



A Study of Assembly Bill A-289

A Report to the New Jersey State Assembly by the

Mandated Health Benefits Advisory Commission



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Introduction

On February 9, 2006 the Mandated Health Benefits Advisory Commission (Commission) was asked to issue a report on Assembly Bill 289 (A-289). The Commission undertook the study with the understanding that it is charged by law with investigating many facets of the impact of A-289. With this in mind and considering the limited time and resources of the Commission and Department staff, an actuarial firm with experience in such investigations, NovaRest, was engaged to study this bill and provide an estimate of impact of A-289 on premiums. The Commission understands that the Legislature specifically desires a discussion of the implications of this bill on the insurance market, including the impact on price and on the availability of necessary medical services.

The Commission received eight comments from members of the public, all in support of A-289. Seven comments were from people with hearing impaired relatives and one comment was from a representative of the American Speech-Language-Hearing Association.

Summary

The consultant's report indicates that this bill, if enacted, would result in average premium increases of approximately 0.07% (7 one-hundredths of a percent) or approximately 20 cents per month. Some carriers estimated that the increases could be as high as 0.1%. Expressed only as the cost of covering children, the estimate is 0.32% of the children's premium, or 68 cents per month per child. The Commission notes that this is a reasonable estimate of the cost increase made with the assumption that utilization and technological sophistication of the devices in question remains static, and considering the permitted limits on coverage (frequency of replacement and cost).

A certain number of people, as many as 1,000, might lose coverage solely as a result of the cost increase associated with this mandate. Estimates of the impact of price increases on the purchase of insurance coverage are based on a number of assumptions, and are consequently not precise.

We are unable to definitively quantify the extent to which the mandate would actually increase the availability of hearing aids for children 15 and under, reduce the financial

burden on those who obtain such devices, or lead to improved results in other areas such as socialization and employability. We do not know the yearly cost for children who use hearing aids, nor do we know the projected cost if insurance coverage were mandated to the extent required by A289. However, qualitatively it can be assumed that a \$1000 (or \$2000) reimbursement every two years will reduce costs to families.

What A-289 Requires

Assembly Bill 289 applies to the state regulated insurance market, the State Health Benefits Plan (SHBP) and NJ FamilyCare. The regulated insurance market includes individual and group contracts sold in New Jersey by hospital, medical and health service corporations (e.g. Horizon Blue Cross Blue Shield), individual and group policies sold by insurance companies and contracts issued by health maintenance organizations (HMOs), including contracts and policies sold in the Individual Health Coverage (IHC) and Small Employer Health (SEH) markets.

Scope

The bill requires plans to which it applies to cover expenses incurred in obtaining medically necessary hearing aids¹ for persons 15 years of age and younger as prescribed or recommended by a licensed physician or audiologist. The bill allows the benefit to be limited to \$1,000 per hearing aid for each hearing-impaired ear every 24 months. The benefits are to be provided to the same extent as for any other condition covered by the plan.²

¹ Although A-289 does not define hearing aids, N.J.S.A. 45:9A-2(c) states that a hearing aid is an electro-acoustic system scientifically designed to be head or body worn by an individual whose basic components include a microphone, amplifier and receiver. A cochlear implant does not fall within the definition of hearing aid.

² We note that eight states currently mandate some form of hearing aid coverage: Connecticut, Kentucky, Louisiana, Maryland, Minnesota, and Missouri. Oklahoma and Rhode Island.

The Current Insurance Market

Approximately 3.3 million people (out of the New Jersey population of 8.5 million) will be affected by the provisions of this bill. They are the 2.5 million people in the regulated insurance market (including 920,000 in the SEH market and 77,600 in the IHC market), approximately 800,000 covered by the SHBP and 28,000 covered by NJ FamilyCare that do not have currently have hearing aid coverage³. The proposed mandate would have no direct effect on the people covered by self funded plans other than the SHBP, Medicare, Medicaid and the uninsured.

The Current Situation

There are currently no state or federal mandates requiring coverage of hearing aids. Riders are available for purchase by groups that provide limited benefits for hearing aids. Hearing aids are covered by Medicaid and the various NJ FamilyCare plans with the exception of Plan D.

The consultant's report notes that two or three of every thousand babies are born with partial hearing loss making it the number one birth defect in America. The report also quotes a report by the Hearing Loss Association of America that "When hearing loss is detected beyond the first few months of life, the most critical time for stimulating the auditory pathways to hearing centers of the brain may be lost, significantly delaying speech and language development."

The Commission notes that in 2002, P.L. 2001, c. 373 was signed which mandates that health plans issued in New Jersey cover universal screening of newborns for hearing loss.

Impact on Premiums of A-289

The actuarial consultant evaluated the cost impact of the proposed mandate on health care premiums. They evaluated estimates provided by carriers at the request of the Department and experience in other states that have imposed a similar mandate. The consultant arrived at an overall estimate of 0.07% of premium (or 7 cents per \$100

³ Although NJ FamilyCare covers over 500,000 lives, only those enrolled in Plan D, 28,000 persons do not currently have coverage for hearing aids.

of premium). As an upper limit, one carrier reported an estimate of 0.1% of premium or 10 cents per \$100 of premium. Expressed only as the cost of covering children, the estimate is 0.32% of the children's premium, or 68 cents per month per child.

As a dollar amount, the estimated premium increase is about \$5.8 million, of total commercial market premium of \$8.3 billion. (This excludes the impact on the SHBP).

In evaluating this estimate, which may seem low, note that the incidence of need for hearing aids among children 15 and under is infrequent. The consultant estimated that 1.7% of children 15 and under require hearing aids, with 60% requiring treatment in both ears.

There are several types of hearing aids. In-the-Ear hearing aids utilize a custom made hard shell that fits completely in the outer ear. In-the-Ear aids are not usually worn by children because the casings must to be replaced as the ear grows. Behind-the-Ear aids are worn on top and behind the ear and are connected to a plastic ear mold that fits inside the outer ear. They are the most appropriate for young children. Canal Aids (In the Canal and Completely in the Canal) fit into the ear canal but must be replaced as the ear grows and therefore are not typically recommended for children. Body Aids are used by persons with profound hearing loss and involve an aid attached to a belt or pocket and connected to the ear by a wire. They are used only when other types of hearing aids are not successful.

The internal mechanics of hearing aids vary. In Analog/Adjustable aids the audiologist determines the volume and other specifications necessary for a particular person and the laboratory builds the hearing aid to those specifications although the audiologist can make some adjustments. With Analog/Programmable aids the audiologist uses a computer to program the hearing aid and can accommodate more than one program. The wearer can change the program with a remote control to adjust to different listening environments. With Digital/Programmable aids, the audiologist programs the aid with a computer and can adjust sound quality and response time on an individual basis. Digital aids provide the most flexibility for the audiologist to make adjustments.

A 2004 survey of hearing aid dispensers concluded that the average cost of hearing aids was \$1,794 with economy behind-the-ear aids averaging \$1,390 and premium behind-the-ear aids averaging \$2,559. (Ross, M. *Why do Hearing Aids Cost So Much?*, 2005. Available at: http://www.hearingresearch.org/Dr.Ross/why_do_HAs_Cost.htm)

Impact on Purchase of Coverage

The consultant's estimate (.07% increase in premium) assumes that the increase in medical costs associated with this mandate is directly reflected in the premium. As a practical matter, carriers, for competitive or other reasons, may not necessarily reflect the cost of the mandated benefit in the premium. However, this is the likely result.

Generally, increases in premiums cause some policyholders to drop insurance coverage. The extent to which an increase in premium causes a decrease in coverage cannot be precisely measured, and depends in part on the reason for the cost increase. In general, premium payers react differently to a price increase that reflects additional benefits than to a price increase that does not do so.

The term "elasticity" refers to the response of purchasers to a small price change that does not provide any additional value. Although the elasticity of demand for insurance is very difficult to measure, one study suggests that it is approximately -0.2. This means that for each 1% "valueless" increase in premium, 0.2% of policyholders will drop coverage.

This number could be high, because this cost increase is not "valueless" - additional coverage is provided as a result of the increased premium. On the other hand, the estimate of elasticity could be low. An elasticity of -0.4, indicating a greater sensitivity to price, could lead to a higher estimate of people losing coverage.

Using a population subject to the mandate of 2.5 million (3.3 million less the 800,000 in the SHBP), the highest cost impact estimated by a carrier of .1%, a high elasticity of -0.4, 1000 people would be estimated to drop coverage as a result of the cost increase arising from this mandate.

Impact on the Affordability and Utilization of Hearing Aids

It is much more difficult to estimate the impact on the affordability and utilization of hearing aids than to estimate the impact on premium. The primary impact will be on the 3.3 million people with coverage from the regulated insurance market, the SHBP and NJ FamilyCare. Some in the affected market have some level of coverage for hearing aids.

It is reasonable to assume that the use of hearing aids will increase to the extent that insurance coverage makes affordable an appliance that would not otherwise be so. Furthermore, covered appliances will be more affordable to the purchaser who might otherwise have to use his own funds to purchase a needed appliance.

It is commonly accepted that insurance coverage of a good or service tends to drive up the price of the good. Moreover, insurance coverage may result in use of more expensive hearing aids, more frequent replacement and greater use of supporting services.

A Report to the New Jersey Mandated Health Benefits Advisory Commission

***Review and Evaluation of Assembly Bill A-289
An Act concerning health benefits coverage for hearing
aids for children and supplementing various parts of the
statutory law***

April 2006

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Background

The New Jersey Legislature has requested the New Jersey Mandated Health Benefits Advisory Commission to conduct a review of Assembly Bill 289 (A-289), a bill that requires all health carriers to cover medically necessary expenses incurred in the purchase of a hearing aid for a covered person 15 years of age or younger when prescribed or recommended by a licensed provider or audiologist. The review was conducted using the requirements stipulated under the Mandated Health Benefits Advisory Commission Act, N.J.S.A. 17B:27D-1 et seq.

Considering the limited time and expertise of the Commission and Department staff, an actuarial firm, NovaRest Consulting, with experience in such investigations was engaged to study this matter and to prepare a report addressing all of those facets.

The Commission understands that the Legislature specifically desires a discussion of the implications of this bill on the insurance market, including impact on price and on the availability of necessary medical services.

What A-289 Requires

A-289 requires health plans to cover medically necessary expenses incurred in the purchase of a hearing aid for a covered person 15 years of age or younger. The definition of health plan includes hospital service corporations, medical service corporations, health service corporations, individual and small employer health benefits plans, individual and group health insurance policies, health maintenance organizations, the State Health Benefits Commission, the Children's Health Care Coverage Program, and the FamilyCare Health Coverage Program.

The bill requires health plans, on and after the bill's effective date, to cover the hearing aid benefits, but allows them to limit the coverage to \$1,000 per hearing aid for each hearing-impaired ear every 24 months.

Conclusion

Based on a macro financial analysis NovaRest estimates that there will be an impact on average health premiums of less than 0.07% for the increased coverage of hearing aids, assuming that health plans limit reimbursements to the full extent allowed in the bill. The impact on premiums would technically only affect premiums for children, but initially, insurance companies are expected to absorb the increased cost into all premiums. Eventually as insurance companies redo their tier factors the premium impact may be migrated to only affect the child premiums. NovaRest estimates the ultimate increase in premiums for children to be less than 0.32%. Carriers issuing health plans in New Jersey estimated the impact on premiums to be between 0.01% and 0.1% of premium. All estimates assume that the increased medical cost and administrative cost to processes

claims will be passed on in the form of increased premiums. Experience shows that there is not always a direct relationship between increased medical cost and increased premiums after all factors are taken into consideration.

The following table shows the estimated population affected and the number of children that will benefit from this bill.

| | Number |
|--|------------------|
| Number of children 15 and under in NJ | 1,868,879 |
| Number of children with hearing problems | 31,771 |
| Number of insured children | 503,735 |
| Number of insured children with hearing problems | 8,563 |
| Estimated number of children that will access the benefit | 6,034 |

The Current Insurance Market

A-289 will affect a small portion of the population. Although most health plans report that they do not cover hearing aids, the population requiring this equipment is small.

The current standard plans in the regulated individual and small employer markets do not cover hearing appliances. Horizon reports that hearing appliances are available as a rider in their large group market, but is generally not selected. HealthNet also offers a rider. Aetna’s traditional product covers \$400 per hearing aid every three years and their HMO product has various benefits available. AmeriHealth does not cover these devices except for on one large employer group and Oxford does not cover hearing aids for any of their medical plans.

The proposed mandate will only impact those New Jersey residents with fully insured group health insurance or individual health insurance. It will not impact those residents with coverage under the self-insured employers (excluding the SHBP, which is self-funded); those covered by Medicare and those without insurance.

The Current Situation

The Hearing Loss Association of America reports that although most hearing impairment occurs in the over age 65 population and takes 25 to 30 years to develop, child hearing loss is common. Two-three of every thousand babies are born with partial hearing loss making it the number one birth defect in America.¹

The Hearing Loss Association of America states:²

Of the 12,000 babies in the United States born annually with some form of hearing loss, only half exhibit a risk factor – meaning that if only high-risk infants are screened, half of the infants with some form of hearing loss will not be tested and identified. In actual implementation, risk-based newborn hearing screening programs identify only 10-20% of infants with hearing loss. When hearing loss is detected beyond the first few months of life, the most critical time for stimulating the auditory pathways to hearing centers of the brain may be lost, significantly delaying speech and language development.

Even mild hearing loss can significantly interfere with the reception of spoken language and education performance. Research indicates that children with unilateral hearing loss (in one ear) are ten times as likely to be held back at least one grade compared to children with normal hearing. Similar academic achievement lags have been reported for children with even slight hearing loss. Children with mild hearing loss miss 25-50% of speech in the classroom and may be inappropriately labeled as having a behavior problem.³

Over 60% of individuals with hearing loss are fit with two hearing aids (binaural). The benefits of wearing two hearing aids are enhanced ability to (a) hear better in the presence of background noise, (b) determine where sound is coming from, and (c) hear soft sounds at lower levels.⁴

There are over 1,000 types and models of hearing aids to satisfy an individual's hearing loss needs.⁵ These devices vary in technology, capability, and price. The cost of hearing aid prices varies, depending on many factors. Hearing aid prices vary, depending on many factors. Factors that influence price include: one versus two hearing aids, aural rehabilitation programs, warranty, services included, accessories, circuit sophistication, telephone coils, directional microphones, insurance coverage and other factors. Generally speaking, a pair

¹The Self Help for Hard of Hearing People has been renamed the Hearing Loss Association of America. Information can be found on their web site http://www.shhh.org/html/hearing_loss_fact_sheets.html

²Facts on Hearing Loss; HearingLoss.org – Self Help for Hard of Hearing People (Hearing Loss Association of America) http://www.shhh.org/html/hearing_loss_fact_sheets.html

³ Hearing Loss Association of America web site <http://www.shhh.org>

⁴ Hearing Loss Association of America web site <http://www.shhh.org>

⁵ NIDCD web site <http://www.nidcd.nih.gov/health/hearing/hearingaid.asp>

of hearing aids can cost anywhere from \$500 to \$6000 depending on all of these services and options.^{6 7}

Alternative Coverage or Financial Assistance

There are coverage alternatives for hearing aids. There are also sources of financial assistance for the purchase of these devices. Hearing aids for children are covered by Medicaid, Family Care (except Part D) and possibly other public programs.

The following Federal and national groups offer financial help or information about hearing aids:

- Hear Now
- AUDIENT Alliance
- U.S. Department of Veteran's Administration
- Easter Seals

Impact on Premiums of A-289

NovaRest Actuarial Consulting's estimate of the financial impact of A-289 is predicated on two important assumptions:

- 1) Health plans will maximize the benefit at the amount allowed by the bill, which is \$1,000 per impaired ear every 24 months; and
- 2) There is a serious under diagnosis and treatment of childhood hearing problems.

⁶ EARINFO.COM at <http://www.earinfo.com/Rehab6.html>

⁷ Healthy Hearing <http://www.healthyhearing.com/>

New Jersey health plans were asked to estimate the financial impact of A-289. Their replies were:

- Horizon BCBS of New Jersey – less than 0.1% in all markets except the individual market, which would be somewhat higher due to anti-selection and induced demand:
- AmeriHealth New Jersey - \$0.19⁸ increase in benefit cost and \$0.23 increase in premiums. The percent of premium impact would depend on the base premium, but would average about 0.08%; and
- Oxford Health Plans - \$0.09 to \$0.28 or around 0.1% of premium.
- Health Net Inc. Of New Jersey - \$0.01 PMPM, or less than 0.01% of overall claim costs.
- Aetna Inc. – less than 0.1% for all types of coverage.

NovaRest Actuarial Consulting has estimated that the maximum cost would be \$0.29 per insured person per month or \$0.97 per insured child, assuming that all children were diagnoses and treated, which is unrealistic. A more realistic estimate would be \$0.20 or 0.07% of average premium at the most. This equates to \$0.68 per child or 0.32% of the average premium charged to children. The NovaRest estimate is based on the following statistics:

- 26% of the New Jersey population under age 65 is 15 years old or younger (This overstates the portion of the insured population since many families cannot afford the contribution charged to cover children);
- 1.7% of children have hearing problems⁹;
- 60% of hearing problems require two hearing aids¹⁰; and
- Childhood hearing problems are under diagnosed.

⁸ All costs are in per-member-per-month or PMPM

⁹ NIDCD website, www.nidcd.nih.gov/health/hearing/hearingaid.asp

¹⁰ Facts on Hearing Loss; HearingLoss.org – Self Help for Hard of Hearing People (Hearing Loss Association of America) http://www.shhh.org/html/hearing_loss_fact_sheets.html