SENATE COMMITTEE ON HEALTH
Senator Caroline Menjivar, Chair

BILL NO: AB 224
AUTHOR: Bonta
VERSION: July 8, 2025
HEARING DATE: July 16, 2025
CONSULTANT: Teri Boughton

SUBJECT: Health care coverage: essential health benefits

SUMMARY: Adds, if approved by the federal government, hearing aids, treatment for infertility, and additional durable medical equipment to California's essential health benefits, which are benefits that are required to be covered for health insurance policies purchased by individual and small groups.

Existing federal law: Establishes, pursuant to the Patient Protection and Affordable Care Act (ACA), federal Essential Health Benefits (EHBs) requirements, including that the Secretary of the United States Department of Health and Human Services (HHS) not make coverage decisions, determine reimbursement rates, establish incentive program, or design benefits in ways that discriminate against individuals because of their age, disability, or expected length of life. [42 U.S.C. §18022]

Existing state law:

1) Establishes the Department of Managed Health Care (DMHC) to regulate health plans under the Knox-Keene Health Care Service Plan Act of 1975 (Knox-Keene Act); California Department of Insurance (CDI) to regulate health and other insurance; and, the Department of Health Care Services (DHCS) to administer the Medi-Cal program. [HSC §1340, et seq., INS §106, et seq. and WIC §14000, et seq.]

2) Requires an individual or small group health plan contract or insurance policy to include at a minimum, coverage for EHBs pursuant to the ACA, and as outlined below:

    a) Health benefits within the ten categories identified below in the ACA:
        i) Ambulatory patient services;
        ii) Emergency services;
        iii) Hospitalization;
        iv) Maternity and newborn care;
        v) Mental health and substance use disorder services;
        vi) Prescription drugs;
        vii) Rehabilitative and habilitative services and devices;
        viii) Laboratory services;
        ix) Preventive and wellness services and chronic disease management;
        x) Pediatric services, including oral and vision care;
    b) Health benefits covered by the Kaiser Foundation Health Plan Small Group HMO 30 (Kaiser Small Group HMO), as this plan was offered during the first quarter of 2014, regardless of whether the benefits are specifically referenced in the evidence of coverage or plan contract for that plan;
    c) Medically necessary basic health care services, as specified;
    d) Health benefits mandated to be covered by the plan pursuant to statutes enacted before December 31, 2011, as described; and,

e) Health benefits covered by the plan that are not otherwise required to be covered, as specified. [HSC §1367.005 and INS §10112.27]

3) Requires pediatric vision care to be the same health benefits for pediatric vision care covered under the Federal Employees Dental and Vision Insurance Program vision plan with the largest national enrollment as of the first quarter of 2014. [HSC §1367.005 and INS §10112.27]

4) Requires pediatric oral care to be the same health benefits for pediatric oral care covered under the dental benefit received by children under the Medi-Cal program as of 2014, including the provision of medically necessary orthodontic care provided pursuant to the federal Children's Health Insurance Program Reauthorization Act of 2009. [HSC §1367.005 and INS §10112.27]

5) Defines "habilitative services" to mean health care services and devices that help a person keep, learn, or improve skills and functioning for daily living. Examples include therapy for a child who is not walking or talking at the expected age. These services may include physical and occupational therapy, speech-language pathology, and other services for people with disabilities in a variety of inpatient or outpatient settings, or both. Requires habilitative services to be covered under the same terms and conditions applied to rehabilitative services under the plan contract. [HSC §1367.005 and INS §10112.27]

This bill:

1) Adds to California's EHB benchmark as it exists in the Insurance Code, the following services, if approved by federal HHS, beginning January 1, 2027:

   a) Services to evaluate, diagnose, and treat infertility. Requires the services to include:
      i) Artificial insemination;
      ii) Three attempts to retrieve gametes;
      iii) Three attempts to create embryos;
      iv) Three rounds of pre-transfer testing;
      v) Cryopreservation of gametes and embryos;
      vi) Two years of storage for cryopreserved embryos;
      vii) Unlimited storage for cryopreserved gametes;
      viii) Unlimited embryo transfers;
      ix) Two vials of donor sperm;
      x) Ten donor eggs; and,
      xi) Surrogacy coverage for the aforementioned services, as well as health testing of the surrogate for each attempted round of covered services.
   b) The following additional durable medical equipment (DME):
      i) Mobility devices, including walkers and manual and power wheelchairs and scooters;
      ii) Augmented communications devices, such as speech generating devices, communications boards, and apps;
      iii) Continuous positive airway pressure (CPAP) machines;
      iv) Portable oxygen; and,
      v) Hospital beds.
   c) An annual hearing exam and one hearing aid per ear every three years.

2) Authorizes the Insurance Commissioner to issue guidance, not subject to the Administrative Procedures Act, to health insurers regarding compliance with this bill.

FISCAL EFFECT: CDI estimates costs of $64,000 in fiscal year 2025-26 and $174,000 in 2026-27 for state administration (Insurance Fund).

PRIOR VOTES:

Assembly Floor:	60 - 1
Assembly Appropriations Committee:	11 - 0
Assembly Health Committee:	14 - 0

COMMENTS:

1) *Author's statement.* According to the author, the ACA requires health insurance sold in the individual and small group markets to offer a comprehensive package of items and services, known as EHBs. Under this federal legislation each state has the authority to choose its benchmark EHB plan, which details the EHBs that must be included in the scope of benefits for each health plan. California's current EHB benchmark plan does not include coverage for a variety of benefits – such as hearing aids, infertility treatment or DME. In order to change California's EHBs, the state was required to update its existing benchmark plan through a review process, which included an actuarial analysis and stakeholder process. In order for new benefits to be in place for the 2027 plan year, the state must notify the federal government of its intention and proposed plan by May of this year. California has completed its review process and has submitted a proposal to the federal government to add hearing aids, infertility treatment, and DME to California's EHB benchmark plan. This bill will codify these new EHBs if that proposal is approved.

2) *California's benchmark plan.* California's current benchmark plan is the Kaiser Small Group HMO plan. The benchmark plan and other state mandates existing prior to December 31, 2011 are used to determine EHBs. Any state mandate exceeding EHBs requires the state to defray the costs associated with the mandate. California last reviewed its benchmark plan in 2015. At that time, the California Health Benefits Review Program (CHBRP) asked Milliman to analyze and compare the health services covered by the ten plans available to California as options for California's EHB benchmark effective January 1, 2017, similar to an analysis completed for Covered California in 2012. Milliman found relatively small differences in average healthcare costs among the ten benchmark options. Among the plan options, Milliman found differing coverage of acupuncture, infertility treatment, chiropractic care, and hearing aids. The three California small group plans were essentially the same average cost as the California EHB plan and the California large group and CalPERS plans were approximately 0.2% to 1% higher in cost. The estimated average costs for the three federal employee plan options was approximately 0.8% to 1.2% higher than the California EHB plan. On April 17, 2015, the Secretary of California's Health and Human Services Agency sent a letter to the federal Center for Consumer Information and Insurance Oversight (CCIIO) selecting the same Kaiser Small Group Plan to remain as California's benchmark plan.

3) *Updating EHBs.* According to a 2022 CHBRP brief on EHBs, the federal HHS issued final rules in 2018 and 2019, which provided new flexibility for states by allowing three new options for the EHB benchmark plan, in addition to the option of retaining the current EHB benchmark plan. Beginning with the 2020 plan year, states could: a) select an EHB benchmark plan used by another state for the 2017 plan year; b) replace one or more of the ten EHB categories in the state's EHB benchmark plan with the same category or categories

of EHBs from another state's 2017 EHB benchmark plan; or, c) otherwise select a set of benefits that would become the state's EHB benchmark plan. At a minimum, the EHB benchmark plan must provide a scope of benefits equal to or greater than a typical employer plan. Furthermore, a new "generosity test" requires that EHBs cannot exceed the generosity of the most generous among the set of ten previous 2017 benchmark comparison plan options. A mandate that is added through the benchmark plan process is not subject to the requirement that the state defray those mandate costs if it is not a state mandated benefit enacted after December 31, 2011. According to the Centers for Medicaid and Medicare Services (CMS) website, for plan years between 2020 and 2025, nine states have updated their EHB benchmark plans.

4) *Updated process rules.* CMS finalized new rules for EHB benchmark updates through the HHS Notice of Benefit and Payment Parameters for 2025. As part of this update, CMS removed a regulatory prohibition on plans and insurers from including routine non-pediatric dental services as an EHB. This allows states to add routine adult dental services as an EHB by updating their EHB benchmark plans. For plan years beginning on or after January 1, 2026, CMS approved three revisions to the standards for state selection of EHB-benchmark plans to address long-standing requests from states to improve, and reduce the burden of, the EHB-benchmark plan update process. First, CMS allows states to consolidate the options for states to change EHB-benchmark plans such that a state may change its EHB-benchmark plan by selecting a set of benefits that would become the state's EHB-benchmark plan. Any changes to state EHB-benchmark plan options is also applicable to states when choosing a benchmark plan used to define EHBs in a state Basic Health Programs (BHPs) established under section 1331 of the ACA and Medicaid Alternative Benefit Plans (ABPs) implemented pursuant to section 1937 of the ACA. Second, CMS removed the generosity standard and revised the typicality standard so that, in demonstrating that a state's new EHB-benchmark plan provides a scope of benefits that is equal to the scope of benefits of a typical employer plan in the state, the scope of benefits of a typical employer plan in the state would be defined as any scope of benefits that is as or more generous than the scope of benefits in the state's least generous typical employer plan, and as or less generous than the scope of benefits in the state's most generous typical employer plan. Third, CMS removed the requirement for states to submit a formulary drug list as part of their documentation to change EHB-benchmark plans unless the state changes its prescription drug EHBs.

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

stakeholder meeting was held on January 28, 2025 with another public comment period established by February 4th.

6) *Benefit analysis.* At the January 28th meeting, the Wakely Consulting Group (Wakely) presented an actuarial analysis that identified the benefit allowance and potential options and prices for the proposed benchmark plan. Through a typicality test following current CMS standards, Wakely determined that California's proposed benchmark plan can impact benefit costs (which is what the plan pays for the service plus member cost share) ranging between 1.06% to 2.23%. This means that the value of the benefit additions cannot exceed 2.23%. Wakely further estimated the pricing of a suite of proposed benefits that potentially could be added, including hearing aids, DME, wigs, chiropractic, infertility, and adult dental. Altogether, the cost of these benefits, with the exception of adult dental would add 1.63% to 3.48% cost. These benefits exceed the allowed cost impact range by 0.57% to 1.25%. This means choices must be made to narrow the set of proposed benefits to be covered. The allowed cost range of adult dental preventive services is 1.26% to 1.83% and for comprehensive dental services, the cost range is 2.6% to 4.6%. In addition to the high cost of adding preventive dental services, there are other challenges with adding adult dental benefits to the EHB, such as that as an EHB there cannot be annual or lifetime dollar limits on benefits. This is not typically how dental benefits are offered today.

7) *Informational hearing.* On February 11, 2025, the Senate and Assembly Committees on Health held an informational hearing on California's EHB benchmark options. Testimony was provided by DMHC, Covered California, CHBRP, and the public. CHBRP included the following fiscal estimates:

Proposed EHB Benefit Expansion	Estimated Plan Paid PMPM (per member per month) Increase for Silver Plans	Estimated Premium Increase for Silver Plans
Hearing Aids	$1.52	.21%
Wigs	$.31	.04%
Chiropractic care	$.78	.11%
DME – General	$1.64	.23%
DME – Augmented Communication Devices	$.03	.00%
DME – Neuromodulators	$.01	.00%
Infertility	$5.36	.76%

CHBRP February 11, 2025

8) *DMHC Announcement.* On March 28, 2025, DMHC announced that California intends to apply to CMS to update the state's benchmark plan to take effect January 1, 2027. A public comment period was held on the draft document submissions to CMS. The documents include a benchmark plan summary, confirmations, certifications, benefits and limits summary and a valuation report. The additional benefits are described in the table below. DMHC received comments from a variety of organizations expressing support for the chosen benefits. Some organizations express disappointment that adult dental benefits were not

included, as well as chiropractic and neuromodulators. Some requested clarifications regarding the artificial insemination benefit, and description of behavioral health provider in the benchmark plan summary. Lastly, two organizations requested a delay in the submission to take additional time for review and consultation of the premium impact of these added benefits, impacts of federal decisions related to terminating enhanced Advanced Premium Tax Credits (APTCs), and guidance on infertility treatment requirements in the large group market. The DMHC application was submitted to CMS on May 5, 2025. As of July 14, the state has not received a response.

Hearing Aid Coverage	Annual exam and one hearing aid per ear every three years	Cost estimate .21% of total allowed claims.
Expanded DME	Removing DME limitation to home use; and, wheelchairs, portable oxygen, CPAP machines, walkers, scooters, hospital beds, and augmented communication devices.	Allowed cost impact 1.03%
Infertility diagnosis, AI, and IVF.	See description of this bill 1a) above.	Allowed cost impact .93%
Total		Allowed cost impact 2.18%
Value of benefit limit based on typicality test		2.23%

8) *Related legislation.* SB 62 (Menjivar) is substantially similar, but amending the Health and Safety Code to apply to health plans. *SB 62 is set to be heard in the Assembly Health Committee on July 15, 2025.*

9) Prior legislation. SB 1290 (Roth) and AB 2914 (Bonta) of 2024 would have placed a sunset on California's EHB benchmark after the 2026 plan year. *SB 1290 and AB 2914 were held on the Assembly and Senate Floor at the request of the authors.*

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

> *This bill would require health plans to cover medically necessary hearing aids for individuals under 21 years of age, up to $3,000 per individual hearing aid without any cost sharing, beginning January 1, 2025. I am committed to ensuring that hearing impaired children have access to the services and supports they need, including hearing aids. Today, children can receive hearing aids and related services through the California Children's Services (CCS) program or through Medi-Cal. In July 2021 we*

launched the Hearing Aid Coverage for Children Program (HACCP) within the Department of Health Care Services (DHCS) for those who do not qualify for hearing aids through CCS or Medi-Cal. HACCP was created to improve access and coverage for children's hearing aids, a shared goal of this proposed bill. Unlike HACCP, however, SB 635 would exceed the state's set of essential health benefits, which are established by the state's benchmark plan under the provisions of the federal Affordable Care Act (ACA). As such, this bill's mandate would require the state to defray the costs of coverage in Covered California. This would not only increase ongoing state General Fund costs, but it would set a new precedent by adding requirements that exceed the benchmark plan. A pattern of new coverage mandate bills like this could open the state to millions to billions of dollars in new costs to cover services relating to other health conditions. This creates uncertainty for our healthcare system's affordability, particularly when we have developed an alternative program that can serve the target population. That said, improving access to hearing aids for children is a priority for my Administration. We can, and we must, do better for these children and their families as we implement HACCP. To this end, I am directing my Administration to explore increases to Medi-Cal provider payments with the goal of incentivizing additional provider participation in HACCP, increasing access for youth in need of hearing aids.

In addition, DHCS has developed a comprehensive plan to increase provider participation and program enrollment. These improvements will enable HACCP to reach and serve more children, which is our shared goal. Specifically, in the next six months, DHCS will take a variety of steps to help patients maximize benefits, including: (1) partnering with other state entities to promote participation and awareness of HACCP, (2) completing translations for HACCP related materials into 18 languages, (3) implementing a streamlined annual eligibility renewal process to simplify provider enrollment, (4) conducting outreach to Medi-Cal providers not yet participating in HACCP to support their participation, (5) hosting quarterly webinars with providers and stakeholders, and (6) continuing to identify potential service improvements and strategies to increase program success. Given the structural concerns this bill presents to our healthcare system and the opportunity to improve the existing HACCP to accomplish the same objectives, I cannot sign this bill.

AB 598 (Bloom of 2019) would have required a health plan contract or a health insurance to include coverage for hearing aids for an enrollee or insured under 18 years of age, and would have limited the maximum coverage amount to $3,000 per hearing aid. *AB 598 was placed on the Assembly inactive file at the request of the author.*

AB 1601 (Bloom of 2017) and AB 2004 (Bloom of 2016) were substantially similar to AB 598. AB 1601 was held in Assembly Appropriations Committee. *AB 2004 was held in the Senate Appropriations Committee.*

SB 43 (Hernandez, Chapter 648, Statutes of 2015) updates California's EHB law to make it consistent with new federal requirements promulgated under the ACA, which includes adoption of the federally required definition of habilitative services and devices.

SB 951 (Hernandez, Chapter 866, Statutes of 2012) and AB 1453 (Monning, Chapter 854, Statutes of 2012) select the Kaiser Small Group HMO as California's benchmark plan to serve as the EHB standard.

AB 368 (Carter of 2007) would have required health care service plans and health insurers to offer, at minimal cost, coverage up to $1,000 for hearing aids, as defined, to all enrollees, subscribers, and insureds under 18 years of age. *AB 368 was vetoed by Governor Schwarzenegger, who stated, in part: "The addition of a new mandate, no matter how small, will only serve to increase the overall cost of health care and increasing the cost of coverage by mandating benefits, may ultimately leave more children without any coverage."*

SB 1223 (Scott of 2006) would have required health plans and health insurers to offer or provide, as specified, coverage up to $1,000 for hearing aids, as defined, to all enrollees, subscribers, and insureds under 18 years of age. *SB 1223 was vetoed by Governor Schwarzenegger, who indicated that the bill may contribute to rising premiums and make health care less affordable and accessible for uninsured Californians.*

SB 174 (Scott of 2004) would have required health plans and health insurers to provide coverage, up to $1,000, for hearing aids, as defined, to all enrollees and subscribers under 18 years of age. *SB 174 was held in the Senate Rules Committee.*

SB 1158 (Scott of 2004) would have required health plans and health insurers to provide coverage up to $1,000 for hearing aids, as defined, to all enrollees, subscribers, and insureds under 18 years of age. *SB 1158 was vetoed by Governor Schwarzenegger, who indicated that increasing the cost of health coverage by mandating benefits, if even by a small amount, would have the far more serious consequence of leaving some children without health insurance.*

10) *Support.* Children Now writes these bills represent a critical opportunity to address a longstanding gap in healthcare coverage for children with hearing loss and to promote equitable access to essential services critical for their developmental and educational success. They also reflect the outcome of months of public engagement and collaborative work with DMHC. Disability Rights Education and Defense Fund (DREDF) indicates that most individuals getting marketplace policies cannot afford a wheelchair and current exclusions mean when paid out of pocket it does not even count toward out-of-pocket limits. DREDF writes there is no substitute for a power wheelchair for anyone who does not have upper body strength or the stamina to propel themselves any distance beyond a few feet in a manual chair, to those who need and use wheelchairs every day it remains the single most vital link to maintaining independence, community integration, and well-being. The National Health Law Program writes the lack of coverage for these services (DME, hearing aids, and infertility treatment) leads to negative health consequences that disproportionately affect individuals with disabilities, Black, Indigenous, and People of Color, LGBTQ+ individuals, and other underserved populations, and, California should ensure that plans are addressing these gaps in coverage. The American Society for Reproductive Medicine writes the proposed benchmark plan meets the standard of care for in vitro fertilization and is based on extensive U.S. and international literature, as well as professional consensus, which is the most cost-effective way to maximize an individual's chances for a healthy pregnancy and neonatal outcome.

11) *Opposition.* The Center for Bioethics and Culture Network writes that it believes this bill is vague in scope, and is specifically concerned with the potential expansion of mandated insurance coverage for elective fertility procedures. The opposition writes, "Surrogacy involves complex medical interventions that carry substantial physical and psychological risks to the women who serve as gestational carriers. These include, but are not limited to:

increased risk of pregnancy complications, including preeclampsia, placenta previa, gestational diabetes, and preterm labor, particularly when carrying multiples, which are more common in IVF or surrogacy; psychological and emotional trauma, including an increased risk for postpartum depression, associated with relinquishing a child they have carried to term, which is often underestimated or dismissed; exposure to intensive hormone treatments, which may have long-term implications for women's health and fertility (studies are sorely lacking). Any legislative move that could incentivize or expand commercial surrogacy through mandated insurance coverage risks turning women—often financially vulnerable—into a means to an end for others' reproductive desires."

SUPPORT AND OPPOSITION:

Support: Alliance for Fertility Preservation
American Society for Reproductive Medicine
California Association of Medical Product Suppliers
California State Council of Service Employees International Union
Children Now
Children's Specialty Care Coalition
Disability Rights Education and Defense Fund
Essential Access Health
Facing Our Risk of Cancer Empowered
Health Access California
Indivisible CA: Statestrong
National Association of Pediatric Nurse Practitioners
National Health Law Program
RESOLVE: The National Infertility Association
Western Center on Law & Poverty, Inc.

Oppose: The Center for Bioethics and Culture

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