November 2, 2020

The Honorable Janet D. Howell, Chair
Senate Finance and Appropriations Committee
Senate of Virginia

The Honorable Luke E. Torian, Chair
House Appropriations Committee
Virginia House of Delegates

Dear Senator Howell and Delegate Torian:

Enclosed is JLARC's report on our review of Senate Bill 423 (2020), which mandates health insurance coverage of hearing aids for children and youth under the age of 19. Item 487 C. 1-3 of the 2020-2022 Appropriation Act requires JLARC and the Bureau of Insurance to examine whether changes could be made to the Essential Health Benefits Benchmark Plan to include hearing aids for minors at no cost to the Commonwealth. The budget language requires that this report be provided to you by November 1, 2020.

Please contact me at (804) 371-4572 or Tracey Smith, Associate Director, at (804) 371-4567 with any questions.

Sincerely,

Hal E. Greer

Hal E. Greer
Director

Enclosure

cc: April Kees, Staff Director, Senate Finance and Appropriations Committee
Anne Oman, Staff Director, House Appropriations Committee

Summary: Health Insurance Mandate Review – Hearing Aids for Youth Under Age 19

Legislation would mandate health insurance coverage of hearing aids for youth under age 19

Senate Bill 423, passed during the 2020 General Assembly session, mandates that insurance plans in the individual and fully insured group markets cover hearing aids for children. The bill requires plans to cover up to $1,500 per hearing impaired ear for hearing aids and related services every two years. In addition, the bill requires that the hearing aid be recommended by an otolaryngologist, a physician specializing in the ears, nose, and throat (commonly referred to as an 'ENT').

WHY WE DID THIS STUDY

The 2020 Appropriation Act directed JLARC to review the impacts of the proposed mandate. As directed by the Code of Virginia, JLARC staff participate in the assessments of bills that would mandate insurance coverage of specific health-care benefits, when requested by the Health Insurance Reform Commission. JLARC's assessments focus on the medical effectiveness of the proposed coverage; the current availability and use of treatment; the current financial impact on people without coverage for treatment; and the proposed mandate's consistency with the purpose of health insurance and impact on public health.

ABOUT SENATE BILL 423 (2020)

SB 423 (2020) would mandate medical insurance coverage for hearing aids for children and youth under the age of 19 with a limit of $1,500 per hearing impaired ear over a two-year period.

Hearing aids are necessary for children with hearing loss but are expensive for families

There is consensus in the medical community that hearing aids are necessary for children with hearing loss. Hearing aids are the primary way to amplify sound and enable children with hearing loss to hear. Enabling children to hear at very young ages is essential to their speech and language development. Audiologists and otolaryngologists have a goal to fit hearing aids to newborns with hearing loss within six months after birth, because the earlier a child is able to hear effectively, the better their speech and language development.

Hearing aids and related services cost between $2,200 and $3,700 per ear over the course of two years, and very few health plans in the individual and fully-insured group markets cover these services. Many children have hearing loss in both ears, doubling the cost to the families. Audiologists report that many families struggle with the financial burden of paying for hearing aids.

Under the Virginia Health Benefit Exchange law, proposed mandate would not apply to individual and small group plans

Maximizing the number of Virginians who would receive coverage for children's hearing aids would necessitate the passage of a new mandate (to include the large group market) and adopting a new benchmark plan (to include qualified individual and small group plans).

Under the Virginia Health Benefit Exchange law that was enacted in 2020, new state health insurance mandates cannot be applied to individual and small group health plans that are part of the exchange. Therefore, if SB423 were enacted it would *not* apply to these plans. The mandate would, however, apply to fully-insured large group plans, including the five state employee health plans.

Virginia could adopt a new essential health benefits benchmark plan that includes hearing aid coverage, which would result in plans in the individual and small group markets providing this benefit. (Under the ACA, individual and small group plans are required to offer coverage included in the state's benchmark plan.) However, large employer group health plans would not be required to provide this coverage. The Centers for Medicare and Medicaid Services clarified this year that a state must defray the cost to insurance plans of any new mandates enacted on or after January 1, 2012 even if they are part of a new benchmark plan. The state would therefore incur costs under this approach. Further, a new benchmark plan must meet all federal requirements and is unlikely to be implemented until at least January 2023.

SB423 would have a fiscal impact for the state, because it would apply to the five state employee health plans. General funds are used to pay for a portion of the state employee plans' premiums. Language in the Appropriation Act states that SB423 will not be enacted on July 1, 2021 if it is expected to have a fiscal impact.

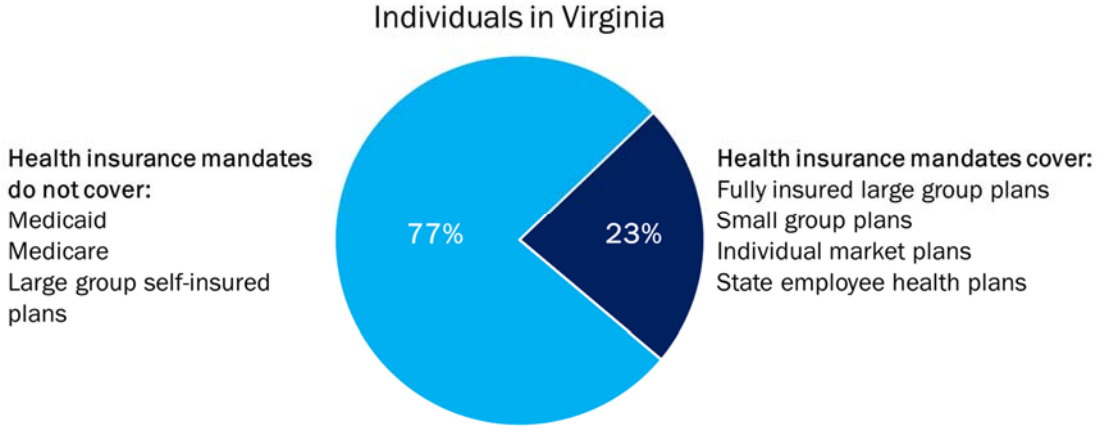
An explanation of the JLARC staff review is included on the pages that follow.

SB423 would require coverage of hearings aids and related services for children and youth under 19

SB423, enacted by the 2020 General Assembly, mandates that individual and fully insured group health insurance plans provide coverage for hearing aids and related services for children and youth under age 19. The bill requires insurance plans to pay up to $1,500 per hearing impaired ear for hearing aids and related services every two years. This would result in a child with hearing loss in both ears being eligible to receive up to $3,000 in coverage over the course of two years. The legislation also requires that the hearing aids be recommended by an otolaryngologist, who is a physician that specializes in the ears, nose, and throat (commonly referred to as an "ENT").

Statutorily mandated health insurance benefits apply to all individual and fully insured group health insurance plans. About 1.8 million Virginians (21 percent) are covered by these plans (Figure 1). Additionally, in 2009 the General Assembly established that the state employee health plan, which includes about 192,000 individuals (2 percent of Virginians), will cover all health insurance mandates. Most Virginians have health insurance through other insurance plans that the bill would not cover, including large self-insured plans, which are primarily used by large employers, and publicly funded plans like Medicaid and Medicare.

FIGURE 1
Mandated health insurance benefits cover 23 percent of Virginians



SOURCE: JLARC analysis of insurance market enrollment data provided by BOI and population data from the U.S. Census Bureau.

Over the last 12 years, four bills have proposed coverage of hearing aids for children, including SB423 (Table 1). Each of these bills provided different dollar limits for coverage and the length of time before the dollar limit resets. Only one bill (HB2156, 2019) included coverage for all plan members, not just children.

TABLE 1
SB423 is the fourth bill to propose mandating coverage of hearing aids for children since 2008

Year	Legislation	Coverage of :
2008	HB 237	Hearing aids and related services for children from birth to age 18 when a licensed audiologist prescribes the hearing aids and related services. The coverage proposed included one hearing aid per hearing-impaired ear, up to a cost of $1,500, every 24 months
2015	HB 2156	Hearing aids and related professional services when prescribed or provided by a licensed audiologist. This bill did not include age or coverage limits.
2019	HB 2601	Hearing aids and related services for children from birth to age 18. The proposed coverage included one hearing and related services aid per hearing impaired ear every 48 months, up to a cost of $4,800. Included exemptions for specific types of health plans.
2020	SB 423	Hearing aids and related services for children from birth to age 18 when an otolaryngologist recommends the hearing aids and related services. The proposed coverage includes one hearing aid per hearing-impaired ear, up to a cost of $1,500, every 24 months.

SOURCE: JLARC analysis of prior legislation that proposed mandated health insurance benefits for hearing aids for children in Virginia.

Hearing aids are necessary for children with hearing loss to develop speech and language skills

Hearing aids are the primary treatment for children with hearing loss. Enabling children to hear adequately at a very young age is critical to the development of speech and language skills. There are no alternatives to amplify sound for children with mild to severe hearing loss. Very few insurance plans cover these necessary services, and insurance plans indicate this is because they have not traditionally been part of standard health insurance coverage. The lack of coverage can cause financial hardships for families who have to pay the full cost of those services.

Hearing loss occurs in less than 1 percent of children, and hearing aids are the primary treatment for child hearing loss

The precise number of children requiring hearing aids in Virginia is unknown, and JLARC estimates that between 0.1 and 0.5 percent of all children under the age of 19 require hearing aids. This equates to between 500 and 2,000 children in the individual and fully insured group markets. All newborns born in Virginia receive a hearing screening in the hospital, and 0.14 percent of newborns have some sort of hearing loss identified during those screenings. According to U.S. Census Bureau surveys, 0.51 percent of children have some sort of hearing loss. Data from two populations within Virginia put the prevalence in the middle of this range, with 0.24 percent of children in Virginia's Medicaid program, and 0.29 percent of children in the state employee health plan received hearing aids or related services in FY19.

Nearly all types of hearing loss require the assistance of hearing aids. Doctors and audiologists characterize the severity of hearing loss from mild to profound (Table 2), depending on the type and volume of sounds that a child can hear without amplification. Hearing loss across every part of this spectrum requires some level of amplification to hear adequately, and only the most profound cases

are unable to be addressed with hearing aids. There are no medical alternatives to help children with mild to severe hearing loss amplify sounds and hear sufficiently. Children with profound hearing loss can be candidates for cochlear implants, but no other alternative treatments exist.

TABLE 2
Hearing loss ranges from mild to profound

Severity	Hearing threshold	Description of symptoms
Mild	25-40 dB	Difficulty understanding quiet conversations, especially with background noise
Moderate	40-60 dB	Difficulty understanding speech; require higher volume for TV/radio
Severe	60-80 dB	Speech must be louder than normal; group conversations are difficult
Severe to profound	80-90 dB	Difficulty with speech; comprehension requires amplification
Profound	>90 dB	Even amplified devices and sounds are difficult to hear and understand

SOURCE: Boys Town National Research Hospital.
NOTE: The normal hearing threshold is between 0 and 25 decibels.

Hearing aids help children with hearing loss develop speech and language skills

There is consensus in the medical community that the use of hearing aids for children with hearing loss improves the child's ability to develop speech and language skills. Hearing aids do not correct the underlying problem that leads to hearing loss, but they amplify sounds so children can hear better. One study found that the longer children wear hearing aids, the better their ability to develop speech and language skills over time.

The earlier a child is properly diagnosed and fitted for a hearing aid, the better their speech and language development will be. To address this, doctors are encouraged to fit infants who are identified with hearing loss on the newborn screening with a hearing aid within six months. To wear hearing aids by six months old, an infant must undergo a more in-depth hearing test at one month of age and be fitted for hearings aids by three months of age. One study found that children fit for hearing aids before six months of age had strong speech and language development by the time they turned two years old. This same study found much lower levels of speech and language development when children were fitted for hearing aids after they were 18 months old.

Hearing aids and associated related services cost, in total, between $2,200 and $3,600 per ear during the first two years

The cost of hearing aids and related services varies, but the total cost is typically between $2,200 and $3,700 over the first two years of the hearing aid and treatment. About 60 percent of children have hearing loss in both ears, doubling the cost to the family. This estimate includes the hearing aid as well as other necessary equipment and follow-up services. The primary factor that drives the difference in cost is the type of hearing aid purchased. The most recent models with advanced technology are more expensive than older models.

The related services and other equipment include follow-up visits as well as the ear mold that fits into the child's hear to transmit the sound. These ear molds need to be replaced as the child grows, which can be every two months for newborns and then typically every six months to a year for older children. Children with hearing aids also need to visit an audiologist regularly to ensure that the hearing aids fit properly and are adjusted based on the severity of their hearing loss. This typically requires visits every six months, and more often (every 2–3 months) for children under two because of their rapid rate of growth.

Hearing aids typically last about three to five years. Audiologists indicated that most new hearing aids come with a five-year warranty. The warranty will cover any defects and also one replacement if the hearing aid is lost. Because many children need hearing aids at a young age, it is not uncommon to have to replace lost hearing aids.

The Virginia Department of Health operates a hearing aid loaner program for families who have difficulty paying for hearing aids. Under the program, families meeting certain financial criteria can borrow hearing aids for several months while they make arrangements to purchase hearing aids. Audiologists indicated that most families facing financial hardship eventually find a way to purchase the hearing aids, through either extended family support or charitable organizations, but that the cost is a significant challenge for many families.

Because SB423 would cover up to $3,000 over two years, parents would likely need to pay between $700 and $2,100 over the first two years that their child has a hearing aid. In the next two years though, the cost of follow-up visits and replacement parts would likely be less and would be fully covered by the plan (Table 3).

TABLE 3
Example cost of hearing aids and related services over time

	Cost of hearing aids and services	Insurance pays (under SB423)	Family pays
Year 1 (hearing aid, office visits, ear molds)	$1,900 - $3,300	$1,500	$400 - $1,800
Year 2 (office visits, replacement ear molds)	$300	$0	$300
Total after 2 years	$2,200 - $3,600	$1,500	$700 - $2,100
Year 3	$300	$300	$0
Year 4	$300	$300	$0
Total after 4 years	$2,800 - $4,200	$2,100	$700 - $2,100

SOURCE: JLARC analysis of other state mandates collected by the National Conference of State Legislatures.

Designating separate dollar limits for hearing aids versus related services would better align the coverage with the typical treatment protocols. A limit could be placed on the cost of the hearing aid

itself, along with a length of time before that limit resets. A second, annual limit could be placed on the coverage of related parts and services, because these are more consistent, annual costs.

Few state-regulated insurance plans in Virginia currently cover hearing aids for children, but coverage is increasingly being required by other states

The vast majority of Virginians enrolled in plans through the individual and fully insured group markets do not have coverage for hearing aids. Only one of the 10 largest insurance carriers in these markets covers hearing aids and related services in all of its health insurance plans. Most of the insurance plans do cover the newborn screening, as well as cochlear implants for children with the most profound hearing loss for whom hearing aids are not an effective treatment.

There are now 24 other states that either require coverage of hearing aids or include it in their essential health benefit benchmark plan. (Under the ACA, all individual and small group health plans must offer coverage included in the state's benchmark plan.) This includes 10 states that required hearing aid coverage since 2010, and four since 2017. The dollar limits in other states tend to be similar to the $1,500 in SB423, but the length of time before that dollar limit resets is most often three years, rather than two (Table 4).

TABLE 4
Other states' hearing aid mandates have similar limits to SB423

	Other states (24)	SB423
Median dollar limit on hearing aids and related services	$1,500 per ear	$1,500 per ear
Time limit on coverage (time until the dollar limit resets)	3 years	2 years

SOURCE: JLARC analysis of other state mandates collected by the National Conference of State Legislatures.

Following enactment of the Virginia Health Benefit Exchange, hearing aid mandate would not apply to individual and small group qualified health insurance plans

The Step 1 review conducted in 2019 by the Bureau of Insurance (BOI) determined that requiring hearing aid coverage for children would be a new health mandate, and federal rules require the state to cover the cost of mandated benefits. The Patient Protection and Affordable Care Act (ACA) requires that all health plans cover 10 essential health benefits, and that states will choose a 'benchmark' plan that establishes the specific coverage required across those 10 categories. If a state chooses to mandate any benefits that exceed the coverage in the benchmark plan, the state is responsible for reimbursing individual and small group insurance plans for the cost of services under that mandate. This keeps the cost from being passed on to consumers through higher premiums. BOI estimates the total state defrayal cost of the coverage in SB423 would be between $72,806 and $273,024 per year.

The 2020 General Assembly created the Virginia Health Benefit Exchange. Under this law, new state health insurance mandates cannot be applied to individual and small group health plans that are part

of the exchange ("qualified health plans"). The benefits mandated by SB423 therefore would *not* apply to these plans and the state would *not* have to defray any costs.

Mandate would apply to fully-insured large group plans, and the only state costs would be for increased state employee health plan premiums

Virginia can require health insurance plans to cover the cost of hearing aids for children and youth, but a new health insurance mandate will only apply to Virginians who are in fully-insured large group plans and fully-insured individual and small group health plans that are *not* qualified health plans in the Virginia Health Benefit Exchange.

Even though there would not be state defrayal costs, there *would* be a fiscal impact to the state, because each of the five state employee health plans would need to cover children's hearing aids. The Code of Virginia requires that all mandated benefits be included in the state employee health plan. State employees have the option to purchase an expanded health plan with hearing aid coverage and pay the entire cost of the premium for these benefits. However, the Office of the Attorney General has determined that, to comply with the Code, each individual state employee health plan would have to include hearing aid coverage. The state's costs would increase because it shares the plans' premium costs with employees. Language in the Appropriation Act stipulates that SB423 will not go into effect on July 1, 2021 if it is determined that the bill has a fiscal impact.

Virginia could modify its Essential Health Benefits benchmark plan to require fully-insured individual and small group plans to cover children's hearing aids

Virginia could adopt a new benchmark health insurance plan that includes hearing aid coverage, which would result in plans in the *individual and small group markets* providing this benefit. Large group plans are not required to provide all essential health benefits, so a revision of the benchmark plan would not extend additional coverage requirements to the fully-insured large group market. Maximizing the number of Virginians who would receive coverage for children's hearing aids would necessitate the passage of a new mandate (to include the large group market) and adopting a new benchmark plan (to include qualified individual and small group plans).

In the past, health insurance plans and consumers—not states—have been responsible for paying the cost of benefits included in states' benchmark health insurance plans that are unrelated to new state mandates. However, according to BOI, the Centers for Medicare and Medicaid Services (CMS), in its recent Notice of Benefit and Payment Parameters, clarified that a state must defray the cost of any new mandates enacted on or after January 1, 2012, even if they are part of a new benchmark plan. Therefore, if the state adopts a new benchmark plan that includes hearing aid coverage for children, the cost of that coverage would have to be paid for by the state. BOI is waiting for additional federal guidance on this matter.

If Virginia were to adopt a new benchmark plan, it would need to ensure that any hearing aid coverage included in the benchmark plan is in compliance with the ACA. For example, benchmark plans cannot limit essential health benefits, and it is not clear if SB423's provision to cap the hearing aid benefit at $1,500 every two years would violate this rule. If so, the benefit in the benchmark plan would need to be expanded. Another rule is that benefits must not discriminate against certain plan members, and it is unclear if limiting the benefit to children and youth under the age of 19 would be

considered discriminatory against adult plan members. CMS is responsible for approving benchmark plans, and BOI would need CMS to determine whether coverage mandated by SB423 would need to be expanded to include it in the benchmark plan.

Actuarial analysis would also need to be conducted to ensure that a new benchmark plan complies with the ACA. Federal rules require that benchmark plans cannot be "more generous" than the most generous of a set of comparison plans. Actuarial analysis is required to estimate 1) the total cost of a benchmark plan's benefits for a typical member, 2) the cost of the benefits provided by the set of comparison plans, and 3) the benchmark plan's relative generosity. BOI would need to hire an outside firm to conduct an actuarial analysis.

Five other states have successfully changed their benchmark plans to include additional coverage in recent years (Table 5). Some of these states removed previously covered services to offset projected increased costs of the new benchmark plans. Staff from these five states indicated that the process took several months, requiring detailed actuarial analysis and a negotiation process with CMS.

Virginia would need federal approval by May 2021 to change the benchmark plan starting in January 2023, based on the timeline prescribed by CMS to approve benchmark plan changes. Based on the experience from South Dakota and Illinois, this timeline is feasible if BOI started the process as soon as possible, if directed to do so by the Health Insurance Reform Commission. However, the process will require significant BOI staff work and the use of outside actuaries.

TABLE 5
Five other states have updated their essential health benefit to add covered services

State	Services added
Illinois	Multiple substance use disorder services
South Dakota	Applied behavioral analysis
Michigan	Opioid reversal agents (Naloxone)
New Mexico	Substance use disorder services, weight loss treatment, and artery calcification testing
Oregon	Chiropractic services, opioid reversal agents (Naloxone)

SOURCE: JLARC analysis of other state essential health benefit changes developed by the State Health and Value Strategies.

Glossary

Audiologist: a licensed hearing health care professional who specializes in the diagnosis and treatment of hearing loss in children and adults.

Cochlear Implants: an electronic prosthetic device that enables individuals with sensorineural hearing loss to recognize some sounds and consists of an external microphone and speech processor and one or more electrodes implanted in the cochlea.

Hearing Aids: an electronic device usually worn in or behind the ear of a hearing-impaired person for amplifying sound.

Otolaryngologist: a doctor who specializes in anatomy, function, and diseases of the ear, nose, and throat.

Abbreviations

ACA……..... The Patient Protection and Affordable Care Act

BOI…… The Bureau of Insurance

CMS……. The Center for Medicare and Medicaid Services

DHRM……....The Department of Human Resource Management

EHB ……..…….. Essential Health Benefits

ENT……... Ear, Nose, Throat

HIRC …….Health Insurance Reform Commission

OAG……..... Office of the Attorney General

VDH……. Virginia Department of Health

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COMMONWEALTH OF VIRGINIA

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October 30, 2020

The Honorable Janet D. Howell
Chair, Senate Finance and Appropriations Committee
Senate of Virginia

The Honorable Luke E. Torian
Chair, House Appropriations Committee
Virginia House of Delegates

Dear Senator Howell and Delegate Torian:

The Governor requested the Bureau of Insurance, along with the Joint Legislative Audit and Review Commission, to conduct an assessment of § 38.2-3418.8, a mandate of coverage of hearing aids for minors, to determine whether changes could be made to the Essential Health Benefits Benchmark Plan to include hearing aids for minors without cost to the Commonwealth.

On behalf of the State Corporation Commission, here is the report of the Bureau of Insurance.

Respectfully Submitted,

Scott A. White
Commissioner of Insurance

REPORT OF THE
STATE CORPORATION COMMISSION
BUREAU OF INSURANCE

HEALTH INSURANCE MANDATE REVIEW OF COVERAGE FOR HEARING AIDS FOR CHILDREN § 38.2-3418.8 OF THE CODE OF VIRGINIA

TO THE GENERAL ASSEMBLY OF VIRGINIA
AT THE REQUEST OF THE GOVERNOR

COMMONWEALTH OF VIRGINIA
RICHMOND

REPORT OF THE BUREAU OF INSURANCE
HEARING AID MANDATE REVIEW

Essential Health Benefits

All individual and small group health insurance coverage must include Essential Health Benefits (EHBs) as required by § 38.2-3451 of the Code of Virginia. Each state has chosen a benchmark plan by which all plans issued must include at least the minimum EHBs as in the benchmark plan.

Federal rules at 45 CFR 155.170 (Additional Required Benefits) state the following:

- A state may require a qualified health plan (QHP) to offer benefits in addition to the EHB. A QHP is defined in 45 CFR 155.20 as a health plan that has been certified to be offered by each Exchange through which the plan is offered. This requirement includes the off-exchange version of QHPs offered through the individual and small group health insurance exchange.

- A benefit required by state action taking place on or before December 31, 2011 is considered an EHB. A benefit required by state action taking place on or after January 1, 2012, other than for purposes of compliance with Federal requirements, is considered an addition to the EHB.

- The state will identify which state-required benefits are in addition to the EHB.

- The state must make payments to defray the cost of additional required benefits to:

    - an enrollee, as defined in § 155.20 of this subchapter; or

    - directly to the QHP carrier on behalf of the individual.

- Either the state or each QHP carrier in the state shall quantify the cost attributable to each additional required benefit. The calculation shall be:

    - Based on an analysis performed in accordance with generally accepted actuarial principles and methodologies;

- Conducted by a member of the American Academy of Actuaries; and

- If developed by each QHP carrier, reported to the state.

In its 2021 Notice of Benefit and Payment Parameters, the federal Centers for Medicare and Medicaid Services (CMS) clarified that any benefit that is the subject of a state mandate on or after January 1, 2012, is considered in addition to EHB. New state-mandated benefit reporting requirements to CMS will begin July 1, 2021.

CMS has indicated to state regulators that specific guidance will be provided prior to the July 1, 2021 reporting date for the new requirements.

Health Insurance Mandates and the Health Insurance Reform Commission Review Process

Generally, there are four categories of health insurance mandates:

- Health care services (such as coverage for hearing aids)
- Limit or remove cost share requirements from benefits
- Types of providers to be covered for covered treatments
- Who must be covered

Code of Virginia § 30-343 outlines a process by which the Health Insurance Reform Commission (HIRC) considers the cost to the state of any new mandate which is determined to be in addition to the EHBs (see subsection B of § 30-343).

In the process outlined in subsection C of § 30-343, the Bureau of Insurance analyzes the extent to which the proposed mandate is currently available under QHPs in the state and advises the HIRC as to whether, on the basis of that analysis, the applicable federal agency has determined or would likely determine, in accordance with applicable federal rules, that the proposed mandate exceeds the scope of the EHB.

Under the recent federal interpretation, if a state requires its QHPs to offer any benefit in accordance with state action taking place on or after January 1, 2012, other than for purposes of compliance with federal requirements, the state may be required to pay the cost of that mandate for health plans certified for sale on its individual and small business Exchange, and for the version of those plans sold off the Exchange.

Governor's Assessment Request

In his 2020 budget amendment, the Governor requested an assessment of the proposed hearing aid mandate for coverage of hearing aids and related services in accordance with Virginia Code § 30-343, notwithstanding the enactment of Chapter 1094 of the 2020 Acts of Assembly. Subsection C of § 30-343 requires the Bureau of Insurance to consider the financial impact of a proposed mandate, including:

- Expected impact on utilization of services and providers
- Expected impact on premium costs and administrative cost of insurers
- Expected additional cost to the state as required by § 1311(d)(3)(B) of the Patient Protection and Affordable Care Act if the proposed mandate exceeds the scope of the essential health benefits
- Expected impact on the total cost of health care in the Commonwealth generally

Chapter 1094 of the 2020 Acts of Assembly requires coverage for hearing aids and related services. The HIRC did consider 2019 House Bill 2601, which required a level of coverage for hearing aids. The Bureau's analysis at the time concluded that coverage for hearing aids is specifically excluded from the Virginia EHB benchmark and would be considered a new mandated benefit for which the state would be required to defray the costs of the benefit for QHPs.

Chapters 916 and 917 of the 2020 Acts of Assembly, which establish the Virginia Health Insurance Exchange, require in § 38.2-6506 A of the Code of Virginia that a QHP must not provide any state-mandated health benefit that is not included in the EHB package. As a result, the hearing aid mandate anticipated in Chapter 1094 of the 2020 Acts of Assembly cannot be offered by the QHPs in the individual and small group markets. Therefore, the state is not required to defray the cost of the hearing aid mandate since benefits will be required only for plans offered in the large group market and for non-QHPs in the individual and small group markets.

A question remains, however, as to whether the provisions of § 38.2-6506 A 1 comply with federal non-discrimination requirements as stated in § 1252 of the PHSA. If this section should be removed from the Code of Virginia or found to be pre-empted by federal requirements, QHPs would be required to provide the new state-mandated benefit triggering state defrayal for this benefit.

The Bureau did not require individual and small group health insurance policies filed and approved for the 2021 benefit year to include coverage for this benefit since the effective date was delayed pending this assessment.

Defrayal of Costs by States

The Bureau understands the following requirements as to defrayal of costs by states, but awaits additional federal guidance prior to July 1, 2021 for clarity of some of the requirements:

- The defrayal of costs requirement applies to any new mandated benefit applicable to QHPs and enacted after December 31, 2011.

- A state may enact a mandate that applies only to the large group health insurance market without having to pay to defray costs of the mandate.

- Pursuant to § 1252 of the Public Health Services Act (PHSA) it is discriminatory for a state to apply mandates only to non-QHPs within a market. As a result, federal law may not allow mandates to be placed only on non-QHPs in the individual or small group markets. The Bureau awaits confirmation of this understanding in the federal guidance to be released.

- The Bureau understands that states are required to defray costs of mandates that require a benefit but are not required to defray costs of mandates related to providers, who must be covered, or cost share requirements. The Bureau awaits confirmation of this understanding in the federal guidance to be released.

- A state must defray the cost of a state mandated benefit enacted after December 31, 2011, whether included in the EHB benchmark or not, unless it was enacted to comply with federal requirements. This interpretation was clarified in the 2021 Notice of Benefit and Payment Parameters.

Estimation of the Cost of the Hearing Aid Mandate

As stated, with the existence of § 38.2-6506 A 1, state defrayal is not required. However, there are questions as to whether federal law pre-empts that law. To provide an estimate of the cost of state defrayal should that section be revised or rendered unlawful, it appears that the state could reasonably estimate the defrayal cost for the hearing aids for minors mandate would range from .004% - .015% of

premium. Oliver Wyman, the Bureau of Insurance's consulting actuarial firm, estimated that in 2022, the number of people enrolled in a QHP on or off the Exchange will be 92% of the individual market, or approximately 240,000 enrollees. There is a percentage of small employer groups enrolled in QHPs (approximately 2,044 in 2017), but this minimal percentage was not included for purposes of this cost estimate.

The average 2022 premium estimated from the most recent Oliver Wyman survey is $632 per member per month. The effective date of the mandated benefit as proposed in the budget language is July 1, 2021, and therefore, the 2022 estimates are used here as the most up-to-date projection. The Bureau's estimation based on the information outlined above indicates total state defrayal costs for this benefit ranging from $72,806 - $273,024 per year.

Conclusion

If Virginia Code § 38.2-6506 A1 (a QHP must not provide any state-mandated benefit that is not included in the EHB) remains in effect and is considered by the Centers for Medicare and Medicaid Services to be an acceptable way to avoid state defrayal of costs, no state defrayal will be necessary. A state may enact a mandate that applies only to the large group health insurance market without having to pay to defray costs of the mandate. However, no state mandated benefits enacted on or after January 1, 2012 will apply to any QHP in the individual or small group market. If either the Exchange provision is repealed or CMS prohibits the use of a provision such as § 38.2-6506 A 1 to avoid state defrayal of costs, the state would be required to defray costs for this hearing aid mandate.