Under federal law, EHBs require plans to cover ten categories of services: (1) ambulatory patient services (outpatient care); (2) emergency services; (3) hospitalization; (4) maternity and newborn care; (5) mental health and substance use disorder services, including behavioral health treatment; (6) prescription drugs; (7) rehabilitative and habilitative services and devices; (8) laboratory services; (9) preventive and wellness services and chronic disease management; and, (10) pediatric services, including dental and vision care. The ACA helps consumers shop for and compare health insurance options in the individual and small group markets by promoting consistency across plans, protecting consumers by ensuring that plans cover a core package of items that are equal in scope to benefits offered by a typical employer plan, and limit out of pocket expenses. Federal rules outline health insurance standards related to the coverage of EHBs and the determination of actuarial value (AV) – (which represents the share of health care expenses the plan covers for a typical group of enrollees), while providing significant flexibility to states to shape how EHBs are defined. Taken together, EHBs and AV significantly increase consumers' ability to compare and make an informed choice about health plans.

ACA subsidies. The ACA also provides federal subsidies for those who qualify, referred to as Advanced Premium Tax Credits (APTCs), to help offset the costs to purchase individual market health insurance purchased through federal or state marketplaces (or health benefit exchanges). According to Covered California, the state's health benefit exchange, in June of 2024, approximately 1.5 million Californians received an average of $519 per member per month in APTCs (this translates to $9.7 billion on an annualized basis). Approximately 19% comes from the federal Inflation Reduction Act enhanced subsidies, which are set to expire at the end of 2025. For 2024, these enhanced APTCs were roughly $1.8 billion.

Defrayal of mandate costs. Under the ACA, if states require plans to cover services beyond those defined as EHBs in law, states must pay the costs of those benefits, either by paying the enrollee directly or by paying the qualified health plan (offered through Covered California). States adopting a new benchmark plan or revising the existing plan will not result in triggering defrayal. This is the process the Legislature and Administration are currently engaged in.

Cost impacts to patients. It should be noted that premiums (what consumers/patients/small employers pay) may increase as a result of setting a new benchmark plan. Individuals who are eligible for premium subsidies may be shielded from premium increases, but those not eligible for subsidies will feel the full impact of any premium increase. Covered California announced

individual insurance market rates for the 2025 coverage year indicating the preliminary statewide weighted average rate change for the 2025 coverage year is 7.9%. Northern and Central valley regions are seeing higher premium increases and the Monterey, San Benito and Santa Cruz county region are seeing the highest average increase at 15.7%. The region with the lowest average increase is San Bernardino and Riverside with 5.3%. San Francisco and Bay Area regions, Los Angeles and San Diego are seeing average premium increases in the 7 to 8% range. Orange County is seeing an average premium increase of 9.6%

California's EHB benchmark plan selection process. The federal Department of Health and Human Services (HHS) defines EHBs based on state-specific EHB benchmark plans and gives each state the authority to choose its "benchmark" plan. California chose the Kaiser Small Group HMO plan in 2012, and last reviewed it in 2015. At that time, an actuarial firm analyzed and compared the health services covered by the ten plans available to California as options for California's EHB benchmark, similar to an analysis completed for Covered California in 2012. The actuarial firm found relatively small differences in average healthcare costs among the ten benchmark options. Among the plan options, the actuarial firm found differing coverage of acupuncture, infertility treatment, chiropractic care, and hearing aids. The three California small group plans were essentially the same average cost as the California EHB plan and the California large group and CalPERS plans were approximately 0.2% to 1% higher in cost. The estimated average costs for the three federal employee plan options was approximately 0.8% to 1.2% higher than the California EHB plan. At that time, California chose to maintain the same Kaiser Small Group Plan initially selected as California's benchmark plan.

Updating EHBs. HHS issued final rules in 2018 and 2019, which provided flexibility for states by allowing three new options for the EHB benchmark plan, in addition to the option of retaining the current EHB benchmark plan. Beginning with the 2020 plan year, states could: (1) select an EHB benchmark plan used by another state for the 2017 plan year; (2) replace one or more of the ten EHB categories in the state's EHB benchmark plan with the same category or categories of EHBs from another state's 2017 EHB benchmark plan; or, (3) otherwise select a set of benefits that would become the state's EHB benchmark plan. At a minimum, the EHB benchmark plan must provide a scope of benefits equal to or greater than a typical employer plan. Furthermore, a new "generosity test" requires that EHBs cannot exceed the generosity of the most generous among the set of ten previous 2017 benchmark comparison plan options. According to the CMS website, for plan years between 2020 and 2025, nine states have updated their EHB benchmark plans.

Updated process rules. In April of 2024, CMS finalized new rules for EHB benchmark updates through the HHS Notice of Benefit and Payment Parameters for 2025. As part of this update, CMS removed a regulatory prohibition on plans and insurers from including routine non-pediatric dental services as an EHB. This allows states to add routine adult dental services as an EHB by updating their EHB benchmark plans. For plan years beginning on or after January 1, 2026, CMS has approved three revisions to the standards for state selection of EHB-benchmark plans to address long-standing requests from states to improve, and reduce the burden of, the EHB-benchmark plan update process. First, CMS will allow states to consolidate the options for

states to change EHB-benchmark plans such that a state may change its EHB-benchmark plan by selecting a set of benefits that would become the state's EHB-benchmark plan. Any changes to state EHB-benchmark plan options would also be applicable to states when choosing a benchmark plan used to define EHBs. Second, CMS has removed the generosity standard and revised the typicality standard so that, in demonstrating that a state's new EHB-benchmark plan provides a scope of benefits that is equal to the scope of benefits of a typical employer plan in the state, the scope of benefits of a typical employer plan in the state would be defined as any scope of benefits that is as or more generous than the scope of benefits in the state's least generous typical employer plan, and as or less generous than the scope of benefits in the state's most generous typical employer plan. Third, CMS removed the requirement for states to submit a formulary drug list as part of their documentation to change EHB-benchmark plans unless the state changes its prescription drug EHBs.

California stakeholder process. On June 27, 2024, DMHC held a public meeting to discuss California's EHBs and the process for updating the benchmark plan. At that meeting, DMHC shared the timeline and introduced the consultant who explained the federal rules and recently approved and proposed EHB benchmark changes from other states. Oral public comment was received and DMHC requested written public comment by July 11, 2024. Public comments included requests for hearing aids for children, infertility treatment, DME (such as wheelchairs, oxygen equipment, and CPAP machines, intermittent catheters, trach tubes, canes, walkers, neuromodulators, transcutaneous electrical nerve stimulation (TENs), and other medically necessary equipment), oral dietary enteral nutritional formulas, dental benefits at parity with other ACA reforms, massage therapy, and chiropractic. Some requested that benefits not fall below the existing EHB floor. Health plans and insurers urged striking a balance between benefits, cost, and access. Dental plans raised concerns about market impacts of embedding dental services into health plan structures and the impact it could have on the stand alone dental plans that exist in the market today. There were also several letters submitted urging wig coverage for individuals with Alopecia areata. A second stakeholder meeting was held on January 28, 2025 with another public comment period established by February 4th. Written comments received by DMHC by February 4th are attached to this background paper.

Benefit analysis. At the January 28th meeting, the Wakely Consulting Group (Wakely) presented an actuarial analysis that identified the benefit allowance and potential options and prices for the proposed benchmark plan. Through a typicality test following current CMS standards, Wakely determined that California's proposed benchmark plan can impact benefit costs (which is what the plan pays for the service plus member cost share) ranging between 1.06% to 2.23%. This means that the value of the benefit additions cannot exceed 2.23%. Wakely further estimated the pricing of a suite of proposed benefits that potentially could be added, including hearing aids, DME, wigs, chiropractic, infertility, and adult dental. Altogether the cost of these benefits, with the exception of adult dental would add 1.63% to 3.48% cost. These benefits exceed the allowed cost impact range by 0.57% to 1.25%. This means choices must be made to narrow the set of proposed benefits to be covered. The allowed cost range of adult dental preventive services is

1.26% to 1.83% and for comprehensive dental services the cost range is 2.6% to 4.6%. In addition to the high cost of adding preventive dental services, there are other challenges with adding adult dental benefits to the EHB, such as that as an EHB there cannot be annual or lifetime dollar limits on benefits. This is not typically how dental benefits are offered today.

Timeline. If California opts to change the current EHB benchmark, a decision on benefit selection must be made by mid-February 2025. Once benefits are selected, Wakely will complete a final analysis for public comment ahead of submission to the federal government. Notification from DMHC to HHS must take place by May 7, 2025 for an effective date of the new benchmark for the January 1, 2027 plan year. If the proposed EHB benchmark is approved by CMS, legislation to codify the new benchmark plan will be necessary. SB 62 (Menjivar) and AB 224 (Bonta) have been introduced to codify any benchmark changes that may come out of this process.

DMHC has outlined the following timeline:

- June 27, 2024: First public meeting
- January 28, 2025: Second public meeting
- February 11, 2025: Legislative hearing
- Mid-February 2025: Finalize benefit decisions (Wakely has asked for final decisions by February 15)
- Mid-February – Mid-March 2025: Wakely prepares CMS application including actuarial report and supporting CMS application documents. DMHC prepares new benchmark plan document.
- Mid-March 2025: First public comment period on CMS application. According to Wakely, CMS requires a "reasonable time period" for a public comment period prior to the May 7 submission. This is believed to be a minimum of two weeks with most states preferring 30 days. Wakely recommends a 3-week comment period starting no later than March 15 and the second comment period starting no later than April 7 if changes need to be made to the package.
- Early April 2025: Second public comment period (if needed)
- May 7, 2025: Submit application to CMS
- January 1, 2027: Effective date of new benchmark plan

Prior legislation. Part of the impetus that moved the Legislature and Newsom Administration towards the process of updating the state's EHB benchmark plan was the ongoing introduction of legislation mandating new benefit coverage. A list of recent legislative efforts is listed below.

SB 729 (Menjivar, Chapter 930, Statutes of 2024) requires a health plan contract or policy of disability insurance sold in the large group market (employers with more than 100 covered individuals) to provide coverage for the diagnosis and treatment of infertility and fertility services, including services of a maximum of three completed oocyte retrievals with unlimited embryo transfers in accordance with the guidelines of the American Society for Reproductive Medicine (ASRM) using single embryo transfer when recommended and medically appropriate. A signing message from the Governor stated:

> I am signing Senate Bill 729, which will require a large group health plan to provide coverage for infertility and fertility services, including in vitro fertilization (IVF), with a maximum of three completed oocyte retrievals and unlimited embryo transfers, beginning July 1, 2025, and delay its implementation for CalPERS until July 1, 2027.
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> California is a reproductive freedom state. As a national leader for increasing access to reproductive health care and protecting patients and providers, including those under assault in other states, I want to be clear that the right to fertility care and IVF is protected in California. In many other states, this is not the case. I wholeheartedly agree that starting a family should be attainable for those who dream to have a child - inclusive of LGBTQ+ families.
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> There is a better way to strengthen IVF coverage across California's health care delivery system, and the state has already begun this work. In January of this year, we started the process of updating the state's "benchmark" plan, which will set a new standard for commercial insurance health coverage. The services under evaluation specifically include infertility treatment and IVF. The state's proposed benefit design will be released later this year and adopted by the Legislature by May 2025.
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> I expect that IVF coverage will be included in the benchmark plan proposal adopted next spring, but may differ from the one in this bill. As a part of that process, I request that the Legislature change the effective date of this measure from July 1, 2025 to January 1, 2026, upon their return in January to allow an evaluation of the costs and benefit design in this bill within that broader context.

AB 1926 (Connolly, 2024) would have required health plan contracts and insurance policies to provide coverage for dietary enteral formulas for the treatment of regional enteritis (Crohn's disease). AB 1926 was held in the Senate Appropriations Committee.

AB 2668 (Berman, 2024) would have required a health plan, insurer, and Medi-Cal to cover a wig or hairpiece for an individual experiencing permanent or temporary medical hair loss, if

prescribed by a licensed provider for a diagnosed health condition. The bill limits coverage to one wig every 12 months, and $750 per wig. AB 2668 was held in the Assembly Appropriations Committee.

AB 2753 (Ortega, 2024) would have included as coverage of existing EHB rehabilitative and habilitative services and devices, DME services, and repairs, if appropriately prescribed or ordered by a health professional, and prohibits a health care service plan (health plan) or health insurance policy from subjecting coverage of DME and services to financial or treatment limitations. This bill defined DME to mean devices that are designed for repeated use, and that are used for the treatment or monitoring of a medical condition or injury in order to help a person to partially or fully acquire, improve, keep, or learn, or minimize the loss of, skills and functioning of daily living. AB 2753 was held in the Assembly Appropriations Committee.

SB 635 (Menjivar, 2023) would have required a health plan contract or health insurance policy issued, amended, or renewed on or after January 1, 2025, to include coverage for hearing aids and related services for all enrollees and insureds under 21 years of age, if medically necessary. Limited the maximum required coverage amount to $3,000 per individual hearing aid, and prohibited hearing aids covered from being subject to a coinsurance, deductible or copayment requirement, or, subject to financial or treatment limitations, including a dollar limit set below $3,000 per individual hearing aid. SB 635 was vetoed by the Governor, who stated:

> This bill would require health plans to cover medically necessary hearing aids for individuals under 21 years of age, up to $3,000 per individual hearing aid without any cost sharing, beginning January 1, 2025.
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> I am committed to ensuring that hearing impaired children have access to the services and supports they need, including hearing aids. Today, children can receive hearing aids and related services through the California Children's Services (CCS) program or through Medi-Cal. In July 2021 we launched the Hearing Aid Coverage for Children Program (HACCP) within the Department of Health Care Services (DHCS) for those who do not qualify for hearing aids through CCS or Medi-Cal.
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> HACCP was created to improve access and coverage for children's hearing aids, a shared goal of this proposed bill. Unlike HACCP, however, SB 635 would exceed the state's set of essential health benefits, which are established by the state's benchmark plan under the provisions of the federal Affordable Care Act (ACA). As such, this bill's mandate would require the state to defray the costs of coverage in Covered California. This would not only increase ongoing state General Fund costs, but it would set a new precedent by adding requirements that exceed the benchmark plan. A pattern of new coverage mandate bills like this could open the state to millions to billions of dollars in new costs to cover services relating to other health conditions. This creates uncertainty for our healthcare

system's affordability, particularly when we have developed an alternative program that can serve the target population.

That said, improving access to hearing aids for children is a priority for my Administration. We can, and we must, do better for these children and their families as we implement HACCP. To this end, I am directing my Administration to explore increases to Medi-Cal provider payments with the goal of incentivizing additional provider participation in HACCP, increasing access for youth in need of hearing aids.

In addition, DHCS has developed a comprehensive plan to increase provider participation and program enrollment. These improvements will enable HACCP to reach and serve more children, which is our shared goal.

Specifically, in the next six months, DHCS will take a variety of steps to help patients maximize benefits, including: (1) partnering with other state entities to promote participation and awareness of HACCP, (2) completing translations for HACCP related materials into 18 languages, (3) implementing a streamlined annual eligibility renewal process to simplify provider enrollment, (4) conducting outreach to Medi-Cal providers not yet participating in HACCP to support their participation, (5) hosting quarterly webinars with providers and stakeholders, and (6) continuing to identify potential service improvements and strategies to increase program success.

Given the structural concerns this bill presents to our healthcare system and the opportunity to improve the existing HACCP to accomplish the same objectives, I cannot sign this bill.