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# Study of Proposed Mandatory Health Insurance for Hearing Aids

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A Report to the  
Governor  
and the  
Legislature of  
the State of  
Hawai'i

Report No. 14-10  
October 2014



**THE AUDITOR**  
STATE OF HAWAI'I

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## Office of the Auditor

The missions of the Office of the Auditor are assigned by the Hawai'i State Constitution (Article VII, Section 10). The primary mission is to conduct post audits of the transactions, accounts, programs, and performance of public agencies. A supplemental mission is to conduct such other investigations and prepare such additional reports as may be directed by the Legislature.

Under its assigned missions, the office conducts the following types of examinations:

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5. Health insurance analyses examine bills that propose to mandate certain health insurance benefits. Such bills cannot be enacted unless they are referred to the Office of the Auditor for an assessment of the social and financial impact of the proposed measure.
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**Compared with the 20 other states that mandate insurance coverage for hearing aids, only Hawai'i would have no parameters on age, costs covered, or frequency at which hearing aids must be provided.**

Recommendation

Response

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<http://auditor.hawaii.gov/>

# Study of Proposed Mandatory Health Insurance for Hearing Aids

Report No. 14-10, October 2014

## *Mandatory health insurance for hearing aids is not recommended*

In Senate Concurrent Resolution No. 34, Senate Draft 1, the 2014 Legislature asked the Auditor to assess the social and financial effects of mandating health insurance coverage for hearing aids, as proposed in Senate Bill No. 309 (SB), Senate Draft 1 (SD), of the 2014 regular session. SB No. 309, SD 1, defines hearing aids as “any wearable instrument or device and any parts, attachments, or accessories, including earmold, but excluding batteries and cords, designed or offered for the purpose of aiding or compensating impaired human hearing.” Hearing aids may be used to treat several types of hearing loss. In Hawai'i, approximately 55 infants with hearing loss are born annually.

Because SB No. 309, SD 1, would not change the status quo concerning coverage for hearing aids, we recommend the Legislature not pass the measure.

## **Social and financial impacts would be insignificant**

Our analysis on the social and financial impacts of mandating health insurance coverage for hearing aids is based on survey responses, literature review, and interviews. In addition to the Children with Special Health Needs Branch of the Department of Health's (DOH) Family Health Services Division and the American Academy of Audiology, we sent surveys to four private health insurance companies: Hawai'i Medical Service Association (HMSA), Kaiser Permanente Hawai'i (Kaiser), University Health Alliance (UHA), and Hawai'i Medical Assurance Association (HMAA). HMSA, UHA, and HMAA now provide coverage for hearing aids, and Kaiser plans to begin covering hearing aids in January 2015.

Although coverage may be inadequate to cover the full cost of hearing aids, which may place a financial hardship on some patients needing treatment, SB No. 309, SD 1, would not require insurers to cover full costs of hearing aids. Because insurers already provide coverage or plan to start providing coverage in 2015, the measure is likely to have minimal effect on insurance premium costs.

## **Proposed bill's lack of coverage parameters is problematic**

SB No. 309, SD 1, has no limits on coverage, such as age, frequency for replacing, or costs covered by insurers, which other states have identified. Without such coverage parameters, the measure as written merely requires that insurers provide for the costs of hearing aids, subject to deductibles, co-payments and maximum payment limits set by insurers.

As of August 2014, 20 states had laws requiring that private health insurers provide coverage for hearing aids. Of those, every state had at least one coverage limitation based on at least one of three factors: the age of the beneficiary, the frequency at which insurers must provide hearing aids to beneficiaries, or the dollar cost the insurer must cover. Hawai'i would have none of these.

## **Agency response**

On October 15, 2014, we transmitted a draft of this report to the Departments of Health and Commerce and Consumer Affairs. The departments opted not to respond.

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# Study of Proposed Mandatory Health Insurance for Hearing Aids

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A Report to the  
Governor  
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the State of  
Hawai'i

Submitted by

**THE AUDITOR**  
STATE OF HAWAI'I

Report No. 14-10  
October 2014

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## Foreword

We assessed the social and financial impacts of mandating insurance coverage for hearing aids as proposed in Senate Bill No. 309, Senate Draft 1, of the 2014 Legislative session, pursuant to Sections 23-51 and 23-52, Hawai‘i Revised Statutes (HRS). Section 23-51, HRS, requires passage of a concurrent resolution requesting an impact assessment by the Auditor before any legislative measure mandating health insurance coverage for a specific health service, disease, or provider can be considered. The 2014 Legislature requested this assessment through Senate Concurrent Resolution No. 34, Senate Draft 1.

We wish to express our appreciation for the cooperation and assistance extended to us by the Hawai‘i State Department of Health, Children with Special Health Needs Branch, and other organizations and individuals we contacted during the course of our study.

Jan K. Yamane  
Acting State Auditor

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# Chapter 1

## Introduction

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In Senate Concurrent Resolution No. 34, Senate Draft 1, the 2014 Legislature asked the Auditor to assess the social and financial effects of mandating health insurance coverage for hearing aids, as proposed in Senate Bill No. 309, Senate Draft 1 (SB No. 309, SD 1), of the 2014 regular session. We conducted this study in accordance with Sections 23-51 and 23-52, Hawai‘i Revised Statutes (HRS). Section 23-51, HRS, requires that before any legislative measure mandating health insurance coverage for a specific health service, disease, or provider can be considered, the Legislature must pass a concurrent resolution requesting an impact assessment by the Auditor. The resolution must designate a specific bill that has been introduced in the Legislature and includes, at a minimum, information identifying the:

- Specific health service, disease, or provider that would be covered;
- Extent of the coverage;
- Target groups that would be covered;
- Limits on utilization if any; and
- Standards of care.

The resolution also asks the Auditor to include an impact assessment of the requirements under the federal Patient Protection and Affordable Care Act of 2010 if mandated health insurance coverage for hearing aids is implemented in Hawai‘i.

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## Background

### *Hearing aids*

Senate Bill No. 309, Senate Draft 1, defines hearing aids as “any wearable instrument or device and any parts, attachments, or accessories, including earmold, but excluding batteries and cords, designed or offered for the purpose of aiding or compensating impaired human hearing.” Hearing aids may be used to treat several types of hearing loss.

### *Incidence, causes, and treatment of hearing loss*

Hearing loss affects an estimated one-third of people in the United States between ages 65 and 75 and close to one-half of those older than 75. Among children, congenital hearing loss affects two to four newborn children in 1,000 in the United States. In Hawai‘i, approximately 55 infants with hearing loss are born annually.

Hearing occurs when sound waves from the environment reach structures inside the ear, which convert the sound waves into nerve signals that the brain recognizes as sound. The ear consists of three main areas: the outer, middle, and inner ear. Sound waves pass through the outer ear and cause vibrations at the eardrum. The eardrum and three small bones of the middle ear amplify the vibrations, which travel to the inner ear. There, the vibrations pass through fluid in a snail-shaped structure called the cochlea. Inside the cochlea are thousands of tiny hairs that convert the vibrations into electrical signals that are transmitted to the brain. Different sounds affect the tiny hairs in different ways, and the brain distinguishes one sound from another. Hearing loss occurs when there is damage to these ear structures.

Several risk factors, such as aging, heredity, occupational and recreational noises, and some medications and illnesses, can cause damage that leads to hearing loss, often known as *sensorineural* hearing loss. Earwax can build up and block sound waves from passing through the ear canal causing *conductive* hearing loss. Other contributing factors include infections, abnormal bone growths or tumors in the outer or middle ear, sudden changes in pressure, loud blasts, and poking the eardrum with foreign objects.

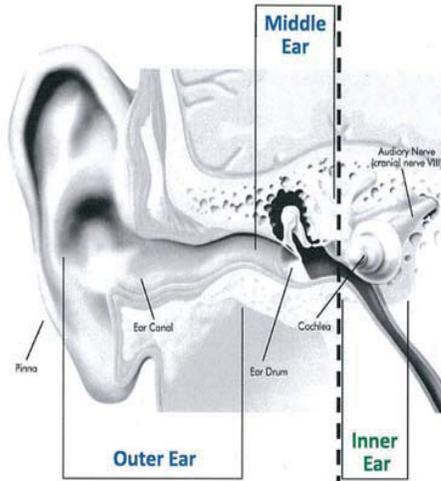
Hearing difficulties associated with outer or middle ear problems may be treated by surgery, antibiotics, or simply by removing wax blocking the ear canal, as described in Exhibit 1.1. Also as shown in Exhibit 1.1, hearing aids may be used if initial treatment does not work. For hearing loss due to inner ear problems, hearing aids can help by making sounds louder and easier to hear.

### ***Types of hearing aids***

A hearing aid is a small electronic device worn in or behind the ear that amplifies some sounds so a person with hearing loss can listen, communicate, and participate more fully in daily activities. A hearing aid has three basic parts: a microphone, amplifier, and speaker. The hearing aid receives sound through the microphone, which converts the sound waves to electrical signals and sends them to the amplifier. The amplifier increases the power of the signals and then sends them to the ear through a speaker.

**Exhibit 1.1**  
**Hearing Loss Causes and Treatment**

**Hearing Loss:  
Causes and  
Treatment**  
**When Are Hearing  
Aids Needed?**



Conductive Hearing Loss <i>Outer and/or Middle Ear</i>			Sensorineural Hearing Loss <i>Inner Ear (Cochlea, Hair Cells)</i>	
Causes	Initial Treatment	Hearing Aids?	Causes	Treatment
Wax/foreign body	Wax removal	No	Congenital (at birth)	Hearing aids
Ear infection/fluid in middle ear	Antibiotics, PE tubes	Hearing aids, if chronic	Progressive (over time)	Hearing aids
Perforated eardrum	Surgery	Hearing aids, if surgery not successful	Ototoxic drugs (chemo, antibiotics)	Hearing aids
Damage to ossicles (bones)	Surgery	Hearing aids, if surgery not successful	Noise	Hearing aids
No ear canal (atresia)	surgery	Hearing aids, if inoperable	Age (presbycusis)	Hearing aids
Cholesteatoma (tumor)	surgery	Hearing aids, post-surgery		
Scarring of eardrum		Hearing aids		

Source: Hawai'i State Department of Health

Hearing aids fall into three basic categories:

- **Behind-the-ear (BTE)** hearing aids consist of a hard plastic case worn behind the ear and connected to a plastic earmold that fits inside the outer ear. Electronic parts are held in the case behind the ear. Sound travels from the hearing aid through the earmold and into the ear. BTE aids are used by people of all ages for mild to profound hearing loss;
- **In-the-ear (ITE)** hearing aids fit completely inside the outer ear and are used for mild to severe hearing loss. The case holding electronic components is made of hard plastic. ITE aids usually are not worn by young children because the casings need to be replaced often as the ear grows; and

- **Canal** aids fit into the ear canal and are available in two styles. In-the-canal (ITC) hearing aids are made to fit the size and shape of a person's ear canal. Completely-in-canal (CIC) hearing aids are nearly hidden in the ear canal. Both types are used for mild to moderately severe hearing loss.

There are generally two types of electronics used in hearing aids: (1) analog hearing aids convert sound waves into signals, which are amplified, and (2) digital hearing aids convert sound waves into numerical codes similar to the binary codes of a computer before amplifying them. Analog hearing aids are generally less expensive than digital hearing aids.

Hearing aids can cost from \$500 to \$4,000 per ear, depending on the type of hearing aid needed and services related to fitting, evaluating, and dispensing the device. Under Hawai'i law, persons who sell hearing aids in Hawai'i must be licensed by the State.

***State-funded programs provide limited coverage for hearing aids***

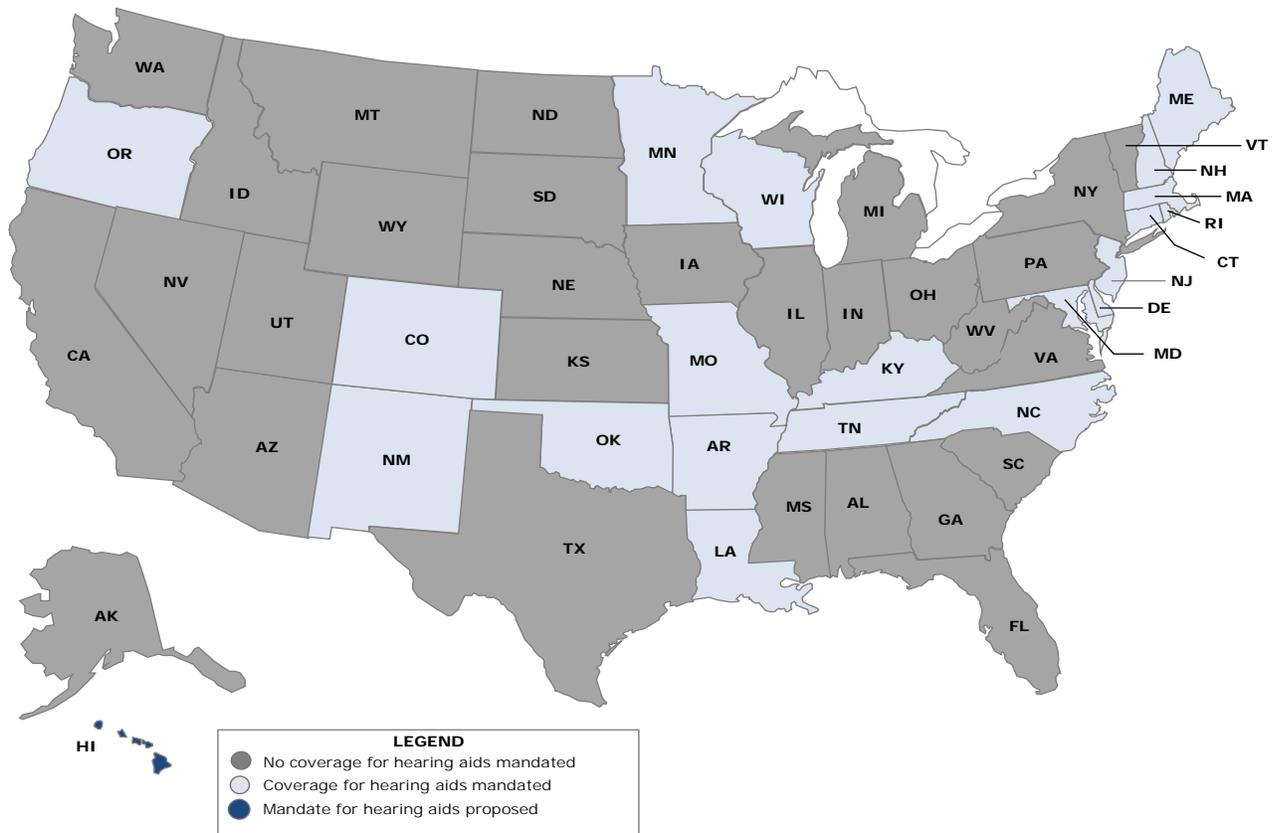
Some state assistance to provide children with hearing aids is available through the Department of Health's Children with Special Health Needs Program (CSHNP) in the Children with Special Health Needs Branch of the Family Health Services Division. CSHNP is a statewide program for infants, children, and youth up to age 21 who have or may have long term or chronic health conditions that require specialized medical care, such as hearing loss. Service coordination is provided to families without regard to income. However, in order to receive limited financial assistance, families must meet the program's financial criteria (267 percent of the Federal Poverty Guidelines). The program may assist eligible children with payment for hearing aids, audiological evaluation procedures, and hearing aid related procedures. As of June 2014, the program had 92 participants. Children eligible under the Department of Human Services's Med-QUEST health plans also may receive limited coverage for screening, diagnosis, treatment, hearing aids batteries, earmolds, and repair.

***Senate Bill No. 309, Senate Draft 1, requires coverage for hearing aids***

The purpose of SB No. 309, SD 1, is to require that private health insurers cover the cost of hearing aids for policyholders and persons covered under the policy. Specifically, the bill would add new sections to Article 10A of Chapter 431, HRS, and Article 1 of Chapter 432, HRS, requiring private health insurers to cover the cost of hearing aids for policyholders and others covered by the policy.

As of August 2014, 20 states had laws requiring private health insurers to cover hearing aids. Thirty states have no such laws, with Hawai'i considering a mandate. Exhibit 1.2 illustrates which states provide coverage and identifies those where insurance coverage is not available.

**Exhibit 1.2**  
**Map of Insurance Coverage for Hearing Aids**



Source: Office of the Auditor

## Objectives of the Study

1. Assess the social and financial effects of mandating health insurance coverage for hearing aids.
2. Make recommendations as appropriate.

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## **Scope and Methodology**

We examined the potential social and financial effects of mandating health insurance coverage for hearing aids as proposed in SB No. 309, SD 1, by applying the following criteria provided in Section 23-52, HRS, as applicable:

### ***Social impact***

1. Extent to which the treatment or service is generally utilized by a significant portion of the population;
2. Extent to which such insurance coverage is already generally available;
3. If coverage is not generally available, the extent to which the lack of coverage results in persons being unable to obtain necessary health care treatment;
4. If coverage is not generally available, the extent to which the lack of coverage results in unreasonable financial hardship on those persons needing treatment;
5. The level of public demand for the treatment or service;
6. The level of public demand for individual or group insurance coverage of the treatment or service;
7. The level of interest of collective bargaining organizations in negotiating privately for inclusion of this coverage in group contracts;
8. The impact of providing coverage for the treatment or service (such as morbidity, mortality, quality of care, change in practice patterns, provider competition, or related items); and
9. The impact of any other indirect costs upon the costs and benefits of coverage as may be directed by the Legislature or deemed necessary by the Auditor in order to carry out the intent of this section.

### ***Financial impact***

1. The extent to which insurance coverage of the kind proposed would increase or decrease the cost of the treatment or service;
2. The extent to which the proposed coverage might increase the use of the treatment or service;

3. The extent to which the mandated treatment or service might serve as an alternative for more expensive treatment or service;
4. The extent to which insurance coverage of the health care service or provider can be reasonably expected to increase or decrease the insurance premium and administrative expenses of policy holders; and
5. The impact of this coverage on the total cost of health care.

We conducted this study between May 2014 and September 2014 in accordance with the Office of the Auditor's *Manual of Guides* and Sections 23-51 and 23-52, HRS.

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# Chapter 2

## Mandatory Health Insurance Coverage for Hearing Aids As Proposed Is Already Provided

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This study assesses the social and financial impacts of mandating insurance coverage for hearing aids as proposed in Senate Bill No. 309, Senate Draft 1, of the 2014 regular session (SB No. 309, SD 1). Health insurance coverage for hearing aids is generally available from three of four private health insurers as well as through the state Department of Human Services' Med-QUEST program, and a fourth private insurer plans to provide coverage beginning in 2015. Although coverage already provided may be limited, SB No. 309, SD 1, would not change the status quo because the measure establishes no minimum coverage amounts that would require insurers to raise coverage levels.

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### Summary of Findings

1. The social impacts of mandating health insurance coverage for hearing aids as proposed in Senate Bill No. 309, Senate Draft 1, are insignificant because the bill would not mandate coverage for hearing aids beyond what is generally available. Because the bill does not expand coverage provided by most insurers, the financial impacts are minimal.
2. Hawai'i would be unique among the states that mandate health insurance coverage for hearing aids because SB No. 309, SD 1, provides no coverage parameters, such as ages or costs covered.

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### Social and Financial Impacts of Senate Bill No. 309, Senate Draft 1, Would Be Insignificant

Our analysis on the social and financial impacts of mandating health insurance coverage for hearing aids is based on survey responses, literature review, and interviews. In addition to the Children with Special Health Needs Branch of the Department of Health's (DOH) Family Health Services Division and the American Academy of Audiology, we sent surveys to four private health insurance companies:

- Hawai'i Medical Service Association (HMSA);
- Kaiser Permanente Hawai'i (Kaiser);
- University Health Alliance (UHA); and
- Hawai'i Medical Assurance Association (HMAA).

All of the insurers responded to our survey. The American Academy of Audiology did not respond. Exhibit 2.1 shows the total membership for each health insurance company.

**Exhibit 2.1  
Membership of Respondent Health Insurers**

Private Health Insurers	Number of Members
HMSA	734,610
Kaiser	229,746
UHA	51,807
HMAA	51,931

Source: Office of the Auditor, based on responses by private health insurers

Overall, we found that insurance coverage for hearing aids provided by HMSA, HMAA, and UHA varies. For example, maximum allowable fees per device range from \$625 paid by UHA, to as much as \$1,500 paid by HMSA. Kaiser now provides hearing aid coverage for its Med-QUEST members, individual and small groups, and as an optional rider to its insurance policies, which not all employers purchase; however, Kaiser plans to provide coverage for hearing aids as part of all of its base plans starting in 2015. As a consequence, DOH noted, patients may face considerable out-of-pocket expenses that cause financial hardship and treatment delays. The department also noted that SB No. 309, SD 1, as written, would not ensure patients have adequate coverage because the bill contains no minimum coverage, either in percentage of cost or dollar amount.

Although the purpose of SB No. 309, SD 1, is to “require that the cost of hearing aids be covered by private health insurers,” the bill also allows insurers to limit coverage with deductibles, copayments, coinsurance, or annual or maximum payment limits of the kind now imposed. In addition, since the bill mandates no minimum coverage, the measure would not enhance coverage beyond what insurers provide now or soon will provide.

***Insurance coverage for hearing aids is generally available***

Based on the responses to our survey, we conclude that the social impact of mandating coverage for hearing aids as provided in SB No. 309, SD 1, would be insignificant and therefore does not warrant passage of the measure.

**1. Extent to which the treatment or service is generally utilized by a significant portion of the population**

Based on responses to our surveys, hearing aids are not used by a significant portion of the population with health insurance coverage. Of HMAA's 51,931 members, 21 (0.04 percent) had received the benefit since January 2013. HMSA estimates that of its 734,610 members, 2,628 (0.4 percent) have hearing aids. In 2013, of HMSA's 2,405 members diagnosed with a hearing loss, 238 (9.9 percent) acquired a hearing aid, which represents 0.03 percent of HMSA's total members.

Although hearing aids are not used by a significant portion of the general population, a substantial percentage of persons with hearing loss do use hearing aids. For example, Kaiser reports that about 95 percent of their patients who are diagnosed with a hearing loss purchase hearing aids at its Hearing Service Center. Also, all 92 of the members in the DOH Children with Special Health Needs Program (CSHNP) have hearing aids.

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

Health insurance coverage for hearing aids is generally available from three of the State's private health insurers—HMSA, HMAA, and UHA—as well as the Med-QUEST program, with Kaiser planning to provide coverage in 2015. However, there are circumstances when a hearing aid is not covered. For HMAA, HMSA, and UHA members, for example, hearing aids are not provided after members have exhausted benefits allowed under their policies. For Kaiser members, hearing aids are covered on certain policy riders that employers may provide as an option; however, not all employers choose the rider.

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

Although some coverage is generally available, there are circumstances when the cost of hearing aids may place an unreasonable financial hardship on those who need the devices but are uninsured, or whose policies do not cover the full costs of hearing aids, depending on the make and model of hearing aid required and how often the device needs to be replaced. Cost estimates for hearing aids range from \$600 to \$3,400 per hearing aid, depending on their make, model, configuration, and other factors.

Because insurers provide coverage for less than the high end of the cost spectrum, their members are expected to pay out of pocket if hearing aids are not covered. HMAA, HMSA, and UHA, for example, limit coverage to one hearing aid per ear every five years. UHA limits benefits to \$625 per ear, while HMAA's maximum is \$1,400 per ear and HMSA's maximum is \$1,500 per ear. HMSA and HMAA both exclude coverage for fitting adjustment and batteries. Beginning in 2015, Kaiser coverage will provide hearing aids every three years subject to the patient covering 60 percent of the cost. According to DOH, Med-QUEST covers diagnosis and treatment of hearing loss, including hearing aids, for eligible children ages 21 and under, and batteries, earmolds and repair, which are usually not covered by private health insurance plans. Med-QUEST requires that hearing services include, at a minimum, diagnosis and treatment for defects in hearing, including hearing aids.

#### **4. The level of public demand for individual or group insurance coverage of the treatment or service**

Based on survey responses, public demand for mandated coverage of hearing aids is low. Although HMAA, Kaiser, and the DOH have received requests from members for coverage, HMSA and UHA have not received requests since coverage is already provided. In addition, when Senate Bill No. 309 was heard publicly in January 2013, the Senate Committees on Human Services and Commerce and Consumer Protection received just three comments in support of the measure from individuals.

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

The level of interest among collective bargaining organizations is largely unknown, but probably low. We received responses from only two of 18 public and private sector unions to which we sent surveys: the Hawai'i Government Employees Association and the Hawai'i Regional Council of Carpenters. Neither group indicated members had expressed interest in coverage.

#### **6. The impact of providing coverage for the treatment or service (such as morbidity, mortality, quality of care, change in practice patterns, provider competition, or related items)**

The impact on quality of care depends on the provider. According to DOH, providing coverage may help avoid delays in treatment timelines; without access to language, hearing technology, and early intervention, children with hearing loss almost always fall behind peers in language, cognition, and social-emotional development.

Since hearing aids are a covered benefit, HMAA, HMSA, and UHA foresee no impact on morbidity, mortality, quality of care, change in practice patterns, provider competition, or related items if coverage for hearing aids is mandated. Kaiser foresees an increase in hearing aid use.

**7. The impact of any other indirect costs upon the costs and benefits of coverage as may be directed by the legislature or deemed necessary by the Auditor in order to carry out the intent of this section**

Senate Concurrent Resolution No. 34, Senate Draft 1, asks the Auditor to assess the impact of SB No. 309, SD 1, in light of the federal Patient Protection and Affordable Care Act (ACA), Section 1311(d)(3), which requires states to pay the costs of state-mandated benefits that exceed benefits required under ACA. Opinions on the impact of SB No. 309, SD 1, in this regard are inconclusive.

In September 2012, the State adopted a benchmark health plan for 2014 and 2015 as required by the ACA, which includes one hearing aid per ear every five years. According to the Hawai'i State Insurance Commissioner, "Hawai'i would have to assume the cost of each hearing aid *in excess* of one hearing aid per ear every five years as provided through every qualified health plan [emphasis added]." The commissioner opined that SB No. 309, SD 1, in certain circumstances would trigger the ACA Section 1311(d)(3) because Hawai'i would be "requiring qualified health plans to offer benefits in addition to the essential health benefits." According to the commissioner, "The state can only make this requirement if the state assumes the costs of the additional benefits." The U.S. Department of Health and Human Services is in the process of updating the essential health benefits in future rulemaking for plan years starting in 2016 and intends to revisit the mandate that states defray the cost of any state-mandated benefit in excess of the benchmark.

However, HMAA, HMSA, and UHA told us they expect SB No. 309, SD 1, would have no impact because the measure's coverage requirement, as written, does not exceed the ACA mandate. DOH said the bill's impact on ACA would depend on what was mandated. Kaiser said that "potentially the state would be required to pay."

***Financial impacts on insurers are minimal, as are benefits to patients***

Results of our survey indicate that the financial impacts would be minimal, as discussed below.

**1. The extent to which insurance coverage of the kind proposed would increase or decrease the cost of the treatment or service**

The extent to which the coverage of the kind proposed would increase or decrease the cost of hearing aids is limited. HMAA, HMSA, UHA, and Kaiser indicated costs to its members are not likely to be affected because these insurers already cover hearing aids or will begin covering hearing aids in 2015. DOH responded that for patients who do not have hearing aid coverage in their health plans, coverage would significantly decrease out-of-pocket expenses. However, the impact would be limited because plan beneficiaries may have to pay a large co-payment for their hearing aids and extra costs for related services. The department noted the bill is too vague and should provide a minimum coverage amount to ensure adequate coverage.

**2. The extent to which the proposed coverage might increase the use of the treatment or service**

Senate Bill No. 309, Senate Draft 1, is not likely to increase usage of hearing aids significantly, except for children who are not covered by private health insurance and who also do not qualify for hearing aids under the DOH's program. HMAA, HMSA, and UHA indicated passage of SB No. 309, SD 1, would not increase use of hearing aids.

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

Hearing aids to treat hearing loss is the standard of care, are not invasive, and can be easily removed; whereas other more invasive options may be surgical hearing aids, such as cochlear implants or bone-anchored hearing aids according to Kaiser and DOH.

**4. The extent to which insurance coverage of the health care service or provider can be reasonably expected to increase or decrease the insurance premium and administrative expenses of policy holders**

If SB No. 309, SD 1, were to pass, there would likely be no change to insurance premiums for HMAA, HMSA, or UHA policyholders because hearing aids are already covered. Kaiser said all increases in benefits would cause increases in costs to a health plan, which can affect premiums; however, it could not say what impact passage of SB No. 309, SD 1, would have on its premiums.

## 5. The impact of this coverage on the total cost of health care

The impact on the total cost of health care if SB No. 309, SD 1, passes is probably insignificant. HMAA, HMSA, and UHA expect little or no increase. Kaiser expects some increase but did not say how much. DOH does not have data to reach a conclusion on this issue.

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### **Senate Bill No. 309, Senate Draft 1, Would Not Alter the Status Quo**

***Bill's lack of coverage parameters is problematic***

Senate Bill No. 309, Senate Draft 1, has no limits on coverage, such as age, frequency for replacing, or costs covered by insurers, which other states have identified. Without such coverage parameters, the measure as written merely requires that insurers provide for the costs of hearing aids,<sup>1</sup> subject to deductibles, co-payments and maximum payment limits set by insurers. The bill does not expand coverage beyond what insurers already provide or, as in the case of Kaiser, plan to provide starting in 2015. In brief, the measure would not alter the status quo.

As of August 2014, 20 states had laws requiring that private health insurers provide coverage for hearing aids. Of those, every state had at least one coverage limitation based on at least one of three factors: the age of the beneficiary, the frequency at which insurers must provide hearing aids to beneficiaries, or the dollar cost the insurer must cover, as shown in Exhibit 2.2.

All states limit how frequently an insurer must provide a new hearing aid. The vast majority of these states (85 percent) also has age limits, mandating coverage only to children or to children and young adults. Fifteen states specified a dollar amount of the benefit insurers must provide. And more than half of the states, 12 of 20, restrict coverage using all three factors: age of recipient, how frequently the insurer must provide a new hearing aid, and cost the insurer must cover.

By contrast, Hawai'i's mandate would include none of these limitations. As proposed, SB No. 309, SD 1, does not limit a recipient's age, the cost of a hearing aid per ear in terms of maximum or minimum amounts, or how often a recipient can replace a hearing aid.

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<sup>1</sup> "Hearing aid" as defined in Section 451A-1, HRS, includes a wearable device, parts or accessories, and earmold, but excludes batteries and cords.

## Exhibit 2.2 Mandated Coverage Limitations in Other States

State	Age	Limitation	
		Dollar	Frequency
Arkansas		✓	✓
Colorado	✓		✓
Connecticut	✓	✓	✓
Delaware	✓	✓	✓
Hawai'i (proposed)			
Kentucky	✓	✓	✓
Louisiana	✓	✓	✓
Maine	✓	✓	✓
Maryland	✓	✓	✓
Massachusetts	✓	✓	✓
Minnesota	✓		✓
Missouri	✓		✓
New Hampshire		✓	✓
New Jersey	✓	✓	✓
New Mexico	✓	✓	✓
North Carolina	✓	✓	✓
Oklahoma	✓		✓
Oregon	✓	✓	✓
Rhode Island		✓	✓
Tennessee	✓	✓	✓
Wisconsin	✓		✓

Source: Office of the Auditor

Frequency for replacing hearing aids is the most common limitation among states that mandate insurance coverage for hearing aids. All 20 states with mandates have some limitation on how often insurers must provide hearing aids. The most common benchmark is three years: 13 states allow beneficiaries to receive new hearing aids according to that timetable. Connecticut and New Jersey are more generous, allowing new hearing aids every two years. Oklahoma and Oregon are more restrictive, requiring beneficiaries to wait four years to replace a hearing aid. In Colorado and New Hampshire, the benchmark is five years. Missouri is the least generous, requiring insurers to cover only “initial amplification” for newborn infants. Hawai'i's proposed mandate, meanwhile, places no such parameters on how frequently a beneficiary may obtain a new hearing aid under mandated coverage. Hence, as written the bill allows HMAA, HMSA, and UHA to limit coverage to one hearing aid per ear every five years.

States also frequently limit mandated coverage to children and young adults. Of the 20 states that require insurance coverage for hearing aids, 17 limit coverage to certain ages. As shown in Exhibit 2.2, those states are Colorado, Connecticut, Delaware, Kentucky, Louisiana, Maine, Maryland, Massachusetts, Minnesota, Missouri, New Jersey, New Mexico, North Carolina, Oklahoma, Oregon, Tennessee, and Wisconsin.

Age parameters generally limit coverage to children and young adults. Nine states—Colorado, Kentucky, Louisiana, Maine, Maryland, Minnesota, Oklahoma, Tennessee, and Wisconsin—set the limit at 18 years old. New Mexico and Oregon also limit the benefit to children under 18 but make exceptions for beneficiaries who are over 18 but still in school. Delaware has the highest limit, allowing the benefit for persons under age 24. Consistent with HMSA, HMAA and UHA’s health plans that already provide coverage for hearing aids, Hawai‘i’s proposed measure has no age limit and specifically identifies persons 65 years old and older as a target group. Hawai‘i would join three other states—Arkansas, New Hampshire, and Rhode Island—with no age limits.

Among states with hearing aid mandates, Hawai‘i would be in a minority with no parameters on the costs of maximum or minimum payments the insurers must provide. Although dollar limits vary, Arkansas, Connecticut, Delaware, Kentucky, Louisiana, Maine, Maryland, Massachusetts, New Hampshire, New Jersey, New Mexico, North Carolina, Oregon, Rhode Island, and Tennessee—15 states—specify a dollar amount of the mandated benefit, typically by ear or hearing aid. For example, Kentucky, Louisiana, Maine, and Maryland require insurers provide coverage up to \$1,400 per ear or hearing aid. North Carolina requires insurers to cover up to \$2,500 per hearing aid. Oregon requires a benefit of up to \$4,000. Like Hawai‘i’s proposed mandate, laws in Colorado, Minnesota, Missouri, Oklahoma, and Wisconsin have no dollar parameters on the mandated benefit. Unlike Hawai‘i, however, these other states limit the hearing aid benefit by age or how often a person can receive a new hearing aid, or both.

Hawai‘i’s proposed measure states that coverage may be subject to deductibles, copayments, co-insurance, or annual maximum payment limits. But it provides no minimum amount that insurers must cover. Hence, as proposed, SB No. 309, SD 1, allows UHA to limit benefits to \$625 per ear, HMAA to limit payments up to a maximum of \$1,400 per ear, and HMSA to limit payments up to a maximum of \$1,500.

***Changes to SB No. 309, SD 1, are sought by Department of Health***

The Department of Health described the bill as “too vague” and thus proposed changes to ensure adequate coverage so that those needing hearing aids are not left with a large co-payment and extra costs that would cause financial hardship. The department recommends that the

bill provide a minimum coverage amount, either in percent of cost or a dollar minimum cost, as well as set a percent of cost or dollar amount to ensure that hearing aid dispensers are fairly reimbursed for hearing aid purchases.

The department additionally suggests that SB No. 309, SD 1, address limits on the timetable for obtaining new hearing aids. Specifically, DOH suggests the bill provide for an appeal system to address instances when hearing loss worsens before the five-year limitation for replacing hearing aids offered by HMSA, HMAA, and UHA, as well as plans provided under the Affordable Care Act. DOH said the bill should allow for hearing aid purchases before 60 months in those cases. The department also would like to expand the definition of hearing aids to cover bone conduction hearing aids, which may be the only form of amplification suitable for certain people with permanent conductive hearing loss, such as atresia (no ear canals) or tumor in the middle ear.

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## Conclusion

HMSA, HMAA, and UHA already provide some coverage for one hearing aid per ear every five years, and Kaiser plans to offer some coverage for hearing aids in its health plans starting in 2015. Although the coverage provided may leave those needing hearing aids with large co-payments, it would be enough to comply with the bill as written. The social and financial impacts of the bill are thus minimal: the measure would not change the status quo and, without limitations on costs, would not ensure that coverage is adequate.

In addition, the impact of SB No. 309, SD 1, in light of the federal Patient Protection and Affordable Care Act is unknown. The insurance commissioner and some insurers have different opinions on whether the measure would have a short-term impact. Moreover, the future impact is unknown. In 2012, the state adopted a benchmark health plan for 2014 and 2015 as required by the ACA; this plan requires one hearing aid per ear every five years. The U.S. Department of Health and Human Services (DHHS) is in the process of setting benchmark plan requirements for 2016 and beyond. DHHS also intends to revisit the provision requiring states to defray the cost of any state-mandated benefit in excess of the benchmark.

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## Recommendation

Senate Bill No. 309, Senate Draft 1, requiring health insurance coverage for hearing aids should not be enacted as written.

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## Responses of the Affected Agencies

### **Comments on Agency Responses**

On October 15, 2014, we transmitted a draft of this report to the Departments of Health (DOH) and Commerce and Consumer Affairs (DCCA). A copy of the transmittal letter to the DOH is included as Attachment 1. A similar letter was sent to DCCA. The departments opted not to respond.

**ATTACHMENT 1**

STATE OF HAWAII  
**OFFICE OF THE AUDITOR**  
465 S. King Street, Room 500  
Honolulu, Hawai'i 96813-2917



**JAN K. YAMANE**  
Acting State Auditor

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October 15, 2014

*COPY*

The Honorable Linda Rosen, M.D., M.P.H.  
Director  
Department of Health  
Kīna'u Hale  
1250 Punchbowl Street  
Honolulu, Hawai'i 96813

Dear Dr. Rosen:

Enclosed for your information are three copies, numbered 6 to 8, of our confidential draft report, *Study of Proposed Mandatory Health Insurance for Hearing Aids*. We ask that you telephone us by Friday, October 17, 2014, on whether or not you intend to comment on our recommendations. If you wish your comments to be included in the report, please submit your hard copy response to our office no later than 4:30 p.m. Wednesday, October 22, 2014.

The Department of Commerce and Consumer Affairs, Governor, and presiding officers of the two houses of the Legislature have also been provided copies of this confidential draft report.

Since this report is not in final form and changes may be made to it, access to the report should be restricted to those assisting you in preparing your response. Public release of the report will be made solely by our office and only after the report is published in its final form.

Sincerely,

Jan K. Yamane  
Acting State Auditor

Enclosures