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April 12, 2025

Via email: [publiccomments@dmhc.ca.gov](mailto:publiccomments@dmhc.ca.gov)

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

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

Dear Director Wantanabe:

Thank you for the opportunity to provide comments regarding the proposed modification to California's Essential Health Benefits (EHB) base-benchmark plan. We appreciate the effort that the Department of Managed Health Care (DMHC), in partnership with the Legislature, has taken towards achieving that goal.

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

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

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



inferior ones that put their health and safety at risk, or turn to publicly-funded health care programs for help.

Western Center on Law and Poverty is pleased and supports that the proposed modification to California's Essential Health Benefits (EHB) base-benchmark plan includes mobility devices including manual and power wheelchairs, continuous positive airway pressure (CPAP) machines, portable oxygen, and other equipment that is critical to an individual's health, functioning, and independence.

Thank you for consideration of our feedback.

Sincerely,

A handwritten signature in black ink that reads "Sandra O. Poole". The script is fluid and cursive, with the first letters of the first and last names being capitalized and prominent.

Sandra O. Poole  
Policy Advocate



April 14, 2025

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

Sent via email to:

[publiccomments@dmhc.ca.gov](mailto:publiccomments@dmhc.ca.gov)

[Mary.Watanabe@dmhc.ca.gov](mailto:Mary.Watanabe@dmhc.ca.gov)

**Re: Updating California's Essential Health Benefits Benchmark Plan – Mental Health and Substance Use Disorder (MHSUD) Services**

Dear DMHC,

On behalf of the California Alliance of Child and Family Services (California Alliance), we would like to thank you for the opportunity to provide feedback on the potential changes to California's Essential Health Benefits (EHB) benchmark plan. The California Alliance represents over 160 community-based organizations who provide services and behavioral health support to children, youth and families representing all 58 counties across the state. Most of our members provide services to those experiencing behavioral health issues, mental illness, and alcohol and substance use disorders across settings and delivery systems, including commercial health insurance.

We are grateful for all the efforts the Department of Managed Health Care (DMHC) has implemented to ensure the care of Californians. As Senate Bill (SB) 855 (Chapter 151, Statutes of 2020) requires commercial health plans and health insurers to cover medically necessary benefits for the prevention, diagnosis and treatment of all recognized MHSUD conditions, we hope the Department of Managed Health Care (DMHC) will consider the following recommendations related to the provision of these services:

**Clarify the Utilization of All Eligible Health Care Providers:** We recommend the addition of requirements that ensure that out-of-network care is covered when medically necessary care is unavailable within the network of a plan. The benchmark plan currently states that health plans shall cover MHSUD services when provided by in-network physicians or other in-network providers who are licensed health care professionals. As written, this language unintentionally omits other eligible health care providers from rendering medically necessary MHSUD services and leaves out the requirement of plans to arrange for out-of-network care when medically necessary care is unavailable from a network provider.

**Inclusion of Associates and Trainees:** SB 855 and DMHC's regulations define "health care provider" under the context of MHSUD coverage requirements to also include associates and trainees.<sup>1</sup> It is important to clarify in the benchmark plan that health plans must cover MHSUD services as medically necessary when rendered not only by a licensed provider, but also by any other eligible health care provider that is inclusive of associates and trainees as defined in statute and regulations.<sup>2</sup>

**Network Adequacy:** Statutes and regulations also establish a process for arranging out-of-network coverage when MHSUD services cannot be provided within the standards for network adequacy.<sup>3</sup> We believe it is important for the benchmark plan to also recognize this requirement as part of the coverage and delivery of MHSUD services.

Thank you for considering our recommendations. We strongly urge the Department to consider inclusion of these clarifying details in the benchmark plan to ensure MHSUD services are covered by all qualified eligible providers. Feel free to reach out ([sraphael@cacfs.org](mailto:sraphael@cacfs.org)) if we can offer any further clarification or can respond to any questions related to any of the recommendations.

Sincerely,

A handwritten signature in black ink, reading "Selena Liu Raphael". The signature is fluid and cursive, with the first name "Selena" being the most prominent.

Selena Liu Raphael, Senior Behavioral Health Policy Advocate

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<sup>1</sup> [Cal. Code Regs. Tit. 28, § 1300.74.72\(b\) - Mental Health and Substance Use Disorder Coverage Requirements](#)

<sup>2</sup> [Health and Safety Code § 1374.72\(a\)\(4\)](#)

<sup>3</sup> [Cal. Code Regs. Tit. 28, § 1300.74.72\(c\) - Mental Health and Substance Use Disorder Coverage Requirements](#)



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April 14, 2025

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

Via email: [publiccomments@dmhc.ca.gov](mailto:publiccomments@dmhc.ca.gov)

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

Dear Director Watanabe,

On behalf of the National Health Law Program (NHeLP), thank you for the opportunity to provide comments on the Department of Managed Health Care's (DMHC) proposed modifications to California's Essential Health Benefits (EHB) benchmark plan. We deeply appreciate the Department's engagement with advocates throughout this process given its importance for addressing current gaps in access to services for individuals in private individual and small-group market plans. As we have repeatedly said in the past, these existing gaps represent a significant barrier to achieving health equity across the State. We believe it is imperative that California join the growing list of states that have updated their benchmark plan in recent years by taking advantage of additional flexibilities that the federal EHB rules afford states.

NHeLP fully supports the addition of durable medical equipment (DME), hearing aids, and infertility treatment services in California's EHB benchmark plan. The lack of coverage for these services leads to negative health consequences that disproportionately affect individuals with disabilities, Black,

Indigenous, and People of Color (BIPOC), LGBTQ+ individuals, and other underserved populations. Therefore, California should ensure that plans are addressing these gaps in coverage as an additional tool in the State's fight towards achieving health equity.

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

Similarly, California's current benchmark plan is an outlier when it comes to coverage of hearing aids, a situation that disproportionately affects children with hearing loss for whom hearing aids are essential for their development. The vast majority of states already require, either through their EHB benchmark plans or through separate legislation, coverage of services and devices (with replacement at appropriate intervals) for children and adults with hearing loss. In California, only one out of ten minors with hearing loss have their hearing aids covered by their private health insurance plan. Therefore, we support the proposal to add coverage of hearing evaluations as necessary, as well as coverage of hearing aids every three years.

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

from IVF and other infertility treatment to have children.<sup>1</sup> With the passing of SB 729, California already started closing this coverage gap by requiring coverage of infertility treatment among large-group plans. The benchmark proposal would achieve the same goal for individuals and families seeking infertility treatment covered by individual and small-group market plans. We commend the listing of various services that take part of IVF, including embryo transfers, preservations, and storage. IVF is riddled with uncertainties where the odds are extremely difficult to assess. We are therefore encouraged that the proposed benchmark plan broadly defines fertility drugs, extraction, and fertilization.

Finally, we encourage DMHC to periodically evaluate the benchmark plan moving forward to identify ongoing gaps in coverage and potential new opportunities to improve access to care. While the actuarial room to expand may have been met with the addition of DME, hearing aids, and infertility treatment, that room may be greater in future years. As such, DMHC should engage in an annual evaluation where additional services, such as adult dental care and additional maternal health benefits, are considered. This process aligns with the Affordable Care Act's mandate for the Secretary of HHS to periodically evaluate EHB coverage and propose changes to the definitions that account for scientific and clinical advancements. Since HHS delegated much of the authority to define EHBs to the states, we believe DMHC has the duty to periodically evaluate EHB coverage in California to address gaps as necessary.

Thank you for considering our feedback. Please do not hesitate to contact me ([hernandez-delgado@healthlaw.org](mailto:hernandez-delgado@healthlaw.org)) should you have any questions.

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<sup>1</sup> See Ashley Wiltshire et. al, Infertility Knowledge and Treatment Beliefs among African American Women in an Urban Community, 4 CONTRACEPT. REPROD. MED 16 (2019), <https://pubmed.ncbi.nlm.nih.gov/31572616> (concluding that Black women between the ages of 33-44 are twice as likely to experience infertility as white women in the same age demographic). See also, Liz McCaman Taylor, Jennifer Lav, Abigail Coursolle & Fabiola De Liban, Nat'l Health Law Program, NHeLP Principles on Assisted Reproduction (Sept. 27, 2021), <https://healthlaw.org/resource/nhelp-principles-on-assisted-reproduction/>.

Sincerely,

A handwritten signature in black ink, appearing to read "Hector Hernandez-Delgado".

Héctor Hernández-Delgado  
Senior Attorney  
National Health Law Program







**RICARDO LARA**  
CALIFORNIA INSURANCE COMMISSIONER

April 14, 2025

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

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

Dear Director Watanabe:

The California Department of Insurance (CDI) would like to take this opportunity to provide input on the proposed amendments to California's Essential Health Benefits (EHB) benchmark plan, which affects the individual and small employer health insurance markets in California.

The Department is pleased that the Newsom Administration and the Legislature are reviewing California's benchmark plan. CDI has long been concerned that the lack of coverage for durable medical equipment (DME) and external prosthetic devices disproportionately and inequitably burdens people with disabilities and chronic illnesses who have individual or small group market coverage. The Department has also strongly supported removing discriminatory barriers blocking LGBTQ+ persons from insurance coverage for building their families, including sponsoring SB 729 (Menjivar, Ch. 930, 2024).

The Department supports the [March 28, 2025](#), proposed updates to California's benchmark plan. Specifically, the expanded coverage of DME, hearing exams, and hearing aids begins to rectify the state's longstanding failure to include coverage for many items essential to daily living for people with disabilities. The Department also generally supports the proposed addition of coverage for diagnosis and treatment of infertility, which begins to address egregious reproductive health discrimination against nontraditional families.

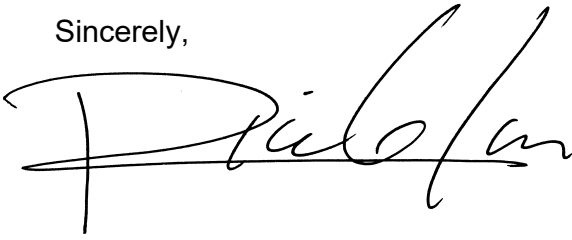
The Department does have a concern about part of the current proposal as it relates to infertility coverage. The proposal includes coverage for artificial insemination (AI) and in vitro fertilization (IVF). However, the proposal specifically excludes coverage for the purchase and storage of donor semen in the AI coverage while covering two vials of sperm and unlimited cryopreservation of sperm for IVF. The Department believes that this benefit coverage discriminates against those who are more likely to use this coverage, including lesbians, trans men, and single women, and it promotes the more expensive and higher risk IVF. Therefore, we believe that this is likely an oversight and recommends that DMHC make clear that coverage of semen purchase and storage will be the same regardless of whether a person uses AI or IVF.

Director Mary Watanabe  
California Department of Managed Health Care  
April 14, 2025  
Page 2 of 3

As the Department has previously communicated, we are disappointed that external prosthetic and orthotic devices and routine dental services for people of all ages were not included in the updated benchmark plan. However, we acknowledge that the limitations set by 45 CFR section 156.111 make those additions challenging.

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

Sincerely,

A handwritten signature in black ink, appearing to read "Ricardo Lara". The signature is fluid and cursive, with a large initial "R" and a long horizontal stroke at the end.

**RICARDO LARA**  
Insurance Commissioner

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



**The Children's  
Movement  
of California®**

**April 2025**

**Director Mary Watanabe**

California Department of Managed Health Care  
980 9th St #500  
Sacramento, CA 95814

CC: Senator Caroline Menjivar, Chair, Senate Health Committee, Assemblymember Mia Bonta, Chair,  
Assembly Health Committee

## **RE: Support for Proposal to Add Hearing Aids in California's Benchmark Plan**

Dear Director Watanabe and the Department of Managed Health Care,

We, the undersigned advocates, write to express our strong support for the proposal to add hearing aid coverage for children and adults in California's updated benchmark health insurance plan. Without early access to hearing aids, children are at risk for speech, language, cognitive, educational, and social-emotional delays. The addition of this essential coverage will significantly enhance the lives of so many Californian children who are deaf or hard of hearing.

Right now, [more than 20,000 children and youth](#) in California use hearing aids, yet their health insurance does not cover them. The gaps in coverage and the cost of hearing aids—\$6,000 per pair on average—also create further burdens on families struggling with the affordability of health care. This has led to what pediatric experts call a developmental emergency.

By adding hearing aid coverage in the benchmark plan, California can ensure that all children have access to the critical services and supports they need to learn, grow, thrive, and reach their full potential. Again, we strongly support the addition of hearing aid coverage in the benchmark plan as proposed, and we appreciate the Department's work on this issue. We urge action to move forward with the proposal so that hearing aid coverage can be available to children in 2027, and we can address the developmental emergency that has been unfolding for years. Kids can't wait!

Thank you for considering our comments.

Sincerely,

The Undersigned 1,000+ Individuals

Andrea Abad Glendora, CA	Nicolyn Alarcon Sausalito, CA	Lisa Annuzzi Valdez Pacifica, CA
Kimberly Abbey Lake Forest, CA	Alondra Alavez Vallejo, CA	Daisy Ante Sharp Healthcare Spring Valley, CA
Kaylyn Abbott Santa Cruz, CA	Roxanna Alavi Concord, CA	Emma Aquilon Hearing Services of Santa Barbara Receptionist Santa Barbara, CA
Judith Aboufares Glendora, CA	Joyce Alderson Laguna Hills, CA	Raquel Arellano Winters, CA
Gary Abraham	Ariana Alex San Francisco, CA	Courtney Armstrong First 5 Association of California Director of Government Affairs San Francisco, CA
Lori Abraham Sacramento, CA	Ruth Almanza Temecula, CA	Arash Aryana El Cajon, CA
Mary Abraham San Bruno, CA	Neil Altimari Redwood Valley, CA	Heather Aryana El Cajon, CA
Marissa Ackroyd Pacifica, CA	Christine Altimari Redwood Valley, CA	Nancy Asmundson Hearing Loss Association of America, East Bay Chapter Newsletter Editor Winters, CA
Valecia Adams Hearing Loss Association of America, California State Association Van Nuys, CA	Keli Amann Redwood City, CA	Catherine Aspiras Santa Clara, CA
Tina Afifi Audiology Associates Santa Rosa, CA	Keila Amavizca California State University, Northridge Student Glendale, CA	Alejandro A Athie Laguna Hills, CA
Moises Aguado San Bruno, CA	Alexandra Amorati San Bruno, CA	Page Aubuchon Rady Children's Hospital Pediatric Audiologist San Diego, CA
Osvaldo Aguilar Gonzalez Antioch, CA	Starla Amos Folsom, CA	Boyer August Hayward, CA
Mursal Ahmad Anaheim, CA	Jealene Anderson Roseville, CA	Vanessa Avendano San Diego, CA
Allison Ahyou Lake Elsinore, CA	Darlene Anderson Granite Bay, CA	
Tatiana Akers San Mateo, CA	Walt Anderson Roseville, CA	
Katie Alanis Clovis, CA	Maya Anderson San Jose, CA	

Shamsu Awudu  
Orange, CA

Kymber Azevedo  
Solano County Office of Education  
Deaf and Hard of Hearing  
Specialist  
Vacaville, CA

Alice Bachelder  
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Melissa Bair  
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Deaf and Blind Foundation  
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Glendale, CA

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Laguna Hills, CA

Anna Balash  
Children's Hospital of Orange  
County  
Lead Audiologist  
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Margaret Bales  
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Sylvia Balestieri  
San Bruno, CA

Amanda Barba  
Daly City, CA

Antonio Barba  
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Olivia Barba  
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Kathryn Bartels  
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Sherwin Basil  
Long Beach, CA

Henrissa Bassey  
Oxnard, CA

Blanca Batlle  
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Kathy Bays  
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Susan Beck  
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Eliana Bedel  
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Liz Beeby  
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Adrienne Beers  
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Rachel Belcher  
Redwood City, CA

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Angelica Belmontes  
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Courtney Campbell Orange, CA		Julie Chalmers Mission Viejo, CA
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Claudia Campos Daly City, CA		Sooling Chan East Palo Alto, CA
Gabriel Campuzano		

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Tina Chang

Molly Chapman  
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Tawna Cooley  
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Theresa Copple  
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Education  
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Sandy Cordon  
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Reid Corley  
Lemon Grove, CA

Jessica Cotton  
San Francisco, CA

Judi Courtney  
Anaheim, CA

Laura Covello  
Children's Choice for Hearing &  
Talking (CCHAT) Center  
Executive Director  
Rocklin, CA

Janna Cowper  
Dana Point, CA

Analiese Cox

Shannon Coyne  
Burlingame, CA

Katherine Crawford  
San Diego, CA

Diana Creswell  
Redwood City, CA



Nathan Creswell  
Redwood City, CA

Christine Crumrine  
Upland, CA

Cristina Cruz  
San Bruno, CA

Marilda Cruz  
Daly City, CA

Kelley Cuerva  
Bonsall, CA

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April 14, 2025

Department of Managed Health Care  
980 9<sup>th</sup> Street, Suite 500  
Sacramento, CA 95814

RE: Position Letter – Regression in Chronic Pain Coverage in the March 2025 Draft of California’s Essential Health Benefits (EHB) Benchmark Plan

To Whom It May Concern:

On behalf of the **California Advocacy Team (CAT)**, a patient-led coalition supported by the **U.S. Pain Foundation**, we respectfully submit this letter to express strong concerns about key regressions in chronic pain coverage within the **March 28, 2025 Draft of the California Essential Health Benefits (EHB) Benchmark Plan**.

As individuals living with chronic pain, patient advocates, caregivers, and allies, we see firsthand the challenges that Californians face in accessing evidence-based, affordable, and non-opioid treatment options. While we appreciate the complexity of developing a benchmark plan that meets diverse health needs, we are deeply troubled by the removal of two critical chronic pain services:

---

### **Elimination of Chiropractic Services**

The previous benchmark plan included **10 annual chiropractic visits**, recognizing the value of chiropractic care in managing back, neck, and joint pain without relying on opioids or invasive interventions. California is one of the few states in which the Benchmark plan does not include chiropractic care. In the current draft, chiropractic services have been **entirely excluded**, unless individuals purchase a separate supplemental plan.

This change:

- Removes access to a **safe, affordable, and effective** non-pharmacologic therapy;
- Disproportionately impacts low-income and underserved populations;
- Contradicts the intent of California law and federal guidance to support **non-opioid pain management**.

---

### **Exclusion of Neuromodulators**

The draft plan also excludes **neuromodulators** under Durable Medical Equipment. These devices—including TENS units and spinal cord stimulators—are **evidence-based tools** often used when conservative treatments have failed. They offer pain relief without medication, surgery, or sedation and are considered a cornerstone of modern pain management.

## A Missed Opportunity for Comprehensive Pain Care

The absence of these services signals a broader oversight: the **lack of a defined, multimodal approach to chronic pain management** in the benchmark plan. Chronic pain is a complex, biopsychosocial condition recognized in the ICD-11 and by all major U.S. health agencies. The plan makes no mention of:

- **Functional rehabilitation programs;**
- **Pain self-management education;**
- **Care coordination or interdisciplinary care teams.**

This omission is inconsistent with national strategies, including the:

- **HHS Pain Management Best Practices Interagency Task Force Report;**
  - **VA/DoD Pain Management Guidelines**, which emphasize integrative, team-based care.
- 

## Recommendations

To ensure equitable and effective chronic pain care in California, we respectfully urge the Department of Managed Health Care to:

1. **Reinstate chiropractic care** with a minimum of 10 visits per year.
  2. **Remove the exclusion of neuromodulators** from Durable Medical Equipment coverage.
  3. **Define chronic pain** as a distinct medical condition and include a comprehensive benefit design that supports multimodal, patient-centered pain care.
  4. **Align the benchmark plan with national best practices** in pain management and California's goals to reduce opioid use and expand access to non-addictive alternatives.
- 

## Closing

Californians living with chronic pain deserve access to treatment pathways that prioritize function, safety, and dignity. The California Advocacy Team, with support from the U.S. Pain Foundation, urges the DMHC to reverse these harmful regressions and advance a plan that reflects the full spectrum of evidence-based chronic pain care.



We thank you for your time, your attention, and your commitment to improving access to health care for all Californians.

Sincerely,

A handwritten signature in black ink that reads "Cindy Steinberg".

Cindy Steinberg  
Advisor to the California Advocacy Team  
National Director of Policy and Advocacy  
U.S. Pain Foundation  
15 N Main St #100  
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**From:** [Erika Oduro](#)  
**To:** [DMHC Public Comments](#)  
**Cc:** [Compliance Regulatory Affairs](#); [Mario Diaz](#)  
**Subject:** EHB Updates Feedback  
**Date:** Monday, April 14, 2025 5:02:48 PM  
**Attachments:** [image104948.png](#)

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Good evening,

Please see the Plan's feedback below. Please let us know if there are any questions.

Inland Empire Health Plan Comment Submission Form Proposed Essential Health Benefits (EHBs) Application Materials	
Current Language	Comment/Recommended Change
Proposed State of California—Essential Health Benefits Benchmark Plan	IEHP's priority is to maintain long-term affordability of the Covered CA (CCA) plans. Adding the services that are not currently covered today would have a very high impact on plan benefit costs. Additionally, the future of the federal enhanced premium tax credits remains unclear and if not renewed by the end of 2025, may also significantly increase costs for those in the individual market, including those not receiving subsidies as <a href="#">estimated</a> (approximately 2.37 million in CA) by the UC Berkeley Labor Center and UCLA Center for Health Policy Research. IEHP recommends not adding the proposed costly benefits as essential health benefits to maintain coverage and access to quality affordable health coverage.
Proposed Covered of Durable Medical Equipment (DME)	CCA plans already cover medically necessary DME. Aligning coverage with a new benchmark plan on items such as wheelchairs, oxygen tanks, wigs, etc. that are medically necessary across all CCA plans will provide consistency in coverage guidelines and reduce confusion for members. IEHP is supportive of coverage consistency and standards for this benefit.

**Erika Oduro, MAOL, CHC**

**Manager, Regulatory Affairs - Medi-Cal  
Compliance**

**Inland Empire Health Plan**

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April 14, 2025

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

Sent Via Email to [publiccomments@dmhc.ca.gov](mailto:publiccomments@dmhc.ca.gov)

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

Dear Director Watanabe,

We, the undersigned sponsors of SB 729 by Senator Caroline Menjivar (Statutes of 2024, Chapter 930)—which required large group health plans and insurers to provide coverage for fertility services—now write in strong support of extending fertility coverage to small group and individual plans. We support the inclusion of infertility services as Essential Health Benefits (EHB) as proposed by the Administration and the Legislature, consistent with the limitations identified by the actuary to be added to California's benchmark plan.

The proposed benefits, including fertility diagnosis, artificial insemination, and in vitro fertilization (IVF) under Pathway C—as outlined by the Wakely Benchmark Plan Benefit Valuation Report dated March 28, 2025—provide medically appropriate coverage, as follows:

- Infertility diagnosis
- Artificial insemination
- In vitro fertilization
  - Three (3) attempts to retrieve gametes, including drugs required for retrieval
  - Three (3) attempts to create embryos

- Three (3) rounds of pre-transfer testing
- Cryopreservation of gametes and embryos
- Two years of storage for cryopreserved embryos
- Unlimited storage for cryopreserved gametes
- Unlimited embryo transfers
- Two (2) vials of donor sperm
- Ten (10) donor eggs
- Surrogacy coverage for the aforementioned services, as well as health testing of the surrogate for each attempted round of covered services

As the American Society for Reproductive Medicine has declared in prior support letters, the proposed benchmark plan meets the standard of care for IVF by covering three egg retrievals and an unlimited number of transfers, among other enumerated services. This standard is based on extensive U.S. and international literature, as well as professional consensus, which supports this approach as the most cost-effective way to maximize an individual's chances for a healthy pregnancy and neonatal outcome. This standard is maintained by most states with similar mandates and closely aligns with what commercial insurance companies provide for their covered lives.

Pathway C includes three egg retrievals, unlimited transfers, and two years of embryo storage. Embryo storage of extended duration is critical because in conventional practice, the egg retrieval and subsequent embryo transfer are often unlinked. The time interval between completion and recovery from an egg retrieval generally requires several months due to coordination and consultation, particularly if the first frozen embryo transfer is unsuccessful. The limited cryo-storage period of six months in Pathways A and B is insufficient for safely completing this process.

When donor sperm is required, multiple insemination cycles are typically needed. To ensure adequate sperm numbers and allow for instances where a single vial is insufficient, two vials are generally needed per cycle. To maximize success rates, six insemination cycles are recommended.

Pathway B's provision of four donor eggs is inadequate to provide a reasonable chance of achieving even a single blastocyst embryo. Egg banks typically sell batches of at least 6-8 eggs, often more, for this reason. Therefore, Pathway C is the only approach that meets the standard of care.

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

Californians struggling with infertility, the very existence of the family they hope to build can depend on income alone.

With attacks on IVF and reproductive health care on the rise, we must implement best practices for IVF treatment that is safe and effective. We applaud the Administration and the Legislature for proposing to adopt these infertility benefits to ensure that all Californians, regardless of the size of their insurance plan, have equitable access to medically appropriate and comprehensive reproductive health care.

Thank you for your consideration of this important matter.

Sincerely,

Alliance for Fertility Preservation  
American Society for Reproductive Medicine  
Equality California  
Our Family Coalition  
Reproductive Freedom For All California  
RESOLVE: The National Infertility Association  
SEIU California

cc: The Honorable Ricardo Lara, Insurance Commissioner  
The Honorable Members, Senate Health Committee  
The Honorable Members, Assembly Health Committee  
Richard Figueroa, Deputy Cabinet Secretary  
Paula Villescaz, Deputy Legislative Affairs Secretary



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Joseph Tomás Mckellar  
PICO California

Sonya Young  
California Black Women's Health Project

Amanda McAllister-Wallner  
Interim Executive Director

Organizations listed for  
identification purposes

April 10, 2025

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

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

Dear Ms. Watanabe,

Health Access California, the statewide health care consumer advocacy coalition committed to quality, affordable health care for all Californians supports the proposal from the Department of Managed Care's Draft Benchmark Plan regarding Essential Health Benefits (EHBs) to be offered by health plans and insurers in the individual and small group markets in California.

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

Health Access supports the Department of Managed Health Care's proposal on additional benefits to include in California's list of Essential Health Benefits. We also appreciate the thoughtful actuarial analysis of the rate impacts of these additional benefits.

- *Hearing Exam and Hearing Aids:* Health Access supports the inclusion of hearing exam and hearing aids, including an annual hearing exam and hearing aids for each ear every three years. According to the World Health Organization, hearing loss can result in delayed language development in children and social isolation among people of all ages<sup>i</sup>. We support hearing aids for consumers in their 50s and early 60s just as much as hearing aids for kids.
- *Durable Medical Equipment:* Health Access supports the inclusion of durable medical equipment for use in the home and outside the home. Many Californians do not have access to the wheelchairs, augmentation communication devices, hearing aids, oxygen equipment, and other DME that they need. Private health plans offered in California's individual and small group markets regularly exclude or severely limit coverage of this equipment. Faced with out-of-pocket costs up to \$50,000, many people go without medically necessary devices or obtain inferior ones that put their health and safety at risk.

- *Infertility Treatment, including IVF:* We appreciate the Department's inclusion of Level C coverage for infertility treatment, including IVF. Equity impacts include the impact on the LGBTQ community as well as other persons seeking to be parents but facing challenges to conceiving including single people. California as a state is committed to reproductive rights: infertility treatment is as much part of that commitment as abortion.

In conclusion, we look forward to continuing to work with the Department and the Legislature to finalize the adoption of the newly added Essential Health Benefits. Much has changed in the dozen years since the EHB standard was initially adopted in California law: it is time and past time to update that standard.

Sincerely,



Christine Smith  
Policy & Legislative Advocate

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

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<sup>i</sup> World Health Organization, "Deafness and Hearing Loss", [https://www.who.int/health-topics/hearing-loss#tab=tab\\_1](https://www.who.int/health-topics/hearing-loss#tab=tab_1)

April 14, 2025

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

*Via electronic submission:* [Mary.Watanabe@dmhc.ca.gov](mailto:Mary.Watanabe@dmhc.ca.gov)  
[publiccomments@dmhc.ca.gov](mailto:publiccomments@dmhc.ca.gov)

Dear Director Watanabe:

On behalf of the California Association of Health Plans (CAHP), which represents 41 public, non-profit, and for-profit organizations in public programs and commercial markets, please accept this comment letter as the Department of Managed Health Care (DMHC) prepares its draft application to update California's Essential Health Benefits (EHBs) and benchmark plan.

Updating the existing benchmark plan is no easy feat, and we applaud the DMHC for leading such a massive undertaking. However, we also caution that updating the existing set of benefits has lasting, potentially even permanent, implications. Prior to submitting the application to the federal Centers for Medicare and Medicaid Services (CMS), the DMHC should ensure that the proposed benefit package aligns with California's objectives to provide and maintain access to quality, affordable health coverage. **In the interest of making the most informed and effective decision, we respectfully request the DMHC delay the submission of its EHB application and take additional time for review and consultation of the following key issues:**

**Thorough Evaluation of Premium Impact and Affordability is Necessary**

Adding additional essential health benefits to the benchmark plan will lead to premium increases for consumers. A key concern is the cost impact estimated in the Wakely studies of adding 2 percent to premiums to cover these benefits, which will make healthcare less affordable. In the Wakely Benchmark Plan Benefit Valuation Report, Wakely noted, "Actual paid cost and premium impacts may vary by issuer, based on their internal data, models, pent up demand, downstream impacts, and drugs that they choose to include in their formulary, etc."

While it is true that premium impacts will vary by issuer, the current analysis lacks any formal assessment of financial impact, and this creates a significant data gap. The State should consult the California Health Benefits Review Program (CHBRP) and perform a more detailed analysis of potential premium impact for these services. Both health plans and consumers need to know how a new set of benefits will impact health care costs before they are submitted for federal approval.

Additionally, it is important the State consider how a new, and more costly, EHB benchmark will impact California's competing priority to advance affordability through the Office of Health Care Affordability (OHCA). Payers are required to meet OHCA's spending growth targets, with a goal of only 3 percent spending increases by 2029. Adding these new benefits to Individual and Family Plans (IFP) and Small Group Plans in 2027 will make it extremely challenging to meet those targets.

### **Greater Clarity and Certainty About Federal Decisions**

The timing of expanding these benefits does not make sense considering the looming expiration of Advanced Premium Tax Credit (APTC) subsidies. This could increase financial obligations on consumers, further lowering participation in the Exchange and leading to higher uninsured rates.

Premiums for Covered California plans increased by an average of more than seven percent from 2024 to 2025; however, most enrollees were shielded from the premium increases by the additional federal APTC subsidies. Unless Congress acts, those subsidies will expire at the end of 2025. The UC Berkeley Labor Center and UCLA Center for Health Policy Research [issued a report](#) estimating that "All 2.37 million Californians in the individual market - including those not receiving subsidies - would face higher insurance premiums."

Additionally, CMS' recent proposed Marketplace Integrity and Affordability rule requiring a \$5 premium responsibility for fully subsidized auto re-enrollees may go into effect in 2027 for State-Based Exchange (SBE) states like California, which would also further dampen enrollment.

Adding expensive benefit mandates at a time when nearly 70,000 Californians could become uninsured due to the expiration of these subsidies is unwise. Instead, it would be prudent to wait until next year when the State would have greater clarity and certainty about federal budgetary decisions.

### **Health Plans Need Guidance and Clarity on Infertility Coverage and Requirements**

CAHP previously emphasized how important it is for the State to consider the broader regulatory landscape as it contemplates its next step in the EHB process. In California's regulatory space, health plans are diligently working to implement the requirements of existing infertility-related legislation, but further clarity is needed to assist that implementation.

First, CAHP's members are concerned about the surrogacy proposal in the draft EHB application. The DMHC proposes requiring coverage of a surrogate's health care services as part of the benchmark fertility benefit. Covering a non-member's services would create a new mandate to cover an additional individual's expenses that are not those of the enrollee, and this will lead to situations where the surrogate's expenses may be covered by both the plan covering the enrollee facing fertility challenges, as well as the surrogate's plan if they have one. Health plans are opposed to adding the surrogate's health services as part of the benefit and we strongly recommend the DMHC exclude this from the proposed set of benefits.

Health plans also raised the following questions regarding the Infertility/Artificial Insemination Proposal:

- Two years of storage for cryopreserved embryos
  - What is the notification process if a member terminates their coverage with the Health Plan? What is the process in general for this type of coverage? If the member were to term in the middle of this 2-year period, would the Health Plan be responsible for coordinating with the new Health Plan on coverage for this?
- Unlimited storage for cryopreserved gametes
  - What is the notification process if a member terminates their coverage with the Health Plan? What is the process in general for this type of coverage? If the member



was to term in the middle of this 2-year period, would the Health Plan be responsible for coordinating with the new Health Plan on coverage for this?

- Unlimited embryo transfers
  - More detail is needed. What are the parameters around this requirement?
- Two (2) vials of donor sperm
  - Clarification is needed on what this means and where this would come from (sperm bank?).
- Ten (10) donor eggs
  - Clarification is needed on what this means and where this would come from.

Many payers are also subject to fertility coverage requirements under SB 600 and SB 729. We request further information from the DMHC on how it intends for these mandates to align. For example, the DMHC has proposed quantified coverage specifications for fertility and IVF services in the benchmark plan proposal that exceed those proposed in regulations related to SB 600 iatrogenic infertility. Plans will need guidance from the DMHC on how it intends for plans to crosswalk these related coverage requirements.

Furthermore, these related mandates (SB 600, SB 729, and the benchmark plan proposal) are all on different timelines, with different requirements and applicability to commercial products.

- The DMHC should work with plans to ensure that proper guidance is provided to the Help Center over the coming years.
- DMHC should ensure that coverage mandate nuances are considered in its work (e.g., AB 118 disclosure templates).

Without further guidance from the DMHC, stakeholders and the State cannot adequately assess the scope of an IVF/infertility EHB benefit. Alignment between markets will be critical, and more time is needed to perform such an analysis.

CAHP and its members are dedicated to keeping health care as affordable as possible for consumers, and we are grateful to be industry partners supporting the DMHC in upholding its mission to ensure a stable health care delivery system. To maintain that vision, the State should take a measured approach to updating the EHB benchmark plan and give due consideration to critical missing elements in the conversation. **We respectfully urge the DMHC to delay submitting an EHB application to CMS until these concerns around affordability, benefit clarity, and looming federal policy changes are resolved.**

We appreciate the Department's consideration, and we look forward to your continued partnership.

Sincerely,



Charles Bacchi  
President & CEO



Children's Hospital Los Angeles  
Medical Group

California Association  
of Neonatologists

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

Sutter Children's Center  
Sutter Medical Center, Sacramento

Children First Medical Group,  
Emeryville

Rady Children's Specialists of  
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Department of Pediatrics  
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UC Irvine Medical Center

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Medical Group, Inc.

Miller Children's and Women's  
Hospital Long Beach

CHOC Children's Specialists, Orange  
County

Cottage Children's Medical Center -  
Santa Barbara

Shriners Hospitals for Children -  
Northern California

Community Regional Medical Center,  
Fresno

Cedars-Sinai Guerin Children's

April 11, 2025

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

**RE: Support for Proposal to Add Hearing Aids in California's Benchmark Plan**

Dear Director Watanabe and the Department of Managed Health Care,

On behalf of the Children's Specialty Care Coalition, I am writing to express our strong support for the proposal to add hearing aid coverage for children and adults in California's updated benchmark health insurance plan. Without early access to hearing aids, children are at risk for speech, language, cognitive, educational, and social-emotional delays. The addition of this essential coverage will significantly enhance the lives of so many Californian children who are deaf or hard of hearing.

Right now, more than 20,000 children and youth in California use hearing aids, yet their health insurance does not cover them. The gaps in coverage and the cost of hearing aids—\$6,000 per pair on average—also create further burdens on families struggling with the affordability of health care. This has led to what pediatric experts call a developmental emergency.

By adding hearing aid coverage in the benchmark plan, California can ensure that all children have access to the critical services and supports they need to learn, grow, thrive, and reach their full potential. Again, we strongly support the addition of hearing aid coverage in the benchmark plan as proposed, and we appreciate the Department's work on this issue.

We urge action to move forward with the proposal so that hearing aid coverage can be available to children in 2027, and we can address the developmental emergency that has been unfolding for years. Kids can't wait! Thank you for considering our comments.

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

Sincerely,

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



California Pan-Ethnic  
HEALTH NETWORK

BOARD OF DIRECTORS

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2991 Sacramento St. #298  
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April 14, 2025

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

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

Dear Director Watanabe:

On behalf of the California Pan-Ethnic Health Network (CPEHN), we thank you for the opportunity to comment on DMHC's March 31<sup>st</sup> notice of proposed modification to California's Essential Health Benefits and Updating the Benchmark Plan. CPEHN is a multicultural health advocacy organization, dedicated to advocating for policies that advance health equity and improve health outcomes for California's communities of color.

As previously shared, CPEHN supports the addition of DME, hearing aides and infertility treatments to California's benchmark plan. Adding these benefits will make access to critical medical equipment and infertility services more affordable for millions of Californians, including low-income and communities of color. More specifically:

- **Adding DME:** Disparities in access to durable medical equipment (DME) in California can include racial and ethnic disparities, socioeconomic disparities, and barriers for people with disabilities. The current benchmark plan limits DME to a list of ten benefits and further limits coverage of DME to equipment for in-home use only. As a result, many plans in California fail to cover essential DME items such as wheelchairs, oxygen tanks, and blood glucose monitors, or have placed strict dollar limitations and/or high-cost sharing on the equipment they will cover, in addition to restrictions to in-home use only. Adding additional DME to the EHB benchmark plan will ensure all Californians can access these critical supports.
- **Adding Hearing Aids:** More than 20,000 children and youth who need access to hearing aids do not have them covered by their private health insurance cannot afford to purchase hearing aids.<sup>1</sup> The majority of states, (32) require private insurance to offer some level of coverage for kids' hearing aids, including 27 that mandate it as a benefit under the Affordable Care Act.

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<sup>1</sup> Kids Can't Wait: Policymakers Must Include Hearing Aids in California's New Health Insurance Benchmark, Children Now. <https://www.childrennow.org/portfolio-posts/kids-cant-wait-hearing-aids-factsheet/>

California only offers coverage to very low-income families through public insurance like Medi-Cal or the program for kids with disabilities, setting the income cap for a family of four around \$40,000. This proposal will ensure California raises the bar for all hearing impaired in the state.

- ***Adding Infertility Treatment:*** Adding infertility treatment as an EHB is critical to achieving full lived equality for LGBTQ+ people and advancing reproductive freedom for all Californians. The CDC's most recent National Survey of Family Growth reports that about 12% of women and nearly 9% of men under the age of 44 in the United States seek advice, testing, or treatment for infertility at some point in their life. Without insurance coverage for fertility care, the out-of-pocket costs for these treatments are simply insurmountable for most Californians. To date, 14 other states have already passed IVF insurance laws. Adding infertility treatments as an EHB will expand access to fertility care for all Californians, including coverage for IVF, and increase access to care, help reduce inequities in health and economic status, and bring existing law up to date on medical advancements in IVF and its uses.

While we are supportive of adding these additional three benefits, we remain disappointed by the omission of adult dental, which is critical to eliminating health disparities and improving health outcomes for millions of Californians, from the list of proposed benefits to add to the current benchmark plan.

- **Ensuring access to dental care will address broader health disparities and improve overall health and well-being:** Numerous studies have demonstrated that oral health is essential to overall health. Poor oral health is linked to a myriad of chronic health conditions - such as heart disease, difficulty managing diabetes, and an increased risk of cancer, creating a cycle of worsening health outcomes that can include death.<sup>2</sup> The lack of comprehensive adult dental benefits disproportionately affects low-income and communities of color who make up the majority of individuals enrolled in Covered California marketplace coverage. In California, close to 48% of adults 30 or older have periodontitis (gum disease), with even higher rates among low-income adults. Among adults with low-incomes in California, almost 50% of Latino adults did not have dental insurance in 2020, compared to 28% of White adults with low-incomes; Black adults are twice as likely to have untreated dental caries as White adults.<sup>3</sup>
- **Ensuring access to dental care will prevent economic hardship for low-income communities:** High costs are a major barrier to accessing dental care, especially for marginalized populations. National polling shows that 44% of LGBTQI individuals, 43% of mothers from communities of color, 42% of Latina women, and 43% of women under 50 report forgoing dental care due to cost.<sup>4</sup> About 4 in 10 Californians have medical debt, which includes dental debt.<sup>5</sup> This number is higher for marginalized groups, such as those

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<sup>2</sup> "The Dental Divide: Oral Health Equity Challenges in Los Angeles County," the California Pan-Ethnic Health Network, December 2024. [https://cpehn.org/assets/uploads/2024/12/2024\\_Report\\_OH-Disparities\\_Los-Angeles.pdf](https://cpehn.org/assets/uploads/2024/12/2024_Report_OH-Disparities_Los-Angeles.pdf)

<sup>3</sup> "Addressing the Root: Dismantling Systemic Barriers to Oral Health Equity," California Pan-Ethnic Health Network (CPEHN), September, 2022.

<sup>4</sup> Woodbury, Terrance, Erica Tebbs, Roshni Nedungafi, Ashley Aylward. "Health and Economic Justice Survey 2024." Community Catalyst & HIT strategies presentation, May 2024.

<sup>5</sup> The 2023 CHCF California Health Policy Survey, February 16, 2023. <https://www.chcf.org/wp-content/uploads/2023/02/2023CHCFCAHealthPolicySurvey.pdf>

who are low-income, Black, or Latino. In 2014, Covered California's Board decided to embed pediatric dental benefits into health plan offerings as it offered a better, more affordable type of coverage than stand-alone dental plans, which are not included in the calculation of a family's federal tax credits. Adding this benefit will make routine dental services more affordable for millions of Californians.

- **Adding an adult dental benefit to California's benchmark plan will strengthen consumer protections:** Unfortunately, stand-alone dental plans are exempt from many of the Knox-Keene consumer protections that apply to the other benefits included under the state's current benchmark plan. As a result, consumers can be denied coverage due to a health status or pre-existing condition or charged more for insurance based solely on their age and geographic region - essentially allowing insurers to deny coverage or charge higher rates to individuals with poorer health. Covered California's decision to embed pediatric dental benefits into health plan offerings helped to strengthen consumer protections. Adding adult dental as a required EHB will allow Covered California to work more collaboratively with dental plans to improve oral health care access and quality for the millions of Californians who utilize these services while bringing dental services under the same consumer protections enacted for the individual and small group markets post-ACA.
- **California has the flexibility to define the benefits it chooses to add:** We understand there are important considerations policymakers must make when deciding which benefits to add to California's benchmark plan, including the costs of a benefit and whether it satisfies the typicality standard. As noted in our previous letter, the federal regulations allow states the flexibility to define "routine" dental services (e.g. frequency of oral health exams, x-rays, or prophylaxis) in order to bring it within the actuarial room to add other benefits.

**Conclusion:** CPEHN supports California's decision to add DME, hearing aids and infertility treatment to the state's benchmark plan. Moving forward, we urge California to periodically evaluate the benchmark plan to identify ongoing gaps in coverage and potential new opportunities to improve access to care, such as by adding adult dental. With HHS' delegation to states of much of the authority to define EHBs, we believe DMHC has the duty to periodically evaluate EHB coverage in California to address gaps as necessary.

Thank you for considering our feedback. If you have any questions, please do not hesitate to contact me at: [csanders@cpehn.org](mailto:csanders@cpehn.org).

Sincerely,



Senior Policy Director/CPEHN



April 14, 2025

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

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

Dear Ms. Watanabe:

Thank you for the opportunity to comment on California's Essential Health Benefits (EHBs) and the process for updating the benchmark plan. The California Dental Association represents 27,000 member-dentists and urges the state to reconsider adding an adult dental EHB benefit to improve oral health access for Californians and create a meaningful standard for dental coverage.

We appreciate the state including adult dental benefits in the previous actuarial analysis. However, CDA is disappointed to see the state's decision to exclude adult dental benefits from the EHB benchmark draft proposal. As CDA brought up in previous public comments as did other stakeholders, adult dental benefits *are* essential. It is never a matter of *if* an individual must visit the dentist, but *when*. The overall health benefits of dental services have been well established for decades; however, the health care system has historically removed the mouth from the rest of the body. Despite its importance, adult oral health has been a low priority in health benefits, disproportionately affecting communities of color, older adults, and low-income individuals.

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. The dental insurance market has no standardized benefit or minimum requirement of plans which leaves consumers purchasing inadequate dental coverage, coverage inappropriate to their dental needs, or simply receiving little value for their premiums. Additionally, federal and state law have put into place numerous patient protections on medical plans. However, dental plans are largely exempted from these fundamental patient protections such as prohibiting annual or lifetime limits on benefits or providing free preventive care. In adding adult dental to the EHB benchmark plan the state has the opportunity to improve the overall health of Californians and to create a meaningful standard for dental coverage with patient protections.

CDA believes the state's EHB Benchmark plan proposal is missing a key component to improve population health and address health equity through leaving out adult dental benefits. CDA urges the state to prioritize oral health and add adult dental into a future EHB benchmark plan.

Please contact Monica Montano at [monica.montano@cda.org](mailto:monica.montano@cda.org) if you have any questions about the above comments, or if we can provide any further information.

**California Dental Association**

1201 K Street, 14th Floor  
Sacramento, CA 95814

916.443.0505  
800.232.7645  
916.443.2943 fax

[cda.org](http://cda.org)

Sincerely,

A handwritten signature in black ink that reads "Moni Montano". The signature is written in a cursive, flowing style.

Monica Montano  
Regulatory and Legislative Advocate



**CONNECT  
ENRICH  
ACHIEVE**

California Association of Marriage and Family Therapists  
3298 Governor Dr. #22627, San Diego, CA 92192  
Phone: (858) 292-2638 | Fax: (858) 292-2666 | [www.camft.org](http://www.camft.org)

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April 10, 2025

VIA EMAIL: [publiccomments@dmhc.ca.gov](mailto:publiccomments@dmhc.ca.gov)  
[Mary.Watanabe@dmhc.ca.gov](mailto:Mary.Watanabe@dmhc.ca.gov)

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

**RE: Updating California's Essential Health Benefits Benchmark Plan – Mental Health and Substance Use Disorder (MHSUD) Services**

Dear Director Watanabe:

Thank you for the opportunity to provide comments on the potential changes to California's Essential Health Benefits (EHB) benchmark plan. The California Association of Marriage and Family Therapists (CAMFT) represents over 38,000 Marriage and Family Therapists (MFTs) in California, with experience treating individuals with behavioral problems, mental illness, and alcohol and substance use across all settings and delivery systems, including commercial health insurance.

As you are aware, Senate Bill (SB) 855 (Chapter 151, Statutes of 2020) requires commercial health plans and health insurers to cover medically necessary benefits for the prevention, diagnosis, and treatment of all recognized MHSUD conditions. We applaud the Department of Managed Health Care (DMHC) for its efforts to ensure that the benchmark plan reflects the coverage of MHSUD treatment and hope the Department will consider the following related to the provision of such services.

**Clarify the Utilization of All Eligible Health Care Providers**

The benchmark plan currently states that health plans shall cover MHSUD services when provided by in-network physicians or other in-network providers who are licensed health care professionals. As written, this language unintentionally omits other eligible health care providers from rendering medically necessary MHSUD services and leaves out the requirement of plans to arrange for out-of-network care when medically necessary care is unavailable from a network provider.



1. SB 855 and DMHC's regulations define "health care provider" under the context of MHSUD coverage requirements to also include associates and trainees.<sup>1</sup> It is important to clarify in the benchmark plan that health plans must cover MHSUD services as medically necessary when rendered not only by a licensed provider, but also by any other eligible health care provider that is inclusive of associates and trainees as defined in statute and regulations.<sup>2</sup>
2. Statutes and regulations also establish a process for arranging out-of-network coverage when MHSUD services cannot be provided within the standards for network adequacy.<sup>3</sup> We believe it is important for the benchmark plan to also recognize this requirement as part of the coverage and delivery of MHSUD services.

**As such, we hope the Department will consider proposed language for inclusion in its final benchmark plan.**

The Plan covers the following Services when provided by any health care provider as defined in Health and Safety Code Sections 1374.72(a)(4)(A)-(H) ~~In-Network Physicians or other In-Network Providers who are licensed health care professionals~~ acting within the scope of their license or under the direction and supervision of a licensed health care professional:

- Individual and group mental health evaluation and treatment
- Psychological testing when necessary to evaluate a Mental Disorder
- Outpatient Services for the purpose of monitoring drug therapy

If services are not timely and geographically accessible, the Plan will provide and arrange coverage for services specified in this section from an out-of-network provider.

Thank you for considering our comments. We strongly urge you to reflect these considerations in the benchmark plan to ensure MHSUD services are covered and provided by all qualified eligible providers. Please feel free to contact me at [sezrine@camft.org](mailto:sezrine@camft.org) for any support or additional information we can provide.

Sincerely,



Shanti Ezrine, MPA  
State Government Affairs Associate



Cathy Atkins, JD  
Deputy Executive Director

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<sup>1</sup> [Cal. Code Regs. Tit. 28, § 1300.74.72\(b\) - Mental Health and Substance Use Disorder Coverage Requirements](#)

<sup>2</sup> [Health and Safety Code § 1374.72\(a\)\(4\)](#)

<sup>3</sup> [Cal. Code Regs. Tit. 28, § 1300.74.72\(c\) - Mental Health and Substance Use Disorder Coverage Requirements](#)