30 years of advancing health equity
California Pan-Ethnic
HEALTH NETWORK

Children Now

WESTERN CENTER
ON LAW & POVERTY

Disability Rights Education & Defense Fund

HEALTH
ACCESS
CALIFORNIA

July 11, 2024 Via email: publiccomments@dmhc.ca.gov

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

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

To whom it may concern,

Thank you for the opportunity to provide comments regarding potential changes to California's Essential Health Benefits (EHB) base-benchmark plan and the process that the Department of Managed Health Care (DMHC), in partnership with the Legislature and the California Health and Human Services Agency (CalHHS), will be undertaking in the next weeks and months towards achieving that goal. The undersigned represent a coalition of statewide organizations focused on advancing the rights of millions of Californians to access high-quality and affordable health care services. Collectively, we have decades of experience fighting for access to essential health services and have

worked closely with California and other states in the implementation of the Affordable Care Act (ACA), including selection of benchmark plans to define coverage of EHBs.

The EHBs are the main tool that the ACA created to ensure that individuals and families had access to comprehensive and high-quality coverage going forward. Prior to the ACA, nationally and for products regulated under the California Insurance Code, many private plans excluded from coverage key services, such as maternal and newborn care, mental health and substance use disorder (SUD) services, and prescription drugs for complex medical needs. Such gaps in coverage had a disproportionate effect on individuals with significant health needs and members of underserved populations, including Black, Indigenous, and People of Color (BIPOC) individuals, LGBTQIA+ individuals, and individuals with disabilities. The EHB coverage requirement significantly expanded access to a wide array of services that are instrumental in addressing these health inequities.

While the benchmark approach, which allows states to select a model plan for all other non-grandfathered individual and small group market plans to follow, helped states address some gaps in coverage, it has also led to persisting gaps in discrete areas of care. For that reason, the U.S. Department of Health and Human Services (HHS) in recent years has significantly expanded the authority that states have to modify their benchmark plans in order to expand the services or benefits plans are required to cover as EHBs and, in so doing, address remaining gaps. To date, nine states have already taken advantage of this new flexibility. Most of these states had originally selected benchmark plans that were not the most comprehensive or generous of the options available to states.

California selected the Kaiser Small Group HMO 30 as the State's benchmark plan in 2012 and that selection has been in place without significant changes since then. The State has made improvements on access to certain services through changes to medical necessity criteria and better enforcement of coverage requirements. Nonetheless, because states are limited in their ability to adopt new state coverage mandates without defraying the costs of those services, some of the services that the Kaiser plan excludes from coverage have remained as gaps in coverage in other plans and have resulted in access difficulties for underserved groups. Further, we believe states, like HHS, have an obligation to periodically evaluate coverage gaps and address them as necessary through adoption of changes in their EHB benchmark plans. Given that scenario, it is appropriate and timely for California to evaluate current gaps in coverage in the individual and small group markets in order to propose changes to the State's EHB benchmark plan. Below we offer various recommendations regarding the process for adoption of the new plan and we discuss specific areas of care where

coverage gaps persist and that we hope will be addressed through this benchmarking process.

1. **The benchmarking process should be transparent and provide sufficient and meaningful opportunity for public and stakeholder comment.**

We commend legislators, DMHC, and CalHHS for beginning the process with sufficient time in advance of the deadline to submit the proposal to the Center for Consumer Information and Insurance Oversight (CCIIO) in order for the new benchmark plan to take effect on January 1, 2027. We also appreciate the opportunities DMHC has provided during the current open comment period for verbal and written comments. We support a timely update to our EHB, and want to ensure the state's ambitious process provides sufficient opportunity for stakeholders to provide input along the way.

The federal rules governing the EHB benchmarking process establish that all states seeking changes to their benchmark plans "must provide reasonable public notice and an opportunity for public comment … that includes posting a notice on its opportunity for public comment with *associated information* on a relevant State website."[1] While CCIIO has not explicitly defined what would satisfy the requirement for public notice or what constitutes associated information, we believe that, at a minimum, stakeholders should have an opportunity to comment on the final proposed benchmark after having an opportunity to review the actuarial analysis certifying that the proposal meets the actuarial limitations outlined in the rule and any other resource DMHC and the Legislature use to arrive at the proposed benchmark plan.

While we understand that stakeholders and the public will be able to provide written and verbal testimony to the Legislature at a hearing in August, we believe that additional opportunities prior to the Legislature finalizing the plan are needed in order to satisfy the requirement of an opportunity for comment with associated information. Part of the reasoning behind a public comment period is to enable a dialogue between the public and agencies involved with development of the new benchmark plan. Because the California legislature has the final word in the selection of the benchmark, it is essential that the Legislature holds additional legislative hearings that are accessible to Limited English Proficient (LEP) and persons with disabilities, before approving the new plan. After that point, feedback from the public may only inform whether or not to approve the proposed benchmark with little opportunity for amendments that may require further actuarial evaluations.

[1] 45 C.F.R. § 156.111(c) (emphasis added).

To avoid that scenario, we recommend that DMHC provides further opportunities for comment at the agency level where stakeholders are able to provide feedback after carefully evaluating the actuarial analysis and with a better understanding of which services can be added without running afoul of federal actuarial limitations. For the benchmarking process and the corresponding public comment opportunity to be successful, DMHC should provide updates and related information to stakeholders and the public at all stages of the process, including making information available, and accepting comments, in accessible formats and in non-English threshold languages. While opportunities for written comment would likely suffice, stakeholder feedback becomes meaningless if DMHC does not actively engage in responding to all comments. Therefore, we recommend holding additional in-person or virtual meetings that are accessible to LEP and persons with disabilities, where DMHC can address concerns from the public and can answer specific requests from stakeholders, even if that requires postponing the legislative hearings on the final proposal.

2. **DMHC should engage in a holistic evaluation of current coverage requirements and plan practices in order to identify coverage gaps that are contributing to health inequities.**

It is encouraging that DMHC has already identified potential services that could be added through the benchmarking process. Nonetheless, we believe it is important for the Department to engage in a holistic evaluation of current coverage requirements and gaps that utilizes data to select the benefits that would ultimately be added to the benchmark. Because of the actuarial constraints, California will not be able to add every single benefit that stakeholders and others identify. Therefore, the process of selecting benefits should be a data-driven one that centers health equity in order to prioritize those benefits where gaps are disproportionately harming underserved populations.

We urge DMHC to work with the California Health Benefits Review Program (CHBRP) and Covered California to produce an analysis of the coverage practices and gaps among a representative sample of individual and small group market plans in the State. That analysis should identify gaps that are present across multiple plans, with particular emphasis on services that are highly utilized by BIPOC individuals, LGBTQIA+ individuals, and individuals with disabilities. This analysis will provide concrete data that supports subsequent changes to the EHB benchmark plan. The analysis could be used as a starting point for the feedback provided to DMHC during the present opportunity for comment period. When completed, the analysis should also be presented to the public for further feedback, which would in turn help inform the Department's subsequent course of action.

3. **DMHC should assess compliance with federal nondiscrimination requirements applying the correct legal standard.**

The EHB benchmarking process does not relieve state agencies from their responsibility of enforcing federal requirements related to nondiscrimination. That is, while states can address discriminatory benefit designs through the addition of specific benefits, they also have tools to address discrimination in benefit design that do not require opening up the benchmark plan for changes that are subject to actuarial limits. To that end, we are pleased to hear that DMHC will be evaluating potential discriminatory benefit designs in the current benchmark plan. However, we are concerned about the legal standard for discriminatory benefit design that DMHC will use in making these determinations.

We remind DMHC that Section 1557 of the ACA, which applies to all plans receiving direct or indirect federal assistance from HHS (including all Covered California plans), prohibits discrimination on the basis of race, color, national origin, age, disability, or sex (including pregnancy, sexual orientation, gender identity, and sex characteristics).[2] In addition, the ACA requires that health benefits established as EHB not be subject to denial on the basis of the individuals' age or expected length of life or of the individuals' present or predicted disability, degree of medical dependency, or quality of life.[3] Together, these provisions provide strong protections for BIPOC individuals, LGBTQIA+ individuals, individuals with disabilities, and other populations traditionally subject to discrimination in benefit design.

Those protections extend not only to bans on explicit facial discrimination, such as when plans exclude a specific population from coverage of an otherwise covered benefit, but also to other forms of discrimination that are actionable in California. This includes proxy discrimination, which applies when a plan excludes a benefit that is so closely associated with a particular protected group that it serves as a “proxy” for that group and thus constitutes discrimination against them. Actionable discrimination also includes benefit designs that have a disproportionately negative result or “disparate impact” on a protected group; as well as benefits designs that function to segregate or unjustifiably limit people from living and participating in their communities within the meaning of *Olmstead v. L.C.*, 527 U.S. 581 (1999).

Legal experts within or working with DMHC should carefully assess California’s current benchmark plan in order to identify benefit designs that lead to discrimination against protected populations. In that vein, we caution about commissioning evaluations from

---

[2] 42 U.S.C. § 18116.
[3] 42 U.S.C. § 18022(b)(4)(D).

outside experts without the appropriate legal training. While actuarial and policy evaluations are essential, we urge DMHC to allow legal experts to evaluate compliance with non-discrimination requirements as well as others related to the EHB benchmarking process. Following this compliance review, DMHC should evaluate whether to address those discriminatory practices through administrative action or whether the practice requires adding a specific benefit through the benchmark plan.

We also urge DMHC to not only evaluate discriminatory practices in the EHB benchmark plan, but to also implement a standard process to evaluate potential discriminatory practices among all plans that are required to comply with the EHB coverage mandate. While addressing discriminatory benefit designs in the benchmark plan will likely result in less discriminatory practices from plans, the reality is that the benchmark coverage does not excuse individual plans from compliance with non-discrimination requirements. That is, insurers must ensure that their plans' benefit designs do not discriminate against protected groups regardless of what the benchmark plan provides.[4]

As such, while we commend DMHC for evaluating discriminatory practices contained in the benchmark plan, we also urge the Department to adopt a standard monitoring mechanism that allows enrollees to submit complaints related to discrimination in coverage. In addition, DHCS should periodically evaluate individual plans to assess whether their benefit designs present potential violations of federal non-discrimination requirements and work with Covered California, the California Department of Insurance, and other potential partners to correct those violations. These tools would enable DMHC to better enforce federal nondiscrimination requirements, including by compelling plans to change their coverage to avoid violations of Section 1557 or the EHB nondiscrimination provision.

4. **The resulting proposed benchmark plan should improve upon current benchmark coverage without cutting or reducing benefits.**

Theoretically, the current federal rules allow states to both add or eliminate benefits, as well as to expand or limit the scope of covered benefits, within actuarial limits. In practice, it is possible for states to eliminate or reduce certain benefits in order to ensure that the addition of new benefits does not exceed the actuarial maximum (or generosity test). However, DMHC should only consider changes to the EHB benchmark plan that add benefits without cutting or reducing the scope of existing covered benefits. Any additional benefits or expansions in scope should be able to meet the generosity requirements without the need to reduce other benefits and should not be adopted at

[4] *Schmitt v. Kaiser Found. Health Plan of WA*. 965 F.3d 945, 955 (9th Cir. 2020).

the expense of other currently covered services. The current benchmark plan and all services it extends to must be the baseline for any potential new benchmark plan. Importantly, given that states now have the option to create a new benchmark plan altogether (without having to rely on other states' benchmark plans or any specific plan within the state), a resulting benchmark that is equal to the current coverage plus additional benefits would be permissible under the federal rules and we urge the Department to stay within those parameters.

5. **DMHC should evaluate (and commission an actuarial report on) the addition of durable medical equipment, doula services, adult dental care, infertility treatment, behavioral health support services, over-the-counter naloxone, and community health workers.**

    a. Durable Medical Equipment (DME)

While we believe DMHC should engage in a holistic evaluation of current coverage before commissioning an actuarial report on the various options, several services that are currently excluded from coverage stand out. First, the current benchmark plan is notorious for its lack of coverage for durable medical equipment (DME). The plan limits DME to a list of ten low-cost benefits and further limits coverage of DME to only equipment that an individual needs in their home, to the exclusion of equipment they may need to move even 10 feet outside their home. Following this benchmark, many plans in California have failed to cover essential DME items such as wheelchairs, hearing aids, and ventilators, or have placed strict dollar limitations (e.g., $2,000 annually) and/or high-cost sharing (e.g., 100% co-insurance) on the equipment they will cover, in addition to restrictions to in-home use only. Because DME is uniquely 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.

Furthermore, California's benchmark plan appears to be an outlier when it comes to coverage of DME. Research into benchmark plans from other states confirms that plans typically do not limit DME coverage to a small number of equipment and that application of the in-home use rule is rare. In addition, previous analyses have shown that the cost of adding coverage of medically necessary DME is minimal because the population that would utilize the services is small. For that reason, DMHC should evaluate the possibility of adding mandatory coverage of all DME subject to medical necessity determinations. We particularly emphasize the significant need that currently exists for

coverage of manual and power wheelchairs as well as hearing aids.[5] These services are widely available in Medi-Cal and Medicare Advantage plans and, therefore, public programs bear the brunt of costs associated with their provision. In fact, many consumers have been forced to quit their jobs or take reduced salaries in order to qualify for these public programs, which offer essential DME items that their employer-sponsored plans do not. The EHB benchmark process presents a timely opportunity to address coverage practices regarding wheelchairs, hearing aids, and other DME that leads to health disparities affecting people with disabilities.

b. Doula Services

Second, DMHC should also consider requiring coverage of full spectrum doula care services as EHB. Doulas are individuals trained to provide non-clinical emotional, physical and informational support for people before, during, and after labor and birth. Doula care is among the most promising approaches to combating disparities in maternal health. Pregnant individuals receiving doula care, including people with disabilities who are increasingly choosing to have children, have been found to have improved health outcomes for both themselves and their infants, including higher breastfeeding initiation rates, fewer low-birth weight babies, and lower rates of cesarean sections.[6] Doulas can also help reduce the impacts of racism and racial bias in health care on pregnant women of color by providing individually tailored, culturally appropriate, and patient centered care and advocacy. DMHC should consider the impact of adding coverage of at least three prenatal doula visits and three postpartum doula visits, as well as coverage that is inclusive of the wide variety of doula training models, traditions, and practices, including those by community-based doula groups and by doula trainers of color. Given the infrastructure that has been developed as part of the new Medi-Cal doula benefit, California is in a unique position to also extend this service to enrollees in the individual and small group markets.

---

[5] We are mindful of the need for hearing aid for children, but also acknowledge that EHB coverage requirements must extend to both adults and children in order to comply with age non-discrimination requirements based on age.

[6] *See* Asteir Bey et al., *Advancing Birth Justice: Community-Based Doula Models as a Standard of Care for Ending Racial Disparities* (Mar. 25, 2019), https://everymothercounts.org/wp-content/uploads/2019/03/Advancing-Birth-Justice-CBDModels-as-Std-of-Care-3-25-19.pdf; Christian Horton & Susan Hall, *Enhanced Doula Support to Improve Pregnancy Outcomes Among African American Women with Disabilities*, 29 J. PERINATAL EDUC. 188–196 (Oct. 2020), https://www.ncbi.nlm.nih.gov/pmc/articles/PMC7662161/; Alison McGarry, Biza Stenfert Kroese, & Rachel Cox, *How do Women with an Intellectual Disability Experience the Support of a Doula During their Pregnancy, Childbirth and After the Birth of their Child?*, 29 J. APPLIED RESEARCH IN INTELLECTUAL DISABILITIES 21–33 (Jan. 2016), https://pubmed.ncbi.nlm.nih.gov/25953324/

c. Adult Dental Care

We further support an evaluation of the possibility of adding adult dental care as EHB. For many years, HHS prohibited states from including routine adult dental services as EHB. HHS rescinded that rule this year and California now has an opportunity to incorporate this important benefit as part of its EHB package, just as pediatric dental care is already covered. For years, public health officials have been calling for the end of outmoded and incongruous segregation of oral health care. In 2009, the World Health Organization (WHO) Global Conference on Health Promotion issued a call for the integration of oral health services and primary care.[7] Evidence overwhelmingly demonstrates that oral health care is a critical, essential part of health care.

Adding routine adult dental care as a covered EHB has the potential to improve health outcomes and improve quality of life for many. In 2000, a report titled *Oral Health in America: Advances and Challenges* concluded, "[t]he mouth is the center of vital tissues and functions that are critical to total health and well-being across the lifespan."[8] Now, more than twenty years later, we know even more about the importance of oral health to whole body health. Yet, routine dental care remains unreachable for many in California and across the U.S. This leads to unnecessary physical and mental suffering, loss of productivity, and higher health care costs.

The state of oral health in the U.S. clearly indicates the need for access to routine dental care. Dental caries, also known as cavities, are a prevalent condition among adults. According to the Centers for Disease and Prevention (CDC) between 2015 and 2018, 25.9% of adults ages 20-44 had untreated dental cavities and 25.3% of adults ages 45-64 had untreated dental cavities.[9] On average, adults have about 9 permanent teeth decayed, missing, or filled due to dental disease.[10] About half of all adults ages 30 and older showed signs of periodontal disease, and severe periodontal disease affects

---

[7] Kwan S Petersen, *The 7th WHO Global Conference on Health Promotion-towards integration of oral health* (Nairobi, Kenya 2009), Community Dental Health 2010; 27(Suppl 1):129–36, https://www.cdhjournal.org/issues/27-3-june-2010-supplement1/274-the-7th-who-global-conference-on-health-promotion-towards-integration-of-oralhealth-nairobi-kenya-2009?downloadarticle=download.

[8] Nat'l Insts. of Health, Oral Health in America: Advances and Challenges. Bethesda, MD: US Department of Health and Human Services, National Institutes of Health, National Institute of Dental and Craniofacial Research 3A-2 (2021), https://www.nidcr.nih.gov/sites/default/files/2021-12/Oral-Health-in-America-Advancesand-Challenges.pdf#page=313.

[9] Ctrs. for Disease Control and Prevention, Oral and Dental Health, FastStats https://www.cdc.gov/nchs/fastats/dental.htm.

[10] Nat'l Insts. of Health, *supra* note 7 at 3A-2.

about 9% of adults.[11] Periodontitis, in turn, may link to chronic diseases like cardiovascular disease, diabetes, respiratory disease, and some cancers and may also exacerbate other health conditions like Alzheimer's disease.[12]

Oral health conditions affect an individual's physical health and affects mental well-being and ability to interact socially. Oral health is not just the physical state of teeth and gums but also includes the ability to speak, eat, smile, and more.[13] These fall into the category of quality-of-life metrics like functional factors, psychological factors, social factors, and the existence of discomfort or pain. Dental conditions are responsible for decreasing these quality-of-life metrics as they cause pain, functional, aesthetic, nutritional, and psychological issues.

Moreover, racial and ethnic disparities persist in adult access to dental care. Recent national data shows that African American and Mexican American adults are more likely to have untreated tooth decay and moderate to severe periodontitis compared to white adults.[14] According to the California Health Interview Survey, in 2020, adults of color were less likely than white adults to report the condition of their teeth as good, very good, or excellent. Researchers have investigated the effects of Medicaid adult dental coverage expansions and found that racial and ethnic disparities decreased after the Medicaid expansion of extensive dental care. Expansion in coverage led to an 8% increase in the likelihood of receiving dental care.[15] This represents a reduction in pre-expansion disparities by 75% for non-Hispanic Black adults and 50% for Hispanic Adults. While no similar studies exist in Marketplace coverage, it is likely that Covered California enrollees would experience similar reductions in racial and ethnic disparities if California were to adopt coverage of routine adult dental care as an EHB.

Lack of access to dental care also disproportionately affects low-income individuals. About 35% of low-income adults reported feeling embarrassment and 30% reported anxiety either very often or occasionally.[16] Almost 18% of working-age adults reported

[11] Ctrs. for Disease Control and Prevention, *supra* note 8.
[12] Am. Acad. of Periodontology, Gum Disease and Other Diseases, https://www.perio.org/for-patients/gum-disease-information/gum-disease-and-otherdiseases/.
[13] Nat'l Insts. of Health, *supra* note 7.
[14] L.N. Borrell & D.R. Williams, *Racism and oral health equity in the United States: Identifying its effects and providing future directions*, 82 J. PUBLIC HEALTH DENT. 8–11 (2022).
[15] G.L. Wehby, W. Lyu, D. Shane, *Racial and Ethnic Disparities In Dental Services Use Declined After Medicaid Adult Dental Coverage Expansions*, 41 HEALTH AFF. 44–52 (2022), https://www.healthaffairs.org/doi/10.1377/hlthaff.2021.01191.
[16] Am. Dental Assoc., Health Policy Inst., *Oral Health and Well-Being in the United States*, https://www.ada.org/-/media/project/ada-organization/ada/ada-org/files/resources/research/hpi/us-oral-health-well-being.pdf.

that the appearance of their mouth and teeth affects their ability to interview for a job.[17] One study researched the association between untreated cavities and missing anterior teeth on employment. They constructed a dental problem index using tooth count and tooth surface condition. The researchers found that a one-point increase in the dental problem index resulted in a decrease in the odds of being employed by 7.7% and having a routine dental visit significantly impacted the dental problem index.[18] In terms of dental care utilization among adults ages 18-64, the CDC found that between 2019 and 2020, the percentage of adults who received a dental visit decreased across income levels, sex, and racial groups.[19] Previous research also indicates that income and health insurance status are important predictors of unmet dental needs that result in losing teeth and gum disease.[20] This research demonstrated that unmet dental needs are effected by the oral health care policies in their state and that improvements to state oral health programs could greatly improve oral health.[21]

d. Infertility Treatment

Our organizations also support the addition of infertility treatment services, including in-vitro fertilization (IVF), into the benchmark plan. Private plans in California often exclude coverage for these services and individuals and families are left to bear the high cost of the treatment. These high costs not only have a disproportionate effect on low-income Californians, but also disproportionately impact underserved individuals, such as LGBTQIA+ individuals, BIPOC populations, and individuals with disabilities, who depend on IVF or other infertility treatment to have children. 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.

In addition, private plan coverage of infertility treatment in California compares unfavorably to coverage in other states. 17 states currently have laws requiring

---

[17] *Id.*

[18] Yara A. Halasa-Rappel et al., *Broken Smiles: The impact of untreated dental caries and missing anterior teeth on employment*, 79 J. PUBLIC HEALTH DENT. 231–237 (2019), https://www.ada.org/-/media/project/ada-organization/ada/ada-org/files/resources/research/hpi/us-oral-health-well-being.pdf.

[19] Ctrs. for Disease Control and Prevention, *supra* note 9.

[20] D.J. Gaskin et al., *Predictors of Unmet Dental; Health Needs in US Adults in 2018: A Cross-Sectional Analysis*, 7 JDR CLINICAL & TRANSLATIONAL RESEARCH 398–406 (2022), https://journals.sagepub.com/doi/10.1177/23800844211035669.

[21] *Id.* J.S. Feine, *Oral Health Care Access, Inequity, and Inequality*, 7 JDR CLINICAL TRANSLATIONAL RESEARCH 332–333 (2022).

coverage of infertility treatment broadly.[22] Most states have state laws mandating coverage of infertility treatment, but some of these laws exempt plans from compliance if HHS determines that the mandate is subject to defrayal under the ACA. To avoid defrayal altogether, California should evaluate the potential of adding these services to the State's benchmark plan.

e. Behavioral Health Support Services and Over-the-Counter Naloxone

DMHC should consider using the EHB benchmarking process to address remaining gaps in coverage of behavioral health services. Governor Newsom's Behavioral Health Modernization initiative has emphasized the importance of aligning Medi-Cal coverage of behavioral health services with coverage among private plans. Such efforts must account for the need to incorporate new coverage requirements into the EHB benchmark plan. While the recently enacted SB 855 and implementing regulations significantly expanded the number of services that private plans are required to cover under California's mental health and SUD parity law, a recent crosswalk by the National Health Law Program comparing requirements regarding Medi-Cal and private coverage of behavioral health services showed that explicit mandates still fell short in one key area: coverage of support services.[23] Behavioral health support services include, but are not limited to, peer support services, care coordination, recovery services, intensive community-based treatment options, dyadic services, targeted case management, transitional rent, and individual placement and supported employment. These services, many of which are covered by Medi-Cal, are essential for ensuring that individuals with behavioral health conditions get the social supports they need to be successful in recovery.

Similarly, the FDA recently approved two versions of naloxone, the opioid overdose reversal medication, to be sold as an over-the-counter (OTC) medication, a move that expanded the availability of the medication, but opened the door to questions about affordability and insurance coverage.[24] Last year, Governor Newsom vetoed a bill that would have required private plan coverage of OTC naloxone, reasoning that the bill risked exceeding the EHB requirement and potentially subjecting the State to defrayal

---

[22] Resolve, Insurance Coverage by State, https://resolve.org/learn/financial-resources-for-family-building/insurance-coverage/insurance-coverage-by-state/ (last accessed July 10, 2024).
[23] Héctor Hernández-Delgado & Kim Lewis, Nat'l Health Law Prog., *Crosswalk Between Coverage of Behavioral Health Services in Medi-Cal and Private Plans in California* (May 2022), https://healthlaw.org/resource/crosswalk-between-coverage-of-behavioral-health-services-in-medi-cal-and-private-plans-in-california/.
[24] FDA, FDA Approves First Over-the-Counter Naloxone Nasal Spray (March 29, 2023), https://www.fda.gov/news-events/press-announcements/fda-approves-first-over-counter-naloxone-nasal-spray.

requirements.[25] Questions regarding coverage of OTC naloxone have persisted. Therefore, the benchmarking process presents an opportunity for California to clarify that all naloxone formulations, including those available OTC, must be covered as an EHB by all non-grandfathered individual and small-group market plans.

f. Community Health Workers (CHW)

We urge DMHC to explore the potential of strengthening coverage requirements related to chronic disease management by including Community Health Worker, Promotoras, and Representative (CHWPR) services. CHWPR are frontline public health workers who serve as liaisons to build bridges between community members and essential health and social services. Often employed by grassroot community-based organizations, social service agencies, clinics, other health care systems, CHWPRs help improve access to health services and improve the quality and cultural competence of service delivery. In addition, CHWPRs are critical allies to People of Color, immigrants, and other underserved and under-resourced communities, who may not have access to the knowledge or resources needed to adequately obtain the health services they need to navigate and manage chronic diseases.

CHWPRs should be included within chronic disease management services because they provide a wide range of essential services that would benefit individuals navigating their chronic diseases. CHWPR services include providing health education and promotion, health system navigation, screening and assessment, and individual and community support, which are all necessary services needed to control, manage, and prevent chronic conditions or infectious diseases. For example, CHWPRs can provide information or instruction on health topics connected to the specific chronic disease that the individual may be experiencing, which can include coaching and goal setting to improve health or ability to self-manage health conditions. In addition, CHWPRs can provide referrals or training that can assist beneficiaries access to understanding the health care system, ways on how they can engage in their own care, or wats to address health care barriers, such as medical translation/interpretation or transportation services. Moreover, CHWPRs can conduct health screenings and assessments (that do not require a license) to help the beneficiary connect to appropriate services or improve their health condition.

Because our health care system is overly saturated, it can be difficult for other health care providers to provide the care coordination, navigation, and coaching that people experiencing chronic health diseases may need. Therefore, by including CHWPRs

---

[25] AB 1060 (2023), Governor Newsom's Veto Message (Oct. 7, 2023), https://www.gov.ca.gov/wp-content/uploads/2023/10/AB-1060-Veto.pdf.

services as an EHB, beneficiaries can access the additional support and resources they need to further enhance the management of their chronic disease.

Conclusion

Thank you for your consideration to our comments. We are excited about the opportunity to expand access to essential health services in California's individual and small group markets and we look forward to providing additional input in the upcoming weeks and months as the Department works with other agencies and the Legislature to approve a new benchmark plan. If you have questions about our comments, please contact Héctor Hernández-Delgado (hernandez-delgado@healthlaw.org).

Sincerely,

Héctor Hernández-Delgado
National Health Law Program

Selena Liu-Raphael
California Alliance of Child and Family Services

Cary Sanders
California Pan-Ethnic Health Network

Mike Odeh
Children Now

Silvia Yee
Disability Rights Education & Defense Fund

Beth Capell
Health Access

Sandra Poole
Western Center on Law and Poverty

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