



CALIFORNIA
HEALTH BENEFITS REVIEW PROGRAM

**EXECUTIVE SUMMARY:
Analysis of Senate Bill 1198
Health Care Coverage:
Durable Medical Equipment**

A Report to the 2007–2008 California Legislature
April 3, 2008

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**California Health Benefits Review Program
1111 Franklin Street, 11th Floor
Oakland, CA 94607
Tel: 510-287-3876
Fax: 510-987-9715
www.chbrp.org**

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EXECUTIVE SUMMARY

California Health Benefits Review Program Analysis of Senate Bill 1198

Senate Bill (SB) 1198, as introduced by Senator Sheila Kuehl, would require health plans and insurers to offer coverage for durable medical equipment (DME) in the group market and do so at the same levels of coverage as other health care benefits. SB 1198 requires health plans and insurers to *offer* DME coverage to all group purchasers as opposed to requiring that they *cover* DME benefits. This means that plans and insurer may structure the DME benefit so that groups have the *option* to purchase the benefit.

DME items are usually external, reusable equipment that are used for the treatment of a medical condition or injury or to preserve the patient's functioning. Examples include walkers, wheelchairs, home oxygen equipment, and hospital beds.

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.

The California Health Benefits Review Program (CHBRP) undertook the analysis of SB 1198, in response to a request from the Senate Committee on Health on February 1, 2008, 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 Code¹.

Specific Provisions of SB 1198

- SB 1198 seeks to ensure that those members in the group market who have DME coverage, would have coverage at the same levels 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 they may not apply 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”
 - 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

¹ California Health and Safety Code, Section 1345 and Section 1300.67 of the California Code of Regulations, Title 28

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.

- SB 1198 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.”
- SB 1198 would place these coverage and cost-sharing requirements only in the *group* market. Therefore, no *individual* DMHC- and CDI-regulated policies would need to make changes to their DME benefit.
- Many of the individuals with high utilization levels of DME relevant to SB 1198 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.
- SB 1198 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 medical necessary, but specialized wheelchair cushions to prevent pressure ulcers would be considered necessary.
- SB 1198 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.
- SB 1198 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 both groups, 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 of the impact of increasing annual or lifetime limits for DME coverage on use of DME were identified, nor were any studies of the effects of reducing deductibles, coinsurance, or copayments for DME found.

Utilization, Cost, and Coverage Impacts

- Total net annual expenditures are estimated to increase by \$42,958,000 annually or 0.0542% mainly due to the administrative costs associated with the implementation of SB 1198, plus an assumed increase in DME utilization due to the reduction in the amounts enrollees must pay for DME through cost sharing.
- Prior to the mandate, *all* enrollees are estimated to have at least some coverage for DME. Postmandate, enrollees would incur a reduction of \$109,178,000 in copayments, due to required reductions in member cost sharing and removal of benefit maximums.
- The mandate is estimated to increase premiums by about \$152,136,000. The distribution of the impact on premiums is as follows:
 - Premiums for private employers are estimated to increase by \$119,630,000, or 0.254%.
 - Enrollee contributions toward premiums for group insurance are estimated to increase by \$32,506,000, or 0.254%.
 - In terms of per member per month (PMPM) costs, the total premiums for large groups are expected to increase by \$0.72 for DMHC-regulated plans and \$0.36 for CDI-regulated plans. Employer premiums for small groups are expected to increase by \$1.20 PMPM for DMHC-regulated plans and by \$0.20 PMPM for CDI-regulated plans.
- Although SB 1198 would apply to 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 likely be no increase in the number of users. Instead, there would be a slight increase in the units of DME or utilization of more-expensive DME among existing DME users in response to reduced cost sharing and lifting of annual and lifetime expenditure limits. The increase in utilization and related expenses are minimal (\$25.58 per DME user per year or 4.1%) because:
 - SB 1198 would continue to allow cost sharing such as deductibles and copayments as long as those are on par with other health care benefits.

- Health plans and insurers still influence the choice of DME through their determination of medical necessity during the utilization review process.
- The number of enrollees who are covered for DME benefits is expected to remain the same after enactment of SB 1198.
 - For the large-group market, plans and insurers would likely continue offering the DME benefits under a “base” (or standard) benefit package. Therefore, CHBRP estimates that all large-group members would continue to have DME coverage postmandate.
 - For the small-group market, it is likely that plans and insurers would offer the DME benefit under a rider. Because the cost of purchasing a DME rider would result in a premium increase of less than 1%, CHBRP estimates small employers would not be likely to forgo purchasing the rider. Therefore, CHBRP estimates that all small-group members would continue to have DME coverage postmandate.
- 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 \$2.56, 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 0.206%. Increases in insurance premiums vary by market segment, ranging from approximately 0.057% to 0.354%. Increases as measured by PMPM payments are estimated to range from approximately \$0.20 to \$1.20. The greatest impact on premiums will be in the small-group DMHC-regulated market. 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, and functionality, increased survival, and decreased morbidity.
- SB 1198 is not expected to increase the number of insured persons using DME. SB 1198, however, is expected to decrease out-of-pocket spending for approximately 11,000 enrollees using DME in excess of their annual benefit limit and therefore may result in reducing the financial hardship associated with their condition. Among the current users of DME, SB 1198 is also expected to result in an increased utilization. The health benefits associated with this increased utilization are unknown.
- Data on health expenditures indicate higher out-of-pocket DME costs among females. Therefore, it is possible that SB 1198 will benefit more females than males.
- SB 1198 is not expected to have an impact on racial disparities.
- The impact of SB 1198 on the economic loss associated with DME-related diseases and conditions is unknown.

Table 1. Summary of Coverage, Utilization, and Cost Impacts of SB 1198

	Before Mandate	After Mandate	Increase/ Decrease	Change After Mandate
Coverage				
Percentage of insured individuals with coverage for DME in base plan only				
In SB 1198–compliant plans	18.2%	43.5%	25.3%	138.5%
In SB 1198–non-compliant plans	34.1%	0.0%	–34.1%	–100.0%
Total	52.3%	43.5%	–8.8%	–16.8%
Percentage of insured individuals with coverage for DME in base plan/rider combinations				
In SB 1198–compliant plans ^a	21.9%	56.5%	34.6%	157.9%
In SB 1198–non-compliant plans ^b	25.8%	0.0%	–25.8%	–100.0%
Total	47.7%	56.5%	8.8%	18.4%
Percentage of insured individuals with no coverage for DME	0.0%	0.0%	0.0%	N/A
Percentage of insured individual with coverage for DME	100.0%	100.0%	0.0%	0.0%
Number of insured individuals with coverage for DME in base plan only				
In SB 1198–compliant plans ^a	3,074,379	7,333,883	4,259,504	138.5%
In SB 1198–non-compliant plans ^b	5,743,485	—	–5,743,485	–100.0%
Total	8,817,864	7,333,883	–1,483,980	–16.8%
Number of insured individuals with coverage for DME in base plan/rider combinations ^c				
In SB 1198–compliant plans ^a	3,694,322	9,528,117	5,833,794	157.9%
In–SB 1198–non-compliant plans ^b	4,349,814	—	–4,349,814	–100.0%
Total	8,044,136	9,528,117	1,483,980	18.4%
Number of insured individuals with no coverage for DME	—	—	—	N/A
Number of insured individual with coverage for DME	16,862,000	16,862,000	0	0.0%
Utilization and cost				
Estimated DME users per 1,000 members per year	50	50	0	0.0%
Estimated average cost per DME user per year	\$623.92	\$649.51	\$25.58	4.1%

Table 1. Summary of Coverage, Utilization, and Cost Impacts of SB 1198 (cont.)

	Before Mandate	After Mandate	Increase/ Decrease	Change After Mandate
DME Benefit Provisions				
Average DME coinsurance rate	14.9%	1.8%	-13.1%	-87.9%
Percentage of covered members subject to DME annual benefit limit	59.9%	0.0%	-59.9%	-100.0%
Average DME annual benefit limit, for plans with limits	\$3,984	N/A		
Percentage of members with costs in excess of DME annual benefit limit	0.1%	0.0%	-0.1%	-100.0%
Percentage of DME Users with costs in excess of DME annual benefit limit	1.3%	0.0%	-1.3%	-100.0%
Number of DME users with costs in excess of DME annual benefit limit	11,060	—	-11,060	-100.0%
Expenditures				
Premium expenditures by private employers for group insurance	\$47,088,966,000	\$47,208,596,000	\$119,630,000	0.2541%
Premium expenditures for individually purchased insurance	\$6,158,288,000	\$6,158,288,000	\$0	0.0000%
Premium expenditures by individuals with group insurance, CalPERS, Healthy Families, AIM, or MRMIP	\$12,819,308,000	\$12,851,814,000	\$32,506,000	0.2536%
CalPERS employer expenditures	\$2,942,984,000	\$2,942,984,000	\$0	0.0000%
Medi-Cal state expenditures ^d	\$4,044,192,000	\$4,044,192,000	\$0	0.0000%
Healthy Families state expenditures	\$644,074,000	\$644,074,000	\$0	0.0000%
Individual out-of-pocket expenditures (deductibles, copayments, etc.)	\$5,602,060,000	\$5,492,882,000	-\$109,178,000	-1.9489%
Out-of-pocket expenditures for noncovered services	\$0	\$0	\$0	0.000%
Total annual expenditures	\$79,299,872,000	\$79,342,830,000	\$42,958,000	0.0542%

Source: California Health Benefits Review Program, 2008.

Notes: The population includes employees and dependents covered by employer-sponsored insurance (including CalPERS). All population figures include enrollees aged 0–64 years and enrollees 65 years or older covered by employment-sponsored insurance. Premium expenditures by individuals include employee contributions to employer-sponsored health insurance and member contributions to public health insurance.

^aSB 1198-compliant plans mean plans that currently have no annual benefit limit and have cost-sharing levels averaging of 1.8% across Department of Managed Health Care (DMHC)-regulated and California Department of Insurance (CDI)-regulated plans.

^bSB 1198-non-compliant plans means those plans that would currently have differential benefit limits and/or cost sharing for the DME benefit compared with other health care benefits.

^cWhen DME are partially covered in the base plan, but augmented in a rider.

^dMedi-Cal state expenditures for members under 65 years of age include expenditures for the Risk Medical Insurance Program (MRMIP) and Access for Infants and Mothers (AIM) program.

Key: AIM=Access for Infants and Mothers; CalPERS=California Public Employees' Retirement System; DME=durable medical equipment; MRMIP=Major Risk Medical Insurance Program.

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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:

California Health Benefits Review Program
1111 Franklin Street, 11th Floor
Oakland, CA 94607
Tel: 510-287-3876
Fax: 510-987-9715
www.chbrp.org

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Susan Philip, MPP
Director

CALIFORNIA HEALTH BENEFITS REVIEW PROGRAM COMMITTEES AND STAFF

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.

Faculty Task Force

Helen Halpin, ScM, PhD, *Vice Chair for Public Health Impacts*, University of California, Berkeley
Gerald Kominski, PhD, *Vice Chair for Financial Impacts*, University of California, Los Angeles
Ed Yelin, PhD, *Vice Chair for Medical Effectiveness*, University of California, San Francisco
Wayne S. Dysinger, MD, MPH, Loma Linda University Medical Center
Susan Ettner, PhD, University of California, Los Angeles
Theodore Ganiats, MD, University of California, San Diego
Sheldon Greenfield, MD, University of California, Irvine
Kathleen Johnson, PharmD, MPH, PhD, University of Southern California
Richard Kravitz, MD, University of California, Davis
Thomas MaCurdy, PhD, Stanford University

Other Contributors

Wade Aubry, MD, University of California, San Francisco
Nicole Bellows, MHSA, PhD, University of California, Berkeley
Meghan Cameron, MPH, University of California, Los Angeles
Janet Coffman, MPP, PhD, University of California, San Francisco
Mi-Kyung Hong, MPH, University of California, San Francisco
Harold Luft, PhD, University of California, San Francisco
Stephen McCurdy, MD, MPH, University of California, Davis
Sara McMenamain, PhD, University of California, Berkeley
Ying-Ying Meng, DrPH, University of California, Los Angeles
Nadereh Pourat, PhD, University of California, Los Angeles
Dominique Ritley, MPH, University of California, Davis

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Lauren LeRoy, PhD, President and CEO, Grantmakers In Health, Washington, DC, *Chair*

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Troyen A. Brennan, MD, MPH, Senior Vice President and Chief Medical Officer, Aetna Inc, Farmington, CT

Deborah Chollet, PhD, Senior Fellow, Mathematica Policy Research, Washington, DC

Michael Connelly, JD, President and CEO, Catholic Healthcare Partners, Cincinnati, OH

Maureen Cotter, ASA, Founder and Owner, Maureen Cotter & Associates, Inc., Dearborn, MI

Susan Dentzer, Health Correspondent, *News Hour with Jim Lehrer*, PBS, Alexandria, Virginia,

Joseph Ditre, JD, Executive Director, Consumers for Affordable Health Care, Augusta, ME

Allen D. Feezor, Chief Planning Officer, University Health System of Eastern Carolina, Greenville, NC

Charles “Chip” Kahn, MPH, President and CEO, Federation of American Hospitals, Washington, DC

Trudy Lieberman, Director, Health and Medicine Reporting Program, Graduate School of Journalism, City University of New York, New York City, NY

Jim Marzilli, State Senator, State House, Boston, MA

Marilyn Moon, PhD, Vice President and Director, Health Program, American Institutes for Research, Silver Spring, MD

Michael Pollard, JD, MPH, Consultant, Federal Policy and Regulation, Medco Health Solutions, Washington, DC

Karen Pollitz, MPP, Project Director, Georgetown University Health Policy Institute, Washington, DC

Christopher Queram, President and CEO, Wisconsin Collaborative for Healthcare Quality, Madison, WI

Richard Roberts, MD, JD, Professor of Family Medicine, University of Wisconsin-Madison, Madison, WI

Frank Samuel, LLB, Former Science and Technology Advisor, State of Ohio, Columbus, OH

Patricia Smith, President and CEO, Alliance of Community Health Plans, Washington, DC

Roberto Tapia-Conyer, MD, MPH, MSc, Senior Professor, Cerrada Presa Escolata, Colonia San Jerónimo Lidice, Delegación Magdalena Conteras, Mexico City, México

Prentiss Taylor, MD, Former Illinois Market Medical Director, United Healthcare, Chicago, IL

Judith Wagner, PhD, Director and Consultant, Technology and Research Associates, Bethesda, MD

CHBRP Staff

Susan Philip, MPP, Director

John Lewis, MPA, Principal Analyst

Cynthia Robinson, MPP, Principal Analyst

Jackie Shelton, Program Assistant

California Health Benefits Review Program

1111 Franklin Street, 11th Floor

Oakland, CA 94607

Tel: 510-287-3876 Fax: 510-987-9715

info@chbrp.org www.chbrp.org

The California Health Benefits Review Program is administered by the Division of Health Affairs at the University of California Office of the President, Wyatt R. Hume, DDS, PhD, Provost and Executive Vice President - Academic and Health Affairs