REPORT OF THE
SPECIAL ADVISORY COMMISSION ON MANDATED
HEALTH INSURANCE BENEFITS

HOUSE BILL 2032 MANDATED COVERAGE FOR HEARING AIDS FOR CHILDREN UNDER AGE 18

TO THE GOVERNOR AND
THE GENERAL ASSEMBLY OF VIRGINIA

COMMONWEALTH OF VIRGINIA
RICHMOND
2004

January 6, 2004

To: The Honorable Mark R. Warner
Governor of Virginia
and
The General Assembly of Virginia

The report contained herein has been prepared pursuant to §§ 2.2-2504 and 2.2-2505 of the Code of Virginia.

This report documents a study conducted by the Special Advisory Commission on Mandated Health Insurance Benefits to assess the social and financial impact and the medical efficacy of House Bill 2032 regarding a proposed mandate of coverage for hearing aids for children under age 18.

Respectfully submitted,

Stephen H. Martin
Chairman
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TABLE OF CONTENTS

INTRODUCTION

The 2003 House Committee on Commerce and Labor referred House Bill 2032 to the Special Advisory Commission on Mandated Health Insurance Benefits (Advisory Commission). House Bill 2032 is patroned by Delegate J. Chapman Petersen.

The Advisory Commission held a public hearing on August 4, 2003 in Richmond to receive public comments on House Bill 2032. In addition to the bill's chief patron, three interested parties spoke in favor of House Bill 2032. Two speakers provided testimony in support of the proposed legislation. One of the speakers was representing the interests of the Virginia Association of Speech-Language-Pathologists. Another speaker, who is hearing impaired and is involved in many hearing associations, provided testimony. The final speaker represented the Virginia Association of Health Plans (VAHP) and was opposed to the proposed legislation.

Additional public testimony was received at the November 17, 2003 meeting of the Advisory Commission. Six speakers provided testimony in support of House Bill 2032. Two speakers were parents of children with hearing impairments. Two were audiologists providing a perspective of helping children with hearing aids. The fifth speaker was a member of the hearing impaired community and who is involved in many hearing associations. The final proponent was a physician. One speaker, representing VAHP, spoke in opposition of House Bill 2032.

In addition, several letters were received by the Advisory Commission addressing House Bill 2032. Four of the letters supported the bill, and three of the letters acknowledged their opposition to the proposed mandate. A letter from the State Health Commissioner outlined the state programs that provide hearing aid assistance.

SUMMARY OF PROPOSED LEGISLATION

House Bill 2032 was introduced by Delegate J. Chapman Peterson in the 2003 General Assembly Session. House Bill 2032 amends and reenacts § 38.2-4319 and adds § 38.2-3418.14 to the Code of Virginia and requires each insurer to provide coverage for hearing aids and related services for children from birth to age 18 under such policy. The bill applies to insurers proposing to issue individual or group accident and sickness insurance policies providing hospital, medical and surgical, or major medical coverage on an expense-incurred basis; each corporation providing individual or group accident and sickness subscription contracts; and each health maintenance organization providing a health care plan for health care services.

Such coverage shall include payment of the cost of 1 hearing aid per hearing-impaired ear every 36 months, up to $1,400 per hearing aid. The insured may choose a higher-priced hearing aid and may pay the difference in cost above $1,400, with no financial or contractual penalty to the insured or to the provider of the hearing aid. The bill also provides that no insurer, corporation, or health maintenance organization shall impose upon any person receiving benefits pursuant to this section any copayment, fee, or condition that is not equally imposed upon all individuals in the same benefit category.

The bill defines hearing aids as "any wearable, nondisposable instrument or device designed or offered to aid or compensate for impaired human hearing and any parts, attachments, or accessories, including earmolds, but excluding batteries and cords." Related services would include earmolds, initial batteries, and other necessary equipment, maintenance, and adaptation training.

PRIOR ADVISORY COMMISSION REVIEW

A similar bill, Senate Bill 1191 of the 2001 Session of the General Assembly, was reviewed by the Advisory Commission in 2001. Senate Bill 1191 required the insurer to pay $1,200 for each hearing impaired ear with a loss of 30 dB or greater for at least one frequency between 500Hz and 4,000 Hz. Hearing aids and related equipment were defined the same as in House Bill 2032. The Advisory Commission recommended against enactment because the price of hearing aids is relatively high, and mandating coverage would cause the cost of insurance to be increased through higher premiums. There was concern that the mandate would increase the number of uninsureds because they would no longer be able to afford the premiums.

Advisory Commission members also had a concern about the process of fitting recipients for hearing aids and the impact a mandate would have on current industry practices.

HEARING LOSS

The NIDCD reports that there are approximately 28 million Americans who have a hearing impairment. Hearing loss is one of the most prevalent chronic health conditions in the United States, affecting those of all ages, in all segments of the population, and across all socioeconomic levels. Hearing loss affects approximately 17 in 1,000 children under age 18. Incidence increases with age; approximately 314 in 1,000 people over age 65 have hearing loss. Hearing loss can be hereditary, or it can result from disease, trauma, or long-term exposure to damaging noise or medications. Hearing loss can vary from a mild but important loss of sensitivity to a total loss of hearing. [i]

Information provided to staff by the Virginia Department for the Deaf and Hard of Hearing indicated that there are approximately 615,000 people with

some degree of hearing loss in Virginia. Approximately 1% of these 615,000 are considered to be profoundly deaf, and 7.7% are considered to be hard of hearing. The rest are considered to have mild to moderate hearing loss.[ii]

There are different types of hearing loss. Conductive hearing loss occurs when sound waves are prevented from passing to the inner ear. This can be caused by a variety of problems, including buildup of earwax (cerumen), infection, fluid in the middle ear (ear infection or otitis media), or a punctured eardrum. Sensorineural (nerve) hearing loss develops when the auditory nerve or hair cells in the inner ear are damaged by aging, noise, illness, injury, infection, head trauma, toxic medications, or an inherited condition. Mixed hearing loss is a combination of both conductive and sensorineural hearing loss. A conductive hearing loss can often be corrected with medical or surgical treatment, while sensorineural hearing loss usually cannot be reversed. [iii]

People with hearing loss may experience some or all of the following problems:

- Difficulty hearing conversations, especially when there is background noise.
- Hissing, roaring, or ringing in the ears (tinnitus).
- Difficulty hearing the television or radio at a normal volume.
- Fatigue and irritation caused by the effort to hear.
- Dizziness or problems with balance. [iv]

HEARING AIDS

The NIDCD defines a hearing aid as, "an electronic, battery-operated device that amplifies and changes sound to allow for improved communication. Hearing aids receive sound through a microphone, which then converts the sound waves to electrical signals. The amplifier increases the loudness of the signals and then sends the sound to the ear through a speaker."[v]

There are several types of hearing aids. Each type offers different advantages, depending on its design, levels of amplification, and size. Before purchasing any hearing aid, the NIDCD suggests asking whether it has a warranty that allows a trial period of the product. Most manufacturers allow a 30- to 60-day trial period during which aids can be returned for a refund.

There are four basic styles of hearing aids for people with sensorineural hearing loss:

- **In-the-Ear (ITE)** hearing aids fit completely in the outer ear and are used for mild to severe hearing loss. The case, which holds the components, is made of hard plastic. ITE aids can accommodate added technical mechanisms such as a telecoil, a small magnetic coil contained in the hearing aid that improves sound transmission during telephone calls. ITE

aids can be damaged by earwax and ear drainage, and their small size can cause adjustment problems and feedback. They are not usually worn by children because the casings need to be replaced as the ear grows.

- **Behind-the-Ear (BTE)** hearing aids are worn behind the ear and are connected to a plastic earmold that fits inside the outer ear. The components are held in a case behind the ear. Sound travels through the earmold into the ear. BTE aids are used by people of all ages for mild to profound hearing loss. Poorly fitting BTE earmolds may cause feedback, a whistle sound caused by the fit of the hearing aid or by buildup of earwax or fluid.

- **Canal Aids** fit into the ear canal and are available in two sizes. The In-the-Canal (ITC) hearing aid is customized to fit the size and shape of the ear canal and is used for mild or moderately severe hearing loss. A Completely-in-Canal (CIC) hearing aid is largely concealed in the ear canal and is used for mild to moderately severe hearing loss. Because of their small size, canal aids may be difficult for the user to adjust and remove, and may not be able to hold additional devices, such as a telecoil. Canal aids can also be damaged by earwax and ear drainage. They are not typically recommended for children.

- **Body Aids** are used by people with profound hearing loss. The aid is attached to a belt or a pocket and connected to the ear by a wire. Because of its large size, it is able to incorporate many signal processing options, but it is usually used only when other types of aids cannot be used. [vi]

According to the NIDCD, using hearing aids successfully takes time and patience. Hearing aids will not restore normal hearing or eliminate background noise. Adjusting to a hearing aid is a gradual process that involves learning to listen in a variety of environments and becoming accustomed to hearing different sounds. Some problems an individual may experience while adjusting to hearing aids include:

- becoming familiar with how to use them properly;

- becoming comfortable with how they feel in the ear;

- getting used to the “whistling” sound they sometimes emit;

- becoming used to the sound of his or her own voice, as it sometimes sounds too loud; and

- hearing background noises.[vii]

REGULATIONS AFFECTING THE HEARING AID INDUSTRY

In Virginia, Hearing Aid Specialists are regulated by The Virginia Department of Professional and Occupational Regulation, Board for Hearing Aid Specialists (The Board). The Board defines a hearing aid specialist as "a person who engages in the practice of fitting and dealing in hearing aids or who advertises or displays a sign or represents himself as a person who practices the fitting and dealing of hearing aids." A licensee means "any person holding a valid license issued by the Board for Hearing Aid Specialists for the practice of fitting and dealing in hearing aids, as defined in § 54.1-1500 of the Code of Virginia." As of July 1, 2003, the Board reported there were 438 licensed hearing aid specialists in Virginia.[viii]

The Virginia Department of Health Professions regulates audiologists and speech-language pathologists (The Department). The Department defines an audiologist as one who practices "conducting measurement, testing and evaluation relating to hearing and vestibular systems, including audiologic and electrophysiological measures, and conducting programs of identification, hearing conservation, habilitation, and rehabilitation for the purpose of identifying disorders of the hearing and vestibular systems and modifying communicative disorders related to hearing loss including but not limited to vestibular evaluation, electrophysiological audiometry and cochlear implants."[ix]

Speech-language pathologists are defined as those who "practice the facilitating development and maintenance of human communication through programs of screening, identifying, assessing and interpreting, diagnosing, habilitating and rehabilitating speech-language disorders, including but not limited to:

1. Providing alternative communication systems and instruction and training in the use thereof;

2. Providing aural habilitation, rehabilitation and counseling services to hearing-impaired individuals and their families;

3. Enhancing speech-language proficiency and communication effectiveness; and

4. Providing audiologic screening.

As of July 1, 2003, the Virginia Department of Health Professions reported there were 405 audiologists, 2,176 speech-language pathologists, and 76 speech-language pathologists in public schools in the state of Virginia.[x]

CURRENT INDUSTRY PRACTICES

The State Corporation Commission's Bureau of Insurance surveyed sixty of the top writers of accident and sickness insurance in Virginia in April 2003, regarding the bills to be reviewed by the Advisory Commission this year. Fifty companies responded by the deadline. Thirteen companies indicated that they have little to no, applicable health insurance business in force in Virginia. These thirteen companies write few, if any, policies that are subject to insurance mandates. Of the remaining 37 companies, only 2 companies reported that they provided the coverage required by House Bill 2032, under their standard benefit package. Thirty-five companies said they did not provide the coverage. Six companies responded that they provide the coverage on an optional basis to group policyholders.

Fifteen companies provided cost estimates of premium prices for providing the coverage for House Bill 2032. Respondents to the survey provided cost figures of between $.27 and $1.87 per month per standard individual policy. One company reported the cost to be .1%. Cost figures were between $.35 and $3.00 per month per standard group certificate, to provide the coverage required by House Bill 2032. Again, one company reported the cost to be .1%. Seven companies providing cost figures for coverage on an optional basis estimated a cost of $.05 to $4.46 per month per standard individual policy, and ten companies estimated a cost between $.05 to $2.67 per month per standard group certificate.

FINANCIAL IMPACT

Staff obtained information on hearing aid prices from the Department of Audiology at the Medical College of Virginia. The body aid style of hearing aid costs approximately $1,100. The range of prices for a Behind-the-Ear style is approximately $700 to $2,800. The In-the-Ear hearing aid prices are approximately $700 to $3,000. The In-the-Canal hearing aids costs range from $800 to $3,200. The Completely-in-Ear hearing aid costs range from $1,300 to $3,600. [xi]

The figures above are cost estimates that represent the prices for a single hearing aid. The audiologist explained that the costs of hearing aids vary depending upon the style of the hearing aid, the make of the hearing aid, and the circuitry inside the hearing aid. A discount of $100-$500 can often be obtained on these prices, when a second hearing aid is ordered at the same time.

SIMILAR LEGISLATION IN OTHER STATES

According to information available to staff from the National Insurance Law Service and the National Association of Insurance Commissioners, 4 states currently have a mandate for hearing aids for those under age 18. Oklahoma requires group plans to cover audiological services and hearing aids for children

up to 18 years of age. The benefit is limited to one hearing aid per hearing impaired ear every 4 years. Maryland requires insurers to cover "hearing aids for a minor child who is covered under a policy or contract, if the hearing aids are prescribed, fitted, and dispensed by a licensed audiologist." Maryland's coverage extends to $1,400 per hearing aid for each hearing impaired ear, every 36 months.

Connecticut also requires insurers to provide coverage for hearing aids for children twelve years of age or younger. The coverage is considered durable medical equipment under the policy and the policy may limit the hearing aid benefit to one thousand dollars within a twenty-four month period. Kentucky provides coverage for cochlear implants for people with profound hearing impairment. The coverage is limited to one hearing aid per hearing impaired ear every 36 months. Rhode Island requires insurers to offer an optional rider to add hearing aid coverage to group policies.

REVIEW CRITERIA

SOCIAL IMPACT

a. The extent to which the treatment or service is generally utilized by a significant portion of the population.

The NIDCD reports that there are approximately 28 million Americans who have a hearing impairment. Hearing loss is one of the most prevalent chronic health conditions in the United States, affecting those of all ages, in all segments of the population, and across all socioeconomic levels. Hearing loss affects approximately 17 in 1,000 children under age 18. Incidence increases with age; approximately 314 in 1,000 people over age 65 have hearing loss. Hearing loss can be hereditary, or it can result from disease, trauma, or long-term exposure to damaging noise or medications.[xii]

Information provided to staff by the Virginia Department for the Deaf and Hard of Hearing indicated that there are approximately 615,000 people in Virginia with some degree of hearing loss. Approximately 1% of these 615,000 are considered to be profoundly deaf, and 7.7% are considered to be hard of hearing. The rest are considered to have mild to moderate hearing loss.[xiii]

b. The extent to which insurance coverage for the treatment or service is already available.

The State Corporation Commission's Bureau of Insurance surveyed sixty of the top writers of accident and sickness insurance in Virginia in April 2003, regarding the bills to be reviewed by the Advisory Commission this year. Fifty companies responded by the deadline. Thirteen companies indicated that they have little to no, applicable health insurance business in force in Virginia. These thirteen companies write few, if any, policies that are subject to insurance

mandates. Of the remaining 37 companies, only 2 companies reported that they provided the coverage required by House Bill 2032, under their standard benefit package. Thirty-five companies said they did not provide the coverage. Six companies responded that they provide the coverage on an optional basis to group policyholders.

In Virginia, children can be helped by two state government programs. Under the Virginia Department of Health, The Care Connection for Children, with a limited amount of money, is set up to help children with special health care needs. The children must be less than 21 years of age and have a family income at or below 300% of the federal poverty level and the pool of funds can only be accessed when all other resources are exhausted.

Also, the Part C Early Intervention System, which is administered by the Department of Mental Health, Mental Retardation and Substance Abuse Services, can be a source for hearing impaired children from birth to age two. Part C must be used as a payer of last resort, when local, state, and national resources are exhausted.

c. If coverage is not generally available, the extent to which the lack of coverage results in persons being unable to obtain necessary health care treatments.

Several proponents testified that they would not be able to provide treatment, in the form of hearing aids to their children. They explained that hearing aids are very expensive, and they could not afford to purchase them for their hearing impaired children. Therefore, if the coverage is not provided many children in need of hearing aids will go without them.

d. If the coverage is not generally available, the extent to which the lack of coverage results in unreasonable financial hardship on those persons needing treatment.

Proponents suggest that without mandating coverage for hearing aids, many would be unable to purchase hearing aids for their children. They suggested that many working families could not afford hearing aids because of their the expensive nature, which could reach over $7,000 for two hearing impaired ears.

e. The level of public demand for the treatment or service.

The NIDCD reports that there are approximately 28 million Americans who have a hearing impairment.[xiv] Information provided to staff by the Virginia Department for the Deaf and Hard of Hearing indicated that there are approximately 615,000 people with some degree of hearing loss in Virginia. Approximately 1% of these 615,000 are considered to be profoundly deaf, and

7.7% are considered to be hard of hearing. The rest are considered to have mild to moderate hearing loss.[xv]

f. The level of public demand and the level of demand from providers for individual and group insurance coverage of the treatment or service.

No providers addressed this issue. Two audiologists made brief remarks at the November 17, 2003 Advisory Commission meeting. Both stated that they see patients, who need hearing aid assistance and cannot afford it. Both also stated their belief that children who need hearing aids and do not receive them will become educationally and socially behind their peers. They both stated that children who do receive assistance for hearing aids often have equipment that is technologically outdated and inexpensive.

g. The level of interest of collective bargaining organizations in negotiating privately for inclusion of this coverage in group contracts.

No information was received from collective bargaining organizations addressing potential interest in negotiating privately for inclusion of this coverage in group contracts.

h. Any relevant findings of the state health planning agency or the appropriate health system agency relating to the social impact of the mandated benefit.

Information provided to staff by the Virginia Department for the Deaf and Hard of Hearing indicated that there are approximately 615,000 people in Virginia with some degree of hearing loss. Approximately 1% of these 615,000 are considered to be profoundly deaf, and 7.7% are considered to be hard of hearing. The rest are considered to have mild to moderate hearing loss.[xvi]

FINANCIAL IMPACT

a. The extent to which the proposed insurance coverage would increase or decrease the cost of treatment or service over the next five years.

VAHP noted that the price of the required coverage is $1,400 per hearing impaired ear. They noted that they have found several advertisements for hearing aids priced much lower than the coverage limits. Some of the advertisements listed the price of hearing aids as low as $300. Proponents also discussed a rise in health insurance premiums. The unifying theme of their comments was that with the addition of each mandate, there will be an increase of premiums in the insurance market, which would cause health insurance to be unaffordable for more Virginians.

b. The extent to which the proposed insurance coverage might increase the appropriate or inappropriate use of the treatment or service.

Proponents expect that with insurance coverage of hearing aids, children with hearing loss would be helped, and there would be a more appropriate use of hearing aids by helping those who need the assistance. The proponents overwhelmingly stated that many children in Virginia and across the nation need hearing aids but cannot afford them, and that insurance coverage is not readily available. They believe that cost and the lack of insurance coverage are barriers that prevent the hard of hearing community from receiving hearing aids. If the benefit was mandated, it is anticipated that hearing aids would be made available to many of those children that need and could use them.

Information provided to staff from the SHHH organization reports that one of the three main reasons that people with hearing loss are not wearing hearing aids is because of the cost. Also, the information stated that of people who would benefit from hearing aids, approximately seven million people cannot afford to buy hearing aids.

c. The extent to which the mandated treatment or service might serve as an alternative for more expensive or less expensive treatment or service.

The alternative of providing coverage for hearing aids for children who have hearing loss or are hard of hearing is for those children to continue with un-aided hearing loss. Hearing aids alleviate the problem of hearing loss for hearing impaired ears. The alternative would be to not provide coverage for hearing aids, and the burden of finding assistance to pay for hearing aids would fall on parents.

d. The extent to which the insurance coverage may affect the number and types of providers of the mandated treatment or service over the next five years.

Mandating insurance coverage for hearing aids may result in an increase in providers. Three professions, Hearing Aid Specialists, Audiologists, and Speech-Language Pathologists, can help fit children with hearing loss with hearing aids.

In Virginia, Hearing Aid Specialists are regulated by The Virginia Department of Professional and Occupational Regulation, Board for Hearing Aid Specialists (The Board). The Board defines a hearing aid specialist as "a person who engages in the practice of fitting and dealing in hearing aids or who advertises or displays a sign or represents himself as a person who practices the fitting and dealing of hearing aids." A licensee means "any person holding a valid license issued by the Board for Hearing Aid Specialists for the practice of fitting and dealing in hearing aids, as defined in § 54.1-1500 of the Code of Virginia."

As of July 1, 2003, the Board reported there were 438 licensed hearing aid specialists in Virginia.[xvii]

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Speech-language pathologists are defined as those who "practice the facilitating development and maintenance of human communication through programs of screening, identifying, assessing and interpreting, diagnosing, habilitating and rehabilitating speech-language disorders, including but not limited to:

1. Providing alternative communication systems and instruction and training in the use thereof;

2. Providing aural habilitation, rehabilitation and counseling services to hearing-impaired individuals and their families;

3. Enhancing speech-language proficiency and communication effectiveness; and

4. Providing audiologic screening. [xix]

As of July 1, 2003, the Virginia Department of Health Professions reported there were 405 audiologists, 2,176 speech-language pathologists, and 76 speech-language pathologists in public schools in the Commonwealth of Virginia.[xx]

e. The extent to which insurance coverage might be expected to increase or decrease the administrative expenses of insurance companies and the premium and administrative expenses of policyholders.

Fifteen companies provided cost estimates of premium prices for providing the coverage for House Bill 2032. Respondents to the survey provided cost figures of between $.27 and $1.87 per month per standard individual policy. One company reported the cost to be .1%. Cost figures were between $.35 and $3.00 per month per standard group certificate, to provide the coverage required by House Bill 2032. Again, one company reported the cost to be .1%. Seven companies providing cost figures for coverage on an optional basis estimated a cost of $.05 to $4.46 per month per standard individual policy, and ten

companies estimated a cost between $.05 to $2.67 per month per standard group certificate.

Several opponents, including VAHP, HIAA, and the Virginia Chamber of Commerce, through letters or at the public hearing, expressed the concern that House Bill 2032 would increase the premium and administrative expenses of policyholders. VAHP stated that some financial assistance is already available to parents of hearing-impaired children. Most of the programs they mentioned are federal and state government programs for families that must qualify based on low income. VAHP also mentioned private organizations that provide hearing aids or assistance to families in need. VAHP also explained that the proposed coverage is $1,400 per hearing impaired ear, when some hearing aids are sold for $300. All three of the aforementioned groups also discussed a rise in health insurance premiums. The unifying theme of their comments was that with the addition of each mandate, there will be an increase in premiums in the insurance market. Opponents believe that additional increases would cause health insurance to be unaffordable for more Virginians.

f. The impact of coverage on the total cost of health care.

One proponent suggested that enacting the legislation for coverage of hearing aids would lead to cost containment features in healthcare. The proponent explained that people who have low incomes and are in need of hearing aids qualify for Supplemental Security Income (SSI). He explained that SSI pays beneficiaries $450 per month, which equates to $91,800 over 17 years. This is substantially less than providing a hearing aid per hearing impaired ear every 36 months until age 18. The same proponent argued that those who cannot learn cued speech because of a lack of hearing aids will have a harder time finding employment, possibly leading to poverty and reliance of federal programs for the poor or needy.

Opponents suggest that coverage for mandated health insurance mandates has a direct link to a rise in health insurance premiums. The unifying theme of their comments was that with the addition of each mandate, there will be an increase of the premiums in the insurance market, causing health insurance to be unaffordable for more Virginians. Opponents believe that small businesses and those who pay for their own insurance costs will feel the greatest economic impact of additional health insurance mandates. Opponents further argued that the group health insurance market would also be impacted because employers would decrease benefits and increase the employee share of the health coverage cost to compensate for an increase in premiums.

MEDICAL EFFICACY

a. The contribution of the benefit to the quality of patient care and the health status of the population, including the results of any research demonstrating the medical efficacy of the treatment or service compared to alternatives or not providing the treatment or service.

The NIDCD defines a hearing aid as; "an electronic, battery-operated device that amplifies and changes sound to allow for improved communication. Hearing aids receive sound through a microphone, which then converts the sound waves to electrical signals. The amplifier increases the loudness of the signals and then sends the sound to the ear through a speaker." [xxi]

A physician testified that permanent hearing loss in children could interfere with a child's development. He argued that if a child cannot hear, then the normal development of speech perception and production, as well as language, literacy skills and social development, may be lost or delayed. If hearing aids are provided for these children, the proponent argued, the children can be mainstreamed in regular classrooms and will achieve improved academic performance.

b. If the legislation seeks to mandate coverage of an additional class of practitioners:

1) The results of any professionally acceptable research demonstrating the medical results achieved by the additional class of practitioners relative to those already covered.

Not applicable.

2) The methods of the appropriate professional organization that assure clinical proficiency.

Not applicable.

EFFECTS OF BALANCING THE SOCIAL, FINANCIAL AND MEDICAL EFFICACY CONSIDERATIONS

a. The extent to which the benefit addresses a medical or a broader social need and whether it is consistent with the role of health insurance.

Proponents suggest that enacting House Bill 2032 would address both a medical and a broader social need. House Bill 2032 seeks to require coverage of hearing aids for those children (under age 18) who are hearing impaired. Proponents clearly noted that by adding this coverage, a broader social need will

be met. They stated that hearing is a part of a normal everyday activity; and hearing aids will initiate social conversation between those who are hearing impaired and those who are not. Educationally, hearing impaired students are as intelligent as their peers, but without hearing aids, the communication and learning process is slowed or lost.

One proponent noted a 30-year study by Gallaudet University. The study concluded that half of the children with hearing loss and no hearing aids would graduate from high school with a 4th grade reading level. It was also noted that children with mild hearing loss in only one ear are ten times more likely to be held back for at least one year in school. These children could possibly miss as much as 25-50% of the speech in their classrooms (without hearing aids), hampering their education.

b. The extent to which the need for coverage outweighs the costs of mandating the benefit for all policyholders.

Fifteen companies provided cost estimates of premium prices for providing the coverage for House Bill 2032. Respondents to the survey provided cost figures of between $.27 and $1.87 per month per standard individual policy. One company reported the cost to be .1%. Cost figures were between $.35 and $3.00 per month per standard group certificate, to provide the coverage required by House Bill 2032. Again, one company reported the cost to be .1%. Seven companies providing cost figures for coverage on an optional basis estimated a cost of $.05 to $4.46 per month per standard individual policy, and ten companies estimated a cost between $.05 to $2.67 per month per standard group certificate

One proponent suggested that enacting the legislation for coverage of hearing aids would lead to cost containment features in healthcare. The proponent explained that people who are poor and in need of hearing aids qualify for Supplemental Security Income (SSI). He explained that SSI paid beneficiaries $450 a month, which equated to $91,800 over 17 years. This is substantially less than providing a hearing aid per hearing impaired ear every 36 months until age 18. The same proponent argued that those who cannot learn cued speech because lack of hearing aids will have a harder time finding employment, possibly leading to poverty and reliance of federal programs for the poor or needy.

Opponents suggest that coverage for mandated health insurance mandates has a direct link to a rise in health insurance premiums. The unifying theme of their comments was that with the addition of each mandate, there will be an increase of the premiums in the insurance market, causing health insurance to be unaffordable for more Virginians. Opponents believe that small businesses and those who pay for their own insurance costs will feel the greatest economic impact of additional health insurance mandates. Opponents further

argued that the group health insurance market would also be impacted because employers would decrease benefits and increase the employee share of the health coverage cost to compensate for an increase in premiums.

c. The extent to which the need for coverage may be solved by mandating the availability of the coverage as an option for policyholders.

In the case of group coverage, the decision whether to select the optional coverage or not would lie with the master contract holder and not the individual insureds.

RECOMMENDATION

The Advisory Commission voted unanimously (10-0) on November 17, 2003 to recommend against the enactment of House Bill 2032.

CONCLUSION

House Bill 2032 would provide hearing aids for children under 18 years of age. The coverage would require coverage of the cost of 1 hearing aid per hearing-impaired ear every 36 months, up to $1,400 per hearing aid. The Advisory Commission believes that those children with hearing impairment would be assisted physically, educationally, and socially if hearing aids were provided. They believe that House Bill 2032 would improve the overall well-being of children needing hearing aids who cannot afford them. However, Advisory Commission members believe that because the price of hearing aids is relatively high, mandating coverage would directly cause the cost of insurance to be increased through higher premiums. There was concern that the mandate would increase the number of uninsureds because they would no longer be able to afford the cost of health care coverage.

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[i] Hearing Aids. June 2003. The National Institute on Deafness and Other Communication Disorders Website. www.nidcd.nih.gov.
[ii] Information provided to Staff, Phone Interview. May 2003. Virginia Department for the Deaf and Hard of Hearing.
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[ix] Professions Regulated by the Board. June 2003. Virginia Department of Health Professions. www.dhp.state.va.us
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