STATE OF CALIFORNIA

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 second public meeting on California's Essential Health Benefits and setting a new Benchmark Plan. I will be your facilitator today. Alongside me is Sarah Ream, our Chief Counsel, and we have Matt Sauter, Senior Consulting Actuary at Wakely that will also be joining us virtually to do a presentation. If you will just bear with me for just a minute I am going to do a couple of really quick housekeeping notes.

This meeting is being conducted in a hybrid format, so we do have the opportunity for public comment both here in the room as well as virtually through video conference or teleconference. Let's see.

The restrooms on this floor are locked. There are bathroom badges on the table in the back of the room. Please remember to return them when you are done. There are two all-gender restrooms on the ground floor of the building next to our mailroom. If you would like to use those please check in with Security and they will give you the code. We have sanitation stations in the back of the room.

Please remember to silence your cell phones, for those in the room.

And just a reminder, we will be taking public comments and questions at the end of the meeting. I will provide more instructions at that time. Depending on how many public comment we have we may limit that to two to three minutes, but we are going to do our best to try to get through everything. We will probably start here in the room and then go to virtual.

All right, let's go to our slide with the agenda here.

The purpose of today's meeting is to share Wakely's analysis on the cost of adding new benefits and talk about how much room we have to add benefits. We have talked a little bit about kind of an a la carte menu and our budget and so we are sharing that analysis today.

We will be looking for public input both on the analysis and what benefits should be considered for inclusion in the new Benchmark Plan. As you will see later in the presentation, for those that have previewed the presentation, you can see we don't have room to add every single thing that is on the wish list, so there are some tough decisions that will need to be made.

I will just remind you that DMHC is hosting this meeting and facilitating and has been very involved in this process; but this really is a collaborative effort between the Administration and the Legislature. I would like to acknowledge the California Health Care Foundation and Covered California for funding our contract with Wakely who is doing the actuarial analysis.

I would also like to acknowledge the legislative staff that are here today or joining virtually and have been involved in this process, including Marjorie Shwartz, Roz Pulmano, Teri Boughton, Riana King and Lara Flynn. We also have Kim Chen with our California Health and Human Services Agency here with us today.

We will have two presentations. Sarah Ream is going to start with an overview, just a reminder of what EHBs are and the Benchmark process; and then we will have Matt, who will really dig into that actuarial analysis for you.

As I mentioned, I will provide additional instructions at the end around public comment. And we will be taking public comment through February

4 of this year, so in one week. So, get busy with your notes after this meeting.

And with that, I am going to turn it over to Sarah to talk about the process.

CHIEF COUNSEL REAM: Thanks, Mary; and good afternoon, everyone. Next slide please.

Under the Affordable Care Act, all health plans that offer individual or small group products must cover essential health benefits, also known as EHBs. These benefits must include 10 broad categories of items and services, which are on the next slide.

Within these 10 broad categories of services, each state can decide which specific services to include, and which services plans do not have to cover. California's Benchmark Plan includes benefits from each of the 10 EHB categories in this list. However, the list of everything that is covered in the Benchmark Plan is too long to 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. Next slide please.

So how did California get to its current Benchmark Plan?

At the time California selected its Benchmark Plan, which was more than a decade ago, federal law prohibited states from doing an a la carte selection of benefits. Instead, to satisfy the federal benchmark plan process, the states had to identify an existing health plan product and then add any additional

benefits if necessary to ensure the product covered all 10 of the federally required categories of EHB. The benefits in that identified product, plus any additional added by the state defined what benefits were considered essential health benefits in that state.

Using this benchmark plan process, California selected as its benchmark plan the Kaiser Foundation Small Group HMO 30, as that product was sold in 2014. The benefits included in that Kaiser product define our current EHBs In California. Per federal law, if California did not adopt a new benchmark plan, but required or were to require health plans to cover any service that is not currently included as an EHB in California, the additional benefits would be said to exceed EHB. As such, the state would have to cover the cost of those additional services or those services that exceed EHB for any individuals purchasing coverage through Covered California.

Turning to the current process to adopt a Benchmark Plan. I mentioned that up until recently states were limited to choosing an off the shelf, currently existing health plan product to serve as the state's benchmark plan, but not anymore. Now a state can select from a suite of benefits to constitute its benchmark plan, and the state does not need to rely on looking at existing products. Next slide please.

However, there are limits to a state's freedom in this process. First, the state cannot exceed the scope of benefits provided by the typical employer plan in the state. This is referred to as the Typicality Test, and ensures that the scope of benefits that constitute EHBs are not overly rich.

Second, the Benchmark Plan cannot have lifetime or annual limits and cannot have discriminatory benefits based on health condition or age. For

example, if a benchmark plan covers medically necessary hearing aids for children, it also has to cover medically necessary hearing aids for adults.

Finally, the state must submit the proposed benchmark plan to CMS and get CMS' approval for the benchmark plan. Next slide please.

Which brings us to the timeline for selecting a new benchmark plan. I would categorize this timeline as hurry up and wait. We have a very condensed timeline, as you can see here, to identify and finalize the benefits to be included in the new plan. Once the legislature finalizes the benefits, there will be at least one or two public comment periods this spring. After that, we will finalize the application and submit it to CMS for approval. We have to submit the new benchmark plan application to CMS by no later than early May. Thereafter, assuming CMS approves the new benchmark plan, that plan will take effect about a year and a half later, so in January of 2027. So, again, it is a hurry up and wait situation.

I will now turn it over to the folks -- oh, sorry.

DIRECTOR WATANABE: Yes. Before we get to Matt's presentation, I will just quickly make a couple of notes on the timeline. There is a joint legislative hearing that is scheduled, actually, for February 11. I think when we put this together we didn't have the exact date. I believe it is starting at 1:30. So, that will be the afternoon of February 11. I am seeing head nodding in here.

I also want to just take a minute to answer some of the questions we have been getting to try to get a little bit ahead of that. Again, we will take questions and public comment at the end. We have had a lot of questions about when you will get to see the report. And I want to be clear, there is not necessarily, like, I don't know, a 30-page narrative report. Really what you are

seeing today is the analysis that Wakely has done. We have had limited time, limited budget, and so we have tried to move quickly to share that analysis. And again, we will be welcoming feedback on that.

I will just note, when we get to the point of the public comment on the package that we are going to submit to CMS, that is that kind of March and April time period. There is an actual report. There is a Plan document and other documentation that CMS requires. So, your public comment will be on kind of that package that we are going to submit. But just wanted to clarify, you are not missing anything if you didn't see a report. So, the PowerPoint we are going to walk through today really is what you are going to see.

We have had some questions about, I got up at the last meeting in June and asked you to consider this benefit or that benefit. As you will see in the presentation, we did not have Wakely price everything under the sun. We had to make some decisions.

There also were a number of benefits that were recommended for certain conditions or for certain age groups. And I think as we talked about at the last meeting and as Sarah indicated, we can't have discriminatory benefits. So, we have really had to think about which of these benefits had the most kind of public support and feedback as well as didn't have kind of these limitations for conditions or ages. So, just know that we have had to make some decisions quickly to get this process moving.

Had some questions about, what does the change in the federal administration mean for this process? I think, as we are all looking at today, there is a lot of uncertainty, but we are planning to move forward with this process. There is a lot of work that went into this last year. We wanted to share

the analysis from Wakely. If anything changes, we will certainly let you know.

And then lastly, I think probably the one slide that you all are very interested in is the slide on adult dental. So, since our meeting in June, we received some information from CMS that states cannot include the value of a standalone dental product when doing that typicality analysis, even if the employer offered a standalone dental product as part of like the benefit package that they offer to their employees. So, as a result of this -- I think this was really intended to be more of a very narrow adult dental benefit. So, Matt is going to walk through a slide that really talks about what it would cost to add either a preventative or kind of the full-scope dental benefit. But that is probably the biggest change from what we shared in June and some new information that we have had since then.

So, I think those are all my caveats and notes before we have Matt do his presentation. So, Matt, I think we will turn it over to you.

MR. SAUTER: Excellent. Thank you, Mary. Yes, as Mary stated, My name is Matt Sauter and I have been the actuary of supporting California on the EHB analysis and the potential application.

Before jumping in to the analysis and the pricing estimates here, on the next slide I wanted to remind everyone that this is a draft and still being refined to a degree, still decisions to be made, so all the estimates provided here today should be viewed as a draft for illustrative and discussion purposes. And then even once we make those decisions, the application will still be contingent on CMS reviewing and approving that application.

So, two slides forward, as we talked about earlier, there is the Typicality Test that we have to keep in mind as we are looking at that, which

essentially places a floor and ceiling on the benefit richness. So, while there's a lot of benefits that have value to be added, there is a kind of ceiling or maximum on what can be added. And as we look at those benefits, specifically in this EHB context, it is important to keep in mind that with CMS regulations we need to be looking at the total allowed costs, or that we are 100% CPT. I will be tossing around that nomenclature, which is just the plan paid and member cost-sharing. So, it is a little disconnected from premium impact, because it does include those two items.

Also, as we are looking at those allowed costs for these benefits, we are going to be looking at that steady state ongoing cost. So, we are not considering the year one pent-up demands that may occur, but really just the steady state.

And additionally with that, when we are analyzing these benefits, we are just looking at that benefit in itself and we are not looking at downstream impacts such as maternity costs for infertility, or potential savings from increased well -being from hearing aids.

And then all of that is just an allowed cost for the sake of this EHB analysis in staying consistent with CMS regulations. And when we get to the premium impact, which is somewhat outside of the scope of this, those might vary from our estimates just because those will be on a different basis than a the total allowed costs and there will be other variables and assumptions that issuers will make with utilization management, pent-up demand and various items like that. Next slide.

So, with that Typicality Test what we are doing is we are evaluating the current Benchmark Plan, which is that Kaiser Small Group Plan, against a set

of plans that CMS dictates what we can compare against. And we are looking for the most generous plan, the plan with the richest benefits, so we identified that to be Kaiser's Traditional Plan for the University of California. And we took those two plans, the Benchmark Plan and the Most Generous Plan, and just stacked every benefit up against each other. So, we looked at PCP, we looked at specialists, acupuncture, chiropractic. And what is listed here are the main differences that we identified between those two plans.

And then as we get to the two right-most columns, we quantified those differences in those benefits. And that is what is going to get us to the bottom number there, the 1.06% to 2.23%. And this is the percent of total allowed costs, so all the costs in member paid and plan paid. The difference in those benefits were about 1 to 2.23% of total costs. So, this is what is going to effectively place that ceiling on the amount of benefits that we can add to the current benchmark Plan. So, listed here are the main one benefit differences we identified, but there are also some other smaller benefits that -- benefit differences as well. But that 1% to 2.23% is what we want to keep in mind as we move to the next slides.

So, with that room in mind, we wanted to look at various benefits to price and consider for inclusion in the Benchmark Plan. So, here is the subset of those benefits that we are currently considering.

So, there is hearing exams and hearing aids. And that would be one hearing exam and a hearing aid for each ear every three years.

There is various DME that we will cover on the next slide.

And then there is also wigs, chiropractic care, infertility diagnosis, artificial insemination, and IVF cycles.

So, these are benefits that are not currently included in the current Benchmark Plan, but we are looking at adding.

And then on the far right we have a, in some cases, large range of pricing estimates. And these pricing estimates for some of the ranges is primarily driven by options and limits and other variables in what that benefit may look like. So, as we are evaluating these, it is also important to look at how the benefit will ultimately be structured. So, we will run through an example of that, particularly on IVF, on how different benefit structures can be had there.

So, on the third-from-bottom row there we have the total benefit cost of these benefits, and that is looking at a wide range of 1.6 to 3.5%. So if you remember the 1 to 2.25% from the last slide, this is going to exceed that limit. So, not all of these benefits will be able to be added at their fullest extent. So, there will have to be some decisions there to make sure that we are complying with that Typicality Test when adding benefits.

And then you also might see on the bottom row there that the math may not look entirely perfect. There is a little give and take with these benefits. So, for example, chiropractic care is in the Typicality Test and the Benchmark that we are adding. So, just as we look at different ways to price that and range of reasonability there are some dynamics where as one goes down the other one goes down, so it is not the cleanest math there. But we did want to illustrate generally that there is there is not enough room for all these benefits.

One benefit not on here is adult dental, which I believe is on the next slide. And this is what Mary was alluding to earlier. We did price out adult dental and found -- in the left box here when we looked at preventative services, those allowed costs for adding that to the Benchmark Plan where 1.3 to 1.8% in

the benefits we priced out that listed there. And then when we looked at all adult dental services, so including the preventive and then also some Class B, C and D services, We got even higher price estimates of 2.6% to 4.6%. So ultimately these price estimates were effectively taking up all of the room if not exceeding the room that we had in the Typicality Test. And then there was also other considerations such as market disruption and other factors that that we considered. But I think the takeaway here is just that the high cost of adding adult dental, especially with CMS, not allowing adult dental standalone plans to be included in the Typicality Test. Next slide.

So, we grouped a lot of DME into the benefit grid we showed a couple of slides ago. These are the DME categories that we have been looking at. Some examples are wheelchairs, portable oxygen, and some TENs under Neuromodulators. And this has a very wide range just with some benefits having extremely wide range of unit costs. So, there's, you know, kind of some basic DME in some categories and then more high end DME. So, the range here is in part due to those variations in unit costs. And also in how the state and issuers may enact utilization management and other factors there that may influence not only unit cost but also utilization. So, really defining these and what will be included and the specific language in the Benchmark Plan will also be important to defining and getting the price estimate. Okay, the next slide.

IVF is one of the benefits that we analyzed and has various components to this benefit. So, we priced out three different scenarios. Going across the top there is A, B and C. So, there's different costs associated with these benefits as we go from relatively high-cost fertility drugs and extraction to maybe lower cost benefits such as transfers and donor sperm and eggs. So, we

wanted to just play with a few different options here. There's definitely other options that can be displayed. This is not meant to be the only three options that we can look at; but just wanted to show a couple price differentials as we look at different benefits.

So, the main thing that is driving the cost here, cost differentials. You can see in Option C has three, fertility drugs, extractions and fertilization. So, that definitely has additional costs. Especially the drugs and extractions are pretty high-cost relative to the other benefits. Option B and C also ratchet up the embryo transfers. So, once we do that high-cost extraction and drug and fertilization process, how many transfers should be covered under the -- under the benefit, and how does that interplay with our Typicality Test and the room that we have? And then there is also some variation on donor sperm and eggs there as well.

On the surrogacy side, a little blurb there at the bottom. This is to cover the IVF medical care of the surrogate and does not include any payment to the surrogate for carrying the baby in itself.

So, with that, we have a little range there of about 0.6 to 0.9%. And again, there are other options that could be explored. And then just because we put a limit such as two transfers doesn't mean a member couldn't do more on their own. This is just what would be covered under the Benchmark Plan. Okay, the next slide.

And here we are just spelling out some of those differences in a more bulleted format if you wanted to look at what is changing. So you can kind of go across and see the 2 covered and 3 covered there. And then next slide.

And here we are just defining those, what we are including and

priced in each of those categories. They are not always easy to bucket in the categories. But we did look at various CPT codes and other factors, including kind of some first principal buildups where data was not available, to price these out. So, if you are looking for any definitions of what we are including in which bucket, that can be found here. And if a bucket wasn't perfectly lined up, just know that we did try to capture that cost in one bucket or the other in our total price estimate there. I believe that is the last slide so I will turn it back over to Mary and team and next steps.

DIRECTOR WATANABE: Thank you, Matt. I think we will take questions and public comment in just a minute. So, let me maybe just quickly go through some of our housekeeping.

For those that are joining virtually, you can use the Raise Hand feature. To raise your hand click on the icon labeled Participants on the bottom of your screen, then click the button labeled Raise Hand. Once you are done giving comment you can lower your hand.

I do think we will start with comments and questions here in the room for those that would like to start lining up.

Can we advance to the public comment slide?

As I noted before, we will take written public comment through February 4. As you saw in our timeline we have a pretty aggressive timeline to make some decisions.

I will just note that the Legislature has asked the California Health Benefit Review Program to look at the premium impact of this. I know the impact to premiums and the overall cost is something that we are all probably thinking about, so just know that that analysis will be forthcoming.

So, for today's meeting and the public comment, again, if you have questions for Matt, or to the extent that Sarah and I can answer them, we are happy to take those questions. But also looking for public comment on now that you have seen the benefits that we have priced, the cost, you have seen we have limited room to add. Looking for feedback on what we should consider to move forward.

So, for those of you in the room, if you would like to start lining up by the podium we will start public comment whenever you are ready and then we will go to those on the phone as soon as we are done here. And there should be a button that says Push that will make the light green, and once that is on, we should be able to hear you. Thank you. Go ahead. And if you can give your name and the organization you represent as well, thank you.

DR. ALVERO: Absolutely, yes. Good afternoon. My name is Dr. Ruben Alvero, and I have been a fertility specialist for more than 30 years. I am currently on the faculty of Stanford Medical School and on the Board of Directors and on the Executive Committee for the American Society for Reproductive Medicine.

It is really my considered opinion and professional opinion that the fertility EHB should exactly mirror Senate Bill 729 by covering three egg retrieval cycles. And very specifically, retrieval as opposed to cycles, and limited number of embryo transfers. This is based on extensive US and international literature that supports this to be the most cost-effective way to maximize an individual's chances for a healthy pregnancy and neonatal outcome.

Pathway C is the standard of care in the community for self-pay patients, and it is comparable to what is covered by commercial insurance locally

as well. It is also similar to what is covered in mandated states that are the most successful in outcomes and low morbidity for patients.

The 10 donor eggs is also optimal for the LGBTQ+ community, and not having these donor eggs as an available resource would be discriminatory towards that community.

The unlimited cryo-storage is also critical, since egg retrievals and transfers are usually not linked in standard practice today. So having the cryopreservation available for a longer period of time is absolutely necessary in order to practice optimally and not be pressured to do unhealthy things such as transfer too many embryos, which leads to really both unsuccessful outcomes as well as very dangerous pregnancies.

So, thank you very much, and I am happy to take any questions if there are any.

DIRECTOR WATANABE: Thank you very much.

DR. ALVERO: Thank you.

DIRECTOR WATANABE: Next? Sorry, I can't see behind the pole so just come up when you are next. Go ahead.

MS. MONTANO: Hello. Monica Montano, with the California Dental Association. CDA strongly recommends the addition of adult dental services to California's Benchmark Plan as an essential health benefit. In the EHB draft analysis of adult dental it is stated to be too costly to fit within the allowed cost range, even with parsing out preventive services and all adult dental services.

Generally, we all value and see preventive services as required, such as vaccines, checkups and pediatric dental services, and yet adult dental is

seen as optional, even though we know oral health is an essential part of a person's overall health, as studies have shown that poor oral health is tied to diseases such as heart disease, diabetes, which are significant cost drivers.

With excluding adult dental from the benchmark plan the state is passing on the opportunity to give many Californians access to dental and access to a meaningful standard of dental coverage. Current dental coverage today is structured in a way that forces consumers to shoulder most of the cost for dental care that is critical to their overall health.

We urge the state to reconsider adding adult dental into the Benchmark Plan to provide the necessary consumer protection and oversight that is missing from dental coverage today. CDA urges the state to add adult dental into the EHB Benchmark Plan.

And I do want to end with a question trying to understand the more details and nuance of the dental services not being able to be -- or a standalone dental plan not being able to add into the Typicality Test. So, definitely wanting to understand more of, you know. It seems like it was an apples and oranges comparison considering adult dental is not already in an embedded health plan. So, a question there.

DIRECTOR WATANABE: I will do my best and, Sarah, jump in here. I think when we initially realized that adult dental might be an option, we thought we could count the value of a standalone dental plan, and CMS clarified that we could not.

MS. MONTANO: Mm-hmm.

DIRECTOR WATANABE: So it had to already be embedded. And so, you know, for many of us that have our dental coverage separate, we thought

the value of that could be added, which would have given us a lot more room to add an adult dental benefit and more benefits. But CMS clarified that that was not the case ad so it really does, does limit the room to add adult dental. I don't know if you would add anything?

MS. REAM: No. I mean, I have had several conversations with CMS in that regard and they said no, it cannot be a standalone dental plan, even if the employer, you know, even if there is 100% uptake on the part of the employees. It is still the dental has to be embedded with the medical for us to count that value towards the Typicality Test.

DIRECTOR WATANABE: As you noted we don't see that here, unfortunately, yes.

MS. MONTANO: Very difficult. Thank you.

DIRECTOR WATANABE: Thank you.

MS. SANDERS: Mary and Sarah, Cary Sanders with the California Pan-Ethnic Health Network. Good afternoon. Thank you for having this hearing today.

As others have said, this is an important opportunity to revisit our current Benchmark Plan and add additional benefits that will improve health outcomes for Californians. We appreciate that California is considering adding certain benefits such as DME, infertility treatments and hearing aids. Adding these benefits will make access to these services and equipment more affordable for millions of Californians, including low-income and communities of color.

While we are appreciative of these additions, we are, as others have mentioned, very disappointed by the omission of adult dental, which has enormous implications in terms of our ability to reduce disparities and improve

health outcomes. As others have said, oral health is health. Forty-two percent of US adults 30 or older have periodontitis or periodontitis, while rates are higher among low-income adults. And poor oral health is linked to a myriad of chronic health conditions such as heart disease, diabetes and dementia. Adults who are not able to access oral health care are at increased risk of other health conditions, and this is more acute and exacerbated for communities of color.

We understand that there are particular considerations, such as satisfying the Typicality standard, which Wakely, and I know you Mary, alluded to, in order to add this. We still request additional background information on Wakely's analysis in conclusion that adding the adult dental is too costly to fit within the allowed cost range. Slide 15 shows the typicality range as being between 1.06 and 2.23. The low end of preventative dental is 1.26, which we feel like is somewhat within range. The federal regulations also allow states the flexibility to define routine dental services and some states are doing that. If California chose to cover adult dental benefits there could still be room to add some of these other preventative benefits that you have on the slides, DME, hearing aids, infertility treatments.

So, I didn't you know -- I appreciate the additional background on the standalone dental plans. That is the first we heard of that was today, it was not in the slides. And frankly, the explanation by the consultant was, to me, it sounded like sort of repeating what was on a slide as opposed to really breaking it down, just as you did a little bit here, in response to a question about what that actually means.

One of the things that consumer advocates had asked for in doing this analysis, if not a full report, which we understand, is at least a written

summary that we can actually take and review and look at to understand what some of the underlying rationale is for inclusion or non-inclusion of benefits. And in particular, you know, we want to know what criteria the state is using beyond cost to determine what is and is not included in that proposed list.

This, again, you know, we appreciate the desire to rush, because we do want -- it is sort of rush and wait. And we support that and we want to make sure that there is a robust, transparent and equitable process here before we make a big decision, or decisions like this that have impacts. Thanks.

DIRECTOR WATANABE: Thank you, Cary. I am going to ask Matt maybe a follow-up question to get to maybe one of your points.

So, Matt, we have kind of the Typicality Test that allows us to go up to the 2.23. But do you have any maybe response on how we should consider that range? Like, can we consider the low end versus the high end? Or should we really be looking at the high end of these benefits and how that fits into the 2.23?

MR. SAUTER: That is a good question. I think the main thing with the range is recognizing that some benefits are in the Typicality Test and also being evaluated for addition. So, for example, if we just said the range was 1 to 2% and one of those benefits was chiropractic at 0.5 to 1%. If we pick the 0.5% there, then that kind of -- for the Typicality we have to pick the 0.5% for the benefit to add as well. In other words, we have to treat each benefit the same within the Typicality and in the benefits we are pricing. So, that is where some of the interplay I was talking about on -- how much room is left that comes into play.

Generally, I think we could look at the midpoint of that range. So, you know, as we are looking at this, the range on preventive dental I think it could

be reasonable to say that if we only added preventive dental, that could be an option. That would just make it so the other benefits would not be able to be added as the dental would take up all the room. And then I think there is also probably consideration there on what adding preventive but not comprehensive made to -- in the marketplace and various other considerations there too.

DIRECTOR WATANABE: Thank you, Matt. All right.

Nick, go ahead.

MR. LOUIZOS: Thank you, Director Watanabe. Nick Louizos with the California Association of Health Plans. Thank you for allowing us to provide comment today.

One of our top priorities is keeping health care as affordable as possible for the greatest number of consumers. This, of course, requires balancing the comprehensiveness of benefits against the associated cost impacts stemming from this particular project. In other words, we need to recognize that we need to balance affordability and accessibility to health care. To that end, this process is very important and certainly preferable to, you know, the approach that we sometimes see in the legislature of considering one-off benefit mandates and we would hope that, you know, those bills be set aside as we move through this particular process.

You know, specifically, you know, the Wakely analysis does include some key considerations for allowed cost. We are still digging into the specifics of the analysis and we will likely be providing some written feedback to you that is more specific. Having said that, the overall debate over a new essential health benefits package, you know, would benefit from some additional elements. We are happy to hear that the California Health Benefits Review Program will be

involved in providing some specific premium impact numbers associated with the addition of new benefits. We think that will be a crucial line of sight as we move forward on this.

Also, while the Wakely analysis does acknowledge that pent up demand for services could drive up consumption in the initial years of a potential new Benchmark Plan, an estimate for this is not incorporated and so we are concerned about the consequences of pent-up demand. We did see post-pandemic that costs did rise in both public programs and the commercial markets after restricted services were back online after the pandemic so it is a real phenomenon.

Also in respect to context and you kind of alluded to this Director Watanabe. There is widespread uncertainty regarding the continuation of enhanced federal subsidies for coverage at the Exchange. If those subsidies expire and are not renewed or they are slashed, the cost of health care coverage may increase for many consumers, or likely increase. And due to this uncertainty we urge the state to move cautiously and just keep this in mind as we continue to move forward on this.

Finally, we would just urge the Department and the Legislature to consider the work being done at the Office of Health Care Affordability. As you know, the Office in April approved a Statewide Health Care Spending Target that CAHP supported. It was uncomfortable to support that, but we did that anyways because we thought it was important to address underlying cost drivers. Today they had a meeting as well and they are considering additional important measures in that regard. So, we would just hope that, you know, there is some coordination or consideration of the work that is being done at the Office as part

of this Essential Health Benefits process. So, I will leave it at that. Thank you very much.

DIRECTOR WATANABE: Thank you, Nick.

MS. LYNN: Good afternoon. Nora Lynn with Children Now urging health aides be -- hearing aids, sorry, be added to the essential health benefits package for children and adults in the state. Updating this benchmark for comprehensive care for children is critical. Starting in 2026, 33 other states will include a hearing aid benefit, and earlier this month the Republican Governor of Ohio signed a law adding hearing aid coverage for children in his state. Closing this gap in California will help ensure the state's estimated 20,000 deaf and hard-of-hearing kids will have comprehensive coverage and services, including hearing aids, to meet their health and developmental needs. According to pediatric experts, the lack of hearing aids coverage is a developmental emergency, and 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 to address this longstanding coverage gap. Senator Menjivar’s legislation two years ago to require hearing aid coverage for children was vetoed by the Governor because it would have set a new precedent by adding requirements that exceed the Benchmark Plan. This year, the Legislature and Administration can finally close the hearing aid coverage gap and ensure children can maintain their care in their medical home. Thank you for holding this important hearing.

DIRECTOR WATANABE: Thank you.

MS. SHULAR: Hi. My name is Caprice Shular. I am a parent of a

child with -- that is hard-of-hearing and was told at four weeks old that she needed hearing aids. Today I am representing the Let California Kids Hear campaign, which is comprised of parents, pediatric audiologists and ENTs in California.

Only 1 in 10 children have hearing aids covered by private health plans. Hardworking families are told that their children's hearing aids are elective. That puts a tremendous strain on so many families to either find a way to pay thousands of dollars out-of-pocket, delay time-sensitive treatment, or forego them all together.

For over 25 years, legislation has received strong support from lawmakers acknowledging this developmental emergency, and has been vetoed multiple times with multiple governors saying, now is not the time. Meanwhile, California now lags behind 33 states that have addressed this issue. Now is the time to add hearing aids to the essential health benefits to ensure a permanent solution for our deaf and hard-of-hearing children. Thank you for the opportunity.

DIRECTOR WATANABE: Thank you.

MR. PULSIPHER: Good afternoon. Craig Pulsipher on behalf of Equality California. We were proud to cosponsor SB 729 last year, which as you know, requires large group health plans to provide coverage for fertility and infertility treatment, and make sure that that coverage is inclusive of LGBTQ parents.

Just a couple quick points. Wanted to first echo the comments of Dr. Alvero, the importance of ensuring that this benefit is consistent with SB 729, and then a couple specifics. Just notice that the presentation does not mention the definition of infertility. This was an incredibly important aspect of 729. So

just urge you to ensure that infertility for the purposes of the Benchmark Plan is defined in an inclusive manner that provides LGBTQ and single people with equal access to this benefit.

Additionally, regarding surrogacy. We believe it is important to clarify that the health testing and related services for surrogacy should be covered by the intended parents' insurance, not the gestational carrier's insurance, and with the gestational carrier's insurance taking over upon confirmation of pregnancy. Also important to clarify that if a gestational carrier is not paid for carrying a baby, then the health insurer must cover all of the costs related to the pregnancy and cannot seek any subrogation of funds.

So, thank you for your consideration and looking forward to continuing engagement on this.

MR. SHANNON: Good afternoon. I am Patrick Shannon from the Greenberg Traurig law firm and we represent the sponsors of SB 729, so have an interest in the EHB process as well.

First, just wanted to thank you for moving forward with this process. I know it is a difficult process, especially in this condensed time frame, and we want to work with you to help elucidate some of the issues.

My next comment is the driving factor here is going to be cost and so far, the cost information has not been sufficient enough to provide really meaningful feedback. For example, when we turn to the IVF section, there is a cost for IVF, for the total cost up to 0.87%. But there is no breakdown for the different categories that are listed there. And what would really be helpful would be the background information that shows the data for the assumptions that are made to price out each and every one of those services. That was painstakingly

done over the years for the large group.

You did mention, thankfully, that CHBRP burp will be involved and will also come up with a PMPM analysis. But in the meantime it would be great first to see the data from Wakely, second to see if they have any discrepancies with CHBRP, at least from 729. And then lastly, what would be the timing of CHBRP to do this kind of analysis. So, the two questions really are, can we see Wakely soon? And secondly, when will CHBRP complete its work? Thank you very much.

DIRECTOR WATANABE: Thank you. On the CHBRP question, I know the goal is to move quickly. I don't think we have a specific time frame other than fast, hopefully fast, given our time frame to make decisions. Two weeks? Okay, I am hearing two weeks. Two fingers are up behind you here. So, hopefully in two weeks we will have the CHBRP analysis.

In terms of Wakely's analysis. So, one of the things I think we will be looking for in the public comment is, what else do you want to see? Obviously, we had Wakely price these three options. There are, you know. There’s costs associated with each of those kind of buckets, which you see in some of the slides. So, I think the question would be, what else is there? Some of this information that Wakely used is proprietary so I think -- you know, we will take that back and see if there is something more that we can share. But I think your public comment and written feedback about what else or maybe what other options you are looking to see priced would be helpful for us to know as well.

Okay, I am not seeing anybody else in the room hop up here, so let's go to public comment online. Are you ready for this? Okay, I think, Patricia, we are going to go with you first so we will unmute your line and you can put your

hand down and go ahead and go ahead and give your comment or question.

PATRICIA: So, thank you very much for doing this. A quick question. The slides that were put up in the agenda differ from what you presented. Can we get an updated slide deck? So, that is the first thing.

Second, I would like a little more information on what amount of the IVF benefit is being compared with SB 729 that was just passed?

DIRECTOR WATANABE: So, we will take that back. I think the slide deck we are presenting should be what you see on our website. I am going to just throw this out here. It could be that you are looking at the presentation from our June meeting, but we will double check that. You can always shoot us a note at public comments@dmhc.ca.gov. If you are not seeing it we can follow up with you.

And then your second question I believe was about SB 729. So just to be clear, the three options that are priced in what you saw today does not include 729 so that was not one of the options. I think the most generous option may be close. But just to be clear, we didn't specifically price SB 729.

PATRICIA: Thank you.

DIRECTOR WATANABE: All right, we are going to go to Christine Smith next. We will unmute your line, you can go ahead.

MS. SMITH: Good afternoon. My name is Christine Smith with Health Access California. We appreciate the Department convening today's meeting and feel like the revisiting of our Benchmark Plan is both timely and necessary.

We view BHPs and the Benchmark Plan as a baseline from which we can improve. And to be clear, we only support changes that would build

upon, rather than subtract from the progress that we have made. Our state is also seeing a plethora of new benefit mandates, and each year even more benefit mandate proposals before the legislature. So, we have also seen increasing costs, underscoring the need for a careful, well thought out process, which we appreciate you doing, including the analyses of the benchmark options, so thank you for doing that.

We look forward to reviewing the new analysis and we will provide detailed written comments as we can before the deadline. And also look forward to participating, continue to participate in this process rather. So, thank you for your time.

DIRECTOR WATANABE: Thank you, Christine.

Let's see. Next we have got Joe Parra. Unmute you now. Go ahead.

MR. PARRA: Hi there. Hi everyone, Joe Parra with the Senate Republican Policy Office. I don't want to speak if this isn't the proper box. I had a couple of probably dumb questions but I can -- if it isn't appropriate to ask them here I can ask him directly to Christen offline via email.

DIRECTOR WATANABE: Yes. I mean, I will defer to you. I mean, you are welcome to ask what you want here.

MR. PARRA: Okay.

DIRECTOR WATANABE: Otherwise, we would certainly be happy to follow up if you want to send us your questions.

MR. PARRA: Because I have the benefit of the Wakely individual here right now, correct?

DIRECTOR WATANABE: So, Matt is online.

MR. PARRA: Okay.

DIRECTOR WATANABE: Yes, he is joining virtually. But, yes, if you have questions for Matt why don't you go ahead and ask those and we will do our best to have Matt answer and can follow up if needed.

MR. PARRA: Just looking at, I mean, going to slide 15. And again, I try to, in my fourth grader mind I try to simplify things to that level. So, all the benefits that have been listed on slide 14, slide 15, the dental benefit on slide 16, and then the slide, I think it was 18 with the in vitro, all that, the Typicality percentages have to get to no more than 2.23%. Am I understanding correctly?

DIRECTOR WATANABE: Yes, maybe I will take a step at this first, Matt. So essentially 2.23 is our budget or our room to add. And so if you look at slide 15 and you add all of those benefits up it comes to on the on the high end 3.48. That does not include adult dental. So, if we were to add adult dental you are looking at adding somewhere between 1.26 to 4.6.

MR. PARRA: Okay.

DIRECTOR WATANABE: We are looking for decisions that will get into that range of 1.06 to 2.23.

MR. PARRA: And so -- thank you. So that was kind of a question 1A that I had that on slide 15, all those -- all those different percentages are additive that gets to on the upper end -- if you included everything that would be that 3.48%, correct?

DIRECTOR WATANABE: Correct.

MR. PARRA: Okay. And then so looking at -- and I think this was the point, and I just want to make sure I understand correctly. The point that I think the individual from CDA made regarding that if you look at the -- and I don't

want to put words in their mouth so let me just ask the question, not attribute it to anybody. That if you -- if the Goal 1, 2 and 3 was to add preventative services only, dental benefit. And I want to make sure I understand the whole concept globally. If you take that 1.83% then that would mean you only have 0.4% remaining to add everything else, or what you could of everything else?

DIRECTOR WATANABE: That is correct. Matt, back me up here. But I think if we were to add the preventative services only for adult dental at let's just say a max of 1.83, that would leave around 0.4 to add another benefit.

MR. PARRA: And then -- so the same thing with the IVF. If you took for sake of argument Option 3, which shows 0.87%, so to find out what is remaining in terms of adding everything else. And again, I am just saying this so to make sure I understand. You would take the 2.23 minus the 0.87?

DIRECTOR WATANABE: Correct.

MR. PARRA: Okay. And then so lastly, and this is just clarification. We heard I think from Children Now about the importance of the children's hearing aids. On slide 15 the very first row where it says Hearing Exam & Hearing Aids. Is that for everybody, adults and children?

DIRECTOR WATANABE: Yes, it would have to be for everyone.

MR. PARRA: Okay.

DIRECTOR WATANABE: We can't have it just for children. So, yes, you are correct.

MR. PARRA: Okay. And so the bottom line, and I apologize for asking these rudimentary questions, is that the challenges, and this is what you are getting the public, the package that -- or yes, the request or the package that you send to the feds, that it is all the things that are on slide 15 and the other two

separate slides. That somehow passing the straight base test or the fig leaf test, it has to stay at or under the 2.23%.

DIRECTOR WATANABE: That is correct.

MR. PARRA: Okay. Thank you very much.

DIRECTOR WATANABE: And Joe, feel free to follow up with Christin or through our public comment box too if you have other questions.

MR. PARRA: No, you guys are awesome.

DIRECTOR WATANABE: But yes, very good questions.

MR. PARRA: Thank you.

DIRECTOR WATANABE: Okay, thanks, Joe.

All right, next we have Hector Hernandez-Delgado from NHeLP. Go ahead, your line is unmuted.

MR. HERNANDEZ-DELGADO: Hi, good afternoon. This is Hector Hernandez-Delgado, I am a senior attorney with the National Health Law Program. First, I wanted to thank the Department of Managed Health Care and Wakely for the presentation and for the opportunity to provide input on proposed changes to the EHB Benchmark Plan.

As we have repeatedly said in the past, we strongly believe it is time for California to join the more than a thousand other jurisdictions across the country who have taken advantage of current federal flexibilities to improve access to health care services. The EHB benchmarking process not only enables states to close remaining gaps in coverage, but it also allows states to address persisting health disparities. To that end, we want to express our preliminary support for the proposal to add certain benefits outlined in the presentation, specifically hearing aids, DME and infertility treatment. For several

years, we have advocated at the Legislature and with corresponding agencies production of policies that expand access to hearing aids and durable medical equipment.

California's current benchmark planning is an outlier when compared to other jurisdictions. In the majority of states a wide array of equipment and devices are covered, and similarly most states require coverage either through benchmarking or through legislation of hearing aids for kids and adults. The gap in coverage for these services disproportionately affects individuals with disabilities. Of course, without adequate coverage the lives of adults and children with disabilities are severely impacted. Many are unable to attend school, work or participate in community life, and others face institutionalization because they cannot function in their own homes without needed equipment. And of course as we have said in the past too, these barriers also present potential violations to federal non-discrimination laws.

I would also like to emphasize, as others have said, that adding hearing aids, particularly for kids, but of course for everyone through benchmarking, has the support of policymakers and legislators in the past, and similar bills have been vetoed precisely for the reasoning that it would be subject to (indiscernible). So, it is encouraging to see that we may add this through the benchmarking where the (indiscernible) is not in question.

Similarly, the lack of access to infertility treatment in California poses significant health and inequities issues. Private plans in the state often exclude coverage for these services. And the high cost not only have has a disproportionate effect on low-income Californians, but also a disproportionate impact on underserved individuals such as LGBTQI+ individuals, BIPOC

individuals, or individuals with disabilities who depend on IVF or other infertility treatment to have children.

I also wanted to mention that while we are disappointed with the exclusion of adult dental care, which also presents significant health equity considerations, we do understand the difficult decisions that have to be made given the generosity limit. We look forward to working with DMHC and other policymakers to look for solutions to the lack of access to basic dental services for adults. But again, I want to emphasize the importance of many of these benefits that are being proposed.

I will close by saying that while we generally support the additional benefits outlined in the presentation, we do plan to provide more specific feedback on the limits being proposed for each service. And to that end, I would join others in expressing the concern with the fact that there is not a full report available for this commenting opportunity. It is good to hear that such a report, like an actual actuarial report, will be available later in the year after the proposal is finalized. But it would also have been good to look at that report to answer our questions before this commenting round.

Some of the issues that we would like to have more clarity on are the methodologies for calculating estimated cost and actuarial value, how Wakely selected the most generous plan since there were some changes to that in the federal rules last year or a couple of years ago. So, those are some of the questions. And then I will also raise the fact that we are also looking to see how Wakely or others -- or CHBRP or others are evaluating the potential discriminatory benefit designs in the Benchmark Plan. This was something that we raised at the previous meeting, at the first meeting, and we are hopeful that

the MHC will be able to address in the future. In particular, this is an analysis that should be done, not only through the policy perspective, but also through the legal perspective, making sure that the benefit design is in compliance with federal nondiscrimination regulations and laws. Thank you so much for the opportunity.

DIRECTOR WATANABE: Thank you, Hector.

Next, we will go to Michelle Marciniak, I believe. Your line is unmuted, go ahead. Michelle, you will need to unmute if you can.

MS. MARCINIAK: Got it. Sorry.

DIRECTOR WATANABE: Go ahead.

MS. MARCINIAK: Can you hear me?

DIRECTOR WATANABE: Yes. Go ahead.

MS. MARCINIAK: Thank you. I am the founder of Let California Kids Hear. And I wanted to echo Caprice's comments and also Children Now and just stress that early intervention is crucial, because delaying it leads to severe and permanent developmental consequences for the child, which is not only devastating of the child and the family, but it is really costly to society. It is estimated it costs over a million dollars for every child who does not receive early intervention, and the LAO estimated that California spends over 400 million every year to educate approximately 14,000 students who are deaf and hard-of-hearing. And much of this could be mitigated if these children had early access to hearing aids. The lack of a permanent solution is costing the state hundreds of millions of dollars, and we just want to thank you today for considering to add hearing aids to the Essential Health Benefits. Thank you.

DIRECTOR WATANABE: Thank you, Michelle.

Next, we will go to Beth Malinowski. Go ahead, Beth.

MS. MALINOWSKI: Hi, good afternoon. Beth Malinowski on behalf of SEIU California. Thanks for the presentation today. In recent years we have heard increasingly from our membership regarding access to infertility services, especially from our physician residents at SEIU CIR. We believe all households regardless of their income, place of work, plan of coverage, have access to these services. Appreciate the modeling of different infertility service bundles today and kind of offering some real food for thought here in terms of how things can balance out across all of the different needs discussed. In general, do want to align my comments with my SB 729 Coalition colleagues, including my colleagues at Equality California. Thank you.

DIRECTOR WATANABE: Thank you, Beth.

Let's see. Next, we have COA. Go ahead, you are unmuted.

MS. SHULTZ: Hi. This is Christine Schultz. I am the Executive Director for the California Optometric Association. Thank you for the opportunity to comment today. We are concerned that adult vision coverage isn't being considered as a benefit. Adult vision coverage would mean catching eye disease like glaucoma early. That is a condition that sometimes has no symptoms until it is too late. It would also catch systemic diseases like diabetes early on in the process. Lastly, this would give workers the ability to thrive in their job and older adults the dignity of independence. We think it would be helpful to see the cost of adding this option. So, thank you so much for your time and your consideration.

DIRECTOR WATANABE: Thank you.

Next, we have Dr. Phil. Go ahead, you are unmuted.

DR. DIETER: Hi. How are you doing? My name is Dr. Phil Dieter, I am from the California Chiropractic Association. I am the President or the organization we thank you for this opportunity to provide comment.

As you know, chiropractic services are not included in the current Benchmark Plan, and we are asking or requesting that this be included to the full scope of our services. Unfortunately, since the Kaiser Small Group 30 Plan was chosen, people have not had that access, and it is a conflict with the 2706 Public Health Service Act, as you know, that prohibits that. So, we are asking for that inclusion to be created again.

Unfortunately, California is one of only four states that does not include the services of chiropractors, for doctors of chiropractic, although we are one of the leaders in conservative management of neck pain, low back pain, headaches. The literature demonstrates that over and over again as primary nonsurgical treatment or nondrug treatment for these conditions. And we would hope that you would acknowledge the utilization by the public of chiropractic services, or the favorable utilization, as well as the scientific studies that support how cost-effective chiropractic is and how effective it is just in general in treating these conditions. So, thank you so much for the time to make this comment and for your consideration.

DIRECTOR WATANABE: Thank you, Dr. Dieter.

Let's see. We have got Mitchell Rosen next. Go ahead.

DR. ROSEN: Okay. Am I muted?

DIRECTOR WATANABE: You are okay. We can hear you. Go ahead.

DR. ROSEN: Great. Give me one second if you can. Okay.

Hi, I am Mitch Rosen. I am a practicing physician at UCSF and I am also the Lab Director at UCSF's CRH fertility clinic.

And I guess I wanted just to touch on -- I am sorry for coming into this meeting late. I am not sure what has been, what has been touched on or what has not. But I wanted to kind of make a comment on the IVF cycle benefit additions, more specifically, the three potential pathways, A, B and C. I really wanted to mostly focus on A and B and the challenges there.

I would say most significantly the challenge there is on the embryo storage. And the problem there is that that could be -- you know, a six-month storage could be very, you know, deeply problematic. It could disregard the realities of many patients that face things that require medical delays or they have illnesses, or just even the standard practice that we have right now which is a single embryo transfer, which takes time. So, if we have this short limit of six months, it could force rush decisions leading to the destruction of possibly viable embryos where we would have to discard, or unsafe choices like transferring multiple embryos, or shortening even the recommended 18 month spacing that we have between pregnancies. Because from one pregnancy to a delivery it is safest to have an 18 month what we call pregnancy interval for the next pregnancy to be safe with minimal risk. So, I do believe that a more reasonable policy would be more towards, I mean, ideally Option C. But a three or possibly five year limit, which would align better with medical guidelines and the diverse needs of patients, supporting their health and family building goals. So, I just wanted to touch on that.

DIRECTOR WATANABE: Thank you, Mitch. That is really helpful. Appreciate your comments.

DR. ROSEN: No problem.

DIRECTOR WATANABE: All right, we have someone -- I am just going to say. It says a Samsung SM, so I am guessing that is your phone's name. So, if that is you, you can go ahead and unmute. Sorry. Whoever is left with their hand up, go ahead.

DR. PALMER: Hello?

DIRECTOR WATANABE: Go ahead.

DR. PALMER: Can you hear me?

DIRECTOR WATANABE: Yes.

DR. PALMER: So sorry. My name is Dr. Marissa Palmer. I am Cal Chiro or the California Chiropractic Association's Board Member, Director of Government Affairs. Just repeating a little bit of what Dr. Phil our President has stated. Cal Chiro would like to thank the group for considering adding chiropractic to an essential health benefit. Chiropractic is one of the best ways to help manage neck pain, low back pain, to help mitigate the opioid crisis. California is one of four states that does not include services by doctors of chiropractic, so we do ask that you please consider that as well when choosing benefits. Thank you.

DIRECTOR WATANABE: Thank you, Dr. Palmer.

Let's see. We have got Lloyd Friesen next. Go ahead, your line is unmuted.

DR. FRIESEN: Good afternoon. Lloyd Friesen with the California Chiropractic Association. My former colleagues here have made comments. And I think specifically that relates today's comments, ours would mirror the California Dental Association and the California Optometric Association in the

context of health affordability and the reduction in long-term illnesses as well as short-term issues related to substance abuse. Because again, the removal of those types of benefits result in other kinds of diseases rather than just dental disease or back conditions and so on. So again, I think that all three, and certainly based on the information in the public arena related to the services rendered by doctors of chiropractic, is an important, an important component.

I think also that with comments made by COA and the CDA, the California Chiropractic Association would agree with those in the context that the frustration, I think, is that many times in public policy that there is an ignoring of the cost savings associated with these benefits. Everyone just talks about the cost of the service in a premium debate, but there is a lack of understanding that the services rendered by those folks as well as doctors of chiropractic typically will reduce overall health costs, and there are numerous reports and studies that support that comment.

So, that will be my comments for today. Certainly the California Chiropractic Association will be submitting written comments, as we have previously, and I thank you for your time.

DIRECTOR WATANABE: Thank you, Lloyd.

It looks like we have Casey Tucker next. Go ahead.

DR. TUCKER: Hi. Can you hear me?

DIRECTOR WATANABE: Yes, we can. Go ahead.

DR. TUCKER: I want to follow up on Dr. Friesen's comments. I am also a chiropractor with the California Chiropractic Association.

Just think of it on a very basic level. If someone has extreme low back pain chances are they may end up in the emergency room. The cost of that

is going to be extraordinary, particularly compared to the cost of going to see a chiropractor. People who start out with chiropractic care when they do have an episode of low back pain, neck pain, headaches, much less likely to prescribed opioids and also much less likely to undergo surgery later on. Thank you very much.

DIRECTOR WATANABE: Thank you, Casey.

Let's see. We have got Alice Kessler next. Go ahead.

MS. KESSLER: Yes. Can you hear me?

DIRECTOR WATANABE: Yes, we can. Go ahead.

MS. KESSLER: Okay, wonderful. Hi. Alice Kessler. I am here also on behalf of the SB 729 Coalition.

Wanted to just ask for some clarifying information, if possible, from Matt with Wakely. Which is, I see that on slide 18 there is a breakdown of the cost estimate for IVF. I am wondering if it is possible to know a more specific breakdown of those estimated costs as between the eight different services that are listed there? We definitely want to submit written comments, and this would be very helpful to know in advance of the deadline to submit those comments. If you could provide any other information we would appreciate it.

DIRECTOR WATANABE: Go ahead. Go ahead. Matt.

MR. SAUTER: Sorry. Yes, we do have some pricing for each of these categories. It does get hard in kind of the interplay with them as you move one up the other prices may be affected. But we definitely do have some ballparks that we can break out. If not precise, at least directional and illustrative. We can work with Mary and team on what to show there.

DIRECTOR WATANABE: Thank you, Matt.

All right, it looks like that is the last of our public --

Yes, go ahead. Come on up. Just nick of time there, Cary.

MS. SANDERS: Cary Sanders with CPEHN. Just had a couple of additional questions we were hoping to get answers to.

One is just a little bit more information on the breakdown -- breakout of DME and what is included in that. Does that include, for example, CPAP machines. Is it just, you know, wheelchairs? Like what exactly are we talking about with that?

And then I think, you know, under -- I don't know if this is possible. I understand that the state decided that, you know, we are not including preventative dental. But, you know, we would love to see what the actual, you know, cost would be for that, to do basic routine, you know, dental. Whether it is one visit a year or what could be included and what the cost would be. So, I don't know if that is possible. I will just put that out there. Thanks.

DIRECTOR WATANABE: So maybe -- can we go to slide 17? So maybe just to be clear. We actually had Wakely break out the cost of individual DME. If you all are sitting there doing the math you can see we can't do hearing aids, all DME, the C option for IVF, like we just don't have room. So again, I think there are some tough decisions. And Cary, you are welcome to follow up with us separately. But is there something more specific within this slide you are looking for? For example, if we were to add wheelchairs, you have got the price there, you have got CPAP machines. Is there something more? I want to make sure we are responsive in getting you more information but is there something more you are looking for there?

MS. SANDERS: Sorry. That’s helpful. I think just to understand,

are we -- you know, when we look at the full slide and the full amounts is the assumption that we are covering all of those things?

DIRECTOR WATANABE: Yes. So, let's go to slide 15. So, the cost there for DME would be if we were to add all DME. This is essentially if we added the entire list on slide 17, the max range there is 1.16.

MS. SANDERS: Okay. And then --

DIRECTOR WATANABE: But you could, you could say, let's just add CPAP and wheelchairs, for example.

MS. SANDERS: Got it, yes. I was just curious because I noticed, we noticed that CPAP is one of the higher costs of all the other DME and so, you know, I didn't know if the state is saying, yes, we want to cover all of that by including that in slide 15 or if that is a question mark.

DIRECTOR WATANABE: No. And just to be clear, I don't think any decisions have been made yet, that is part of why we are sharing this information and looking for public comment. I think we had to make some decisions about what Wakely would price and what we are sharing today. But again, looking for input. If there is something that is missing or you want it split out differently, we are looking for that feedback. Acknowledging the very quick turnaround time that we have too. So, yes, thank you.

MS. SANDERS: Thank you.

DIRECTOR WATANABE: Go ahead.

DR. ALVERO: Similar question. Given the short turnaround before the next, before we are supposed to submit the comments, would it be possible for Wakely to give us the breakout for the IVF with the assumptions they made within a day or two? Because it is going to take a bit of time for us to kind of

process and then comment. So, any kind of accelerated process would be great. Thank you so much.

DIRECTOR WATANABE: We will take that back. But appreciate the urgency and getting that into your feedback so thank you.

All right, let's go to my last slide here with the timeline again. So, again, appreciate all of the public comment today. We, again, are looking for your feedback. Just in terms of next steps, we are asking for public comment by the 4th. That legislative hearing is also scheduled for February 11, as we already talked about and you have got the rest of the dates here.

We will take back some of the feedback about providing more information. We will take that back quickly and talk to Wakely and see how responsive we can be to that. And again, I know we are really looking for very specific feedback. So, again, if we have to collectively make decisions by around mid-February, what would you like us to consider in making those decisions.

So, with that, I think that is all I have. We look forward to further conversation. Appreciate your participation today. That concludes our meeting. Thank you.

(The public meeting concluded at 2:18 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 11th day of February, 2025.

RAMONA COTA, CERT*478

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