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DEPARTMENT OF MANAGED HEALTH CARE

PUBLIC MEETING ON CALIFORNIA'S ESSENTIAL HEALTH BENEFITS AND UPDATING THE BENCHMARK PLAN

DEPARTMENT OF MANAGED HEALTH CARE

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PROCEEDINGS

1:01 p.m.

DIRECTOR WATANABE: Good afternoon. My name is Mary Watanabe, I am the Director of the Department of Managed Health Care. Welcome to our public meeting on California's Essential Health Benefits and updating the Benchmark Plan. I am going to cover a couple of housekeeping notes here really quickly so just bear with me before we get into the meeting here.

This meeting is being conducted in a hybrid format with the opportunity for public participation in-person and virtually through video conference or teleconference. This meeting is being recorded and we will have a transcript.

For those joining in-person today, there are restrooms on this floor right outside the doors. The doors are locked so you do need a badge which is on the table in the back of the room. Please return the badges for your fellow participants when you are done. We also have two all-gender restrooms on the ground floor, so if you would like to use those you can get the code from our security desk. There is a sanitation station located in the back of the room where you will find masks and hand sanitizer.

Please remember to silence your cell phones.

And public comment will be taken at the end of the meeting both in the room and virtually. I will give more instructions on how to give public comment when we get to that point of the agenda.

So, with that, let me maybe move on to the purpose of this meeting. The primary purpose is really to solicit public input on benefits that should be

considered for inclusion in the new Benchmark Plan. While the DMHC is hosting this meeting today, this really is a collaborative effort between the Administration and the Legislature. I would like to maybe give a couple of shoutouts here. We do have Kimberly Chen with the California Health and Human Services joining us today. We also have Kelly Green and Brandon Ross from Covered California that are joining virtually. They are part of what I am going to call our Steering Committee. We also have Marjorie Swartz and Teri Boughton representing the Senate here in the room with us, and Roz Pulmano I believe will be joining shortly along with Kristene Mapile. So, this is really a joint effort, again, with the Administration and the Legislature. I don't want anybody thinking that DMHC is out making decisions on their own.

I also would like to acknowledge the California Health Care Foundation and Covered California for funding the contract with Wakely, who you will hear from later today. Wakely is an actuarial consultant that will be helping us with the very detailed analysis of our current Benchmark Plan, as well as the options and the actuarial analysis that we will need for the submission to CMS if we decide to move forward with that.

Again, I will provide additional instructions on public comment. But I will just note for those that may be wondering, we will be accepting public comment through July 11, so you will have some time to formulate that. With the holiday we know you may need a little more time, so there will be an opportunity for written comment.

We will have two presentations today. We are going to try to move quickly through the presentations because we want to allow as much time as possible for public comment.

Sarah Ream, the DMHC's Chief Counsel will be providing just a very brief overview of what are EHBs or Essential Health Benefits; and then Matt Sauter with Wakely will be doing a more detailed overview of the process that we will be going through in the selection of a new Benchmark Plan, talking about some of the new federal requirements.

So, with that I am going to turn it over to Sarah Ream.

CHIEF COUNSEL REAM: Thank you, Mary. As Mary said -- Next slide, please. Maybe the next one, too. There we go.

I am Sarah Ream, I am the Chief Counsel of the Department, and I am going to be providing just a very brief overview of Essential Health Benefits in California now.

The Affordable Care Act requires individual and small group health plan products to cover Essential Health Benefits, also referred to as EHBs. These benefits must include benefits from 10 broad categories of items and services, which are listed on the next slide. One more slide. There you go. There they are. I won't subject you to me reading them all, you can see them there. Within these broad categories of services, each state can decide which specific services to include and which services the plans in that state do not have to cover. However, federal law puts guardrails on the scope of benefits a state can determine to be Essential Health Benefits. These guardrails include requiring the state to use a quote/unquote Benchmark Plan Process to define the state's EHBs.

The Benchmark Plan Process requires a state to look at the scope of benefits provided by the typical employer plan in the state. And that is in quotes, typical employer plan in the state. The process ensures that the scope of

benefits that constitute EHBs in the state are not too skimpy nor too rich. It is important to note here that until very recently a state could not do an a la carte selection of benefits to be defined as EHB in the state. Instead, to satisfy the federal Benchmark Plan Process, the state had to identify an existing health plan product and then supplement any benefits, if necessary, to ensure the product covered all 10 federally required categories of EHB. The benefits in that identified product, plus any supplemental benefits, defined what benefits are considered EHB in the state. Also please note that EHBs define the services that a health plan must cover. However, EHBs do not dictate who provides the services, what the cost sharing is for the services, nor whether a plan can do utilization management for those services. The EHB, again, defines the services that are considered EHB for that state.

Using this Benchmark Plan Process, California selected for its Benchmark Plan the Kaiser Foundation Health Plan Small Group HMO 30, as that plan was sold in 2014. The benefits included in that Kaiser product defined what are EHBs in California. The Benchmark Plan includes benefits from each of the 10 EHB categories. The list of benefits is entirely too long for me to read or go through here, but the benefits include primary care and specialty visits, emergency and urgent care, behavioral health care services, including services to treat substance use disorders, maternity care and hospital and surgical services.

Despite the long list of covered services there are services and items that California's current Benchmark Plan does not cover. These include hearing aids, wheelchairs, infertility treatments, dental services for adults, and chiropractic care. Per federal law, if California were to require health plans to

cover any of these additional services without first adopting a new Benchmark Plan, so if California required coverage of those services without California first adopting a Benchmark Plan that included those benefits, the additional benefits would be said to quote/unquote, exceed EHB. Any state coverage mandate that exceeds EHB does not qualify for federal subsidies for individuals purchasing coverage through Covered California. As such, the state would have to cover the costs of those services that exceed EHB.

You will notice, just as an aside, that when I have been talking about EHBs -- when we talk about EHBs we are only talking about individual and small group products. This is because per federal law, large group health plan products do not have to cover EHBs. However, there may still be an impact to large group products in California if California updates its EHBs. Specifically, even though a large group product is not required to cover EHBs, if the large group product does cover any benefit that is considered to be an EHB in that state, then the product cannot impose any annual or lifetime dollar limits on the product.

Where this could come into play is if a large group product currently covers a non-EHB benefit. So, for example, infertility services. But that large group product imposes a dollar limit on the benefit. Currently, because infertility services are not an EHB in California, the large group product can impose a dollar limit either lifetime or annual. But if California adopts a new Benchmark Plan that includes coverage of infertility services, for example, then no product, whether in the individual or small group markets, or in the large group market, could have a dollar limit on the benefit. Accordingly, a change to California's Benchmark Plan could have some indirect effects on large group products here

in California.

Our next presenter, Matt, is going to get into the details of the process to establish a new Benchmark Plan. But before that I want to give you a very high-level overview of our timelines. Next slide, please. There we go.

So, we have a pretty fast timeline, as you can see, to identify potential options for a new Benchmark Plan this summer.

So, we are here June 27, we are having our public meeting. The legislature is planning to have a hearing in August and then they will have to consider and adopt a new Benchmark Plan.

So, between now and August the state will be analyzing the current Benchmark Plan and determining what benefits perhaps to add and how to change that.

California must also notify the federal Health and Human Services Agency of our selection of a new Benchmark Plan and this is actually where the timing gets a little weird, a little strange. We have to notify Health and Human Services by the first Wednesday in May, two years before the effective date of the new Benchmark Plan. Per this timeline, we are aiming to notify HHS by the first Wednesday in May of next year, May 2025, the exact date is May 7, 2025. The new Benchmark Plan would then take effect January 1 of 2027. So, a short timeframe immediately, a longer timeframe getting the notice to HHS and then rolling it out.

With that, I will turn it over to Matt.

MR. SAUTER: Thank you. Next slide, please.

As Mary stated, I am Matt Sauter of Wakely Consulting Group here in the Denver office and I will be helping support California as the explore the

EHB Benchmark Plan analysis and potentially the application. Historically, myself and Wakely has helped, I believe, four to five states with applications in the past. To date, three of those have been approved and two are in the process now. Next slide, please.

We will talk through a few items today as we look through the process of how this analysis and application will go and those will cover a few topics such as federal regulations, the typicality test, benefit pricing and establishing EHB pathways to explore, and then we will also talk through some quick disclosures, limitations and caveats there. Next slide.

So, jumping into the federal regulations.

On the next slide here, what really started the genesis of this EHB application analysis and changes to the Benchmark Plan was some new flexibility in the 2019 Notice of Benefit and Payment Parameters, and that was effective for the 2020 benefit year. And before that, states essentially picked their Essential Health Benefit plan back in 2012 or so for that first 2014 ACA plan year. And for the large part, this plan has really just been in effect for all of those states at least through 2020, and in a lot of states through today. And this new flexibility in the 2019 NBPP has allowed states to start revising their Benchmark Plans. So, to date there's about 10 plans who have done this and more such as California are looking at doing this now.

So there's various guardrails and regulations that we must follow as we work to establish this new Benchmark Plan. But in layman terms and what most states have done is effectively kept the current benefit coverage and then added a number of marginal benefits on top of that. But in theory you could reset the Benchmark Plan in a variety of different ways. But as mentioned on the

previous slide, there's 10 categories that we have to cover that are relatively defined. So most states are really just keeping their current Benchmark Plan and adding a few benefits in addition to that.

And then as stated earlier as well, we are looking for the next application cycle, which would have a due date of May 2025 and that would be effective in the benefit year 2027. We have to submit a variety of application documents and analyses with that, in addition to adhering to those guardrails such as the typicality test standard, which we will get into more in the next slide. And then ultimately post this collective set of documents for a public comment period for about two weeks. So that will happen, that official public comment period will happen pretty close to our official application, but we will also have a few other public comment opportunities such as this one here today.

Also, as we talk about the Benchmark Plan there are limitations such as lifetime or annual limits and then also a variety of other, sometimes nice-to-haves or refreshes that we will also accomplish throughout this application process. So for example, any discriminatory benefits that are no longer in compliance with regulation. And even as we look at the plan document itself, currently it is a plan branded, a plan document with some non EHB items in it such as cost-sharing and other language. In most cases, once this Benchmark Plan has been revised we will strip a lot of that unnecessary language and really focus on just the benefits that are covered, the true EHB items.

And of course, CMS will review and approve this application once submitted. And we will likely have a dialogue going with them as well throughout the process.

So getting into that main federal regulation and the guardrail here.

That is going to be the typicality test standard. For those of you who have maybe researched this in the past or have seen what other states have done, you may have seen a typicality test and a generosity test. It affects the 2025 NBPP, which had a few changes in the Benchmark Plan process. It effectively merged those two tests into just the typicality test. This is basically going to be our limitation and guardrails on our floor and ceiling or the maximum and minimum richness the California Benchmark Plan can have.

The official definition is here at the top. It is: The Benchmark Plan must provide a 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. So again, it is essentially a floor and a ceiling relative to the typical employer plans.

And as we get into Step 1 here, we are going to identify and gather the plan documents of these eligible comparison plans, our typical employer plans, that are defined by CMS for testing. So these will be the state's 10 base-Benchmark Plan options. There's also in the regulations that the state could have selected in 2017. And there's also flexibility to have one of the five largest group plans, provided that they meet some requirements as listed in the regulations for a plan that was listed in 2014 or later. So a little bit more flexibility there on the large group side.

So we will stack up these identified plans next to each other and do a pretty detailed analysis of all the benefits covered and compare these and use this comparison to identify the most generous plan among that group and that will effectively set our ceiling there.

Now that we have that ceiling in mind once completing Step 1, we will move on to Step 2 and further analyze the benefits that we are looking to add and determine the room we have to add those benefits. As we do that we will calculate the expected value of covering all the benefits at 100% actuarial value in the proposed Benchmark Plan and in the two comparison points there in the typicality standard.

And then we are looking -- the current Benchmark Plan falls relative to that most generous plan or the ceiling, will shed light into what benefits we have room to add or remove.

And the phrasing there in the first bullet of Step 2, the benefits at 100% actuarial value. We will get into this in a bit more detail in a subsequent slide. But this is essentially saying we are looking at the plan-paid plus member-paid total costs there or allowed amount. We might see phrases such as allowed amount, 100% actuarial value or total benefit costs kind of used interchangeably. But the main point here is we are looking at the total allowed cost here and we aren't taking into account things such as cost-sharing, for example.

So then in Step 3, once we know where the current benchmark sits relative to the ceiling, and we also have a floor, we will compare the comparison plans to that proposed Benchmark Plan with the additional benefits that we've added and just ensure that we are within that range there. Okay, the next slide. I think one more.

So we are going to take a look at those benefits that were noted earlier and potentially some other benefits as we get feedback. And then we will try to price these benefits out as we look forward to the 2027 proposed Benchmark Plan. And we will do this using a variety of ACA data where

appropriate and available, some publicly available data, and then also some input from the stakeholders in the California health care service plans, and then also some actuarial judgment. And if there is a case where we are looking at adding a new benefit that the existing ACA data or the publicly available data is not sufficient to look at that, we may also use some first principle build ups in our approach. So again, once we have these benefits priced, we will compare that newly proposed Benchmark Plan against the typicality test and make sure that we are in compliance there.

And as we look at the cost here of these benefits, we also wanted to highlight that this is not fully analogous to and comparable to premium impacts. Since we will be looking at total allowed costs, we will not be taking into account things such as cost-sharing. We will be looking at steady states, we won't be looking at things such as year one pent-up demand. And then there's also a variety of other factors that will make this not completely comparable to things such as a premium change. And then also with our assumptions and pricing build up here, we are going to price them based on our best understanding of those benefit coverages and how are they offered and then also establish a range around what those benefits can be. To the next slide.

So again, the EHB regulations do focus on the allowed costs. So again, this is that 100% actual value or total expected costs, and that is going to be different from premium.

As we look at the allowed costs, we are looking at steady state, not necessarily taking into year one pent-up demand or adverse selection that may occur in an initial year or may have some variation between issuers.

And then we also are going to look at just the specific benefit costs

for that benefit being added. We don't look at the downstream costs, such as if we add IVF we won't look at the potential downstream costs for maternity costs or the potential of adding or removing costs from those benefits.

For hearing aids, we don't look at things such as increased wellbeing or reduced costs from falls. We will really just look at the marginal costs for adding those hearing aids there.

And then I have already talked through some of the changes that may not be completely analogous with premium changes. I think some new ones here at the end is there could also be some administrative costs due to these changes that won't be factored in.

So as we are talking about this Benchmark Plan document, again, we will tackle the discriminatory benefits in there.

And then we will also strip out that non-EHB language.

So as we look at some discriminatory language that we might identify and have identified in other states, it could be things such as conditions that are discriminatory by looking in or specifying it is only covered for a particular condition. So the most common one we see there is routine foot care for diabetics. And since this is isolated, just one diagnosis or condition, that is considered discriminatory based on CMS regulations, and therefore we would likely revise this language to read something like routine foot care as medically necessary. And perhaps the medical necessity and evidence points to only being necessary for diabetics, but that language does allow us to be flexible in the future. As medical evidence and necessity changes, we can remain in compliance there without having to change the actual Benchmark Plan document.

Other examples include benefit limits for different conditions. So we have seen instances where acupuncture visits limits do not apply for chemical dependency or other conditions so we have to make corrections there as well.

And then we have also seen age limits being included in the Benchmark Plan document as well as identifying preventive services. So in both cases we would likely remove these references to ages and replace with medical necessity. I think one good example there is colonoscopies are currently covered for ages under 45. If that changes in the future to be for ages under 40 as well, changing that plan language to be as medically necessary allows us to keep up to date with emerging evidence.

And if there's any lifetime maximums or other limits that aren't allowed in the ACA we will remove those as well.

Okay. I'll sort of walk through a few of these. But some of the benefits that we are looking to price include adult dental, which can include a variety of periodontics, prosthetics and other options. This is actually a new benefit that could be added as an EHB in 2025 Notice of Benefit and Payment Parameters. So that's when we will be looking at.

Also hearing aids. And the most common is -- a few states have added this in the past few years and the most common benefit description we have kind of seen there is offering an annual hearing aid exam. And then also a set of hearing aids every three years or one hearing aid per year for every three years.

Also plan on looking at a variety of durable medical equipment or DME items such as wheelchairs, oxygen intakes and wigs.

And then also looking at infertility, which can cover a variety of

things such as artificial insemination. And as we get into IVF there's also a lot of definitions there such as, does it include the fertility medications, preservations, and how many rounds or how do we define those rounds of IVF treatment?

And then also planning on looking at chiropractic services, which is not currently covered in the Benchmark Plan.

So again, as we look at these we will look at these based on merging ACA data where possible, and then also price out a variety of ranges of costs that may be seen at a desired benefit level there.

As we looked to other states who have revised their Benchmark Plan in the past few years there are some patterns that are listed so we've kind of tried to summarize a few of them here. There is a complete exhaustive list available online. But some of the most common ones we have seen in the past include opioid reversal agents, the hearing exams and hearing aids, expansion of mental wellness and psychiatric benefits, the expansion of prosthetic coverage, and then also chiropractic and acupuncture limit expansions as well. And then there's a variety of other benefits that are looked at here.

And again, just want to emphasize that these are true benefit additions; and to really think about what is being covered is probably the easiest way to think about this rather than how. So on the how side, EHBs do not govern cost-sharing or, you know, adding doulas to allow (indiscernible) type. Those are both things on how the benefit is covered, where EHBs are really going to look at what is covered. Next slide.

Lastly, just wanted to talk about a few disclosures and limitations. Again, we will be looking at this data based on our best understanding of how the benefit will be applied and in many cases that will include assumptions in

actuarial judgment. We do our best to explain these items in our important documentation. But again, it will -- it may vary from premium changes as well since we do look at EHBs on a different basis.

So with that I will turn it back over to Mary to wrap things up.

DIRECTOR WATANABE: Thank you, Matt, that was great.

All right, we are going to move on to public comment. Just quickly, for those that are joining virtually, if you wish to give public comment please use the Raise Hand feature. I think we have disabled the Q&A option. We want to make sure all of the comment is on the record and can be heard here in the room as well as online.

If you are joining on your phone, I think we have a few participants that are doing that, you are going to dial *9 and then that will help to indicate you would like to give public comment. Once we say your name you can unmute.

And then please remember, both virtually and in the room, to state your name and the organization you represent.

For those that wish to get public comment here in the room, you are welcome to start lining up. We are going to make sure that the microphone is on. There is a button that you press, it will be green.

So just a couple other really quick items here. We did get a question about whether or not the slides were going to be available. They are actually posted on our website right now. So, if you go to dmhc.ca.gov or healthhelp.ca.gov and scroll down you will see under kind of our news, a link that says DMHC announces EHB meeting. The agenda is posted there as well as a PowerPoint.

So again, just a reminder, the focus here on public comment is

really about the benefits that we should be considering but welcome to take any other comments. Depending on if there is a question that either Sarah, Matt or I can answer quickly we can certainly try to do that.

I am going to try to alternate a little bit here in the room and online so just bear with me. And I think with that we will go ahead and get started here in the room. Why don't you go ahead and come up.

MR. LOUIZOS: Good afternoon, Nick Louizos with the California Association of Health Plans. CAHP represents public, nonprofit and private organizations that operate in Medi-Cal and the commercial markets and deliver coverage to approximately 28 million Californians.

Thanks for accepting this as initial testimony as you embark on this process of updating California's Essential Health Benefits and Benchmark Plan. Of course, reopening the EHBs is not without its challenges and will be a complex process. But it is a process that offers policymakers the opportunity to be thoughtful about the relationship between affordability and accessibility.

Reevaluating the EHBs as a package is certainly preferable to considering, you know one-off, you know, coverage mandates that we often do, particularly in the legislature. Because those, you know, one-off mandates, inflate health care premiums for all and we have urged policymakers across the street to hold off considering such legislation while this process moves forward.

We hope for an open and transparent process moving forward that will allow stakeholders, including our member health plans, the opportunity to provide critical feedback prior to the plan being submitted to the federal government for consideration.

We also ask policymakers to strongly keep in mind work that is

being done at the Office of Health Care Affordability, which just initiated a statewide spending target that CAHP supported. And the adoption of a new Benchmark Plan and new set of EHBs will likely impact cost and premiums. So, any discussion around EHBs we hope, you know, takes into consideration, doesn't conflict with the work that is being done at OHCA and its underlying mission of consumer affordability.

So, we look forward to working together to ensure high quality and accessible care to all. And I am not sure if I stated this, but my name is Nick Louizos with the California Association of Health Plans, at the outset; and I thank you for your time.

DIRECTOR WATANABE: Thank you, Nick.

I am going to take one more in the room. I am getting a message here that the sound is a little bit light so if you could maybe, I don't know, angle that little wire down and we'll see. Someone will message me if it's not loud enough. Yes, go ahead. Thank you.

MS. MONTANO: Thank you. Monica Montano with the California Dental Association. CDA strongly supports the addition of adult dental services to California's Benchmark Plan as an Essential Health Benefit.

CMS recently finalized a rule allowing states to add adult dental to their Benchmark Plan, which really has the opportunity to be a huge step forward for many Californians being able to access dental care. Because of the way CMS is allowing states to add this, states are not required to defray the cost of this dental benefit, and California should not pass on the opportunity to add a benefit that does not have a high fiscal responsibility to the state.

It is important to note that dental coverage lacks many of the

standards and protections and oversight that exists for health insurance. Oftentimes, people with dental coverage will assume their necessary treatment will be covered but end up paying out of pocket for care that is critical to their overall health. That is because dental coverage is structured in a way that forces consumers to shoulder most of the costs. CDA stands ready to work with DMHC and Covered California to ensure there is a meaningful standard to dental coverage, and that adding adult dental will not be an illusory benefit.

Oral health care is an essential part of a person's overall health, as studies have shown that poor oral health is tied to various diseases such as heart disease and diabetes. In adding adult dental to the EHB Benchmark Plan, there is the opportunity to improve the overall health of Californians and to create a meaningful standard for dental coverage. CDA urges the state to add adult dental to the EHB benchmark. Thank you.

DIRECTOR WATANABE: Thank you. All right. We are going to attempt to go to someone on the line here. I believe Casey Tucker is first. Can we unmute Casey? All right. Casey, you should be able to unmute and give your comment.

DR. TUCKER: I have unmuted, thank you.

DIRECTOR WATANABE: Great.

DR. TUCKER: I am the president of the California Chiropractic Association. We highly support this embarkation on benefits, on changing benefits affecting for the 2027 plan year.

We are specifically requesting that new Benchmark Plan include full scope -- the full scope -- include the full scope of services provided by Doctord of Chiropractic as a covered benefit. Since the enactment of the Kaiser Foundation

plan, Small Group HMO 30 Plan, chiropractic care, specifically chiropractic manipulative therapy, has been excluded as a covered benefit. This exclusion conflicts with Section 2706(a) of the Public Health Service Act that essentially prohibits health plans from discriminating participation of coverage by category of health provider. California is one of four states that does not include services provided by doctors of chiropractic.

This is noteworthy as chiropractic manipulative therapy is at the top of critical intervention choices for conservative management of neck pain, low back pain, and headaches. The scientific literature demonstrates that CMT is the most -- is the preferred and primary nonsurgical, nondrug treatment for these conditions. Why would the state of California ignore the scientific studies to ensure this access to California residents for these cost-effective services?

Thank you for the opportunity to comment and the Association is available at any time to answer any questions the Department may have. Thank you.

DIRECTOR WATANABE: Thank you, Casey.

We are going to maybe alternate every two here. I am going to go to Ryan Spencer online and then we will get to you here, Cary. Go ahead, Ryan.

MR. SPENCER: Thank you very much. I will be very brief and I will submit more detailed comments before your July 11th deadline. But I would just like to say I am Ryan Spencer on behalf of the Crohn's and Colitis Foundation. And we are requesting the Benchmark include all types of dietary enteral formulas that would be able to take in orally for patients diagnosed with digestive disorders. The current coverage in the Benchmark is fairly limited to just one type of formula that really cannot be ingested orally. And so even

though the coverage may exist in the Benchmark, it is really not utilized and it is also limited to one particular type of condition. So that's what we are asking for is coverage of all oral dietary enteral formulas for patients diagnosed with any digestive disorder. And again, I will submit more detailed comments by the July 11th deadline. Thank you for your time.

DIRECTOR WATANABE: Thank you, Ryan.

All right, Cary.

MS. SANDERS: Can you hear me?

DIRECTOR WATANABE: I can hear you, and someone will message me online if they can't, so go ahead.

MS. SANDERS: Good afternoon, Cary Sanders, Senior Policy Director with CPEHN, the California Pan-Ethnic Health Network. Thank you for the opportunity to testify today.

With the recent federal EHB flexibilities and introduction of AB 1290, lawmakers now and consumers have the opportunity to update the Benchmark and close remaining coverage gaps. This is especially important for California's communities of color who continue to experience disparities in health, oral and mental health outcomes.

We urge California to consider as part of its review adding mental health benefits to bring us towards parity, DME, hearing aids, other services that folks have mentioned, and most importantly, adult dental benefits. Oral health is essential to overall health. The lack of comprehensive adult dental benefits disproportionately impacts Black, Indigenous People of Color in California. Currently nearly all states, 47 and DC, offer some dental benefits to their base adult Medicaid population. Thirty-six cover services beyond defined emergency

situations and all but one state offer the same dental benefits package to their base and expansion populations. So, with that, you know, it's time for California and commercial coverage to also add that as a benefit.

We appreciate concerns, you know, about cost that some have raised. However, our current status quo is unacceptable. We support California exploring uniform minimum standards to address variation across the dental insurance market, a robust dental loss ratio, which could also potentially help control costs, as well as other consumer protections, like no annual or lifetime limits, to ensure that these policies are really reaching and can provide extensive coverage, particularly for our low-income communities.

Revisiting the EHB is a complicated issue. So, because of that we also urge California to conduct a robust stakeholder process. We support the ambitious -- we support the ambitious timeline, I should say, that you are working towards, and we would love to see the benefits start in 2027. We just want to make sure that folks who are, you know who need additional supports like language access, other, you know, ways to provide input, are able to do so.

And additionally this may -- lastly, this may go without saying, as the state reviews the Benchmark EHB we urge DMHC and the legislature to view the current Essential Health Benefits as the minimum starting point. We don't, you know, we can't go backwards as a, as a way of moving forwards. Thanks for your time.

DIRECTOR WATANABE: Thanks, Cary.

All right, we will take one more in the room.

MS. POOLE: Good afternoon, I am Sandra Poole, Health Policy Advocate at Western Center on Law and Poverty. I will limit my comments today

and provide more detailed written by your deadline.

At Western Center we believe that health care is a human right, so we work to preserve and expand equitable health care for all Californians. Unfortunately, under the current Benchmark Plan, thousands of Californians have been denied access to medically necessary devices, some of which were mentioned earlier, such as wheelchairs, hearing aids, ventilators and other durable medical equipment that they need. This happens because our current health plans regularly exclude or severely limit coverage of this equipment. These policies harm people with disabilities and chronic conditions. Without access to the devices they need for basic functions such as breathing, communication and mobility, a person's health, independence and livelihood is compromised.

We look forward to participating in this process and strongly encourage the Department to also hear directly from consumers who are impacted by the decisions that are made by this process. It is also critically important, as was stated earlier, that our current Benchmark Plan be viewed as the baseline and we make a concerted effort to identify and correct the current gaps that exist.

I appreciate DMHC for beginning this process of reviewing California's Benchmark Plan. For thousands of Californians the opportunity to close the gap in their EHB is long overdue. Thank you.

DIRECTOR WATANABE: Thank you, Sandra.

All right, we are going to go back to our virtual participants. I have -- forgive me if I get any of these names wrong. I think it's P Dieter is next. We are going to unmute your line. All right, go ahead.

DR. DIETER: Thank you. My name is Dr. Phil Dieter. Sorry, I thought my name came through there. But I am the President-Elect of the California Chiropractic Association and I wanted to reiterate Dr. Tucker's comments regarding the inclusion of chiropractic services in the Benchmark Plan.

To add something just a little bit different to what he already suggested. We are really hoping to resolve the issue that exists where patients are able to come in, be examined, get referred out, possibly have X-rays taken in the event that their health plan provides for that currently, but not really receive the actual chiropractic treatment for which they came into the office for. So, our hope is that we are able to resolve that situation regarding access to chiropractic benefits, along with the other things that Dr. Tucker suggested in terms of being the primary method of treatment or sought out treatment for lower back pain, neck pain, headaches, et cetera. And resolving what really is one of only four states that doesn't offer this as a Benchmark Plan or benchmark access, excuse me, regarding services in the rehabilitative area. Also in terms of preventative and wellness services and chronic management of what is lower back pain, particularly it's considered one of the primary chronic diseases in our country.

DIRECTOR WATANABE: Thank you, Dr. Dieter.

I think we are going to go to Diana Douglas next. Give us just a minute to unmute your line.

MS. DOUGLAS: Good afternoon. This is Diana Douglas with Health Access California. We appreciate the Department convening today's meeting to kick off public discussions of revisiting our state's Benchmark Plan. Health Access feels that revisiting the Benchmark is timely and necessary. In the

10 years since the current Benchmark was selected, we have seen the potential of leveraging the ACA to improve quality of care and coverage. We have seen new health inequities emerge along with new priorities and areas of disparity to address. Health Access views EHBs and the existing Benchmark Plan as a baseline from which we can improve. And just to be clear, we only support changes made that would build upon rather than subtract from all the progress that we have made.

Our state has also seen a plethora of new benefit mandates and each year even more benefit mandate proposals before the legislature; and we have seen increasing costs underscoring the need for a careful, well thought process to bring together analyses of the impact of various benchmark options on consumers, along with the voice and expertise of advocates, many of whom are here commenting today to ensure we are properly centering equity, reducing disparities and meeting consumer needs.

Currently, coverage for crucial benefits such as adult dental services especially, hearing aids for children, durable medical equipment and fertility services are left to the discretion of plans and often are not covered at all. We feel these are all issues to be addressed and look forward to discussion through the process. While the benefits of new EHBs must be weighed against rising premiums, we really believe that California can lead the way in setting higher standards of care than we have now, while also ensuring that coverage remains affordable. We look forward to participating in this process and ensuring the voices of consumers are adequately centered and thank you to the Department for convening us all here today and for the very helpful presentations. Thank you.

DIRECTOR WATANABE: Thank you, Diana.

All right back to the room.

MS. MYERS: Good afternoon. My name is Carly Myers, and I am a staff attorney with the National Health Law Program, a nonprofit public interest law firm that protects and advances the rights of low-income and underserved individuals and families to access.

We thank the Department today for the opportunity to provide feedback on potential changes to California's EHB Benchmark Plan and for beginning the process on updating the Benchmark to address remaining gaps in health coverage. EHBs are the main tool that the Affordable Care Act created to ensure that individuals and families had access to comprehensive and high-quality coverage going forward. Through the benchmarking process, states have the responsibility to periodically review the EHBs and address coverage gaps.

In California, the original Benchmark Plan selected was not the most comprehensive plan option. While the plan offered many benefits that were not available for enrollees prior to the ACA, its design has resulted in significant and persistent gaps in areas such as durable medical equipment, behavioral health services, and maternal and newborn care. These gaps disproportionately harm people with disabilities, Black, Indigenous and People of Color, and other underserved populations.

While we plan to provide feedback on specific services in our written comments, today, we want to focus on process and specifically the need for the Department to engage in a transparent, holistic, equity-centered and data driven. We emphasize the need for the Department to give stakeholders various opportunities to comment throughout this process and to structure it such that it

utilizes evidence and data to address coverage gaps that contribute to health inequities. For example, the Department should engage in a comprehensive evaluation of current marketplace coverage that is inclusive of public feedback. Additionally, it should commission an actuarial analysis that considers the impact of adding various benefits to the Benchmark, the results of which should be presented to stakeholders with the opportunity to provide further feedback. Any proposed updates to the Benchmark should also be subject to public comment prior to it being finalized.

Finally, we urge the Department to consider adding benefits to the Benchmark Plan without weakening existing coverage. While the actuarial limitations require the state to be intentional about the cost of new benefits, any potential cuts could cancel out potential gains. The starting point for any proposal should be the current coverage standard, and only improvements and additions to those levels of coverage should be considered.

We look forward to providing written comments in the coming weeks. And we hope this is the first of many opportunities to provide feedback on this important topic. Thank you.

DIRECTOR WATANABE: Thank you, Carly.

All right, one more in the room here.

MS. LYNN: Good afternoon. I am Nora Lynn with Children Now. I am here on behalf of Children Now as well as the organization Let California Kids Hear, asking that coverage for children's hearing aids be included among the Essential Health Benefits currently being legislated for California.

Updating this benchmark for comprehensive care for children is critical. Currently, 32 other states include a hearing aid benefit, and we have

been advocating for this coverage for children in California as well. Closing this gap will help ensure the state's estimated 20,000 deaf and hard of hearing children will have comprehensive coverage and services, including hearing aids, to meet their health and developmental needs. According to pediatric experts, failure to provide appropriate intervention to these children by three to six months of age leads to speech, language, cognitive, educational and social-emotional deficits and permanent delays.

Lawmakers have the opportunity this year through Senator Roth and Assemblymember Bonta's pending legislation to address the coverage gap our organizations have been trying to address for a decade. These bills present 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. Thank you.

DIRECTOR WATANABE: Thank you, Nora Lynn.

I am going to take one more in the room because we have only got one person left. Go ahead, Jeff.

MR. ALBUM: Thank you. Jeff Album, Vice President Public and Government Affairs for Delta Dental California. We have about 20 million Californians who are covered privately; we are also the largest dental plan in Covered California with about 150,000 or so enrollees.

We know a lot about Exchange and Off-Exchange dental care and the dynamics that follow being embedded versus being a standalone plan and also the implications, implications of including adult dental. We all agree adult dental ought to be covered. We wish everybody had coverage. And I am not here to speak against adding adult dental to EHB. But I am here to point out the

serious implications and major disruptions to the marketplace were this to happen and were it not to be implemented very carefully and very thoughtfully.

Just to give you an example, a PPO dental plan, average, typical, sold in the small group marketplace and allows freedom to choose any dentist you want to seek your care from, is probably around $50 a month. Remove the annual maximum and the cost of that premium goes up double, probably 100. So you have just added $600 to every small -- every employer in the small group marketplace who is offering off-exchange coverage. You have also added that cost, of course, to people who buy dental in Covered California. You will have to think about the premium and at what point do employers start charging, basically just start charging their employees to pay a higher and higher share in order to get these EHB benefits?

We certainly have to think about the deductible because in states where a combined medical-dental deductible is $7,000, the average is 3800 throughout the country, a combined medical-dental deductible would essentially render the adult dental care illusory. Most people would never even get -- only first dollar coverage for diagnostic and preventive because that's the rules and nothing beyond that. Now that's easily mitigated, because Covered California already requires a separate lower deductible for pediatric dental and so that type of tactic would certainly be an important one to use for adult dental. But there are still other things that cannot be altered and we need to make sure we are ready to do it.

There are health plans, many health plans that do not do dental, do not have dental, have no capability of it. They tend to partner with a private dental plan or a standalone plan. And that can work, it's called bundling. Where

the two plans are separate, but they are marketed together, work together. We would urge that that practice be continued to be encouraged were you to go forward and add adult dental.

We could go on by procedure. Orthodontics, right. A typical orthodontic benefit in the marketplace has a lifetime maximum of $2,500. And I think we heard from Wakely that that type of thing would have to change to medical necessity. Well, if all of a sudden, you have 5%, 4% of an adult population are finally deciding now it's time to go full on braces, those are $6,000 to $8,000 worth of care. That is going to have to be paid for by all of the people who don't need braces. So again, a premium, a very large premium impact. Premium impact maybe could be mitigated a little bit by waiting, with the use of waiting periods.

Anyway, these are all things. I am grateful to see Wakely is involved and consulting because they can verify and validate what I am saying about pricing. And I would urge my friends at CDA to consider the fact that it is going to be DHMO, not PPO, that health plans are going to turn to in order to embrace adult dental, they cannot afford the PPO. That means all of a sudden a form of dental coverage, which is currently only serviced by about 10,000 or so of California's dentists who participate, will suddenly have millions of more Americans who cannot choose their dentist by the way or cannot stay with their own dentists, they are not going to duplicate dental plans. They are not going to buy a PPO while they are already being given an HMO. So, you are going to -- we will have a capacity issue. How do we serve all of these patients with 10,000 dentists who are already telling us that they are busy and their earliest appointment schedule except for emergency care is about five, six months; and

there's a shortage of dental hygienists, too.

So, these are all aspects, implications that we would ask you to think through very carefully. And we are happy to be your thought partner in pricing out some of these things and considering ways to mitigate the risk in thinking through how health and dental plans can work together to provide this instead of just forcing all health plans to embed, which is complicated in its own, in its own right. Thank you.

DIRECTOR WATANABE: Thank you, Jeff.

MR. ALBUM: Oh, one last thing, sorry.

DIRECTOR WATANABE: Go ahead.

MR. ALBUM: It's this issue more than anything, and there's already good reasons to do it, means that the ability of people who already have health care outside the Exchange ought to be given the ability to independently purchase dental benefits from a standalone plan in the Exchange. These are the most affordable individual products that are available in the marketplace. Medicare beneficiaries don't get it in Part B. And so it would be -- especially if we go down this route with adult dental it is important that we make standalone dental available to people who don't -- aren't eligible for a Covered California Health Plan. Thank you.

DIRECTOR WATANABE: Thanks, Jeff.

So just for those that are in the room and can't see this, we have six more individuals that would like to give public comment online so we will move to those now. And again, forgive me if I get any of these names wrong. I believe it is Ruqayya Ahmad, you're next. We are going to unmute your line. You can unmute and go ahead.

MS. AHMAD: Hi, thank you so much. My name is Ruqayya Ahmad, I use she/her pronouns, and I am a Policy Manager at CPEHN.

Just want to say thank you for the presentation and allowing us to provide some feedback on California's EHBs and, you know, the process of updating the Benchmark Plan.

So, I facilitate the California Chapter of the Oral Health Progress and Equity Network or OHPEN, through which we are building power to ensure that good oral health care is a fundamental right for all Californians. And from that work we have created our Oral Health Equity Core Group, which is a collaboration of racial, health equity focused grassroots and safety net organizations that represent the racial, ethnic and regional diversity of California.

And so today I am here on behalf of CA-OHPEN and the Oral Health Equity Core Group to strongly advocate for the inclusion of adult dental benefits in California’s Essential Health Benefits Benchmark Plan. We are really happy to see that as a benefit that you were considering as part of the EHBs. I just wanted to, you know, say that oral health is really essential to overall health and poor oral health can contribute to chronic diseases like cardiovascular disease, diabetes, and even cancer. And the consequences of poor oral health are very severe and very widespread including chronic pain, difficulties in obtaining employment and increased school absences amongst children. But specifically, the lack of comprehensive adult dental benefits disproportionately affects Black, Indigenous and People of Color communities.

In California, according to dental data, among adults with low incomes, almost 50% of Latino adults did not have dental insurance in 2020, compared to 20% of white adults with low incomes. And then adults who didn't

have dental insurance were also about three times more likely to have no natural teeth compared to adults who did have dental insurance, which really, you know, demonstrates the importance of adults having consistent dental coverage as part of their health benefits. And these disparities, as we know, are exacerbated by structural racism, which really impacts access to health services and overall health outcomes for Black, Indigenous and People of Color communities.

And I also just wanted to talk a little bit about how like inconsistent coverage of dental benefits across different insurance plans has really impacted access to dental care, especially in communities of color. And the fluctuation of benefits in both public programs like Medi-Cal and in private insurance plans really creates confusion among members who are left wondering whether they will have access to dental care each year. In Medi-Cal specifically, in the last 15 years California has eliminated and restored dental benefits for adult recipients multiple times, and that instability really causes confusion and so folks don't know that they have access to dental benefits. And then also a lot of dental providers have left the Medi-Cal program due to the fluctuation, so that further reduces access to care for those that really need it the most. And the instability leads to interruptions in ongoing treatment, interruptions and gaps in preventative services and just an increased use of emergency rooms for preventable dental conditions.

And we heard from a previous speaker about the cost associated with adding dental benefits, adult dental benefits. But I just wanted to say that investing in preventative dental care can significantly reduce the need for more expensive emergency and restorative procedures. And emergency room visits for preventative dental conditions as we know are expensive, and so they can be

minimized with consistent preventative care. And so by providing those regular checkups, cleanings and early interventions, we can prevent severe dental issues that require those costly treatments later.

Lastly, I will just say establishing, you know, adult dental benefits as California's EHBs are going to reduce health disparities and improve overall health, so I really urge the Department to include comprehensive adult dental benefits in the EHB Benchmark Plan. It will not only improve the health and wellbeing of millions of Californians, but also move us closer to achieving true health equity in the state. Thank you.

DIRECTOR WATANABE: Thank you.

All right, we are going to move on to I believe it is Rikki Pelta. Your line is unmuted, go ahead.

MS. PELTA: Hi, thank you. I am Rikki Pelta from the American Council of Life Insurers. We are the national trade for the life insurance industry consisting of 280 member companies.

We are very supportive of expanding access to dental insurance. Many others have said it, but I will reiterate it here. It is critical not only for oral health but overall health.

We do have some concerns specific to embedding adult dental in medical plans, even where standalone plans are available. Which is unlike how pediatric dental benefits are currently treated and we are concerned about unintended consequences that could actually result in less access.

I will be brief; we will follow up with a more detailed comment letter. But at a high level, if dental services are embedded in medical coverage and subject to the high deductibles and out of pocket maximums, insureds are likely

to end up spending much more on services and will lose out on benefits that they currently enjoy through standalone dental plans and many of those benefits will largely be illusory. With those costs being passed on to the insurer, there's a higher likelihood that routine care will be skipped, and then oral and overall health issues will be missed. Dental is very price sensitive and this in turn could lead to higher costs related to emergency room care.

We really urge you to protect the standalone dental plan market on the Exchange. It could disrupt coverage adding, embedding adult dental in medical plans. And this could also disrupt pediatric coverage. If standalone plans leave the market then pediatric coverage could be disrupted.

Dental Plans are also experts in providing dental coverage and already have the technical capabilities in place to do, so while medical plans largely do not. Developing this capability will be costly, even if contracting with a dental plan are a vendor that already does this. So, we do also have concerns about costs. And again, with dental being so price sensitive we are concerned about costs going up and people skipping care. So again, we will follow up with a more detailed comment letter but thank you for the opportunity to speak today.

DIRECTOR WATANABE: Thank you.

All right, we are going to go to Benita Trujillo, your line is unmuted. Benita, I think you need to unmute, we are not hearing you yet. There you go.

MS. TRUJILLO: Sorry about that. Hi. Good afternoon, everyone. My name is Benita Trujillo, and I am a California legislative liaison with the National Alopecia Areata Foundation. And I am also representing my 13-year-old granddaughter Mia, who was diagnosed with alopecia areata at the young age of five years old. I would like to thank the Department of Managed Care for

hosting this public meeting today to discuss the California Essential Health Benefits and the process for updating the Benchmark Plan.

I would like to address the Department on the urgency to please include the wig coverage in the new Benchmark Plan. Currently, we have eight states already requiring coverage of wigs for enrollees in state-regulated individuals, as well as group health plans. In addition, this year's AB 2668 brought greater awareness in the cost barrier of wigs and their vital role in one's mental health.

So, my granddaughter Mia, she started losing small patches of hair at the young age of five years old. At nine years of age she lost all of her body hair from head to toe. Her parents are both employed, but unfortunately they are not financially stable to purchase any of her expensive wigs as they live paycheck to paycheck. I am currently retired and I am on a fixed income, but I am sacrificing to help my granddaughter Mia to purchase her wigs, and so far from 9 to 13 I've helped purchase six wigs ranging from $350 to $3500. It just breaks my heart to see her suffering emotionally and mentally at such a young age with the alopecia areata autoimmune disease.

Mia plays a variety of sports and requires more wigs than the norm because of the sweating in the sports and such and the washing, it tends to fall apart faster. Wigs are very expensive and trying to avoid purchasing the Barbie shiny wigs to avoid her peers teasing her at school, which has happened more times than not. Mia has missed a lot of days of school for not having a decent wig to wear to school.

So I urge you on behalf of the National Alopecia Areata Foundation and my beautiful granddaughter Mia and other young children and adults who

also have the alopecia areata autoimmune disease, who had this for so many years and some for decades, who cannot afford to purchase wigs, to please have wigs covered under the update Benchmark Plan. Thank you so much and thank you for hearing me. I also submitted a longer letter on the public comment email. Thank you.

DIRECTOR WATANABE: Thank you, Benita.

All right, next we will go to Dr. Meg Spicer. Your line is unmuted.

DR. SPICER: Hi, thank you very much. My name is Dr. Margaret Spicer, I am with the California Chiropractic Association. I would like to thank you very much for having this opportunity to be able to speak. I will keep this brief.

Chiropractic services addresses the ninth benchmark requiring offering preventative and wellness services for chronic disease management. Oftentimes, we are the portal of care for a lot of patients. And it's an opportunity not only for them to be able to access quality services, but also to keep them off of medication that could be detrimental to their ability to perform their job, take care of their children, or even operate a vehicle, such as opioids, which also has been known for a highly addictive issue.

We also help to decrease the cost of health care expenses. Oftentimes, when we are the first route of defense for patients we can actually reduce the amount of surgeries by 40%. So, addressing the cost of adding chiropractic services to the essential health care benefits, we also address being able to reduce the amount of overall expenses. Thank you.

DIRECTOR WATANABE: Thank you, Dr. Spicer.

Let's see, we will go to Sylvia Yee next.

MS. YEE: Hello, thank you for the opportunity to speak. My name is Sylvia Yee. I am the Policy Director with Disability Rights Education and Defense Fund.

Like many of those who have spoken before I would like to support the idea of having the present plan as a floor for the process of considering additions to or updating of California's Essential Benchmark Plan. Certainly, would alleviate the need to figure out whether or not the new essential benchmark plan or a modified essential benchmark plan would meet the requirement to have a present, a present plan choice as a floor.

I also support the idea of having adult dental benefits for many of the reasons that have been given. For people with disabilities there are many reasons that dental issues and dental health can be a concern. Anything ranging from conditions that affect the ability -- or taking medications for conditions that affect the ability to uptake calcium or that affect how much saliva is produced. There are many reasons that people with disabilities can have concerns about their dental health.

Of course, it would be terribly ironic if someone couldn't, someone with mobility disabilities couldn't reach the dentist because they couldn't afford a wheelchair, so that is another very critical component. And I would -- DREDF strongly supports the inclusion of durable medical equipment within the modified Essential Health Benefit Benchmark Plan. DME, anything ranging from BiPAP, CPAP machines that help one breathe at night, to the mobility that allows one to participate in the community, get health care, go to one's job, and so forth, are critical components of life, obviously of mental health as well as physical health.

Finally, we have achieved with federal regulations the recognition

that medical and examination equipment is and will be a requirement for provider offices. And that was a wonderful thing to see finally happen in the last month or so with the final section 504 regulations. Part of that, of course, is being able to reach the medical offices where care is received, the dental offices where critical care is received.

So once again, DREDF strongly supports the inclusion of durable medical equipment within an updated Benchmark Plan. Thank you very much.

DIRECTOR WATANABE: Thank you, Silvia.

And next we will go to Amanda Herrington. Your line is unmuted.

MS. HERRINGTON: Thank you, Amanda Herrington with America's Health Insurance Plans.

I would like to echo some of the comments that were conveyed by Rikki Pelta of ACLI. First and foremost, we do support expanding access to dental insurance coverage; we do view that is very important to overall oral health. I think on behalf of AHIP, and I think one thing we need to be cautious of, is how we go about expanding that dental coverage and expansion and making sure how we move forward on this does not create any harm or unintended consequences. So, I think it is going to need careful consideration and we look forward along with our industry trade partners to working with this group on that expansion and how it could look. Thank you.

DIRECTOR WATANABE: Thank you, Amanda.

Next we will go to Ellen Miller. You have been unmuted, go ahead.

MS. MILLER: Good afternoon. Can you hear me okay?

DIRECTOR WATANABE: Yes, we can.

MS. MILLER: Wonderful. Thank you for the opportunity to speak.

My name is Ellen Miller, and I am the Executive Director of the International Ombuds Association. However, today I am here as a community member of the National Alopecia Areata Foundation to ask that wigs be included in the new Essential Health Benefits Benchmark Plan.

Just by way of a very quick background, alopecia areata is an autoimmune condition that attacks the hair's follicles. Similar to other autoimmune conditions, it is caused by a hyperactivated auto immune response. As a result of this response, your hair falls out. For some it regrows and falls out again, and for others it does not regrow at all. You may be surprised to know that alopecia areata is the most common autoimmune skincare disease that affects almost 6.9 -- excuse me -- it affects almost 6.9 million Americans and disproportionately affects children and members of the Black and Latinx communities. And it is a disease that directly impacts mental health, self-esteem and one's right to privacy.

My daughter developed alopecia areata when she was nine years old and within six months lost all of the hair on her head and her body, including her eyelashes and eyebrows. She has the rarest form of the condition, alopecia areata universalis. The extent and pace of her hair loss hit her so quickly she wasn't able to process it and as a result she lost all of her hair and without a wig in front of her third-grade class and the entire elementary school community. Parents would ask me if she was ill or had cancer. Her friend group ostracized her. Her class made fun of her and others in the school bullied her. She experienced such extreme trauma that she has been in therapy since she was 10 years old. She is now 21 and still significantly impacted by that trauma and fear that alopecia can bring.

Imagine if today as an adult all of your hair started to fall out very publicly over a period of six months, and all your friends and colleagues either abandoned or questioned you. While public education and increased awareness can certainly help, the only thing that can make a difference is a wig until a cure is found. We are a family that can more afford to pay for a wig than others, similar to Benita. Yet every year I fight with our insurance company for the ability to be reimbursed for a small percentage of the cost, even though she has a prescription explaining the wig's necessity. But it is a fight that I have the luxury to have with our insurance provider. And when I do not win the battle, I can still afford the wig.

Like my daughter many individuals affected by alopecia areata utilize wigs as there is currently few effective treatment options, especially for children. But unfortunately, these wigs cost from $100 to several thousands, which is out of reach for those with lower fixed incomes. This is especially challenging for families with children who often want wigs for attending school like my daughter realized she needed. Wigs are not about vanity or cosmetic or a fashion choice. They are a medical and privacy necessity for those with alopecia and allow those impacted by the disease to not be stared at or bullied. Given the scope of mental health issues plaguing our youth, this is one external aid that can help mitigate other costs.

Currently, eight states have recognized the importance of providing coverage for wigs. In California specifically we want to thank Assemblymember Mark Berman for his leadership by introducing AB 2668 to address wig coverage. I appreciate the opportunity to share the direct impact this has had on my family and I would be happy to discuss further if needed. Thank you.

DIRECTOR WATANABE: Thank you, Ellen.

And let me just check. Benita, did you have additional comment you would like to give? We have your hand up still.

MS. TRUJILLO: No, I'm sorry, I forgot to un-raise it.

DIRECTOR WATANABE: No problem.

MS. TRUJILLO: Thank you.

DIRECTOR WATANABE: That's okay. I didn't want to wrap things up if you had additional comments.

I will just maybe give one more opportunity either here in the room or online if anybody had any comments they would like to give, otherwise we will move to wrap things up. Okay, I've got one, two, maybe two more here.

So, Lloyd Friesen, let's go to you next. We are going to unmute your line. Go ahead.

DR. FRIESEN: Hi, Lloyd Friesen, I am the Chair of the Governmental Affairs Committee for the California Chiropractic Association. You have already heard three of our speakers comment on the issues related to our concerns. I would ask that the DMHC, which I thank very much for having this open discussion today and hopefully more during the course of the time, but there's three compliance issues that I would like for the Department to consider in their review of new Benchmark Plans.

Number one is to comply with Section 2706(a) of the Public Health Service Act, which deals with discrimination towards category of providers.

The second point would be consistent with the scope of benefits in employer benefit plans, which do include the services that doctors of chiropractic provide.

And thirdly and obviously most important, is that the new Benchmark Plan chiropractic benefit would be full scope for the services authorized by the scope of practice here in the state of California.

We will submit written comments at the appropriate time before the deadline, but I would like for those three considerations to be considered in your deliberations between now and then. Thank you very much.

DIRECTOR WATANABE: Thank you, Lloyd.

And let's see here. We have Michelle Marciniak, I believe. Go ahead.

MS. MARCINIAK: Great. Thank you so much. (Echo heard.) Sorry about that. My name is Michelle Marciniak. I am cofounder of Let California Kids Hear and the mom of a hard of hearing child who has access to hearing aids.

Dr. Dylan Chan at UCSF describes hearing loss as a developmental emergency that has been unfolding for years in California and we urge you to add hearing aids for kids in the EHB.

Only one in ten health plans cover hearing aids in California. Newborn hearing screening passed in 1998, acknowledging the urgent need to screen, diagnose and provide interventions to deaf and hard of hearing kids. There have been multiple efforts to cover hearing aids for kids since 2004 and more recently all efforts have been pulled, blocked or vetoed, despite overwhelming support by the legislature, because it would exceed the EHB and create a deferral cost. Now 32 states, as Children Now stated, cover it, and California is not one of them. Thank you. It is time to let California kids hear.

DIRECTOR WATANABE: Thank you, Michelle.

All right, I am not seeing any other comments or hands being raised or anybody else here in the room so I think we will move to wrap up.

If we can maybe put the slide up again with our timeline. Just a reminder, the next step, maybe let's go back to the timeline really quickly. The legislature does intend to have a hearing in August so watch for that.

Again, if there's additional public meetings from the DMHC we will send that out.

Just a reminder again, this is a joint effort between the Administration and the Legislature even though we are hosting so please keep that in mind. And I appreciate my colleagues from the Assembly, the Senate and Covered California and Health and Human Services Agency that participated in hearing all of this comment today.

And then again, public comment, lots of great testimony today. We would appreciate more detail about your concerns or your comments by submitting those to us by July 11. And that can come into public comments@dmhc.ca.gov. And with that, I will conclude our meeting. Thank you for joining today. Bye.

(The public meeting concluded at 3:52 p.m.)

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CERTIFICATE OF REPORTER

I, RAMONA COTA, an Electronic Reporter and Transcriber, do hereby certify:

That I am a disinterested person herein; that the foregoing Department of Managed Health Care Public Meeting was electronically reported by me, and I thereafter transcribed it.

I further certify that I am not counsel or attorney for any of the parties in this matter, or in any way interested in the outcome of this matter.

IN WITNESS WHEREOF, I have hereunto set my hand this 15th day of July, 2024.

RAMONA COTA, CERT*478

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