



**CALIFORNIA**  
HEALTH BENEFITS REVIEW PROGRAM

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## **EXECUTIVE SUMMARY**

Analysis of Assembly Bill 214,  
Health Care Coverage:  
Durable Medical Equipment

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A Report to the 2009-2010 California Legislature  
April 9, 2009

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## **EXECUTIVE SUMMARY Analysis of Assembly Bill 214, Health Care Coverage: Durable Medical Equipment**

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## EXECUTIVE SUMMARY

### **California Health Benefits Review Program Analysis of Assembly Bill 214, Health Care Coverage: Durable Medical Equipment**

Assembly Bill (AB) 214, as introduced by Assembly Member Wesley Chesbro, would require health plans and insurers to provide coverage for durable medical equipment (DME) and do so at the same levels of coverage as other health care benefits.

DME items are usually external, reusable equipment used for the treatment of a medical condition or injury or to preserve the patient's functioning. Examples include crutches, wheelchairs, home oxygen equipment, infusion pumps, and hospital beds, any of which may be needed for shorter or longer periods of time, depending on the individual's condition.

Many persons use DME in conjunction with medical care to improve their health, functioning, and quality of life. Persons may use DME on either a long-term or a temporary basis. Some persons use DME on a long-term basis to cope with or treat a physical disability or chronic illness. Others use DME temporarily while being treated for or recovering from an illness or injury, such as a strain, sprain, or a broken bone. Many of the persons with relatively high DME costs include persons in the following categories: (1) persons with conditions related to physical disabilities, such as musculoskeletal disorders; (2) persons with sequelae from traumatic injuries such as spinal cord injuries and head trauma; (3) respiratory diseases and related conditions requiring the use of home oxygen equipment; and (4) persons with diagnoses related to complications of the digestive system requiring DME for nutrition.

The California Health Benefits Review Program (CHBRP) undertook the analysis of AB 214, in response to a request from the Assembly Committee on Health on February 6, 2009, pursuant to the provisions of Senate Bill 1704 (Chapter 684, Statutes of 2006) as chaptered in Section 127600, et seq. of the California Health and Safety Code<sup>1</sup>.

#### **Specific Provisions of AB 214**

- AB 214 seeks to ensure that individuals with health insurance have DME coverage and have coverage at the same level or "at parity" with other health care benefits.
  - Department of Managed Health Care (DMHC)-regulated plans would be required to ensure that "the amount of the benefit for DME and services shall be no less than the annual and lifetime benefit maximums applicable to the basic health care services." If the plan does not have annual or lifetime maximum benefit limits for basic health care services, then the plans may not apply such limits to the DME benefit. DMHC-regulated plans are also required to ensure that "any copayment, coinsurance, deductible, and maximum out-of-pocket amount applied to the benefit for DME and services shall be no more than the most common amounts applied to the basic health care services"

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<sup>1</sup> California Health and Safety Code, Section 1345 and Section 1300.67 of the California Code of Regulations, Title 28

- California Department of Insurance (CDI)-regulated policies are required to ensure that benefit limits do not exceed the “annual and lifetime benefit maximums applicable to all benefits in the policy.” In addition, these policies would be required to provide DME with cost-sharing levels on par with those applied to the “most common amounts contained in the policy.”

Thus, any benefit limits specifically for DME would be required to be lifted and cost-sharing levels would be required to be on par with cost-sharing levels for other health care services.

- AB 214 defines “durable medical equipment” as “equipment that is used for the treatment of a medical condition or injury or to preserve the patient’s functioning and that is designed for repeated use and includes, but is not limited to, manual and motorized wheelchairs, scooters, oxygen equipment, crutches, walkers, electric beds, shower and bath seats, and mechanical patient lifts.”
- AB 214 would place these coverage and cost-sharing requirements on both the *group* and *individual* markets.
- AB 214 would not alter the plans’ and insurers’ ability to “conduct a utilization review to determine medical necessity prior to authorizing these services.” Medically necessary DME is usually considered to be equipment that treats an injury or preserves functioning. For example, equipment that would be solely used for the patient’s comfort or convenience (such as air conditioners) would not generally be considered medically necessary, but specialized wheelchair cushions to prevent pressure ulcers would be considered necessary.
- AB 214 would require that coverage for DME occur when it is “prescribed by a physician and surgeon or doctor of podiatric medicine acting within the scope of his or her license, or is ordered by a licensed health care provider acting within the scope of his or her license.” Physicians, podiatrists, and physical and occupational therapists are the providers who typically prescribe or order DME.
- AB 214 requires that plans and insurers “communicate the availability” of the DME coverage after the contract or policy is amended to become compliant with its provisions.

### **Medical Effectiveness**

- There are two major groups of persons who use DME:
  - Persons who use DME temporarily while being treated for an injury or illness or recovering from surgery.
  - Persons who use DME on a long-term basis due to a physical disability or chronic illness.
- For persons in either group, use of DME can improve health, functioning, and quality of life.
- Few studies have examined the effect of having private health insurance coverage for DME on use of DME, and the findings of these studies are inconsistent.

- No studies were found that specifically address the effects of increasing annual or lifetime limits for DME coverage on DME usage or the impact of reducing deductibles, coinsurance, or copayments for DME on such usage.
- There is some evidence from a small number of studies that utilization management reduces use of some types of DME.

### **Utilization, Cost, and Coverage Impacts**

- Total net annual expenditures are estimated to increase by \$72,991,000 annually, or 0.09%, mainly due to the administrative costs associated with the newly covered and newly enhanced DME benefits mandated by AB 214 (Table 1).
- Prior to the mandate, 99.73% of enrollees subject to the mandate have at least some coverage for DME. Postmandate, only an estimated 57,000 enrollees (0.27% of those with coverage subject to the mandate) would gain coverage for DME. The persons with no coverage are all enrolled in CDI-regulated, individual market policies, although 94% of enrollees in that market have some coverage for DME.
- Prior to the mandate, enrollees without coverage for DME incurred an estimated \$1,085,000 in out-of-pocket expenses annually. Postmandate, that \$1,085,000 in out-of-pocket expenses would be shifted to health plans and insurers. Other enrollees would also incur a reduction of \$145,731,000 in out-of-pocket expenses due to required reductions in member cost sharing and removal of benefit maximums.
- The mandate is estimated to increase premiums by about \$219.81 million. The distribution of the impact on premiums is as follows:
  - Total premiums for private employers are estimated to increase by \$146,860,000, or 0.29%.
  - Enrollee contributions toward premiums for group insurance are estimated to increase by \$38,033,000, or 0.28%.
  - Total premiums for those with individually purchased insurance are estimated to increase by \$34,914,000, or 0.59%.
  - In terms of per member per month (PMPM) costs, employer premiums for large groups are expected to increase by \$0.77 for DMHC-regulated plans and \$0.40 for CDI-regulated policies. Employer premiums for small groups are expected to increase by \$2.12 PMPM for DMHC-regulated plans and by \$0.70 PMPM for CDI-regulated policies.
- Although AB 214 would apply to the DMHC-regulated plans offered by the California Public Employees' Retirement System (CalPERS), Medi-Cal Managed Care, and Healthy Families program, these programs would not be expected to face any expenditure or premium increases because they currently provide DME benefits at parity.

- CHBRP estimates that there would be a \$28.68 per DME user per year (4.03%) increase in DME utilization and related expenses. This utilization estimate is based on the following:
  - Prior to the mandate, 99.73% of enrollees with coverage subject to the mandate have at least some coverage for DME. The remainder, an estimated 57,000 enrollees (all with coverage from CDI-regulated, individual market policies) would gain coverage for DME post mandate.
  - The potential change in benefit structure from one with an annual benefit limit to a benefit with no limit but a coinsurance rate (such as 20%) or deductible might maintain a disincentive for an enrollee to upgrade a DME device.
  - Health plans and insurers would continue to influence the choice of DME through their determination of medical necessity during the utilization review process.
- CHBRP estimates that the costs for a given DME item (or per-unit cost) would not be affected by the mandate. At present, CHBRP estimates that, for a typical insured population, DME and services have a total PMPM cost of \$3.22, including both the amounts paid by the plan and member cost sharing. However, as discussed above, although the *per-unit* costs would not change for each DME item, the *average cost per user* would be expected to increase.
- Premiums are expected to increase by 0.28% across all coverage subject to the mandate, which includes privately insured group market plans and policies, privately insured individual market plans and policies, and publicly funded plans. Increases in insurance premiums vary by market segment, ranging from 0% for market segments already compliant with the mandate, to approximately 0.091% to 0.668% for market segments that are not compliant with the mandate. Increases as measured by PMPM payments are estimated to range from approximately \$0.40 to \$2.12. The greatest impact on premiums will be in the small-group and individual DMHC-regulated markets. These premium increases will be largely offset by reductions in out-of-pocket expenditures.

## **Public Health Impacts**

- The health outcomes associated with the use of DME vary according to the type of DME that is being used. Some health outcomes include increased independence, mobility, functionality, survival, and decreased morbidity.
- AB 214 is expected to increase the scope of insurance coverage for DME for approximately 720,000 insured users of DME. A majority of these 720,000 DME users will financially benefit due to decreased copays associated with DME expenses. More than 3,100 DME users are expected to be newly covered for DME because previously DME was not included in their insurance coverage. An additional approximate 14,000 DME users are expected to financially benefit due to increasing the annual benefit limit. The increased coverage is expected to reduce the financial hardship associated with the health conditions requiring the use of DME, particularly for the approximately 3,100 DME users with new coverage and the 14,000 DME users who formerly would have exceeded the annual limits on DME coverage.

- Among the current users of DME, AB 214 is expected to result in an increased utilization because increased annual limits and coinsurance are expected to lead to some persons receiving more DME, more expensive DME items, and more-frequent replacement of existing DME items. The health benefits associated with this increased utilization are unknown.
- Utilization data suggest that AB 214 will not have a substantial impact on gender disparities. AB 214 is not expected to have an impact on racial or ethnic disparities.
- The impact of AB 214 on the economic loss associated with DME-related diseases and conditions is unknown.

**Table 1. Summary of Coverage, Utilization, and Cost Impacts of AB 214**

	<b>Before Mandate</b>	<b>After Mandate</b>	<b>Increase/Decrease</b>	<b>Change After Mandate</b>
<b>Coverage</b>				
Total population in plans subject to state regulation (a)	21,340,000	21,340,000	0	0.00%
Total population in plans subject to AB 214	21,340,000	21,340,000	0	0.00%
Percentage of insured individuals with coverage for DME				
In AB 214-compliant plans (b)	38.65%	100.00%	61.35%	158.74%
In non-AB 214-compliant plans (c)	61.08%	0.00%	-61.08%	-100.00%
Total with coverage	99.73%	100.00%	0.27%	0.27%
Percentage of insured individuals with no coverage for DME				
Total without coverage	0.27%	0.00%	-0.27%	-100.00%
Total	100.00%	100.00%	0.00%	0.00%
Number of insured individuals with coverage for DME				
In AB 214-compliant plans	8,248,000	21,340,000	13,092,000	158.74%
In non-AB 214-compliant plans	13,035,000	0	-13,035,000	-100.00%
Total with coverage	21,283,000	21,340,000	57,000	0.27%
Number of insured individuals with no coverage for DME				
Total without coverage	57,000	0	-57,000	-100.00%
Total	21,340,000	21,340,000	0	0.00%
<b>Utilization and Cost</b>				
Estimated DME users per 1,000 members per year	55	55	0	0.00%
Estimated average cost per DME user per year	\$711.45	\$740.13	\$28.68	4.03%
<b>DME Benefit Provisions</b>				
Average DME coinsurance rate	6.46%	2.87%	-3.59%	-55.63%
% of covered members subject to DME annual benefit limit	45.40%	0.00%	-45.40%	-100.00%
Average annual benefit limit in non-AB214-compliant plans	\$3,877	N/A		
% of members in non-AB 214-compliant plans with costs in excess of DME annual benefit limit	0.11%	0.00%	-0.11%	-100.00%
% of DME users in non-AB 214-compliant plans with costs in excess of DME annual benefit limit	1.94%	0.00%	-1.94%	-100.00%
Number of DME Users In non-AB 214-compliant plans with costs in excess of DME annual benefit limit	13,880	0	-13,880	-100.00%

**Table 1. Summary of Coverage, Utilization, and Cost Impacts of AB 214 (Cont'd)**

	<b>Before Mandate</b>	<b>After Mandate</b>	<b>Increase/ Decrease</b>	<b>Change After Mandate</b>
<b>Expenditures</b>				
Premium expenditures by private employers for group insurance	\$50,546,207,000	\$50,693,067,000	\$146,860,000	0.29%
Premium expenditures for individually purchased insurance	\$5,944,229,000	\$5,979,143,000	\$34,914,000	0.59%
Premium expenditures by individuals with group insurance, CalPERS, Healthy Families, AIM or MRMIP (d)	\$13,475,994,000	\$13,514,027,000	\$38,033,000	0.28%
CalPERS employer expenditures (e)	\$3,161,160,000	\$3,161,160,000	\$0	0.00%
Medi-Cal state expenditures	\$4,112,865,000	\$4,112,865,000	\$0	0.00%
Healthy Families state expenditures	\$643,247,000	\$643,247,000	\$0	0.00%
Individual out-of-pocket expenditures for covered benefits (deductibles, copayments, etc.)	\$6,384,077,000	\$6,238,346,000	-\$145,731,000	-2.28%
Out-of-pocket expenditures for noncovered benefits	\$1,085,000	\$0	-\$1,085,000	-100.00%
<b>Total annual expenditures</b>	<b>\$84,268,864,000</b>	<b>\$84,341,855,000</b>	<b>\$72,991,000</b>	<b>0.09%</b>

Source: California Health Benefits Review Program, 2009.

Notes: (a) This population includes privately insured (group and individual) and publicly insured (e.g., CalPERS, Medi-Cal, Healthy Families, Access for Infants and Mothers [AIM], Major Risk Medical Insurance Program [MRMIP]) individuals enrolled in health insurance products regulated by DMHC or CDI. This population includes enrollees aged 0-64 years and enrollees 65 years or older covered by employment sponsored insurance.

(b) AB 214 compliant plans have *no* annual benefit limits and *no* different cost sharing for DME benefits than for other health care benefits.

(c) AB 214 noncompliant plans do have differential benefit limits and/or do have different cost sharing for DME benefits than for other health care benefits.

(d) Premium expenditures by individuals include employee contributions to employer-sponsored health insurance and member contributions to public insurance.

(e) Of the CalPERS employer expenditures, about 59% would be state expenditures for CalPERS members who are state employees, however CHBRP estimates no impact of the mandate on CalPERS employer expenditures.

Key: CalPERS = California Public Employees' Retirement System.

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CHBRP gratefully acknowledges all of these contributions but assumes full responsibility for all of the report and its contents. Please direct any questions concerning this report to:

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A group of faculty and staff undertakes most of the analysis that informs reports by the California Health Benefits Review Program (CHBRP). The CHBRP **Faculty Task Force** comprises rotating representatives from six University of California (UC) campuses and three private universities in California. In addition to these representatives, there are other ongoing contributors to CHBRP from UC. This larger group provides advice to the CHBRP staff on the overall administration of the program and conducts much of the analysis. The CHBRP **staff** coordinates the efforts of the Faculty Task Force, works with Task Force members in preparing parts of the analysis, and coordinates all external communications, including those with the California Legislature. The level of involvement of members of the CHBRP Faculty Task Force and staff varies on each report, with individual participants more closely involved in the preparation of some reports and less involved in others.

As required by the CHBRP authorizing legislation, UC contracts with a certified actuary, Milliman Inc. (Milliman), to assist in assessing the financial impact of each benefit mandate bill. Milliman also helped with the initial development of CHBRP methods for assessing that impact.

The **National Advisory Council** provides expert reviews of draft analyses and offers general guidance on the program to CHBRP staff and the Faculty Task Force. CHBRP is grateful for the valuable assistance and thoughtful critiques provided by the members of the National Advisory Council. However, the Council does not necessarily approve or disapprove of or endorse this report. CHBRP assumes full responsibility for the report and the accuracy of its contents.

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The California Health Benefits Review Program is administered by the Division of Health Sciences and Services at the University of California Office of the President, John D. Stobo, M.D., Senior Vice President – Health Sciences and Services.