

Date of Hearing: April 2, 2024

ASSEMBLY COMMITTEE ON HEALTH  
Mia Bonta, Chair  
AB 2753 (Ortega) – As Introduced February 15, 2024

**SUBJECT:** Rehabilitative and habilitative services: durable medical equipment and services.

**SUMMARY:** Includes durable medical equipment (DME), as specified, under essential health benefits (EHBs) coverage of rehabilitative and habilitative services and devices. Specifically, **this bill:**

- 1) Includes DME, 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, under EHB coverage of rehabilitative and habilitative services and devices.
- 2) Prohibits coverage of DME and services from being subject to financial or treatment limitations, including annual caps or requirements limiting coverage of the devices to those for home use.
- 3) Defines 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. Includes, under the prescription or order for DME, fittings, design, adjustment, programming, and other necessary services for the provision or maintenance of the devices.
- 4) Makes various findings and declarations, including the following:
  - a) Lack of access to DME disproportionately affects individuals with disabilities or chronically ill individuals;
  - b) In order to comply with federal and state requirements regarding nondiscrimination in benefit design, coverage of EHBs offered by all nongrandfathered individual and small-group market plans must include DME and services;
  - c) Coverage of DME is necessary to comply with federal requirements, and is therefore not subject to defrayal, as specified; and,
  - d) Because California's EHB base-benchmark plan has been codified in state law, the Legislature has the responsibility to address the lack of DME coverage in the current benchmark that has led to violations of federal nondiscrimination law regarding benefit design. Amending California's DME statute ensures that Californians with disabilities receive the benefits of these federal nondiscrimination protections without delay.

**EXISTING LAW:**

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

- 2) Establishes as California's EHB benchmark under the Patient Protection and Affordable Care Act (ACA), the Kaiser Small Group Health Maintenance Organization, existing California health insurance mandates, and the 10 ACA mandated benefits. Specifies EHBs in the following 10 categories: ambulatory patient services; emergency services; hospitalization; maternity and newborn care; mental health and substance use disorder services; prescription drugs; rehabilitative and habilitative services and devices; laboratory services; preventive and wellness services and chronic disease management; and, pediatric services, including oral and vision care. [HSC §1367.005 and INS §10112.27]
- 3) Includes, in regulations, DME for home use as other health benefits that EHBs must cover. [Title 28 Code of Regulations §1300.67.005]
- 4) Defines “basic health care services” as all of the following:
  - a) Physician services, including consultation and referral;
  - b) Hospital inpatient services and ambulatory care services;
  - c) Diagnostic laboratory and therapeutic radiologic services;
  - d) Home health services;
  - e) Preventive health services;
  - f) Emergency health care services, including ambulance and ambulance transport services and out-of-area coverage. Basic health care services includes ambulance and ambulance transport services provided through the 911 emergency response system; and,
  - g) Hospice care. [HSC §1345]

**FISCAL EFFECT:** Unknown. This bill has not yet been analyzed by a fiscal committee.

**COMMENTS:**

- 1) **PURPOSE OF THIS BILL.** According to the author, private health plans regularly exclude or severely limit coverage for DME such as wheelchairs, hearing aids, or ventilators, causing people to go without medically necessary devices or obtaining inferior ones that put their health and safety at risk. This gap in private coverage occurs despite the ACA’s clear mandate to cover all EHBs, including rehabilitative and habilitative devices, in a nondiscriminatory way. Without adequate coverage, the lives of adults and children with disabilities are severely impacted, many are unable to attend school, work, or participate in community life. Others face institutionalization because they cannot function in their own homes without needed equipment. The author states that this bill would clarify that DME is a covered EHB in California-regulated health plans, when prescribed by a provider for rehabilitative or rehabilitative purposes. This bill would also prohibit targeted limitations, such as annual dollar caps and “home use only” restrictions on DME coverage, consistent with all EHBs. The author concludes that this bill would be cost neutral because, when a benefit is required through state action for the purpose of complying with federal requirements (in this case federal nondiscrimination law), then the State is not responsible for defraying the cost of the benefit.
- 2) **BACKGROUND.** According to the California Health Benefits Review Program (CHBRP), DME is not currently defined under California law. However, the ACA requires that all state-regulated nongrandfathered health plans and policies in the individual and small-group markets — plans regulated by the DMHC and policies regulated by the CDI — cover all tests, treatments, and services included within the California 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. CHBRP states 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.

- a) **DME Coverage.** Health plans are required to cover DME for use in the enrollee's home (or another location used as the enrollee's home). DME for home use is 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. Under regulations, a health plan may limit coverage to the standard equipment or supplies that adequately meet the enrollee's medical needs. Coverage includes repair or replacement of covered equipment. The health plan may decide whether to rent or purchase the equipment, and may select the vendor. The enrollee may be required to return the equipment to the plan or pay the fair market price of the equipment or any unused supplies when they are no longer medically necessary.
- b) **CHBRP analysis.** AB 1996 (Thomson), Chapter 795, Statutes of 2002, requests the University of California to assess legislation proposing a mandated benefit or service and prepare a written analysis with relevant data on the medical, economic, and public health impacts of proposed health plan and health insurance benefit mandate legislation. CHBRP was created in response to AB 1996. SB 125 (Hernandez), Chapter 9, Statutes of 2015, added an impact assessment on EHBs, and legislation that impacts health insurance benefit designs, cost sharing, premiums, and other health insurance topics. CHBRP reviewed AB 1157 (Ortega) of 2023, which is substantially similar to this bill, and states the following in its analysis:
  - i) **Enrollees covered.** This bill impacts 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 health insurance that may be subject to any state mandate law. Since this bill

specifies “group and individual” plans and policies, the health insurance of Medi-Cal beneficiaries enrolled in DMHC-regulated plans would not be subject to this bill’s requirements. This bill 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 insurers. 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 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).

CHBRP calculated those cost estimates 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.

- ii) Impact on expenditures.** Estimates of utilization and cost are likely to be higher if DMHC and CDI interpret this bill 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. This bill 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). Postmandate percent changes in premiums are in the range of \$0.001 to \$0.002 per member per month (PMPM), with the greatest value in the DMHC-regulated small-group and individual plans (\$0.002 PMPM for both). This bill’s changes in cost sharing for covered benefits (deductibles, copays, etc.) and out-of-pocket expenses for noncovered benefits would vary by market segment. 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. 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.
- iii) EHBs.** According to CHBRP, this bill requires 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.
- iv) Long-term impacts.** Qualitatively, CHBRP expects the key long-term impact of this bill 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.

- 3) **SUPPORT.** The National Multiple Sclerosis Society writes that the medical costs associated with living with Multiple Sclerosis (MS) are \$65,612 more each year than medical costs for individuals who do not have MS. The lack of adequate coverage for needed DME adds to that high cost and the difficulty of living with this expensive disease. By clarifying that DME is a covered EHB in California-regulated health plans and policies when prescribed by a doctor for rehabilitative or habilitative purposes and removing limitations such as annual caps, this bill will help people living with MS maintain their quality of life. Children Now states that many Californians do not have access to the wheelchairs, hearing aids, oxygen equipment, and other DME that they need. Children Now writes that the importance of this bill also extends to the fact that individuals with disabilities would be able to receive the benefits of comprehensive DME coverage without delay.
- 4) **OPPOSITION.** The California Chamber of Commerce (CCC) writes that employer-based health care coverage is usually one of the largest expenses a business experiences and, while this bill is well-intentioned, it will unintentionally exacerbate health care affordability issues. When health plans and insurers are required to cover new services or to waive/limit cost-sharing requirements for certain services, premiums for all enrollees and purchasers go up. This is true even though only some enrollees will utilize the mandated product or services, or benefit from the reduction in cost-sharing. CCC states that premiums for employers and enrollees consistently increase year after year due to a number of issues including benefit mandates. The 2022 Kaiser Family Foundation Employer Health Benefits Survey indicated that the average premium for family coverage has increased 20% over the last five years and 43% over the last 10 years. CCC concludes that annual premiums for employer-sponsored family health coverage reached \$22,463 in 2022, with workers on average paying \$6,106 toward the cost of their coverage.
- 5) **RELATED LEGISLATION.** SB 1290 (Roth) expresses the intent of the Legislature to review California's EHB benchmark plan and establish a new benchmark plan for the 2027 plan year. Limits the applicability of the current benchmark plan benefits to plan years on or before the 2027 plan year. SB 1290 is pending in Senate Health Committee.
- 6) **PREVIOUS LEGISLATION.**
- a) AB 1157 (Ortega) of 2023 is substantially similar to this bill and was held in Senate Appropriations Committee.
- b) SB 842 (Dodd) of 2021 would have required the Department of Rehabilitation (DOR), upon appropriation by the Legislature, to establish a device reutilization pilot program in Contra Costa, Napa, Solano, and Yolo Counties to facilitate the reuse and redistribution of assistive technology, including DME. The Governor Newsom's veto stated, in part:
- “This bill would require DOR to contract with one or more nonprofit entities to establish a three-year device reutilization pilot program in the Counties of Contra Costa, Napa, Solano, and Yolo to facilitate the reuse and redistribution of assistive technology, including durable medical equipment. The bill would also require the contracting nonprofit agency to use a computerized system to track the available inventory of equipment and supplies and organize pickup and delivery of those items.

I agree with the author's goal of increasing access to assistive technology for people with disabilities and older adults, while also reducing waste in landfills. Although the bill is

subject to appropriation, the proposed pilot is duplicative of existing assistive technology reuse programs and would cost an estimated \$5.1 million General Fund over a three-year period that was not included in the state budget.

The Legislature sent measures with potential costs of well over \$20 billion in one-time spending commitments and more than \$10 billion in ongoing commitments not accounted for in the state budget. Bills with significant fiscal impact, such as this measure, should be considered and accounted for as part of the annual budget process.”

- 7) **COMMENTS. EHBs.** The ACA requires states to defray the costs of state-mandated benefits in qualified health plans that are in excess of the EHB. If a state were to choose a benchmark plan that does not include all State-mandated benefits, the ACA requires the state to defray the cost of those mandated benefits in excess of EHB as defined by the selected benchmark. CHBRP’s analysis notes that DME for use outside of the home are not included in California’s EHB package. It is unclear whether the appropriate state regulators have conducted this analysis. As this bill moves forward, the author may wish to request DMHC to conduct this analysis.

## **REGISTERED SUPPORT / OPPOSITION:**

### **Support**

Western Center on Law and Poverty (sponsor)  
 Access Reproductive Justice  
 Asian Americans Advancing Justice-Southern California  
 Association of Regional Center Agencies  
 Bay Area Legal Aid  
 California Domestic Workers Coalition  
 California Federation of Teachers AFL-CIO  
 Children Now  
 Children's Specialty Care Coalition  
 Community Legal Aid Social  
 County Health Executives Association of California  
 Courage California  
 Hand in Hand: the Domestic Employers Network  
 Health Access California  
 Let California Kids Hear Coalition  
 National Health Law Program  
 National Multiple Sclerosis Society  
 The Leukemia & Lymphoma Society

### **Opposition**

America’s Health Insurance Plans  
 Association of California Life & Health Insurance Companies  
 CalChamber  
 California Association of Health Plans

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