Date of Hearing: July 15, 2025

ASSEMBLY COMMITTEE ON HEALTH

Mia Bonta, Chair

SB 62 (Menjivar) – As Amended July 1, 2025

SENATE VOTE: 39-0

SUBJECT: Health care coverage: essential health benefits.

SUMMARY: Requires, beginning January 1, 2027, if the United States Department of Health and Human Services (HHS) approves a new essential health benefits (EHBs) benchmark plan for the State of California (state) pursuant to the submission by the state, the existing EHB benchmark plan for health care service plans (health plans) to additionally include coverage for hearing aids, durable medical equipment (DME), and infertility benefits, as specified. Specifically, **this bill**:

1) Requires, beginning January 1, 2027, if HHS approves a new EHB benchmark plan for the state pursuant to submissions to HHS made by the state in 2025 for this purpose, the existing EHB benchmark plan (the Kaiser Foundation Health Plan Small Group HMO 30 plan) to additionally include the following benefits:

    a) Services to evaluate, diagnose, and treat infertility that include all of the following:

        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;

        xi) Surrogacy coverage for the services described above; and,

        xii) Health testing of the surrogate for each attempted round of covered services.

    b) All of the following DME:

i) Mobility devices, including, but not limited to, walkers and manual and power wheelchairs and scooters;

ii) Augmented communications devices, including, but not limited to, speech generating devices, communications boards, and computer applications;

iii) Continuous positive airway pressure machines;

iv) Portable oxygen; and,

v) Hospital beds.

c) An annual hearing exam and one hearing aid per ear every three years.

2) Permits the Department of Managed Health Care (DMHC), on or before January 1, 2027, to issue guidance to health plans regarding compliance with this bill, exempts this guidance from the rulemaking provisions of the Administrative Procedure Act (APA), permits DMHC to promulgate regulations subject to the APA, and prohibits this provision of this bill from being construed to impair or restrict the DMHC's rulemaking authority pursuant to another provision of this code or the APA.

3) Requires the DMHC to consult with the California Department of Insurance (CDI) in issuing guidance and in adopting regulations for the purpose of implementing this section.

EXISTING LAW:

1) Establishes DMHC to regulate health plans under the Knox-Keene Health Care Service Plan Act of 1975 and CDI to regulate health insurers. [Health and Safety Code (HSC) § 1340, *et seq*., and Insurance Code (INS) § 106, *et seq*.]

2) Establishes California's EHB benchmark under the federal Patient Protection and Affordable Care Act (ACA) as the Kaiser Foundation Health Plan Small Group HMO 30 plan. Establishes existing California health insurance mandates and the 10 ACA mandated benefits. [HSC § 1367.005 and INS § 10112.27]

3) Specifies EHBs in the following 10 categories: ambulatory patient services; emergency services; hospitalization; maternity and newborn care; mental health and substance use disorder services; prescription drugs; rehabilitative and habilitative services and devices; laboratory services; preventive and wellness services and chronic disease management; and, pediatric services, including oral and vision care. [HSC § 1367.005 and INS § 10112.27]

4) Defines "basic health care services" as all of the following:

a) Physician services, including consultation and referral;

b) Hospital inpatient services and ambulatory care services;

c) Diagnostic laboratory and therapeutic radiologic services;

d) Home health services;

e) Preventive health services;

f) Emergency health care services, including ambulance and ambulance transport services and out-of-area coverage. Basic health care services includes ambulance and ambulance transport services provided through the 911 emergency response system; and,

g) Hospice care. [HSC § 1345]

FISCAL EFFECT: According to the Senate Appropriations Committee, DMHC anticipates absorbable costs for state administration. Unknown costs for CDI for state administration (Insurance Fund).

COMMENTS:

1) **PURPOSE OF THIS BILL**. According to the author, gaps have been identified in coverage in California's EHB benchmark plan for health insurance under the Affordable Care Act. For example, the existing benchmark excludes coverage for hearing aids, some medically necessary durable medical equipment and infertility treatment. California's benchmark plan can be updated to expand benefits to cover these needed services and treatment. After a stakeholder process held by the DMHC, which included an actuarial report comparing California's EHB to the most generous typical employer health plan, California decided to keep the current benchmark plan but add coverage for hearing aids, additional durable medical equipment, and infertility diagnosis and treatment. This bill is needed to update California's EHB law to incorporate these changes.

2) **BACKGROUND**.

   a) **ACA & EHBs**. Signed into law by President Obama in 2010, the ACA marked a significant overhaul of the U.S. health care system. According to the Kaiser Family Foundation, prior to the passage of the ACA high rates of uninsurance were prevalent due to unaffordability and exclusions based on preexisting health conditions. Additionally, insured people faced extremely high out-of-pocket costs and coverage limits. With the goal of addressing these issues, the ACA built upon the existing health insurance system and made significant changes to Medicare, Medicaid, and the employer-sponsored plan system. This impacted all aspects of the health system, from insurers, providers, state governments, employers, taxpayers, and consumers.

   The ACA established EHBs, which are ten categories of services that plans are required to cover: (1) ambulatory patient services (outpatient care); (2) emergency services; (3) hospitalization; (4) maternity and newborn care; (5) mental health and substance use disorder services, including behavioral health treatment; (6) prescription drugs; (7) rehabilitative and habilitative services and devices; (8) laboratory services; (9) preventive and wellness services and chronic disease management; and, (10) pediatric services, including dental and vision care. Individual and small group health plans have to cover the ten EHBs, and while large group and self-insured plans are not required to cover EHBs**,** if they do cover any EHB category, they must comply with the ACA's ban on annual and lifetime dollar limits for EHBs.

   The ACA helps consumers shop for and compare health insurance options in the individual and small group markets by promoting consistency across plans, protecting

consumers by ensuring that plans cover a core package of items that are equal in scope to benefits offered by a typical employer plan, and limit out of pocket expenses. Federal rules outline health insurance standards related to the coverage of EHBs and the determination of actuarial value (AV) – (which represents the share of health care expenses the plan covers for a typical group of enrollees), while providing significant flexibility to states to shape how EHBs are defined. Taken together, EHBs and AV significantly increase consumers' ability to compare and make an informed choice about health plans.

b) California's initial EHB benchmark plan selection process. HHS defines EHBs based on state-specific EHB benchmark plans and gives each state the authority to choose its "benchmark" plan. California chose the Kaiser Foundation Health Plan Small Group HMO 30 plan in 2012, and last reviewed it in 2015.

c) Updating EHBs. HHS issued final rules in 2018 and 2019, which provided 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: (1) select an EHB benchmark plan used by another state for the 2017 plan year; (2) 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, (3) 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" required that EHBs not exceed the generosity of the most generous among the set of ten previous 2017 benchmark comparison plan options. According to the Centers for Medicare & Medicaid Services (CMS) website, for plan years between 2020 and 2025, nine states updated their EHB benchmark plans.

In April of 2024, new rules were finalized for EHB benchmark updates through the HHS Notice of Benefit and Payment Parameters for 2025. For plan years beginning on or after January 1, 2026, the federal government 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, states are allowed to consolidate the options for changing EHB benchmark plans, meaning a state may select a set of benefits that would become the state's EHB benchmark plan. Second, the generosity standard was removed and a revised typicality standard was introduced. Under this typicality standard a state's new EHB benchmark plan must demonstrate that it 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, 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 was removed.

d) California's 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 consultants who explained the federal rules

and recently approved and proposed EHB benchmark changes from other states. A second stakeholder meeting was held on January 28, 2025. At this meeting, the Wakely Consulting Group (Wakely) presented an actuarial analysis that identified the benefit allowance and potential options and prices for a 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) that range 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 meant choices had to be made to narrow the set of proposed benefits to be covered. A joint legislative hearing was held on February 11, 2025 to provide the Assembly and Senate Health Committees with information about the analysis and options that may be considered for updating the EHB benchmark plan.

On March 28, 2025, DMHC announced California's intent to submit a proposal to the federal government to add three new benefits to the state's EHB benchmark plan: hearing aids, durable medical equipment, and infertility treatment. DMHC submitted an application to CMS on Monday, May 5, 2025, on behalf of the state to update California's benchmark plan. If the proposed EHB benchmark is approved by CMS, legislation to codify the new benchmark plan will be necessary for it to go into effect for the January 1, 2027 plan year. This bill and AB 224 (Bonta) were introduced to codify any benchmark changes that may come out of this process. Recent amendments to these plans have SB 62 implementing the health plan provisions in the Health and Safety Code, and AB 224 amending the health insurance provisions in the Insurance Code.

e) Cost impacts to patients. It should be noted that premiums may increase as a result of setting a new benchmark plan. Individuals who are eligible for premium subsidies may be shielded from premium increases, but those not eligible for subsidies will feel the full impact of any premium increase. Covered California announced individual insurance market rates for the 2025 coverage year indicating the preliminary statewide weighted average rate change for the 2025 coverage year is 7.9%. Northern and Central valley regions are seeing higher premium increases and the Monterey, San Benito and Santa Cruz county region are seeing the highest average increase at 15.7%. The region with the lowest average increase is San Bernardino and Riverside with 5.3%. San Francisco and Bay Area regions, Los Angeles and San Diego are seeing average premium increases in the 7 to 8% range. Orange County is seeing an average premium increase of 9.6%.

f) ACA subsidies. The ACA also provides federal subsidies for those who qualify, referred to as Advanced Premium Tax Credits (APTCs), to help offset the costs to purchase individual market health insurance purchased through federal or state marketplaces (or health benefit exchanges). According to Covered California, the state's health benefit exchange, in June of 2024, approximately 1.5 million Californians received an average of $519 per member per month in APTCs (this translates to $9.7 billion on an annualized basis). Approximately 19% comes from the federal Inflation Reduction Act enhanced subsidies, which are set to expire at the end of 2025. For 2024, these enhanced APTCs were roughly $1.8 billion.

g) **Defrayal of mandate costs**. Under the ACA, if states require plans to cover services beyond those defined as EHBs in law, states must pay the costs of those benefits, either by paying the enrollee directly or by paying the qualified health plan (offered through Covered California). States adopting a new benchmark plan or revising the existing plan will not result in triggering defrayal.

3) **SUPPORT**. The Western Center on Law and Poverty (WCLP) supports this bill, stating that the current benchmark creates a significant gap in services due to its lack of coverage for DME. WCLP continues that as a result, many Californians do not have access to the wheelchairs, hearing aids, oxygen equipment or other DME that they need because private health plans in California's individual and small group markets regularly exclude or limit coverage of this equipment. WCLP notes that 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.

   SEIU California supports this bill, citing the inclusion of infertility services as an EHB. SEIU California argues that this bill moves our health care delivery system forward for those seeking to start or grow their family. SEIU California notes that with 7 out of 10 of their members identifying as women and 60% as women of color, this bill is personal for many. SEIU California continues, that for their members, like the physician residents and interns in SEIU Committee of Interns and Residents, who may train and study for decades before being financially stable to consider a family, this bill is particularly important. SEIU states that with 1 in 4 physicians with wombs experiencing infertility, this allows them the reassurance that they can fulfill their professional vision while honoring their personal family vision, too.

4) **OPPOSITION**. The Center for Bioethics and Culture Network (CBCN), writes in opposition that, while supporting individuals facing infertility is a worthy goal, this bill conflates elective reproductive technologies with medically necessary care, and in doing so, raises serious ethical, medical, and financial concerns, particularly because restorative reproductive medicine has similar outcomes with far less health risks, financial burden, or ethical implications. CBCN argues this bill goes well beyond the current requirements of a recently enacted law which mandates coverage of up to three in vitro fertilization (IVF) cycles and unlimited embryo transfers for large group plans. CBCN argues these provisions lack fiscal transparency, with no commitment from the state to subsidize the increased cost, and this creates the real risk of premium hikes, particularly burdening small businesses and individuals. CBCN also argues mandating coverage for procedures that expose women—often financially vulnerable—to such risks raises profound bioethical concerns. Finally, CBCN argues this bill fails to incorporate any meaningful bioethical review or public oversight mechanisms, and this lack of accountability is unacceptable for legislation with such far-reaching implications. CBCN concludes that this bill should include safeguards to limit coverage to medically necessary interventions, to create an independent multidisciplinary board to review reproductive health policy changes, to study the short- and long-term health outcomes of surrogate mothers, egg donors, and children conceived via assisted reproductive technology (ART), and to ensure that premium and actuarial projections account for the significant costs of repeat IVF, NICU care, and high-risk pregnancies.

5) **CONCERNS**. The California Association of Health Plans (CAHP) and Association of California Life and Health Insurance Companies (ACLHIC) understand the intent to enhance

healthcare coverage for Californians, but believe that proceeding with this bill now is premature and warrants a delay to allow for a more thorough review and consultation on several critical issues. CAHP and ACLHIC's primary concern lies with the potential premium impact and affordability for consumers. CAHP and ACLHIC also state that the federal uncertainty surrounding the future of healthcare funding also necessitates a delay in considering this legislation.

6) RELATED LEGISLATION.

a) AB 224 (Bonta) is substantially similar to this bill except it amends the Insurance Code while this bill amends the Knox-Keene Act provisions in the Health and Safety Code. AB 224 is pending in the Senate Health Committee.

7) PREVIOUS LEGISLATION.

a) AB 2914 (Bonta) of 2024 expressed the intent of the Legislature to review California's EHB benchmark plan and would have established a new EHB plan for the 2027 plan year. AB 2914 was moved to the inactive file on the Senate floor.

b) AB 2753 (Ortega) of 2024 would have included as coverage of existing EHB rehabilitative and habilitative services and devices, DME services, and repairs, if appropriately prescribed or ordered by a health professional, and prohibits a health care service plan (health plan) or health insurance policy from subjecting coverage of DME and services to financial or treatment limitations. AB 2753 defined DME to mean devices that are designed for repeated use, and that are used for the treatment or monitoring of a medical condition or injury in order to help a person to partially or fully acquire, improve, keep, or learn, or minimize the loss of, skills and functioning of daily living. AB 2753 was held on the Assembly Appropriations suspense file.

c) SB 729 (Menjivar) Chapter 930, Statutes of 2024, requires a health plan contract or policy of disability insurance sold in the large group market (employers with more than 100 covered individuals) to provide coverage for the diagnosis and treatment of infertility and fertility services, including services of a maximum of three completed oocyte retrievals with unlimited embryo transfers in accordance with the guidelines of the American Society for Reproductive Medicine (ASRM) using single embryo transfer when recommended and medically appropriate. A signing message from the Governor stated:

> I am signing Senate Bill 729, which will require a large group health plan to provide coverage for infertility and fertility services, including in vitro fertilization (IVF), with a maximum of three completed oocyte retrievals and unlimited embryo transfers, beginning July 1, 2025, and delay its implementation for CalPERS until July 1, 2027.
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> California is a reproductive freedom state. As a national leader for increasing access to reproductive health care and protecting patients and providers, including those under assault in other states, I want to be clear that the right to fertility care and IVF is protected in California. In many other states, this is not the case. I wholeheartedly agree that starting a family should be attainable for those who dream to have a child - inclusive of LGBTQ+ families. There is a

better way to strengthen IVF coverage across California's health care delivery system, and the state has already begun this work. In January of this year, we started the process of updating the state's "benchmark" plan, which will set a new standard for commercial insurance health coverage. The services under evaluation specifically include infertility treatment and IVF. The state's proposed benefit design will be released later this year and adopted by the Legislature by May 2025. I expect that IVF coverage will be included in the benchmark plan proposal adopted next spring, but may differ from the one in this bill. As a part of that process, I request that the Legislature change the effective date of this measure from July 1, 2025 to January 1, 2026, upon their return in January to allow an evaluation of the costs and benefit design in this bill within that broader context."

d) AB 116 (Committee on Budget), Chapter 21, Statutes of 2025, the health budget trailer bill, delayed the operative date of SB 729 by six months (from July 1 2025 to January 1, 2026), authorizes the DMHC and CDI to issue guidance regarding compliance with the provisions of SB 729 until January 1, 2027, and exempts that guidance from the rulemaking provisions of the Administrative Procedure Act. AB 116 also requires DMHC and CDI to consult with each other and stakeholders in issuing the guidance.

e) SB 1290 (Roth) of 2024 was substantially similar to AB 2914. SB 1290 was moved to the inactive file on the Assembly floor.

f) SB 635 (Menjivar) of 2023 would have required hearing aid coverage for enrollees or insureds under 21 years of age. Governor Newsom vetoed SB 635, stating in part, that the Department of Health Care Services has developed a comprehensive plan to increase provider participation and program enrollment for the Hearing Aid Coverage for Children Program.

g) AB 1157 (Ortega) of 2023 was substantially similar to AB 2753 (Ortega). AB 1157 was held in Senate Appropriations Committee.

REGISTERED SUPPORT / OPPOSITION:

Support

California Academy of Audiology
California Association of Medical Product Suppliers
Children Now
Children's Specialty Care Coalition
Health Access California
Indivisible Ca: StateStrong
SEIU California
Western Center on Law & Poverty, Inc.

Oppose

The Center for Bioethics and Culture

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