



Abbreviated Analysis

California Assembly Bill 1157: Rehabilitative and Habilitative Services: Durable Medical Equipment and Services

Report to the 2023–2024
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SUMMARY

The California Assembly Committee on Health requested that the California Health Benefits Review Program (CHBRP)¹ conduct an evidence-based assessment of California Assembly Bill (AB) 1157.

AB 1157 would require coverage of rehabilitative and habilitative services to include durable medical equipment (DME), services, and repairs. DME prescriptions and orders would be required to include fittings, design, adjustment, programming, and other necessary services for the provision or maintenance of the devices. The bill would also prohibit coverage of DME from being subject to financial or treatment limitations, including annual caps or requirements limiting coverage of the devices to those for home use.

Under AB 1157, DME is defined as “devices, including replacement 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.”

Background

DME is not currently defined under California law. However, the Affordable Care Act requires that all state-regulated nongrandfathered health plans and policies in the individual and small-group markets — plans regulated by the Department of Managed Health Care (DMHC) and policies regulated by the California Department of Insurance (CDI) — cover all tests, treatments, and services included within the California essential health benefit (EHB) benchmark plan, which includes coverage for a limited number of DME. It should be noted that state-regulated health plans and policies may cover more than what is required within the EHB benchmark plan.

There are five major categories of DME, including personal mobility devices, bathroom safety devices, medical furniture, monitoring and therapeutic devices, and patient lifts. DME can be used for either chronic or temporary conditions. Although some DME equipment comes in a standard size, others require special modifications or customization to meet the medical needs of the user.

The process of obtaining authorization for coverage of DME varies by health plan or policy. Health plans and policies may impose terms and conditions on authorization of coverage for DME, such as limiting coverage to only a single item that meets the minimum specifications for the enrollee’s needs, limiting coverage based on the proposed location of use of the device, or

authorizing only one type of DME device to be covered within a certain timeframe. Health plans and policies also typically require a prescription, medical chart notes, and a letter of medical necessity written by a physician, occupational therapist, or physical therapist as part of the prior authorization process. The process for authorization of coverage may take several months, depending on the request.

Barriers to access to DME include challenges such as differences in commercial insurers’ coverage and a lack of transparency in guidelines; lack of understanding by health care professionals on device coverage; varying health plan and policy guidelines on patient testing, clinical policies and standards, and documentation requirements; and communication difficulties with commercial insurers.

Studies have demonstrated disparities in populations with disabilities, use of DME, and authorization of DME requests.

Relevant Populations

Per the bill language, AB 1157 would impact small-group and individual plans regulated by DMHC and policies regulated by CDI, which includes the health insurance of approximately 4.7 million enrollees (12% of all Californians). This represents approximately 21% of the 22.8 million Californians who will have state-regulated

¹ Refer to CHBRP’s full report for full citations and references.

health insurance that may be subject to any state health benefit mandate law.

Because AB 1157 specifies “group and individual” plans and policies, the health insurance of Medi-Cal beneficiaries enrolled in DMHC-regulated plans would not be subject to AB 1157 requirements.

Analytic Approach

AB 1157 does not define or delineate specific devices or equipment that would be covered under the mandate, thus CHBRP assumes these definitions are subject to interpretation by regulators, plans, and policies. For the purposes of this analysis, CHBRP assumed that at baseline, some DMHC-regulated health plans and CDI-regulated policies cover only the minimum requirements for DME — per the state’s essential health benefits (EHB) benchmark plan — and that postmandate, coverage would shift to be similar to those health plans and policies that include coverage for a more expansive list of DME (i.e., plans and policies with the fewest coverage restrictions); cost estimates were then calculated based on those shifts in coverage. Thus, the estimates in this report are based on a modeling scenario where, while DME coverage would be expanded by the mandate, it would be principally bounded by the DME covered by health plans and policies with the fewest restrictions on coverage.

Estimates of utilization and cost are likely to be higher if DMHC and CDI interpret AB 1157 to require coverage for more DME than the plans and policies with the fewest restrictions cover and without caps on coverage, prior authorization, or other techniques that plans and policies with the most restrictions use to manage utilization and cost of DME.

Essential Health Benefits

AB 1157 would require coverage for a new state benefit mandate that may exceed the definition of EHBs in California by requiring benefit coverage for DME beyond what is present in the California EHB benchmark plan.

Benefit Coverage

At baseline, 100% of enrollees with health insurance that would be subject to AB 1157 have coverage for DME included in the EHB benchmark plan. About 55% or 2,599,294 enrollees have coverage for DME beyond the EHB benchmark plan list that could be interpreted as “compliant with AB 1157.” Postmandate, enrollees with coverage for DME fully compliant with AB 1157 would be estimated to increase by 81% as enrollees without fully compliant coverage at baseline would be expected to obtain fully compliant coverage.

Utilization

At baseline, CHBRP estimates there are 285,082 enrollees using DME with coverage and 77,811 enrollees using DME without coverage.

Postmandate, due to the implementation of AB 1157, CHBRP expects the 77,811 enrollees using DME without coverage at baseline would shift to using DME with coverage, plus an additional 5% of new users, thus totaling 81,907 new users for an increase of about 29% of enrollees using DME with coverage.

Unit Cost

The average per unit cost of DME inclusive of services and repairs was estimated to be \$121.67. CHBRP does not expect any change in the unit cost due to AB 1157 postmandate.

Expenditures

AB 1157 would increase total net annual expenditures by \$26,411,000 or 0.02% for enrollees with DMHC-regulated plans and CDI-regulated policies. This is due to a \$57,162,000 increase in total health insurance premiums paid by employers and enrollees for newly covered benefits, adjusted by an increase in enrollee expenses for covered benefits (\$11,432,000) and decrease in enrollee expenses for noncovered benefits (-\$42,184,000).

Number of Uninsured in California

The impacts of AB 1157 on expenditures would not be large enough to expect any change in the number of uninsured.

Long-Term Impacts

Qualitatively, CHBRP expects the key long-term impact of AB 1157 would be increased utilization of DME should a greater number of items be classified as DME by DMHC and CDI or interpreted by plans/policies over time; however, CHBRP is unable to assess the likelihood of this occurring.

Table 1. Impacts of AB 1157 on Benefit Coverage, Utilization, and Cost, 2024

	Baseline	Postmandate	Increase/ Decrease	Percentage Change
Benefit coverage				
Total enrollees with health insurance subject to state benefit mandates (a)	22,842,000	22,842,000	0	0%
Total enrollees with health insurance subject to AB 1157	4,714,000	4,714,000	0	0%
Number of enrollees with coverage for DME compliant with AB 1157 (b)	2,599,294	4,714,000	2,114,706	81.36%
Utilization and unit cost				
Number of enrollees using DME with coverage	285,082	366,989	81,907	28.73%
Number of enrollees using DME with no coverage	77,811	–	-77,811	-100%
Utilization of DME, services & repairs with coverage (number of units)	1,270,233	1,740,023	469,800	36.99%
Utilization of DME, services & repairs with no coverage (number of units)	346,700	–	-346,700	-100%
Average per unit cost of DME, services & repairs	\$121.67	\$121.67	0	0%
Average enrollee cost sharing for DME, services & repairs with coverage	\$24.33	\$24.33	0	0%
Average enrollee cost sharing for devices, services & repairs with no coverage	\$121.67	\$121.67	0	0%
Expenditures				
<i>Premiums</i>				
Employer-sponsored (b)	\$57,647,993,000	\$57,665,649,000	\$17,656,000	0.03%
CalPERS employer (c)	\$6,158,262,000	\$6,158,262,000	\$0	0%
Medi-Cal (excludes COHS) (d)	\$29,618,383,000	\$29,618,383,000	\$0	0%
<i>Enrollee premiums</i>				
Enrollees, individually purchased insurance	\$21,229,233,000	\$21,261,148,000	\$31,915,000	0.15%
Outside Covered California	\$4,867,955,000	\$4,874,575,000	\$6,620,000	0.14%
Through Covered California	\$16,361,278,000	\$16,386,573,000	\$25,295,000	0.15%
Enrollees, group insurance (e)	\$18,263,775,000	\$18,271,366,000	\$7,591,000	0.04%
<i>Enrollee out-of-pocket expenses</i>				
Cost sharing for covered benefits (deductibles, copays, etc.)	\$13,857,141,000	\$13,868,573,000	\$11,432,000	0.08%
Expenses for noncovered benefits (f) (g)	\$42,184,000	\$0	-\$42,184,000	-100%
Total expenditures	\$146,816,971,000	\$146,843,381,000	\$26,410,000	0.02%

Source: California Health Benefits Review Program, 2023.

Notes: (a) Enrollees in plans and policies regulated by DMHC or CDI. Includes those associated with Covered California, CalPERS, or Medi-Cal.²

(b) Plans compliant with AB 1157 DME coverage defined as those with coverage of DME beyond the minimum listed in California's EHB benchmark plan.

(c) In some cases, a union or other organization. Excludes CalPERS.

(d) Includes only CalPERS enrollees in DMHC-regulated plans. Approximately 51.1% are state retirees, state employees, or their dependents.

(e) Includes only Medi-Cal beneficiaries enrolled in DMHC-regulated plans.

(f) Enrollee premium expenditures include contributions by enrollees to employer (or union or other organization)-sponsored health insurance, health insurance purchased through Covered California, and any contributions to enrollment through Medi-Cal to a DMHC-regulated plan.

(g) Includes only expenses paid directly by enrollees (or other sources) to providers for services related to the mandated benefit that are not covered by insurance at baseline. This only includes those expenses that would be newly covered postmandate. Other components of expenditures in this table include all health care services covered by insurance.

(h) For covered benefits, such expenses would be eliminated, although enrollees with newly compliant benefit coverage might pay some expenses if benefit coverage is denied (through utilization management review).

Key: CalPERS = California Public Employees' Retirement System; CDI = California Department of Insurance; COHS = County Organized Health Systems; DME = durable medical equipment; DMHC = Department of Managed Health Care; EHB = essential health benefits.

² For more detail, see CHBRP's resource *Sources of Health Insurance in California*, available at http://chbrp.org/other_publications/index.php.

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POLICY CONTEXT

The California Assembly Committee on Health has requested that the California Health Benefits Review Program (CHBRP)³ conduct an evidence-based assessment of Assembly Bill (AB) 1157, Rehabilitative and Habilitative Services: Durable Medical Equipment and Services.

Bill-Specific Analysis of AB 1157, Durable Medical Equipment and Services

Bill Language

AB 1157 would require coverage of rehabilitative and habilitative services to include durable medical equipment (DME), services, and repairs. The bill would also prohibit coverage of DME from being subject to financial or treatment limitations, including annual caps or requirements limiting coverage of the devices to those for home use.

AB 1157 would define DME as “devices, including replacement 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.” The bill would require DME prescriptions and orders to include fittings, design, adjustment, programming, and other necessary services for the provision or maintenance of the devices.

The full text of AB 1157 can be found in Appendix A.

Relevant Populations

If enacted, the law would apply to the health insurance of enrollees in nongrandfathered individual and small-group health plans regulated by the Department of Manage Health Care (DMHC) and health policies regulated by the California Department of Insurance (CDI), which includes the health insurance of approximately 4.7 million enrollees (12% of all Californians). This represents approximately 21% of the 22.8 million Californians who will have health insurance regulated by the state that may be subject to any state health benefit mandate law, which includes health insurance regulated by DMHC and CDI.

Because AB 1157 specifies “group and individual” plans and policies, the health insurance of Medi-Cal beneficiaries enrolled in DMHC-regulated plans would not be subject to AB 1157 requirements.⁴

Analytic Approach and Key Assumptions

AB 1157 does not define or delineate specific devices or equipment that would be covered under the mandate, thus CHBRP assumes these definitions are subject to interpretation by regulators, plans, and policies. For this reason, CHBRP uses a scenario model approach in this analysis.

For the purposes of this analysis, CHBRP assumed that at baseline, some DMHC-regulated health plans and CDI-regulated policies cover only the minimum requirements for DME — per the state’s essential health benefits (EHB) benchmark plan. The EHB benchmark plan is the health plan selected as the state’s standard for coverage of certain categories of care (i.e., EHBs), as required by the Affordable Care Act.

CHBRP assumed that the DME required to be covered postmandate would reflect those of “loosely managed” health plans or policies, i.e., those, at baseline, that have the most expansive list of devices covered under the DME benefit. Thus, the estimates in this report are based on a modeling scenario

³ CHBRP’s authorizing statute is available at www.chbrp.org/about_chbrp/faqs/index.php.

⁴ Personal communication, W. White, California Department of Health Care Services, March 2020.

where, while DME coverage would be expanded by the mandate, it would be principally bounded by what is viewed as covered DME by plans and policies with the fewest restrictions on coverage. Estimates of utilization and cost are likely to be higher if DMHC and CDI interpret AB 1157 to require coverage for more DME than the plans and policies with the fewest restrictions cover and without caps on coverage, prior authorization, or other techniques that plans and policies with the most restrictions use to manage utilization and cost of DME.

CHBRP also assumed that, at baseline, loosely managed health plans/policies do not limit coverage of devices under the DME benefit to only those for home use.

CHBRP uses the following terms in this analysis:

- Tightly managed health plan/policy: DMHC-regulated health plans and CDI-regulated policies that provide coverage of devices based on the state's minimum requirements for DME (i.e., only the DME required per the state's benchmark plan for essential health benefits [EHBs]). See the California Policy Landscape section for more information.
- Loosely managed health plan/policy: DMHC-regulated health plans and CDI-regulated policies that provide more DME coverage than what is required by the state's EHB benchmark plan.

CHBRP's analysis of AB 1157 includes estimated financial impacts of the legislation and provides an overview of the current process to obtain DME, barriers to access, and disparities among different demographic groups. As DME encompasses a large array of devices and equipment, it was not feasible for CHBRP to conduct an analysis of the medical effectiveness or public health impact of all DME that would be impacted by AB 1157.

The cost analysis presented does not provide estimates of utilization or cost for specific DME items because no specific DME are defined in the bill language.

CHBRP made the following assumptions:

- There would be no change to EHB-specific DME under California's benchmark plan, as they are already covered under existing law.'
- Items with DME-specific Healthcare Common Procedure Coding System (HCPCS) codes that are not included on the EHB benchmark plan would be impacted by the bill.

If AB 1157 is enacted, should greater or fewer items be classified as DME by DMHC and CDI, the estimated impacts of the bill would be greater or lesser, accordingly. Furthermore, as health plans and insurers have different levels of coverage for their DME benefit at baseline, the impacts of AB 1157, if enacted, would vary depending on the baseline DME coverage of each health plan or insurer.

Interaction With Existing State and Federal Requirements

Health benefit mandates may interact and align with the following state and federal mandates or provisions. With regard to AB 1157, one of the significant interactions is with EHBs. Federal law mandates that all nongrandfathered individual and small-group health insurance must cover 10 essential health benefits;⁵ coverage of the EHBs must be at least the same as the state's EHB benchmark plan. See more information in the Essential Health Benefits section.

California Policy Landscape

California law and regulations

Existing law defines “habilitative services” as 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. 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.⁵ Habilitative services must be covered under the same terms and conditions applied to rehabilitative services under a plan and policy contract. Rehabilitative services are health care services and devices that help a person keep, get back, or improve skills and functioning for daily living that have been lost or impaired because of being sick, hurt, or disabled.⁶

Per California’s EHB benchmark plan, rehabilitative and habilitative services are covered if they meet the following requirements (KHP, 2015):

- Services address a health condition;
- Services are to help enrollees partially or fully acquire or improve skills and functioning to perform activities of daily living, to the maximum extent practical; and
- Rehabilitative and habilitative services include physical and occupational therapy provided in various settings, including those for individual and group outpatient care, skilled nursing facilities, organized, multidisciplinary rehabilitation day-treatment program, and inpatient hospitals.

DME is not currently defined under the Knox-Keene Act or Insurance Code. Existing law requires DMHC-regulated plans and CDI-regulated policies for the individual and small-group markets to include coverage for certain DME according to its EHB benchmark plan and other state mandate. Per the EHB benchmark plan, DME covered is for home use. EHB-specific DME for home use is defined as “an item that is intended for repeated use, primarily and customarily used to serve a medical purpose, generally not useful to a person who is not ill or injured, and appropriate for use in the home.”⁷ See

⁵ HSC 1367.005; INS 10112.27.

⁶ 28 CCR § 1300.67.005(d)(12)(B);

⁷ California Code of Regulations (CCR) 28 §1300.67.05(d)(5)(A).

Table 2 for a list of EHB-specific DME covered under existing law. Except for breastfeeding supplies, all other DME is considered “supplemental” and not covered under the benchmark plan. Consequently, health plans and policies vary in their coverage of DME in excess of that specific to EHBs.

DMHC-regulated health plans may limit coverage that includes repairs or replacements of DME to the standard equipment or supplies that adequately meet the medical needs of the enrollee. DMHC-regulated plans may also decide whether to purchase equipment or rent and may select their vendor of choice. Enrollees may be required to return the equipment to their health plan or insurer or pay the fair market price of the equipment or any unused supplies when they are no longer needed.⁸

State law prohibits annual and lifetime dollar limits on EHBs in individual and group plans and policies; they are allowed for non-EHBs covered by group plans or policies.⁹

⁸ CCR 28 §1300.67.005(d)(5)(B).

⁹ Health and Safety Code (HSC) 1367.001; Insurance Code (INS) 10112.1.

Table 2. Essential Health Benefits–Specific Durable Medical Equipment Covered Under Existing California Law

EHB-Specific DME
Blood glucose monitors for diabetes blood testing and their supplies (such as blood glucose monitor test strips, lancets, and lancet devices)
Bone stimulator
Canes (standard curved handle or quad) and replacement supplies
Cervical traction (over door)
Crutches (standard or forearm) and replacement supplies
Dry pressure pad for a mattress
Enteral pump and supplies
Infusion pumps (such as insulin pumps) and supplies to operate the pump (but not including insulin or any other drugs)
IV pole
Nebulizer and supplies
Peak flow meters
Phototherapy blankets for treatment of jaundice in newborns (i.e., biliblankets)
Tracheostomy tube and supplies

Source: California Health Benefits Review Program, 2023; KHP, 2015.

Note: (a) Per CCR 28§1300.67.005(d)(5)(C)(ix), coverage must include equipment and medical supplies required for home hemodialysis and home peritoneal dialysis. Items not required to be covered include those for comfort, convenience, or luxury equipment, supplies and features, and nonmedical items such as generators or accessories to make home dialysis equipment portable for travel.

Key: DME = durable medical equipment; EHB = essential health benefits.

Similar requirements in other states

Each of the 50 states and the District of Columbia has its own benchmark plan that serves as the standard for EHBs. All states include DME on their EHB benchmark plan (CIGNA, 2022).

Minnesota, New Jersey, Oklahoma, and Virginia have introduced legislation related to DME coverage. Minnesota has a pair of bills that would modify the payment methodology for enteral nutrition and supplies, all of which are considered DME in the state, and another pair that would mandate seizure detection devices be covered as DME.¹⁰ New Jersey introduced legislation that would mandate wigs be covered as DME under certain conditions.¹¹ Oklahoma introduced a bill that would prohibit health plans and policies from refusing coverage to an enrollee who was prescribed DME by an out-of-network provider, except under certain conditions.¹² Virginia’s bill would amend the state plan for medical assistance services to include a provision for payment of medical assistance for the initial purchase or replacement of complex rehabilitative technology manual and power wheelchair bases and related accessories for patients residing in nursing homes.¹³

¹⁰ Minnesota House Bill (HB) 2750; SB 2616; HB 2077; SB 2079.

¹¹ New Jersey Assembly Bill 4964; Senate Bill (SB) 3427.

¹² Oklahoma HB 1712.

¹³ Virginia HB 1512.

Federal Policy Landscape

Federal regulation and coverage

DME is not defined under the Affordable Care Act (ACA), however it is under federal regulations for Medicare coverage. CMS defines DME¹⁴ as equipment furnished by a supplier or a home health agency that meets the following conditions:

- Can withstand repeated use.
- Is primarily and customarily used to serve a medical purpose.
- Is generally not useful to an individual in the absence of an illness or injury.
- Is appropriate for use in the home.
- Effective with respect to items classified as DME after January 1, 2012, has an expected life of at least 3 years.

Medicare Part B (which provides coverage for medical insurance) covers medically necessary DME if prescribed by a Medicare-enrolled physician, nurse practitioner, physician assistance, or clinical nurse specialist (either through a contract with Original Medicare¹⁵ or a Medicare Advantage plan) for use in a beneficiary's home. It should be noted that Medicare Advantage plans are authorized to impose additional requirements on beneficiaries prior to providing coverage for DME.

Medicare beneficiaries have the option of either buying or renting DME. If equipment is bought, it may be replaced if lost, stolen, damaged beyond repair, or used for more than the reasonable useful lifetime of the equipment. Medicare considers the reasonable useful lifetime of equipment to generally be five years from the date the item is first used (CMS, 2021).

Affordable Care Act

A number of ACA provisions have the potential to or do interact with state benefit mandates. Below is an analysis of how AB 1157 may interact with requirements of the ACA as presently exist in federal law, including the requirement for certain health insurance to cover EHBs.^{16,17}

Essential health benefits

In California, nongrandfathered¹⁸ individual and small-group health insurance is generally required to cover EHBs.¹⁹ In 2024, approximately 12.1% of all Californians will be enrolled in a plan or policy that

¹⁴ 42 Code of Federal Regulations § 414.202.

¹⁵ Medicare is divided into different parts that cover specific services. "Original Medicare" includes Part A (hospital insurance) and Part B (medical insurance). For more information, see CHBRP's explainer *California's Population Aged 65 Years and Older* at <https://www.chbrp.org/other-publications/explainers>.

¹⁶ The ACA requires nongrandfathered small-group and individual market health insurance — including but not limited to qualified health plans sold in Covered California — to cover 10 specified categories of EHBs. Policy and issue briefs on EHBs and other ACA impacts are available on the CHBRP website: www.chbrp.org/other_publications/index.php.

¹⁷ Although many provisions of the ACA have been codified in California law, the ACA was established by the federal government, and therefore, CHBRP generally discusses the ACA as a federal law.

¹⁸ A grandfathered health plan is "a group health plan that was created – or an individual health insurance policy that was purchased – on or before March 23, 2010. Plans or policies may lose their 'grandfathered' status if they make certain significant changes that reduce benefits or increase costs to consumers." Available at: www.healthcare.gov/glossary/grandfathered-health-plan.

¹⁹ For more detail, see CHBRP's issue brief *California State Benefit Mandates and the Affordable Care Act's Essential Health Benefits*, available at https://chbrp.org/other_publications/index.php.

must cover EHBs.²⁰ States may require state-regulated health insurance to offer benefits that exceed EHBs.^{21,22,23} Should California do so, the state could be required to defray the cost of additionally mandated benefits for enrollees in health plans or policies purchased through Covered California, the state’s health insurance marketplace. However, state benefit mandates specifying provider types, cost sharing, or other details of existing benefit coverage would not meet the definition of state benefit mandates that could exceed EHBs.^{24,25}

Table 3, below, describes the conditions that may trigger the requirement for the state to defray costs, and AB 1157 interaction with each condition. As outlined in the table, AB 1157 would require coverage for a new state benefit mandate that may exceed the definition of EHBs in California.²⁶ See the *Benefit Coverage, Utilization, and Cost Impacts* section for estimates on the state costs for exceeding EHBs.

Table 3. AB 1157 and Essential Health Benefits

Conditions That May Trigger State to Defray the Cost of a New Benefit Mandate	Services Mandated by AB 1157
Bill would mandate benefit coverage not included in the Kaiser Small Group HMO 30 plan, which is part of the definition of the EHB benchmark package in California (a) or required by BHCS (b).	Would require benefit coverage (for durable medical equipment) beyond what is present in Kaiser Small Group HMO 30 plan or required by BHCS.
Bill would mandate new benefit coverage (not just alter the terms/conditions of existing benefit coverage) (c).	Would require new benefit coverage (durable medical equipment outside of EHB-specific DME) for many enrollees.

Source: California Health Benefits Review Program, 2023.

Notes: (a) California selected Kaiser Small Group HMO 30 as its base EHB benchmark plan and supplemented this plan with pediatric dental and vision benefits and rehabilitative services to meet federal requirements.

(b) Basic health care services are defined by the Knox Keene Health Care Service Plan Act of 1975.

(c) Federal regulations define benefit mandates that could exceed EHBs as benefits that are specific to care, treatment, and/or services.²⁷

Key: BHCS = basic health care services; DME = durable medical equipment; EHB = essential health benefit; HMO = health maintenance organization.

²⁰ See CHBRP’s resource *Sources of Health Insurance in California for 2024* and CHBRP’s issue brief *California State Benefit Mandates and the Affordable Care Act’s Essential Health Benefits*, both available at https://chbrp.org/other_publications/index.php.

²¹ ACA Section 1311(d)(3).

²² State benefit mandates enacted on or before December 31, 2011, may be included in a state’s EHBs, according to the U.S. Department of Health and Human Services (HHS). Patient Protection and Affordable Care Act; Standards Related to Essential Health Benefits, Actuarial Value, and Accreditation. Final Rule. Federal Register, Vol. 78, No. 37. February 25, 2013. Available at: www.gpo.gov/fdsys/pkg/FR-2013-02-25/pdf/2013-04084.pdf.

²³ However, as laid out in the Final Rule on EHBs the U.S. Department of Health and Human Services (HHS) released in February 2013, state benefit mandates enacted on or before December 31, 2011, would be included in the state’s EHBs, and there would be no requirement that the state defray the costs of those state-mandated benefits. For state benefit mandates enacted after December 31, 2011, that are identified as exceeding EHBs, the state would be required to defray the cost.

²⁴ Essential Health Benefits. Final Rule. A state’s health insurance marketplace would be responsible for determining when a state benefit mandate exceeds EHBs, and qualified health plan issuers would be responsible for calculating the cost that must be defrayed. Patient Protection and Affordable Care Act; Standards Related to Essential Health Benefits, Actuarial Value, and Accreditation. Final Rule. Federal Register, Vol. 78, No. 37. February 25, 2013. Available at: www.gpo.gov/fdsys/pkg/FR-2013-02-25/pdf/2013-04084.pdf.

²⁵ Both Massachusetts and Utah currently pay defrayment costs for exceeding EHBs (Maine Bureau of Insurance, 2023).

²⁶ Communication with CDI in March 2023.

²⁷ Patient Protection and Affordable Care Act; Standards Related to Essential Health Benefits, Actuarial Value, and Accreditation. Final Rule. Federal Register, Vol. 78, No. 37. February 25, 2013. Available at: www.gpo.gov/fdsys/pkg/FR-2013-02-25/pdf/2013-04084.pdf.

Benefit and Treatment Limits

AB 1157 would prohibit coverage of DME from being subject to benefit or treatment limitations. This section provides an overview of the structures for annual and lifetime limits, and utilization management used for health insurance benefits.

Benefit Limits

For health care services that are not considered EHBs, federal law allows for health plans and policies to impose annual or lifetime limits on covered benefits. An annual limit is the maximum dollar amount that a health plan or policy will spend for a covered benefit for the year; a lifetime limit is a dollar limit during the entire time a person is enrolled in that plan or policy. AB 1157 would eliminate both these limits for all DME that met the definition under the bill.

Treatment Limitations

The term “treatment limitation” includes limits on the frequency of treatment, number of visits, days of coverage, or other similar limits on the scope or duration of treatment.²⁸ These limitations are not associated with determination of eligibility. AB 1157 would characterize coverage of DME based on the location in which it is used as a treatment limitation and prohibit such limitations.

BACKGROUND ON DURABLE MEDICAL EQUIPMENT

AB 1157 would require coverage of rehabilitative and habilitative services to include that for durable medical equipment (DME), services, and repairs. The bill would also prohibit coverage of DME from being subject to financial or treatment limitations, including annual caps or requirements limiting coverage of the devices to those for home use. This section provides an overview of DME and the general process of acquiring DME to assist a person’s medical condition.

What Is Durable Medical Equipment?

In general, there are five major categories of DME:

- Personal mobility devices (e.g., walkers, crutches, canes, wheelchairs)
- Bathroom safety devices (e.g., commode chairs)
- Medical furniture (e.g., mattress pads, hospital bed)
- Monitoring and therapeutic devices (e.g., continuous positive airway pressure [CPAP] devices, infusion pumps, traction equipment)
- Patient lifts (e.g., Hoyer lifts and slings)

Disposable items, such as ACE bandages, are generally not considered DME. In addition, although orthotics and prosthetics meet California’s definition of DME, these items are covered under a separate benefit.

DME can be used for either chronic or temporary conditions. Some chronic conditions can result in long-term needs for DME. The types of DME used by persons with chronic illness vary across diseases and conditions. For example, persons with chronic obstructive pulmonary disease use oxygen and related respiratory equipment because their disease impairs their ability to breathe. Persons who have had all or

²⁸ 29 U.S. Code § 1185a(3)(B)(iii).

part of the small intestine, colon, rectum, or bladder removed to treat cancer, digestive disease, or nerve damage use pouches and/or catheters to collect and remove feces or urine from the body. Examples of persons who use DME on a temporary basis include persons who experience a strain, sprain, or a broken bone. They may use crutches, canes, and other mobility aids (e.g., walkers). Similarly, persons who have had surgery on joints, tendons, or ligaments may use mobility aids during recovery. Persons being treated for cancer may use infusion pumps to obtain pain medication and/or chemotherapy at home.

Although some DME equipment comes in a standard size, others require special modifications or customization to meet the medical needs of the user. For example, wheelchairs for pediatric patients are designed with the ability to adapt to the patient's body as they grow; to do so, the wheelchair must be modified by an expert so that it continues to provide the proper medical support. In addition to these adjustments, some DME with a more complex design, such as CPAP machines, require regular repairs and service to ensure continued function.

Process for DME Authorization

Several health plans and insurers in California base their guidelines for authorization of DME on Medicare or Medi-Cal guidelines.^{29,30,31} Because of this, CHBRP used these two guidelines as the primary sources for the overview that follows on requirements for enrollees of commercial plans and policies to obtain coverage to purchase, rent, maintain, or repair DME. It is important to note that DME authorization requirements for coverage of specific DME may differ between health plans and insurers, and therefore the following section may not be inclusive of, or completely align with, the requirements for all commercial plans and policies.

Common Terms and Conditions

State law authorizes health plans to limit DME coverage to only that which would adequately meet the medical needs of the enrollee. Under some health plans and policies, when one or more DME items would qualify to meet the functional needs of the enrollee, benefits are only available for the single item that meets the minimum specifications for the enrollee's needs. This can lead to coverage for less complex items, such as the use of a noncustomizable electric wheelchair versus a customized one.

Another condition of coverage can be the proposed location of use. As noted in the *Policy Context* section, under existing law, EHB-specific DME must be appropriate for in-home use. Although some health plans and policies include DME that may be used both in and out of the home, others limit coverage to only DME that health plans and insurers deem appropriate for use in the home. For example, wheelchairs may be considered items not appropriate for in-home use if a person is able to ambulate in their home without one and are therefore not covered.

Per CMS guidelines for DME for Medicare, beneficiaries are limited to only one request for a particular type of item within a 5-year period, i.e., the general useful lifetime of the equipment (CMS, 2021). Thus, if a piece of equipment breaks, needs modification, or the patient's needs change within 5 years of initially receiving a certain type of DME, the patient is either responsible for the full cost of the item or must submit a new request for equipment with a different diagnosis.³²

Prescription and Prior Authorization

Like many benefits, DME coverage is based on medical necessity and must be prescribed by a health care professional authorized to prescribe the items. In California, only physicians, nurse practitioners,

²⁹ Medicare guidelines. Available at: https://www.medicare.gov/media/publication/11045-medicare-coverage-of-dme-and-other-devices.pdf?linkit_matcher=1

³⁰ Medi-Cal guidelines. Available at: <https://files.medi-cal.ca.gov/pubsdoco/publications/masters-mtp/part2/dura.pdf>

³¹ Communication with N. Anzures and J. Mok, March 2023.

³² Communication with N. Anzures and J. Mok, March 2023.

clinical nurse specialists, or physician assistants are authorized to prescribe DME for Medi-Cal coverage.³³ In addition to a prescription, medical chart notes and a letter of medical necessity written by a physician or a specialist (e.g., occupational therapist or physical therapist) for the item requested is generally part of prior authorization. The letter of medical necessity includes medical justification for each item requested, a justification for why a less expensive device would be inappropriate for the patient, and confirmation that the patient meets the medical criteria for the item in question. Not all prescribers are familiar with the complex DME needs of patients with certain disabilities, and thus rely on support from specialists to successfully process a DME request or else risk rejection of the coverage request.³⁴

Timing

The process to obtain DME can take several months.³⁵ Approval times for California health plans and insurers vary based on the plan or policy (Kun et al., 2016). It is not uncommon to have several resubmissions for a single request, which delays the time it takes to deliver a device to a patient. Multiple handoffs occur during a DME ordering process, which can lead to human error (Kun et al., 2016). There is also often a lack of training or knowledge by physicians on the DME process for each health plan or insurer. Kun et al. (2016) notes that DME ordering is “often more of an art than science in many clinics” due to the lack of transparency in ordering guidelines by health plans and insurers, and lack of understanding by physicians and support staff of what is covered by each plan or policy.

Cuppert et al. looked at the variability in time from a person’s initial assessment to delivery of a wheeled mobility device (cycle time). The results showed the average national cycle time for people with disabilities to be delivered a wheeled mobility device was an average of 101.5 days. Customizable devices were associated with higher cycle time. Years since onset of disability were also associated with an increased cycle time (Cuppert et al., 2022).

Barriers to DME Access

Studies show there are several barriers to accessing DME. Some relate to the differences between commercial insurers and lack of transparency in guidelines. With each plan or policy covering different devices, it can be difficult for physicians and support staff to know what devices are covered. Furthermore, each plan or policy’s guidelines on patient testing, clinical policies and standards, and documentation requirements regarding specific equipment can differ and are not always made transparent to healthcare professionals, thereby leading to confusion, greater errors in submissions, and increased rejections of requests (Jacobs et al., 2019; Kun et al., 2016). The wide range of complexity in devices within a category of DME can lead to a wide range of policies that govern the provision of DME (Hostak et al., 2013). Communication difficulties with commercial insurers and DME vendors has also been shown to create barriers for healthcare professionals and patients (Jacobs et al., 2019; Kun et al., 2016).

One study showed that even if patients have insurance coverage for DME, they may turn to charitable organizations for their DME needs. Martinez et al. characterized the demographics of DME needs of 763 persons with disabilities at a philanthropic rehabilitation clinic through chart review and found that 43% of the DME requests were from patients with private insurance, Medicare, or Medicaid. Potential explanations included a lack of coverage, a patient preference to avoid the process of obtaining DME

³³ 22 California Code of Regulations § 51321.

³⁴ Communication with N. Anzures and J. Mok, March 2023.

³⁵ For Medicare beneficiaries, the Centers for Medicare and Medicaid Services (CMS) contracts with a third party (known as the DME Medicare Administrative Contractor, or DME MAC) to process DME claims. DME MAC aims to respond to initial prior authorization requests within 10 business days. CMS asserts that DME MAC works to process each resubmission for non-affirmed prior authorization requests within 20 business days (https://www.cms.gov/Research-Statistics-Data-and-Systems/Monitoring-Programs/Medicare-FFS-Compliance-Programs/DMEPOS/Downloads/DMEPOS_PA_ODF_Slides_2017-07-06.pdf).

through insurance, the inability to wait for insurance approvals, affordability, and lack of awareness of benefits because of lack of communication or continuity of care (Martinez et al., 2020).

Disparities

CHBRP identified some studies showing disparities in populations with disabilities, use of DME, and authorization of DME requests (Casey et al., 2021; Goyat et al., 2016; Groah et al., 2014; Gulley et al., 2014).

Adults from families with a lower income, lower educational levels, and who are minorities show disproportionately higher rates of severe (20.8%) and moderate disability (19%) (Goyat et al., 2016; Gulley et al., 2014).

Casey et al. looked at trends in rentals of electricity-dependent DME prevalence and individual- and area-level sociodemographic inequalities. The results showed increased annual prevalence and longer duration of DME rental among Medicaid recipients. Area-level sociodemographic factors, such as rates of unemployment and attaining less than a high school diploma, were also associated with an increase in annual prevalence of DME rental (Casey et al., 2021).

Regarding procurement of DME, Groah et al. examined disparities in obtaining wheelchairs by payer among patients with spinal cord injuries and found that the standard of care for manual and power wheelchair procurement — defined by the authors based on clinical guidelines as the lightest possible customizable and custom manual wheelchairs and power wheelchairs with customizability and programmable controls — was not met across all categories of payers, with the exception of power wheelchairs provided by worker’s compensation or by the Department of Veterans Affairs (VA). Of those insured by Medicare, Medicaid, private insurance, worker’s compensation/VA, or self-pay, Medicare beneficiaries were least likely to have a manual or power wheelchair that met standard of care (Groah et al., 2014).

BENEFIT COVERAGE, UTILIZATION, AND COST IMPACTS

As discussed in the *Policy Context* section, AB 1157 would require nongrandfathered individual and small-group health plans and health policies regulated by DMHC or CDI coverage of rehabilitative and habilitative services and devices to include DME, services, and repairs. AB 1157 would also prohibit all individual and small-group health plans and policies from financial or treatment limitations, including annual caps or home use limitations in coverage of DME.

If enacted, the law would apply to the health insurance of enrollees in only individual and small-group DMHC-regulated plans and CDI-regulated policies. Thus, if enacted, AB 1157 would apply to the health insurance of approximately 4,714,000 million enrollees (12% of all Californians). This represents about 21% of the 22.8 million Californians who have health insurance regulated by the state that may be subject to any state health benefit mandate law, which includes health insurance regulated by DMHC or CDI. As noted in the *Policy Context* section, AB 1157 would not impact CalPERS enrollees’ and Medi-Cal beneficiaries’ benefit coverage.

This section reports the potential incremental impacts of AB 1157 on estimated baseline benefit coverage, utilization, and overall cost.

Analytic Approach and Key Assumptions

In this analysis, CHBRP has made the following overarching assumptions:

- There would be no change to EHB-specific DME under California's benchmark plan, as they are already covered under existing law.
- Items with DME-specific Healthcare Common Procedure Coding System (HCPCS) codes that are not included on the EHB benchmark plan would be impacted by the bill.

Assumptions and Approach Regarding Baseline and Postmandate Coverage

As explained in the *Policy Context* section, individual and small-group plans and policies are required at minimum to cover the DME that are delineated in California's EHB benchmark plan. In California's benchmark plan, DME coverage exists only for those items listed in Table 1 in the *Policy Context* section. All individual and small-group health plans and policies must have this minimum level of coverage. Health plans and policies can vary widely in the DME they cover with some covering the minimum and others going beyond the minimum by including items that are not listed in the EHB benchmark plan. Plans are currently prohibited by law from applying financial caps for EHB-specific DME but may apply caps to non-EHB-specific DME. To assess baseline coverage, CHBRP queried DMHC-regulated plans and health insurers with plans and policies subject to AB 1157 regarding their current coverage of DME and use of financial caps for DME. Postmandate, CHBRP assumed health plans and insurers would fully comply with AB 1157 such that DME coverage would include equipment used outside of the home and without any financial caps.

Assumptions and Approach Regarding Baseline and Postmandate Utilization and Cost

As described in the *Policy Context* section, for this analysis CHBRP determined that a detailed analysis by individual service codes (i.e., specific DME, services, and repairs) was not feasible given the lack of what would be defined by the bill. Thus, CHBRP used a scenario approach for which it used Milliman's 2023 Commercial Health Cost Guidelines (HCG) to model DME utilization, reimbursement and cost-sharing under various plan designs and healthcare management scenarios ("loosely managed" vs. "tightly managed" plans/policies). CHBRP used Milliman's 2021 Consolidated Health Cost Guidelines Database (CHSD) to determine representative coverage, reimbursement, and required cost sharing of DME. These data were used to estimate aggregate cost of DME along with related services and repairs.

CHBRP assumed that the DME required to be covered postmandate would reflect those of "loosely managed" health plans or policies, i.e., those, at baseline, that have the most expansive list of devices covered under the DME benefit. Estimates of utilization and cost are likely to be higher if DMHC and CDI interpret AB 1157 to require coverage for more DME than the plans and policies with the fewest restrictions cover and without caps on coverage, prior authorization, or other techniques that plans and policies with the most restrictions use to manage utilization and cost of DME.

- To estimate the number of enrollees who would use DME with coverage postmandate, CHBRP assumes a shift of the enrollees who use DME without coverage at baseline would be users with coverage postmandate plus an additional 5% of new enrollee users postmandate who would have forgone using DME at baseline due to the lack of coverage. This assumption is based on actuarial judgement, taking into consideration literature that suggests cost is one of many factors in not obtaining DME through one's insurance carrier (Martinez et al., 2020) and that cost may have an impact on demand (DME price elasticity of demand is estimated to be -0.26 in Ellis et al., 2017). It is likely that price elasticity of demand varies by type of DME; however, these values would have no impact on the analysis given that DME was examined in aggregate in this report. CHBRP notes that utilization changes postmandate would likely differ by DME, dependent on how health plans and policies would change coverage and cost sharing due to AB 1157.
- AB 1157 would not directly impact coinsurance for DME and related services and repair as cost sharing is not included in the bill language. Thus, in this analysis, CHBRP does not model any coinsurance change between baseline and postmandate. It is possible that as a result of the

mandate for expanded coverage and the removal of financial caps that plans and policies increase coinsurance for DME to offset potential increased costs they might incur due to expanded coverage.

- AB 1157 would not impact a plan's ability to conduct utilization reviews to determine medical necessity prior to authorizing DME nor does it impact the plan's ability to contract with specific vendors of their choice; thus, CHBRP expects no additional postmandate utilization due to changes in these review practices.
- AB 1157 is expected to require DMHC-regulated and CDI-regulated nongrandfathered individual and small-group plans and policies to offer benefits that exceed the state's EHB. In this scenario, the state is required to defray the cost of the additionally mandated benefits for enrollees in individual and small-group health plans or policies purchased through Covered California. Thus, CHBRP estimated the costs required to defray the expansion of EHBs.

If AB 1157 is enacted, should greater or fewer items be classified as DME by DMHC and CDI, the estimated impacts of the bill would be greater or lesser, accordingly. Furthermore, as health plans and insurers have different levels of coverage for their DME benefit at baseline, the impacts of AB 1157, if enacted, would vary depending on the baseline DME coverage of each health plan or insurer. Impacts to cost sharing are also highly dependent on the reactions of health plans and policies to expanded coverage.

For further details on the underlying data sources and methods used in this analysis, please see Appendix B.

Baseline and Postmandate Benefit Coverage

At baseline, 100% of enrollees with health insurance that would be subject to AB 1157 have coverage for DME included in the EHB benchmark plan. About 55% or 2,599,294 enrollees have coverage for DME beyond the EHB benchmark plan list that could be interpreted as "compliant with AB 1157." Postmandate, coverage for DME that is fully compliant with AB 1157 is estimated to increase 81% as enrollees without fully compliant coverage at baseline are expected to obtain fully compliant coverage.

Baseline and Postmandate Utilization

At baseline, CHBRP estimates 285,082 enrollees using DME with coverage and 77,811 enrollees using DME without coverage. Postmandate, CHBRP expects a shift of these 77,811 enrollees using DME without coverage at baseline to enrollees using DME with coverage plus an additional 5% of new users, totaling 81,907 new users for an increase of about 29% of enrollees using DME with coverage. This translates into an additional 469,800 units of DME, services, and repairs, or a 37% increase postmandate (note this includes all types of DME and not just those that are included in the EHB benchmark plan). See estimates in Table 1.

Baseline and Postmandate Per-Unit Cost

The average per-unit cost of DME inclusive of services and repairs was estimated to be \$121.67. CHBRP does not expect any change in the unit cost due to AB 1157 postmandate. See estimates in Table 1 and Appendix B for detail on how costs were calculated.

Baseline and Postmandate Expenditures

Table 6 and Table 7 present baseline and postmandate expenditures by market segment for DMHC-regulated plans and CDI-regulated policies. The tables present per member per month (PMPM) premiums, enrollee expenses for both covered and noncovered benefits, and total expenditures (premiums as well as enrollee expenses).

AB 1157 would increase total net annual expenditures by \$26,410,000 or 0.02% for enrollees with DMHC-regulated plans and CDI-regulated policies. This is due to a \$57,162,000 increase in total health insurance premiums paid by employers and enrollees for newly covered benefits, adjusted by an increase in enrollee expenses for covered benefits (\$11,432,000) and decrease in enrollee expenses for noncovered benefits (-\$42,184,000).

Premiums

Changes in premiums as a result of AB 1157 would vary by market segment. Note that such changes are related to the number of enrollees (see Table 1, Table 6, and Table 7), with health insurance that would be subject to AB 1157. Postmandate percent changes in premiums are in the range of \$0.001 to \$0.002 per member per month, with the greatest value in the DMHC-regulated small-group and individual plans (\$0.002 PMPM for both). Premiums for Covered California plans broken down by market are shown in Table 8 and Table 9.

Enrollee Expenses

AB 1157-related changes in cost sharing for covered benefits (deductibles, copays, etc.) and out-of-pocket expenses for noncovered benefits would vary by market segment. Note that such changes are related to the number of enrollees (see Table 1, Table 6, and Table 7) with health insurance that would be subject to AB 1157 expected to use DME and related services and repairs during the year after enactment.

CHBRP projects no change to copayments or coinsurance rates but does project an increase in utilization of DME and related services and repairs and therefore an increase in enrollee cost sharing for covered DME.

It is possible that some enrollees incurred expenses related to DME and related services and repairs for which coverage was denied, but CHBRP cannot estimate the frequency with which such situations occur and so cannot offer a calculation of impact.

Average enrollee out-of-pocket expenses per user

For enrollees with coverage for DME at baseline, 6.0% of enrollees in small-group and 5.8% of enrollees in individual plans and policies have out-of-pocket expenses due to DME. For enrollees for whom postmandate DME coverage would be new, 1.6% of enrollees in small-group and 1.6% in individual plans and policies would experience an average decrease in out-of-pocket expenses for noncovered DME benefits of -\$395.21.

Table 4. Impact of AB 1157 on Average Annual Enrollee Out-of-Pocket Expenses Per User

	Large Group	Small Group	Individual	CalPERS	Medi-Cal
% of enrollees with out-of-pocket expenses impact due to AB 1157 (a)	0%	6.05%	5.80%	0%	0%
Avg. annual out-of-pocket expenses impact for enrollees (b)	\$0	\$0.0	\$0.00	0%	0%
Enrollees with new benefit coverage					
% of enrollees with out-of-pocket expenses impact due to AB 1157 (a)	0%	1.65%	1.65%	0%	0%
Avg. annual out-of-pocket expenses impact for enrollees (b)	\$0	-\$395.21	-\$395.21	0%	0%

Source: California Health Benefits Review Program, 2023.

Notes: (a) Not including impacts on premiums.

(b) Average enrollee out-of-pocket expenses include expenses for both covered and noncovered benefits.

Key: CalPERS = California Public Employees' Retirement System.

Postmandate Administrative Expenses and Other Expenses

CHBRP estimates that the increase in administrative costs of DMHC-regulated plans and/or CDI-regulated policies would remain proportional to the increase in premiums. CHBRP assumes that if health care costs increase as a result of increased utilization or changes in unit costs, there is a corresponding proportional increase in administrative costs. CHBRP assumes that the administrative cost portion of premiums is unchanged. All health plans and insurers include a component for administration and profit in their premiums.

Other Considerations for Policymakers

In addition to the impacts a bill may have on benefit coverage, utilization, and cost, related considerations for policymakers are discussed below.

Potential Cost of Exceeding Essential Health Benefits

As explained in the *Policy Context* section, DME for use outside of the home and DME that are not currently specifically listed in the EHB benchmark plan are not included in California's EHB package. The state is required to defray the additional cost incurred by enrollees in qualified health plans (QHPs) for any state benefit mandate that exceeds the state's definition of EHBs. Coverage for DME required by mandate, as would be required if AB 1157 were enacted, could trigger this requirement, and so require the state to defray related costs.

CHBRP has considered means of projecting the potential cost to the state of enacting a benefit mandate that would exceed EHBs. As federal regulations are not yet final, CHBRP presents in Table 5 two scenarios regarding the cost to the state, should AB 1157 be judged to exceed EHBs. Impacts would vary by market segment (and by market segment enrollment) but would likely range between the lowest impact scenario 2 in the small-group CDI-regulated market to the largest impact scenario 1 in the individual DMHC-regulated market.

Table 5. Estimated State Responsibility for Portion of Mandate that Is in Excess of EHB, California, 2024

	DMHC-Regulated		CDI-Regulated		TOTAL
	Small Group	Individual	Small Group	Individual	
Enrollee counts					
Total enrollees in plans/policies subject to state mandates	2,212,000	2,618,000	35,000	127,000	4,992,000
Number of enrollees in QHPs (a)	2,047,000	2,561,000	35,000	71,000	4,714,000
Premium cost of mandated benefit					
Estimated premium cost of mandated benefit (b)	\$3.74	\$3.74	\$3.74	\$3.74	\$3.74
Marginal premium impact considering baseline coverage (c)	\$1.01	\$1.01	\$1.01	\$1.01	\$1.01
Estimated annual state-responsibility for portion of mandate that is in excess of EHB					
Scenario 1 - Full estimated cost = (a) x (b) x 12	\$91,935,000	\$115,020,000	\$1,572,000	\$3,189,000	\$211,715,000
Scenario 2 - With baseline coverage offset= (a) x (c) x 12	\$24,822,000	\$31,055,000	\$424,000	\$861,000	\$57,162,000

Source: California Health Benefits Review Program, 2023.

Notes: (a) States are required to defray the costs of state-mandated benefits that are in excess of EHBs for QHPs. QHPs are a subset of the plans offered in the individual and small-group markets.

(b) Estimated full cost of the mandated benefit without offsets for reduction in costs for related benefits that are EHBs.

(c) Estimated marginal premium impact of the proposed mandated benefit considering some QHPs may already cover the mandated benefit. It is yet to be determined whether the state is responsible for defraying the full cost of the mandated benefit in this circumstance.

Key: CDI = California Department of Insurance; DMHC = Department of Managed Health Care. EHB = essential health benefits; QHP = qualified health plan.

Postmandate Changes in the Number of Uninsured Persons

Because the change in average premiums does not exceed 1% for any market segment (see Table 1, Table 6, and Table 7), CHBRP would expect no measurable change in the number of uninsured persons due to the enactment of AB 1157.

Changes in Public Program Enrollment

CHBRP estimates that the mandate would produce no measurable impact on enrollment in publicly funded insurance programs due to the enactment of AB 1157.

How Lack of Benefit Coverage Results in Cost Shifts to Other Payers

In general, CHBRP assumes that enrollees who do not have benefit coverage for needed DME pay for the equipment, services, and repairs directly (e.g., self-pay). However, in some cases, those noncovered benefits may be provided by public programs or by other alternative sources. There are charitable organizations and private groups where help is obtained to purchase DME. CHBRP is unable to provide a quantifiable estimate; however, CHBRP expects a portion of those who use these means to shift to using coverage instead postmandate.

Table 6. Baseline Per Member Per Month Premiums and Total Expenditures by Market Segment, California, 2024

	DMHC-Regulated						CDI-Regulated			Total
	Commercial Plans (by Market) (a)			Publicly Funded Plans			Commercial Policies (by Market) (a)			
	Large Group	Small Group	Individual	CalPERS (b)	Medi-Cal (excludes COHS) (c) Under 65 65+		Large Group	Small Group	Individual	
Enrollee counts										
Total enrollees in plans/policies subject to state mandates (d)	7,780,000	2,212,000	2,618,000	882,000	8,043,000	774,000	371,000	35,000	127,000	22,842,000
Total enrollees in plans/policies subject to AB 1157	0	2,047,000	2,561,000	0	0	0	0	35,000	71,000	4,714,000
Premiums										
Average portion of premium paid by employer (e)	\$473.17	\$417.10	\$0.00	\$581.85	\$254.61	\$543.16	\$490.57	\$517.32	\$0.00	\$93,424,638,000
Average portion of premium paid by enrollee	\$122.17	\$180.13	\$645.33	\$113.49	\$0.00	\$0.00	\$180.61	\$168.99	\$626.90	\$39,493,007,000
Total premium	\$595.34	\$597.23	\$645.33	\$695.34	\$254.61	\$543.16	\$671.18	\$686.31	\$626.90	\$132,917,645,000
Enrollee expenses										
Cost sharing for covered benefits (deductibles, copays, etc.)	\$40.98	\$127.06	\$168.73	\$49.17	\$0.00	\$0.00	\$99.22	\$184.48	\$208.51	\$13,857,141,000
Expenses for noncovered benefits (f)	\$0	\$0.69	\$0.73	\$0	\$0	\$0	\$0	\$0.75	\$0.42	\$42,184,000
Total expenditures	\$636.33	\$724.98	\$814.79	\$744.50	\$254.61	\$543.16	\$770.40	\$871.54	\$835.82	\$146,816,970,000

Source: California Health Benefits Review Program, 2023.

Notes: (a) Includes enrollees with grandfathered and nongrandfathered health insurance acquired outside or through Covered California (the state's health insurance marketplace).

(b) Includes only CalPERS enrollees in DMHC-regulated plans. Approximately 51.7% are state retirees, state employees, or their dependents.

(c) Includes only Medi-Cal beneficiaries enrolled in DMHC-regulated plans. Includes those who are also Medicare beneficiaries.

(d) Enrollees in plans and policies regulated by DMHC or CDI. Includes those associated with Covered California, CalPERS, or Medi-Cal.³⁶

(e) In some cases, a union or other organization, or Medi-Cal for its beneficiaries.

(f) Includes only those expenses that are paid directly by enrollees (or other sources) to providers for services related to the mandated benefit that are not covered by insurance at baseline. This only includes those expenses that would be newly covered, postmandate. Other components of expenditures in this table include all health care services covered by insurance.

Key: CalPERS = California Public Employees' Retirement System; CDI = California Department of Insurance; COHS = County Organized Health Systems; DMHC = Department of Managed Health Care.

³⁶ For more detail, see CHBRP's resource *Sources of Health Insurance in California*, available at http://chbrp.org/other_publications/index.php.

Table 7. Postmandate Per Member Per Month Premiums and Total Expenditures by Market Segment, California, 2024

	DMHC-Regulated						CDI-Regulated			Total
	Commercial Plans (by Market) (a)			Publicly Funded Plans			Commercial Policies (by Market) (a)			
	Large Group	Small Group	Individual	CalPERS (b)	Medi-Cal (excludes COHS) (c) Under 65	65+	Large Group	Small Group	Individual	
Enrollee counts										
Total enrollees in plans/policies subject to state mandates (d)	7,780,000	2,212,000	2,618,000	882,000	8,043,000	774,000	371,000	35,000	127,000	22,842,000
Total enrollees in plans/policies subject to AB 1157	0	2,047,000	2,561,000	0	0	0	0	35,000	71,000	4,714,000
Premiums										
Average portion of premium paid by employer (e)		\$0.653	\$0.000	–	–	–	–	\$0.762	\$0.000	\$17,655,000
Average portion of premium paid by enrollee	–	\$0.282	\$0.989	–	–	–	–	\$0.249	\$0.565	\$39,507,000
Total premium	–	\$0.935	\$0.989	–	–	–	–	\$1.011	\$0.565	\$57,162,000
Enrollee expenses										
Cost sharing for covered benefits (deductibles, copays, etc.)	–	\$0.187	\$0.198	–	–	–	–	\$0.202	\$0.113	\$11,432,000
Expenses for noncovered benefits (f)	–	–\$0.690	–\$0.729	–	–	–	–	–\$0.746	–\$0.417	–\$42,184,000
Total expenditures	–	\$0.432	\$0.457	–	–	–	–	–\$0.467	\$0.261	\$26,411,000
Percent change										
Premiums	–	0.157%	0.153%	–	–	–	–	0.147%	0.090%	0.043%
Total expenditures	–	0.060%	0.056%	–	–	–	–	0.054%	0.031%	0.018%

Source: California Health Benefits Review Program, 2023.

Notes: (a) Includes enrollees with grandfathered and nongrandfathered health insurance acquired outside or through Covered California (the state's health insurance marketplace).

(b) Includes only CalPERS enrollees in DMHC-regulated plans. Approximately 51.7% are state retirees, state employees, or their dependents.

(c) Includes only Medi-Cal beneficiaries enrolled in DMHC-regulated plans. Includes those who are also Medicare beneficiaries.

(d) Enrollees in plans and policies regulated by DMHC or CDI. Includes those associated with Covered California, CalPERS, or Medi-Cal.³⁷

(e) In some cases, a union or other organization, or Medi-Cal for its beneficiaries.

(f) Includes only those expenses that are paid directly by enrollees (or other sources) to providers for services related to the mandated benefit that are not covered by insurance at baseline. This only includes those expenses that would be newly covered, postmandate. Other components of expenditures in this table include all health care services covered by insurance.

Key: CalPERS = California Public Employees' Retirement System; CDI = California Department of Insurance; COHS = County Organized Health Systems; DMHC = Department of Managed Health Care.

³⁷ For more detail, see CHBRP's resource *Sources of Health Insurance in California*, available at http://chbrp.org/other_publications/index.php.

Table 8. Postmandate Per Member Per Month Premiums and Total expenditures for Commercial DMHC-Regulated Health Plans by Market Segment, California

	Commercial DMHC-Regulated							
	Small Group				Individual			
	Grand-fathered	Nongrand-fathered Covered California	Nongrand-fathered Mirror Plans	Other Nongrand-fathered	Grand-fathered	Nongrand-fathered Covered California	Nongrand-fathered Mirror Plans	Other Nongrand-fathered
Enrollee counts								
Total enrollees in plans/policies subject to state mandates (a)	165,000	80,000	634,000	1,333,000	57,000	2,031,000	358,000	172,000
Total enrollees in plans/policies subject to AB 1157	0	80,000	634,000	1,333,000	0	2,031,000	358,000	172,000
Premium costs								
Average portion of premium paid by employer (b)	–	\$0.71	\$0.71	\$0.71	–	\$0.00	\$0.00	\$0.00
Average portion of premium paid by enrollee	–	\$0.30	\$0.30	\$0.30	–	\$1.01	\$1.01	\$1.01
Total premium	–	\$1.01	\$1.01	\$1.01	–	\$1.01	\$1.01	\$1.01
Enrollee expenses								
Cost sharing for covered benefits (deductibles, copays, etc.)	–	\$0.20	\$0.20	\$0.20	–	\$0.20	\$0.20	\$0.20
Expenses for noncovered benefits (c)	–	–\$0.75	–\$0.75	–\$0.75	–	–\$0.75	–\$0.75	–\$0.75
Total expenditures	–	\$0.47	\$0.47	\$0.47	–	\$0.47	\$0.47	\$0.47
Postmandate percentage change								
Percent change insured premiums	–	0.178%	0.185%	0.161%	–	0.154%	0.165%	0.183%
Percent change total expenditure	–	0.067%	0.069%	0.061%	–	0.057%	0.058%	0.062%

Source: California Health Benefits Review Program, 2023.

(a) Enrollees in plans and policies regulated by DMHC or CDI. Includes those associated with Covered California, CalPERS, or Medi-Cal.

(b) In some cases, a union or other organization, or Medi-Cal for its beneficiaries.

(c) Includes only those expenses that are paid directly by enrollees (or other sources) to providers for services related to the mandated benefit that are not covered by insurance at baseline. This only includes those expenses that would be newly covered, postmandate. Other components of expenditures in this table includes all health care services covered by insurance.

Key: CalPERS = California Public Employees' Retirement System Health Maintenance Organizations; CDI = California Department of Insurance; DMHC = Department of Managed Health; COHS = County Operated Health Systems

* Fewer than 500 enrollees.

Table 9. Postmandate Per Member Per Month Premiums and Total Expenditures for Commercial CDI-Regulated Health Policies by Market Segment, California

	Commercial CDI-Regulated							
	Small Group				Individual			
	<i>Grand-fathered</i>	<i>Nongrand-fathered Covered California</i>	<i>Nongrand-fathered Mirror Plans</i>	<i>Other Nongrand-fathered</i>	<i>Grand-fathered</i>	<i>Nongrand-fathered Covered California</i>	<i>Nongrand-fathered Mirror Plans</i>	<i>Other Nongrand-fathered</i>
Enrollee counts								
Total enrollees in plans/policies subject to state mandates (a)	*	1,000	17,000	17,000	56,000	55,000	6,000	10,000
Total enrollees in plans/policies subject to AB 1157	*	1,000	17,000	17,000	0	55,000	6,000	10,000
Premium costs								
Average portion of premium paid by employer (b)	*	\$0.76	\$0.76	\$0.76	–	\$0.00	\$0.00	\$0.00
Average portion of premium paid by enrollee	*	\$0.25	\$0.25	\$0.25	–	\$1.01	\$1.01	\$1.01
Total premium	*	\$1.01	\$1.01	\$1.01	–	\$1.01	\$1.01	\$1.01
Enrollee expenses								
Cost sharing for covered benefits (deductibles, copays, etc.)	*	\$0.20	\$0.20	\$0.20	–	\$0.20	\$0.20	\$0.20
Expenses for noncovered benefits (c)	*	–\$0.75	–\$0.75	–\$0.75	–	–\$0.75	–\$0.75	–\$0.75
Total expenditures	*	\$0.47	\$0.47	\$0.47	–	\$0.47	\$0.47	\$0.47
Postmandate percentage change								
Percent change insured premiums	*	0.140%	0.130%	0.170%		0.188%	0.204%	0.096%
Percent change total expenditure	*	0.051%	0.049%	0.059%		0.062%	0.063%	0.032%

Source: California Health Benefits Review Program, 2023.

(a) Enrollees in plans and policies regulated by DMHC or CDI. Includes those associated with Covered California, CalPERS, or Medi-Cal.

(b) In some cases, a union or other organization, or Medi-Cal for its beneficiaries.

(c) Includes only those expenses that are paid directly by enrollees (or other sources) to providers for services related to the mandated benefit that are not covered by insurance at baseline. This only includes those expenses that would be newly covered, postmandate. Other components of expenditures in this table includes all health care services covered by insurance.

Key: CalPERS = California Public Employees' Retirement System Health Maintenance Organizations; CDI = California Department of Insurance; DMHC = Department of Managed Health; COHS = County Operated Health Systems.

* Fewer than 500 enrollees.

LONG-TERM IMPACTS

CHBRP does not provide quantitative estimates of long-term impacts, which CHBRP defines as impacts occurring beyond the first 12 months after implementation, because of unknown improvements in clinical care and DME, changes in prices, implementation of other complementary or conflicting policies, and other unexpected factors. Qualitatively, CHBRP expects the key long-term impact of AB 1157 would be increased utilization of DME should a greater number of items be classified as DME by DMHC and CDI or interpreted by plans/policies over time; however, CHBRP is unable to assess the likelihood of this occurring.

APPENDIX A TEXT OF BILL ANALYZED

On February 17, 2023, the California Assembly Committee on Health requested that CHBRP analyze AB 1157 as introduced on February 16, 2023.

ASSEMBLY BILL

NO. 1157

Introduced by Assembly Members Ortega and Wilson

February 16, 2023

An act to amend Section 1367.005 of, and to add Section 1342.9 to, the Health and Safety Code, and to amend Section 10112.27 of, and to add Section 10112.275 to, the Insurance Code, relating to health care coverage.

LEGISLATIVE COUNSEL'S DIGEST

AB 1157, as introduced, Ortega. Rehabilitative and habilitative services: durable medical equipment and services.

Existing law, the Knox-Keene Health Care Service Plan Act of 1975, requires the Department of Managed Health Care to license and regulate health care service plans and makes a willful violation of the act a crime. Other existing law requires the Department of Insurance to regulate health insurers. Existing law requires an individual or small group health care service plan contract or health insurance policy issued, amended, or renewed on or after January 1, 2017, to include, at a minimum, coverage for essential health benefits pursuant to the federal Patient Protection and Affordable Care Act. Under existing law, essential health benefits includes, among other things, rehabilitative and habilitative services. Existing law requires habilitative services and devices to be covered under the same terms and conditions applied to rehabilitative services and devices under the plan contract or policy, and defines habilitative services to mean health care services and devices that help a person keep, learn, or improve skills and functioning for daily living.

This bill would specify that coverage of rehabilitative and habilitative services and devices under a health care service plan or health insurance policy includes durable medical equipment, services, and repairs, if the equipment, services, or repairs are prescribed or ordered by a physician, surgeon, or other health professional acting within the scope of their license. The bill would define “durable medical equipment” to mean devices, including replacement 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. The bill would prohibit coverage of durable medical equipment and services from being subject to financial or treatment limitations, as specified.

Because a violation of the bill’s provisions by a health care service plan would be a crime, the bill would impose a state-mandated local program.

The California Constitution requires the state to reimburse local agencies and school districts for certain costs mandated by the state. Statutory provisions establish procedures for making that reimbursement.

This bill would provide that no reimbursement is required by this act for a specified reason.

Vote: majority Appropriation: no Fiscal Committee: yes Local Program: yes

THE PEOPLE OF THE STATE OF CALIFORNIA DO ENACT AS FOLLOWS:

SECTION 1. Section 1342.9 is added to the Health and Safety Code, to read:

1342.9. The Legislature finds and declares all of the following:

(a) Lack of access to durable medical equipment disproportionately affects individuals with disabilities or chronically ill individuals.

(b) Because of their effect on protected population classes, categorical exclusions of durable medical equipment by health care service plans, and burdensome financial limitations imposed by plans on durable medical equipment, result in plan designs that discriminate against people with disabilities in violation of federal and state nondiscrimination provisions, including Sections 1302 and 1557 of the federal Patient Protection and Affordable Care Act (Public Law 111-148), as amended by the federal Health Care and Education Reconciliation Act of 2010 (Public Law 111-152).

(c) In order to comply with federal and state requirements regarding nondiscrimination in benefit design, it is important that coverage of rehabilitative and habilitative services and devices include durable medical equipment and services.

SEC. 2. Section 1367.005 of the Health and Safety Code is amended to read:

1367.005. (a) An individual or small group health care service plan contract issued, amended, or renewed on or after January 1, 2017, shall include, at a minimum, coverage for essential health benefits pursuant to the federal Patient Protection and Affordable Care Act (PPACA) and as outlined in this section. For purposes of this section, “essential health benefits” means all of the following:

(1) Health benefits within the categories identified in Section 1302(b) of PPACA: ambulatory patient services, emergency services, hospitalization, maternity and newborn care, mental health and substance use disorder services, including behavioral health treatment, 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.

(2) (A) The health benefits covered by the Kaiser Foundation Health Plan Small Group HMO 30 plan (federal health product identification number 40513CA035) as this plan was offered during the first quarter of 2014, as follows, regardless of whether the benefits are specifically referenced in the evidence of coverage or plan contract for that plan:

(i) Medically necessary basic health care services, as defined in subdivision (b) of Section 1345 and Section 1300.67 of Title 28 of the California Code of Regulations.

(ii) The health benefits mandated to be covered by the plan pursuant to statutes enacted before December 31, 2011, as described in the following sections: Sections 1367.002, 1367.06, and 1367.35 (preventive services for children); Section 1367.25 (prescription drug coverage for contraceptives); Section 1367.45 (AIDS vaccine); Section 1367.46 (HIV testing); Section 1367.51 (diabetes); Section 1367.54 (alpha-fetoprotein testing); Section 1367.6 (breast cancer screening); Section 1367.61 (prosthetics for laryngectomy); Section 1367.62 (maternity hospital stay); Section 1367.63 (reconstructive surgery); Section 1367.635 (mastectomies); Section 1367.64 (prostate cancer); Section 1367.65 (mammography); Section 1367.66 (cervical cancer); Section 1367.665 (cancer screening tests); Section 1367.67 (osteoporosis); Section 1367.68 (surgical procedures for jaw bones); Section 1367.71 (anesthesia for dental); Section 1367.9 (conditions attributable to diethylstilbestrol); Section 1368.2 (hospice care); Section 1370.6 (cancer clinical trials); Section 1371.5 (emergency response ambulance or ambulance transport services); subdivision (b) of Section 1373 (sterilization operations or procedures); Section 1373.4 (inpatient hospital and ambulatory maternity); Section 1374.56 (phenylketonuria); Section 1374.17 (organ transplants for HIV); Section 1374.72 (mental health parity); and Section 1374.73 (autism/behavioral health treatment).

(iii) Any other benefits mandated to be covered by the plan pursuant to statutes enacted before December 31, 2011, as described in those statutes.

(iv) The health benefits covered by the plan that are not otherwise required to be covered under this chapter, to the extent required pursuant to Sections 1367.18, 1367.21, 1367.215, 1367.22, 1367.24, and 1367.25, and Section 1300.67.24 of Title 28 of the California Code of Regulations.

(v) Any other health benefits covered by the plan that are not otherwise required to be covered under this chapter.

(B) If there are any conflicts or omissions in the plan identified in subparagraph (A) as compared with the requirements for health benefits under this chapter that were enacted prior to December 31, 2011, the requirements of this chapter shall be controlling, except as otherwise specified in this section.

(C) Notwithstanding subparagraph (B) or any other provision of this section, the home health services benefits covered under the plan identified in subparagraph (A) shall be deemed to not be in conflict with this chapter.

(D) For purposes of this section, the Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008 (Public Law 110-343) shall apply to a contract subject to this section. Coverage of mental health and substance use disorder services pursuant to this paragraph, along with any scope and duration limits imposed on the benefits, shall be in compliance with the Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008 (Public Law 110-343), and all rules, regulations, or guidance issued pursuant to Section 2726 of the federal Public Health Service Act (42 U.S.C. Sec. 300gg-26).

(3) (A) With respect to habilitative services, in addition to any habilitative services and devices identified in paragraph (2), coverage shall also be provided as required by federal rules, regulations, and guidance issued pursuant to Section 1302(b) of PPACA. Habilitative services and devices shall be covered under the same terms and conditions applied to rehabilitative services and devices under the plan contract. Limits on habilitative and rehabilitative services and devices shall not be combined.

(B) Coverage of rehabilitative and habilitative services and devices includes durable medical equipment, services, and repairs, if the equipment, services, or repairs are prescribed or ordered by a physician, surgeon, or other health professional acting within the scope of their license.

(4) With respect to pediatric vision care, 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. The pediatric vision care benefits covered pursuant to this paragraph shall be in addition to, and shall not replace, any vision services covered under the plan identified in paragraph (2).

(5) With respect to pediatric oral care, 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. The pediatric oral care benefits covered pursuant to this paragraph shall be in addition to, and shall not replace, any dental or orthodontic services covered under the plan identified in paragraph (2).

(b) (1) Treatment limitations imposed on health benefits described in this section shall be no greater than the treatment limitations imposed by the corresponding plans identified in subdivision (a), subject to the requirements set forth in paragraph (2) of subdivision (a).

(2) Notwithstanding paragraph (1), with respect to rehabilitative and habilitative services and devices, coverage of durable medical equipment and services shall not be subject to financial or treatment limitations, including annual caps or requirements limiting coverage of the devices to those for home use.

(c) Except as provided in subdivision (d), this section does not permit a health care service plan to make substitutions for the benefits required to be covered under this section, regardless of whether those substitutions are actuarially equivalent.

(d) To the extent permitted under Section 1302 of PPACA and any rules, regulations, or guidance issued pursuant to that section, and to the extent that substitution would not create an obligation for the state to defray costs for any individual, a plan may substitute its prescription drug formulary for the formulary provided under the plan identified in subdivision (a) if the coverage for prescription drugs complies with the sections referenced in clauses (ii) and (iv) of subparagraph (A) of paragraph (2) of subdivision (a) that apply to prescription drugs.

(e) A health care service plan, or its agent, solicitor, or representative, shall not issue, deliver, renew, offer, market, represent, or sell any product, contract, or discount arrangement as compliant with the essential health benefits requirement in federal law, unless it meets all of the requirements of this section.

(f) This section applies regardless of whether the plan contract is offered inside or outside the California Health Benefit Exchange created by Section 100500 of the Government Code.

(g) This section does not exempt a plan or a plan contract from meeting other applicable requirements of law.

(h) This section does not prohibit a plan contract from covering additional benefits, including, but not limited to, spiritual care services that are tax deductible under Section 213 of the Internal Revenue Code.

(i) Subdivision (a) does not apply to any of the following:

(1) A specialized health care service plan contract.

(2) A Medicare supplement plan.

(3) A plan contract that qualifies as a grandfathered health plan under Section 1251 of PPACA or any rules, regulations, or guidance issued pursuant to that section.

(j) This section shall not be implemented in a manner that conflicts with a requirement of PPACA.

(k) An essential health benefit is required to be provided under this section only to the extent that federal law does not require the state to defray the costs of the benefit.

(l) This section does not obligate the state to incur costs for the coverage of benefits that are not essential health benefits as defined in this section.

(m) A plan is not required to cover, under this section, changes to health benefits that are the result of statutes enacted on or after December 31, 2011.

(n) (1) The department may adopt emergency regulations implementing this section. The department may, on a one-time basis, readopt any emergency regulation authorized by this section that is the same as, or substantially equivalent to, an emergency regulation previously adopted under this section.

(2) The initial adoption of emergency regulations implementing this section and the readoption of emergency regulations authorized by this subdivision shall be deemed an emergency and necessary for the immediate preservation of the public peace, health, safety, or general welfare. The initial emergency regulations and the readoption of emergency regulations authorized by this section shall be submitted to the Office of Administrative Law for filing with the Secretary of State and each shall remain in effect for no more than 180 days, by which time final regulations may be adopted.

(3) The initial adoption of emergency regulations implementing this section made during the 2015–16 Regular Session of the Legislature and the readoption of emergency regulations authorized by this subdivision shall be deemed an emergency and necessary for the immediate preservation of the public peace, health, safety, or general welfare. The initial emergency regulations and the readoption of emergency regulations authorized by this section shall be submitted to the Office of Administrative Law for filing with the Secretary of State and each shall remain in effect for no more than 180 days, by which time final regulations may be adopted.

(4) The director shall consult with the Insurance Commissioner to ensure consistency and uniformity in the development of regulations under this subdivision.

(5) This subdivision shall become inoperative on July 1, 2018.

(o) For purposes of this section, the following definitions apply:

(1) *“Durable medical equipment” means devices, including replacement 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. The prescription or order for durable medical equipment shall include fittings, design, adjustment, programming, and other necessary services for the provision or maintenance of the devices.*

(4)

(2) “Habilitative services” means 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. Habilitative services shall be covered under the same terms and conditions applied to rehabilitative services under the plan contract.

(2)

(3) (A) “Health benefits,” unless otherwise required to be defined pursuant to federal rules, regulations, or guidance issued pursuant to Section 1302(b) of PPACA, means health care items or services for the diagnosis, cure, mitigation, treatment, or prevention of illness, injury, disease, or a health condition, including a behavioral health condition.

(B) “Health benefits” does not mean any cost-sharing requirements such as copayments, coinsurance, or deductibles.

(3)

(4) “PPACA” means the federal Patient Protection and Affordable Care Act (Public Law 111-148), as amended by the federal Health Care and Education Reconciliation Act of 2010 (Public Law 111-152), and any rules, regulations, or guidance issued thereunder.

(4)

(5) “Small group health care service plan contract” means a group health care service plan contract issued to a small employer, as defined in Section 1357.500.

SEC. 3. Section 10112.27 of the Insurance Code is amended to read:

10112.27. (a) An individual or small group health insurance policy issued, amended, or renewed on or after January 1, 2017, shall include, at a minimum, coverage for essential health benefits pursuant to the federal Patient Protection and Affordable Care Act (PPACA) and as outlined in this section. This section shall exclusively govern the benefits a health insurer must cover as essential health benefits. For purposes of this section, “essential health benefits” means all of the following:

(1) Health benefits within the categories identified in Section 1302(b) of PPACA: ambulatory patient services, emergency services, hospitalization, maternity and newborn care, mental health and substance use disorder services, including behavioral health treatment, 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.

(2) (A) The health benefits covered by the Kaiser Foundation Health Plan Small Group HMO 30 plan (federal health product identification number 40513CA035) as this plan was offered during the first quarter of 2014, as follows, regardless of whether the benefits are specifically referenced in the plan contract or evidence of coverage for that plan:

(i) Medically necessary basic health care services, as defined in subdivision (b) of Section 1345 of the Health and Safety Code and Section 1300.67 of Title 28 of the California Code of Regulations.

(ii) The health benefits mandated to be covered by the plan pursuant to statutes enacted before December 31, 2011, as described in the following sections of the Health and Safety Code: Sections 1367.002, 1367.06, and 1367.35 (preventive services for children); Section 1367.25 (prescription drug coverage for contraceptives); Section 1367.45 (AIDS vaccine); Section 1367.46 (HIV testing); Section 1367.51 (diabetes); Section 1367.54 (alpha-fetoprotein testing); Section 1367.6 (breast cancer screening); Section 1367.61 (prosthetics for laryngectomy); Section 1367.62 (maternity hospital stay); Section 1367.63 (reconstructive surgery); Section 1367.635 (mastectomies); Section 1367.64 (prostate cancer); Section 1367.65 (mammography); Section 1367.66 (cervical cancer); Section 1367.665 (cancer screening tests); Section 1367.67 (osteoporosis); Section 1367.68 (surgical procedures for jaw bones); Section 1367.71 (anesthesia for dental); Section 1367.9 (conditions attributable to diethylstilbestrol); Section 1368.2 (hospice care); Section 1370.6 (cancer clinical trials); Section 1371.5 (emergency response ambulance or ambulance transport services); subdivision (b) of Section 1373 (sterilization operations or procedures); Section 1373.4 (inpatient hospital and ambulatory maternity); Section 1374.56 (phenylketonuria); Section 1374.17 (organ transplants for HIV); Section 1374.72 (mental health parity); and Section 1374.73 (autism/behavioral health treatment).

(iii) Any other benefits mandated to be covered by the plan pursuant to statutes enacted before December 31, 2011, as described in those statutes.

(iv) The health benefits covered by the plan that are not otherwise required to be covered under Chapter 2.2 (commencing with Section 1340) of Division 2 of the Health and Safety Code, to the extent otherwise required pursuant to Sections 1367.18, 1367.21, 1367.215, 1367.22, 1367.24, and 1367.25 of the Health and Safety Code, and Section 1300.67.24 of Title 28 of the California Code of Regulations.

(v) Any other health benefits covered by the plan that are not otherwise required to be covered under Chapter 2.2 (commencing with Section 1340) of Division 2 of the Health and Safety Code.

(B) If there are any conflicts or omissions in the plan identified in subparagraph (A) as compared with the requirements for health benefits under Chapter 2.2 (commencing with Section 1340) of Division 2 of the Health and Safety Code that were enacted before December 31, 2011, the requirements of Chapter 2.2 (commencing with Section 1340) of Division 2 of the Health and Safety Code shall control, except as otherwise specified in this section.

(C) Notwithstanding subparagraph (B) or any other provision of this section, the home health services benefits covered under the plan identified in subparagraph (A) shall not be in conflict with Chapter 2.2 (commencing with Section 1340) of Division 2 of the Health and Safety Code.

(D) For purposes of this section, the Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008 (Public Law 110-343) shall apply to a policy subject to this section. Coverage of mental health and substance use disorder services pursuant to this paragraph, along with any scope and duration limits imposed on the benefits, shall be in compliance with the Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008 (Public Law 110-343), and all rules, regulations, and guidance issued pursuant to Section 2726 of the federal Public Health Service Act (42 U.S.C. Sec. 300gg-26).

(3) (A) With respect to habilitative services, in addition to any habilitative services and devices identified in paragraph (2), coverage shall also be provided as required by federal rules, regulations, or guidance issued pursuant to Section 1302(b) of PPACA. Habilitative services and devices shall be covered under the same terms and conditions applied to rehabilitative services and devices under the policy. Limits on habilitative and rehabilitative services and devices shall not be combined.

(B) Coverage of rehabilitative and habilitative services and devices includes durable medical equipment, services, and repairs, if the equipment, services, or repairs are prescribed or ordered by a physician, surgeon, or other health professional acting within the scope of their license.

(4) With respect to pediatric vision care, 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. The pediatric vision care services covered pursuant to this paragraph shall be in addition to, and shall not replace, any vision services covered under the plan identified in paragraph (2).

(5) With respect to pediatric oral care, 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. The pediatric oral care benefits covered pursuant to this paragraph shall be in addition to, and shall not replace, any dental or orthodontic services covered under the plan identified in paragraph (2).

(b) (1) Treatment limitations imposed on health benefits described in this section shall be no greater than the treatment limitations imposed by the corresponding plans identified in subdivision (a), subject to the requirements set forth in paragraph (2) of subdivision (a).

(2) Notwithstanding paragraph (1), with respect to rehabilitative and habilitative services and devices, coverage of durable medical equipment and services shall not be subject to financial or treatment limitations, including annual caps or requirements limiting coverage of the devices to those for home use.

(c) Except as provided in subdivision (d), this section does not permit a health insurer to make substitutions for the benefits required to be covered under this section, regardless of whether those substitutions are actuarially equivalent.

(d) To the extent permitted under Section 1302 of PPACA and any rules, regulations, or guidance issued pursuant to that section, and to the extent that substitution would not create an obligation for the state to defray costs for any individual, an insurer may substitute its prescription drug formulary for the formulary provided under the plan identified in subdivision (a) if the coverage for prescription drugs complies with the sections referenced in clauses (ii) and (iv) of subparagraph (A) of paragraph (2) of subdivision (a) that apply to prescription drugs.

(e) A health insurer, or its agent, producer, or representative, shall not issue, deliver, renew, offer, market, represent, or sell any product, policy, or discount arrangement as compliant with the essential health benefits requirement in federal law, unless it meets all of the requirements of this section. This subdivision shall be enforced in the same manner as Section 790.03, including through the means specified in Sections 790.035 and 790.05.

(f) This section applies regardless of whether the policy is offered inside or outside the California Health Benefit Exchange created by Section 100500 of the Government Code.

(g) This section does not exempt a health insurer or a health insurance policy from meeting other applicable requirements of law.

(h) This section does not prohibit a policy from covering additional benefits, including, but not limited to, spiritual care services that are tax deductible under Section 213 of the Internal Revenue Code.

(i) Subdivision (a) does not apply to any of the following:

(1) A policy that provides excepted benefits as described in Sections 2722 and 2791 of the federal Public Health Service Act (42 U.S.C. Sec. 300gg-21; 42 U.S.C. Sec. 300gg-91).

(2) A policy that qualifies as a grandfathered health plan under Section 1251 of PPACA or any binding rules, regulations, or guidance issued pursuant to that section.

(j) This section shall not be implemented in a manner that conflicts with a requirement of PPACA.

(k) An essential health benefit is required to be provided under this section only to the extent that federal law does not require the state to defray the costs of the benefit.

(l) This section does not obligate the state to incur costs for the coverage of benefits that are not essential health benefits as defined in this section.

(m) An insurer is not required to cover, under this section, changes to health benefits that are the result of statutes enacted on or after December 31, 2011.

(n) (1) The commissioner may adopt emergency regulations implementing this section. The commissioner, on a one-time basis, may readopt any emergency regulation authorized by this section that is the same as, or substantially equivalent to, an emergency regulation previously adopted under this section.

(2) The initial adoption of emergency regulations implementing this section and the readoption of emergency regulations authorized by this subdivision shall be deemed an emergency and necessary for the immediate preservation of the public peace, health, safety, or general welfare. The initial emergency regulations and the readoption of emergency regulations authorized by this section shall be submitted to the Office of Administrative Law for filing with the Secretary of State and each shall remain in effect for no more than 180 days, by which time final regulations may be adopted.

(3) The initial adoption of emergency regulations implementing this section made during the 2015–16 Regular Session of the Legislature and the readoption of emergency regulations authorized by this subdivision shall be deemed an emergency and necessary for the immediate preservation of the public peace, health, safety, or general welfare. The initial emergency regulations and the readoption of emergency regulations authorized by this section shall be submitted to the Office of Administrative Law for filing with the Secretary of State and each shall remain in effect for no more than 180 days, by which time final regulations may be adopted.

(4) The commissioner shall consult with the Director of the Department of Managed Health Care to ensure consistency and uniformity in the development of regulations under this subdivision.

(5) This subdivision shall become inoperative on July 1, 2018.

(o) This section does not impose on health insurance policies the cost sharing or network limitations of the plans identified in subdivision (a) except to the extent otherwise required to comply with this code, including this section, and as otherwise applicable to all health insurance policies offered to individuals and small groups.

(p) For purposes of this section, the following definitions apply:

(1) *“Durable medical equipment” means devices, including replacement 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. The prescription or order for durable medical equipment shall include fittings, design, adjustment, programming, and other necessary services for the provision or maintenance of the devices.*

(4)

(2) *“Habilitative services” means 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. Habilitative services shall be covered under the same terms and conditions applied to rehabilitative services under the policy.

(2)

(3) (A) “Health benefits,” unless otherwise required to be defined pursuant to federal rules, regulations, or guidance issued pursuant to Section 1302(b) of PPACA, means health care items or services for the diagnosis, cure, mitigation, treatment, or prevention of illness, injury, disease, or a health condition, including a behavioral health condition.

(B) “Health benefits” does not mean any cost-sharing requirements such as copayments, coinsurance, or deductibles.

(3)

(4) “PPACA” means the federal Patient Protection and Affordable Care Act (Public Law 111-148), as amended by the federal Health Care and Education Reconciliation Act of 2010 (Public Law 111-152), and any rules, regulations, or guidance issued thereunder.

(4)

(5) “Small group health insurance policy” means a group health insurance policy issued to a small employer, as defined in subdivision (q) of Section 10753.

SEC. 4. Section 10112.275 is added to the Insurance Code, immediately following Section 10112.27, to read:

10112.275. The Legislature finds and declares all of the following:

(a) Lack of access to durable medical equipment disproportionately affects individuals with disabilities or chronically ill individuals.

(b) Because of their effect on protected population classes, categorical exclusions of durable medical equipment by health insurers, and burdensome financial limitations imposed by those insurers on durable medical equipment, result in insurance policy designs that discriminate against people with disabilities in violation of federal and state nondiscrimination provisions, including Sections 1302 and 1557 of the federal Patient Protection and Affordable Care Act (Public Law 111-148), as amended by the federal Health Care and Education Reconciliation Act of 2010 (Public Law 111-152).

(c) In order to comply with federal and state requirements regarding nondiscrimination in benefit design, it is important that coverage of rehabilitative and habilitative services and devices include durable medical equipment and services.

SEC. 5. No reimbursement is required by this act pursuant to Section 6 of Article XIII B of the California Constitution because the only costs that may be incurred by a local agency or school district will be incurred because this act creates a new crime or infraction, eliminates a crime or infraction, or changes the penalty for a crime or infraction, within the meaning of Section 17556 of the Government Code, or changes the definition of a crime within the meaning of Section 6 of Article XIII B of the California Constitution.

APPENDIX B COST IMPACT ANALYSIS: DATA SOURCES, CAVEATS, AND ASSUMPTIONS

With the assistance of CHBRP's contracted actuarial firm, Milliman, Inc, the cost analysis presented in this report was prepared by the faculty and researchers connected to CHBRP's Task Force with expertise in health economics.³⁸ Information on the generally used data sources and estimation methods, as well as caveats and assumptions generally applicable to CHBRP's cost impacts analyses are available at CHBRP's website.³⁹

This appendix describes analysis-specific data sources, estimation methods, caveats, and assumptions used in preparing this cost impact analysis.

Analysis-Specific Data Sources

Current coverage of durable medical equipment (DME) was assessed by a survey of the largest commercial health plans and insurers in California. The survey distinguished between coverage of DME included in Essential Health Benefits (EHB) as defined by the California benchmark plan and non-EHB DME, and between DME intended for in-home use and for outside-the-home use. Responses to this survey represented 84.7% of DMHC-regulated commercial plans and 21.7% of CDI-regulated policies that can be subject to state benefit mandates.

CHBRP used Milliman's 2021 Consolidated Health Cost Guidelines Database (CHSD) to determine representative coverage, reimbursement, and required cost sharing of DME in the California commercial large-group market. For this analysis, CHBRP determined that a detailed analysis by individual service code was not feasible. Instead, this analysis relies on Milliman's 2023 Commercial Health Cost Guidelines (HCG) to model DME utilization, reimbursement, and cost sharing under various plan designs and healthcare management scenarios.

Analysis-Specific Caveats and Assumptions

Methodology and Assumptions for Baseline Benefit Coverage

- The population subject to the mandated offering includes all individuals with health insurance through commercial, nongrandfathered small-group or individual health plans or policies regulated by the DMHC or CDI.
- CHBRP surveyed managed commercial plans and insurers to determine the percentage of the population with coverage for services and testing related to the provision of DME. The responses received represented 84.7% of the relevant population in DMHC-regulated plans and 21.1% of affected enrollees in CDI-regulated policies. For the purposes of this analysis, DME coverage within CDI-regulated policies was assumed to be the same as the coverage in DMHC-regulated plans for the corresponding market segments.

Methodology and Assumptions for Baseline Utilization

- Baseline utilization of DME was estimated using Milliman's HCG with coverage modeled to correspond to California's benchmark plan. CHBRP assumed an 80% degree of healthcare management (DOHM) applicable to DME, where a DOHM of 0% represents nationwide average large-group levels of prior authorization and other healthcare management tools, and 100%

³⁸ CHBRP's authorizing statute, available at https://chbrp.org/about_chbrp/index.php, requires that CHBRP use a certified actuary or "other person with relevant knowledge and expertise" to determine financial impact.

³⁹ See method documents posted at http://chbrp.com/analysis_methodology/cost_impact_analysis.php; in particular, see *2022 Cost Analyses: Data Sources, Caveats, and Assumptions*.

DOHM corresponds to a tightly managed environment in which only medically necessary DME is provided.

- The HCG model was calibrated to 2024 utilization levels. Please note that DME utilization represents a mix of equipment, replacement parts, and maintenance services.
- The resulting baseline utilization rate corresponds to a utilization rate that is 77.7% of that observed in the CHSD data.
- The 23.3% difference between the observed large group utilization rate in the CHSD data and the assumed small-group and individual baseline utilization rate includes equipment, parts, and services obtained by enrollees via out-of-pocket payments, borrowed from friends and relatives, received from charity, or otherwise obtained outside the provider-insurer framework, as well as equipment, parts, and services that the enrollees have not obtained. It was assumed that 95% of this difference entails enrollees obtaining equipment, parts, and services from alternative sources, while 5% of the difference is explained by foregone equipment, parts, and services.

Methodology and Assumptions for Baseline Cost

- CHBRP calculated the average California commercial cost per service for DME using Milliman's 2021 CHSD.
- The average costs per service were trended at 3.5% annually from 2021 to 2024.

Methodology and Assumptions for Baseline Cost Sharing

- CHBRP assumed cost sharing for DME in the small-group and individual markets to be 20% coinsurance at baseline. This is reflective of the in-network DME cost-sharing requirement observed in a survey of plans available in the small-group and individual marketplace.

Methodology and Assumptions for Postmandate Utilization

- CHBRP estimated that the DME utilization observed in the CHSD data corresponded to approximately a 10.5% DOHM. CHBRP set postmandate utilization equal to this level.
- CHBRP did not assume a change in utilization in response to any change in cost sharing occurring as a result of AB 1157.
- CHBRP assumed that the postmandate mix of DME services would not change from the baseline.

Methodology and Assumptions for Postmandate Cost

- CHBRP assumed the average cost per unit of DME would not change as a result of AB 1157.

Methodology and Assumptions for Postmandate Cost Sharing

- CHBRP assumed there would be no change in cost sharing postmandate as a result of AB 1157.

Determining Public Demand for the Proposed Mandate

CHBRP reviews public demand for benefits relevant to a proposed mandate in two ways. CHBRP:

- Considers the bargaining history of organized labor; and
- Compares the benefits provided by self-insured health plans or policies (which are not regulated by the DMHC or CDI and therefore not subject to state-level mandates) with the benefits that are provided by plans or policies that would be subject to the mandate.

On the basis of conversations with the largest collective bargaining agents in California, CHBRP concluded that in general, unions negotiate for broader contract provisions such as coverage for dependents, premiums, deductibles, and broad coinsurance levels.

Among publicly funded self-insured health insurance policies, the preferred provider organization (PPO) plans offered by CalPERS have the largest number of enrollees. The CalPERS PPOs currently provide benefit coverage similar to what is available through group health insurance plans and policies that would be subject to the mandate.

To further investigate public demand, CHBRP used the bill-specific coverage survey to ask plans and insurers who act as third-party administrators for (non-CalPERS) self-insured group health insurance programs whether the relevant benefit coverage differed from what is offered in group market plans or policies that would be subject to the mandate. The responses indicated that there were no substantive differences.

Second-Year Impacts on Benefit Coverage, Utilization, and Cost

CHBRP has considered whether continued implementation during the second year of the benefit coverage requirements of AB 1157 would have a substantially different impact on utilization of either the tests, treatments, or services for which coverage was directly addressed, the utilization of any indirectly affected utilization, or both. CHBRP reviewed the literature and consulted content experts about the possibility of varied second-year impacts and determined the second year's impacts of AB 1157 would be substantially the same as the impacts in the first year (see Table 1). Minor changes to utilization and expenditures are due to population changes between the first year postmandate and the second year postmandate.

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ABOUT CHBRP

The California Health Benefits Review Program (CHBRP) was established in 2002. As per its authorizing statute, CHBRP provides the California Legislature with independent analysis of the medical, financial, and public health impacts of proposed health insurance benefit-related legislation. The state funds CHBRP through an annual assessment on health plans and insurers in California.

A group of faculty, researchers, and staff complete the analysis that informs California Health Benefits Review Program (CHBRP) reports. The CHBRP **Faculty Task Force** comprises rotating senior faculty from University of California (UC) campuses. In addition to these representatives, there are other ongoing researchers and analysts who are **Task Force Contributors** to CHBRP from UC that conduct much of the analysis. The **CHBRP staff** works with Task Force members in preparing parts of the analysis, and manages external communications, including those with the California Legislature. As required by CHBRP's authorizing legislation, UC contracts with a certified actuary, **Milliman**, to assist in assessing the financial impact of each legislative proposal mandating or repealing a health insurance benefit. 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. Information on CHBRP's analysis methodology, authorizing statute, as well as all CHBRP reports and other publications, are available at www.chbrp.org.

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CHBRP assumes full responsibility for the report and the accuracy of its contents. All CHBRP bill analyses and other publications are available at www.chbrp.org.

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