

MAINE STATE LEGISLATURE

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A Report to the Joint Standing Committee on Insurance and Financial Services of the 126th Maine Legislature

Review and Evaluation of LD 523 *An Act To Require Health Insurance Coverage for Hearing Aids for Adults*

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Updated

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I. Executive Summary

The Joint Standing Committee on Insurance and Financial Services of the 126th Maine Legislature (the Committee) directed the Maine Bureau of Insurance (the Bureau) to review LD 523, *An Act to Require Health Insurance Coverage for Hearing Aids for Adults*. The review was conducted using the requirements stipulated under 24-A M.R.S.A., §2752. This review was a collaborative effort of the Bureau and NovaRest, Inc., an actuarial consulting firm.

The Committee requested the analysis be based on the following:

- The extent to which coverage of hearing aids is included in the State's essential benefits package and the manner in which the bill may expand this coverage;
- If the bill expands coverage beyond the essential benefits package, the estimated costs to the State to defray the costs of including the coverage in qualified health plans;
- The impact of amending LD 523 to require coverage for adults up to age 26; and
- The impact of the federal Affordable Care Act's provisions for cost-sharing in qualified health plans on existing coverage of hearing aids and the expanded coverage required by LD 523.

LD 523 is an act to require health insurance coverage for hearing aids for adults in all individual and group health insurance policies. The requirements of LD 523 would apply to all medical insurance policies, contracts and certificates executed, delivered, issued for delivery, continued or renewed in this State on or after January 1, 2014. It would not apply to self-insured employer health benefits. This act would expand coverage to individuals over the age of 18 where the current law does not apply to individuals over 18 years of age.

Hearing loss is not always an age induced event. Hearing loss may be developed due to noise exposure at an individual's place of employment. Hearing may also be diminished by recreational activities such as riding a motorcycle or swimming. Hearing loss is a major public health issue that is the third most common physical condition in the United States after arthritis and heart disease. About 20 percent of adults in the United States report some degree of hearing loss.¹ The appropriately selected hearing aid is often the most effective therapeutic measure for an individual with hearing loss.

A summary of specific state mandates is included in Appendix B. Colorado, Connecticut, Delaware, Kentucky, Louisiana, Maine, Maryland, Massachusetts, Minnesota, Missouri, New Jersey, New Mexico, North Carolina, Oklahoma, Oregon, and Tennessee require that health benefits plans in their states pay

¹ The Hearing Loss Association of America (HLAA), "Basic Facts About Hearing Loss," www.hearingloss.org/content/basic-facts-about-hearing-loss.

for hearing aids for children. Arkansas, New Hampshire and Rhode Island require coverage for both children and adults. Wisconsin requires coverage for both hearing aids and cochlear implants for children.

Requirements vary state by state for:

- Ages covered;
- Dollar amount of coverage;
- Frequency of replacement; and
- Provider qualifications.²

Federal law and regulations related to the Early Periodic Screening, Diagnosis, and Treatment (EPSDT) Program require Medicaid to provide medically necessary services for children. Accordingly, items such as hearing aids are generally covered more frequently for children than for adults. Further, services that may not be covered for adults, e.g., binaural hearing aids, are often available for children, although Medicaid may use a prior approval process to assure medical necessity and appropriate utilization.³

A survey of the major health insurers in Maine indicates that most cover hearing aids as mandated up to age 18. Aetna provides coverage to age 19 and UnitedHealthcare covers hearing aids with no stipulation for age.

Maine's Essential Health Benefits (EHB) only requires hearing aids to be covered up to age 18, as provided for in the current law. As written, LD 523 would eliminate the age 18 restriction, but would not change the limit on charges of \$1,400 per device or the maximum replacement of 36 months in the current statute.

ACA requires states to subsidize the cost of mandated benefits not included in the Essential Health Benefits (EHB). Since the EHB plan covers the hearing aid benefit to age 18 currently, the benefit not covered by the EHB plan would be for individuals over age 18. Maine will be required to pay both a portion of the premium for consumers eligible for federal premium subsidies and the cost of reduced cost-sharing for federally subsidized individuals. It is estimated that there will be 38,000 federally subsidized individuals in Maine.⁴ We assume that all of the subsidized individuals are over age 18 and therefore would receive the expanded benefit. We also assume that no cost limit will be allowed on the cost of the device. Using these assumptions, the approximate cost to the State for all subsidized members could be up to \$374,000 per year or \$29,000 per year if the bill was amended to limit coverage

² American Speech-Language-hearing Association, "State Insurance Mandates for Hearing Aids," www.asha.org/advocacy/state/issues/ha_reimbursement/.

³ Better Hearing Institute, "MEDICAID and SCHIP Programs," www.betterhearing.org/hearing_loss_resources/_viewResource.cfm/resourceID/5/resourceArticleID/295.

⁴ Gorman report, "The Impact of the ACA on Maine's Health Insurance Markets."

to age 26. It is likely that at least the amount up to age 26 would be considered immaterial and therefore, may not have to be paid by the State. Guidance for EHB after 2015 has not been released and it is possible that HHS will broaden the definition of what benefits have to be subsidized even if they are included in the EHB plan.

UPDATE: A recent email from CMS/CIIO (Centers for Medicare and Medicaid Services/Center for Consumer Information & Insurance Oversight) stated that amending a law that was initially enacted prior to 2012 to expand the applicable age would not be enacting a law that establishes a new requirement (a new mandate) to offer a new benefit. Therefore, Maine would not be required to pay the additional premium due to expanding the current mandate.

Some states have already reacted to reduce the financial burden that ACA is requiring for mandated benefits by:

- 1) Not requiring mandated benefits above the EHB benefits for plans on the insurance exchange;
- 2) Only requiring the mandate for large groups; or
- 3) Finding outside funding such as new insurer fees.

The carriers' estimates of premium increases are included in the following table:

Premium Increase PMPM		
Carrier	To Age 26	Unlimited Age
Aetna	\$0.00	\$0.21
Harvard Pilgrim	\$0.03	
United Healthcare	\$0.00	\$0.00
Cigna		\$0.22
Anthem		\$0.75

NovaRest estimates that the premium impact for providing hearing aids for an unlimited age would range from \$0.00 for UnitedHealthcare members to \$0.57 PMPM for other carrier members. If the bill was amended to only cover individuals up to age 26, the estimated impact on premium for non-UnitedHealthcare members would be \$0.04 PMPM. The estimate assumes that the limit of \$1,400 per device would not be allowed under ACA due to ACA provisions that do not allow cost limitations.

For small group and individual plans the ACA preempts Maine law dollar limits on mandates. An actuarially equivalent quantitative or visit limit may be used to replace the dollar limits. The ACA compliant plans will offer 1 hearing aid per ear every 3 years. Large group plans may continue to impose the \$1,400 dollar limit on hearing aids.

II. Background

The Joint Standing Committee on Insurance and Financial Services of the 126th Maine Legislature (the Committee) directed the Maine Bureau of Insurance (the Bureau) to review LD 523, *An Act to Require Health Insurance Coverage for Hearing Aids for Adults*. The review was conducted using the requirements stipulated under 24-A M.R.S.A., §2752. This review was a collaborative effort of the Bureau and NovaRest, Inc.

The Committee requested the analysis be based on the following:

- The extent to which coverage of hearing aids is included in the State's essential benefits package and the manner in which the bill may expand this coverage;
- If the bill expands coverage beyond the essential benefits package, the estimated costs to the State to defray the costs of including the coverage in qualified health plans;
- The impact of amending LD 523 to require coverage for adults up to age 26; and
- The impact of the federal Affordable Care Act's provisions for cost-sharing in qualified health plans on existing coverage of hearing aids and the expanded coverage required by LD523.

LD 523 is an act to require health insurance coverage for hearing aids for adults over age 18. Currently all health insurance policies, contracts and certificates must provide coverage for the purchase of a hearing aid for each hearing-impaired ear for an individual to age 18 covered under the policy, contract or certificate in accordance with the specific requirements. This act expands the requirements to those over 18 years of age.

The final requirements would include:

- A. The hearing loss must be documented by a physician or audiologist licensed pursuant to Title 32, chapter 77;
- B. The hearing aid must be purchased from an audiologist licensed pursuant to Title 32, chapter 77 or a hearing aid dealer licensed pursuant to Title 32, chapter 23-A; and
- C. The policy, contract or certificate may limit coverage to \$1,400 per hearing aid for each hearing-impaired ear every 36 months.

The proposed bill would add the following section to the statute to apply to an individual:

- D. Over 18 years of age, who is covered under a contract that is issued or renewed on or after January 1, 2014.

The effective date would need to be updated.

Hearing loss is diagnosed based on the patient history, behavior, and the result of medical and audiological examinations. The degree of hearing loss is measured as: mild, moderate, severe or profound. In adults, the most common causes of hearing loss are noise and aging. Hearing loss can occur suddenly or there may be a gradual decrease in hearing ability over time. There is a strong relationship between age and reported hearing loss.⁵ Hearing loss can affect all ages, but specifically, there are more baby boomers aged 45-64 with hearing loss (10 million) than there are people over the age of 65 with hearing loss (9 million).⁶ If hearing loss were officially considered a disability, it would rank as the most common disability in the United States.⁷

Hearing aids are dispensed by audiologists and hearing instrument specialists. There are many types of hearing aids, varying in cost, design, and features. Hearing aids are covered by some private insurance plans, some company plans, the Federal Employee Health Benefit Plan, and Tricare, the plan for active and retired military and their families. Some plans cover hearing testing, but not hearing aids. Medicare does not cover hearing aids.⁸

III. Social Impact

A. Social Impact of Mandating the Benefit

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

Hearing loss is a major public health issue that is the third most common physical condition in the United States after arthritis and heart disease. About 20 percent of adults in the United States report some degree of hearing loss.⁹ Hearing loss affects all ages, but specifically, there are more baby boomers aged 45-64 with hearing loss than there are people over the age of 65 with hearing loss.¹⁰

Accurate estimates of those suffering from hearing loss are very difficult to obtain. There are

⁵ Hearing Loss Association of America, “Basic Facts About Hearing Loss,” www.hearingloss.org/content/diagnosing-hearing-loss.

⁶ AARP, “Consumer Guide to Hearing Aids,” 2007 AARP.

⁷ Cable News Network, Hearing loss as ‘invisible,’ and widely uninsured, problem, www.cnn.com/2012/07/10/health/hearing-aid-insurance.

⁸ Hearing Loss Association of America, “Diagnosing Hearing Loss,” www.hearingloss.org/content/diagnosing-hearing-loss.

⁹ The Hearing Loss Association of America (HLAA), “Basic Facts About Hearing Loss,” www.hearingloss.org/content/basic-facts-about-hearing-loss.

¹⁰ AARP, “Consumer Guide to Hearing Aids,” 2007 AARP.

two main reasons for this. First, most of the research available relies on self-reports and the inconsistent use of terms and definitions. Second, it is common for people to deny their hearing loss and/or not realize the extent of their hearing impairment. For example, many hard-of-hearing people have adapted well to their hearing loss and may not report any hearing difficulties, therefore excluding themselves from national estimates.¹¹

Mark King, who is a licensed hearing instrument specialist in Maine, quoted the Better Hearing Institute, testifying that 173,000 (13%) have hearing loss in Maine.

2. *The extent to which the service or treatment is available to the population.*

Hearing aids are tiny instruments that are worn in or behind the ear to amplify sound. There are many types of hearing aids available for people with mild to moderate hearing loss that are hardly noticeable once fitted. To seek treatment, a patient would have to consult an audiologist or other hearing specialist.

Maine requires a separate hearing aid dispenser license for an audiologist to dispense hearing aids.¹² According to Mark King's testimonial email on March 21, 2013, there are only three types of provider groups licensed to furnish hearing help in Maine: Licensed Hearing Instrument Specialists, Audiologists, and Medical Doctors (Ears, Nose & Throat).

3. *The extent to which insurance coverage for this treatment is already available.*

Aetna currently provides coverage for the purchase of a hearing aid for each hearing-impaired ear for an individual up to age 19. The hearing aid must be purchased from a licensed audiologist or licensed hearing aid dealer, and is limited to \$1,400 per hearing aid for each hearing-impaired ear, every 36 months.

Harvard Pilgrim Health Care covers the purchase of hearing aids for each hearing-impaired ear for members through the age required by Maine law. The hearing aid must be purchased from a state licensed audiologist or hearing aid dealer. Coverage of hearing aids is provided up to the benefit limit stated in the Schedule of Benefits for the applicable plan. If an Employer Group offers additional hearing aid coverage, that information is described in the Schedule of Benefits.

UnitedHealthcare provides hearing aid coverage above the current mandated coverage.

¹¹ Ohio State University Extension, "Have You Heard? Hearing Loss and Older Adults," ohioline.osu.edu/ss-fact/0164.html.

¹² Academy of Doctors of Audiology, *State Licensure*, www.audiologist.org/publications20/state-licensure.

Deductible and coinsurance apply, and benefits are limited to \$1,400 per year and are limited to a purchase of one hearing aid per ear (including repair/replacement) every three years with no stipulation about age.

MEGA, Cigna and Anthem currently provide for the purchase of a hearing aid for each hearing-impaired ear per member from birth through 18 years of age. Coverage is limited to \$1,400 per hearing aid for each hearing-impaired ear every 36 months.

The \$1,400 dollar limit is prohibited by the ACA for individual and small group policies sold or renewed after January 1, 2014, except grandfathered plans.

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

If an individual's medical insurance does not cover this service, they would be able to obtain the treatment, but would have to pay for it themselves. MaineCare covers hearing aids for members under the age of 21.

5. *If coverage is not generally available, the extent to which the lack of coverage involves unreasonable financial hardship.*

Assuming that an individual's health plan did not cover the cost of hearing aids, the individual would have to pay the cost of the hearing aid.

Hearing aids range from approximately \$1,000 to \$4,000 each, depending on the technology selected. Several factors contribute to the cost of hearing aids, including: research and development costs; customization of each hearing aid to fit the needs of the wearer; manufacturing costs; and time spent by the professional who selects, fits, programs, adjusts and services the instruments.

Averaged over the lifetime of the instruments (3 – 5 years or more), the cost per day of a pair of highly featured, advanced digital hearing aids is about \$3.00.¹³

6. *The level of public demand and the level of demand from the providers for this treatment or service.*

¹³ Healthy Hearing, "Hearing Aid Costs," www.healthyhearing.com/content/faqs/Buying/Prices/30928-Much-do-hearing-aids.

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The percentage of Maine residents that are expected to utilize the proposed mandate is 0.43%. Therefore the demand is quite small.

Jessica Maurer, Executive Director of Maine Association of Area Agencies on Aging testified in support of this act.

Approximately 5 individual citizens provided letters of support.

7. *The level of public demand and the level of demand from the providers for individual or group coverage of this treatment.*

Mark King, who is a licensed hearing instrument specialist in Maine provided support for this act and indicated that it would help many who are in need of hearing services.

8. *The level of interest in and the extent to which collective bargaining organizations are negotiating privately for the inclusion of this coverage by group plans.*

No information is available.

9. *The likelihood of meeting a consumer need as evidenced by the experience in other states.*

Colorado, Connecticut, Delaware, Kentucky, Louisiana, Maine, Maryland, Massachusetts, Minnesota, Missouri, New Jersey, New Mexico, North Carolina, Oklahoma, Oregon, and Tennessee require that health benefits plans in their state pay for hearing aids for children. Arkansas, New Hampshire and Rhode Island require coverage for both children and adults. Wisconsin requires coverage for both hearing aids and cochlear implants for children.

Requirements vary state by state for:

- Ages covered
- Amount of coverage
- Benefit period
- Provider qualifications

Most states establish minimum hearing loss criteria for initial and replacement hearing aids, and many require a medical exam as well as an audiological evaluation to determine if a hearing aid is medically appropriate. Some states limit the types of hearing aids covered, and many establish a limit on the number of aids and accessories, such as batteries, that beneficiaries may receive within a particular period of time. Some states allow interim replacements or repairs if aids are lost or broken. Often, prior approval requirements are implemented to assure compliance with

these standards. Existing hearing aid mandates in states can be found in appendix B.

10. *The relevant findings of the state health planning agency or the appropriate health system agency relating to the social impact of the mandated benefit.*

State agencies did not provide findings pertaining to the proposed legislation.

11. *Alternatives to meeting the identified need.*

Aetna indicated:

While we wouldn't see any benefit to choosing another age limit, one potential alternative is to increase the time interval between replacements. The current bill states 36 months. If the objective is to lower or keep premiums stable, then increasing that time interval to 48 or 60 months after age 18 would be an alternative option. Another and potentially better alternative is to only cover one hearing aid per ear after age 18, and until age 26 (or even older, as long as it is only one pair).

12. *Whether the benefit is a medical or a broader social need and whether it is inconsistent with the role of insurance and the concept of managed care.*

The requirements of LD 523 are not inconsistent with the role of insurance and the concept of managed care.

13. *The impact of any social stigma attached to the benefit upon the market.*

Despite the fact that hearing loss is one of the most chronic conditions diagnosed today, many hearing-impaired individuals decline to use hearing aids. One of the most common reasons offered relates to the social stigma associated with hearing aids.

What a majority of people fail to realize is that untreated hearing loss can be far more obvious than any hearing aid on the market today. In fact, allowing the stigma of hearing aids to influence the acceptance of help can be very detrimental to a person who needs it.

Many people think about their mortality when it comes to getting a hearing aid and it can make them feel old. Adults may also feel that a hearing aid makes them look weak and feeble.

14. *The impact of this benefit upon the other benefits currently offered.*

Multiple studies indicate that untreated hearing loss can lead to further hearing damage, as well as to social anxiety, isolation, depression, and even Alzheimer's.¹⁴ Hearing loss can also lead to accidents resulting in injuries. For example, not hearing warning alarms or bells, or not clearly hearing medication instructions given by doctors.

15. *The impact of the benefit as it relates to employers shifting to self-insurance and the extent to which the benefit is currently being offered by employers with self-insured plans.*

State legislation that imposes benefit mandates will heighten an employer's concern with regard to future costs and make self-insurance a more attractive alternative. A March 23, 2011 report by Deloitte stated that nearly six in ten American private and public sector workers covered by employer-provided health care in 2010 were covered under a self-insured plan, up from about four in ten in 1999. Self-insurance coverage increases with employer size. In 2010, 16% of covered workers at small employers (3 to 199 workers) had self-insurance coverage, compared with 93% of covered workers at very large employers (5,000 or more workers).¹⁵

Annual increases in medical care costs and new ACA fees lead employers to be particularly sensitive to any legislation that places limits on managed care and even minimal increases in the cost of health care.

No information is available as to the extent to which this benefit is currently being offered by employers with self-insured plans.

16. *The impact of making the benefit applicable to the state employee health insurance program.*

Aetna reports that the impact on the state employee health insurance program would be the same as for other group programs. For other group programs, Aetna estimated that to provide coverage to age 26 would have a minimal premium impact and for coverage to an unlimited age, an average annual premium increase of \$2.56 per person.

¹⁴ Soquel Hearing Aid Center, Social Stigmas Associated with Hearing Aids, www.soquelhearingaidcenter.com/blog/2013/04/15/Social-Stigmas-Associated-with-Hearing-Aids.aspx.

¹⁵ *Self-Insured Health Benefit Plans*, by Michael J. Brien and Constantijn W.A. Panis, March 23, 2011.

IV. Financial Impact

B. Financial Impact of Mandating Benefits.

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

The impact on the cost of services from having hearing aids covered by insurance for ages over 18 is unknown.

2. *The extent to which the proposed coverage might increase the appropriate or inappropriate use of the treatment or service over the next five years.*

This bill does not preclude applying a prior approval process or other utilization review procedures to minimize inappropriate usage.

To the extent that hearing aids are not used when they should be, due to cost and lack of coverage, this act would increase appropriate use, but this increase cannot be quantified at this time.

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

Without a specific dollar limit permitted on new small group and individual plans, the mandate could lead to individuals purchasing the more expensive devices.

4. *The methods which will be instituted to manage the utilization and costs of the proposed mandate.*

LD 523 allows health plans to require prior authorization for hearing aids in the same manner that prior authorization is required for other covered diseases or conditions. Also, the utilization of the coverage would be limited to every three years. This would not reduce the possibility of a patient choosing a more expensive device than is medically necessary.

5. *The extent to which insurance coverage may affect the number and types of providers over the next five years.*

It is not known at this time what impact the mandated coverage of hearing aids will have on providers, but in general, when medical services are covered by insurance it increases demand and eventually the number of providers.

6. *The extent to which the insurance coverage of the health care service or providers may be reasonably expected to increase or decrease the insurance premium or administrative expenses of policyholders.*

Harvard Pilgrim Health Care stated in its testimony at the public hearing on the proposed legislation that the expansion contemplated in LD 523 will lead to higher premiums for members. In addition, due to the requirements and regulations regarding “Essential Health Benefits,” Harvard Pilgrim Health Care has concerns regarding how new mandates will be covered and paid for inside and outside of the federal marketplace, including the additional costs to the state of Maine. Harvard Pilgrim Health Care has already made changes to the hearing aid benefits to comply with the Affordable Care Act (ACA). Specifically, benefits have been changed to remove the \$1,400 dollar limit as required by ACA. This change has already altered the premium cost of the benefit, and an additional change would only add to the premium paid by members.

Anthem estimates a per member per month (PMPM) cost of \$0.35 to \$1.15 for all lines of business, with a midpoint of \$0.75 PMPM without limitation on age.

Aetna predicts that providing coverage to age 26 would have a claim impact of \$0.03 per member per year (PMPY) causing a premium increase of the same amount for all group plans. To provide coverage to an unlimited age, Aetna predicts an estimated claim impact of \$2.18 PMPY and an average premium increase of \$2.56 PMPY.

Cigna states that the cost will vary a bit by plan design, but for hearing aid coverage at \$1,400 per ear every three years from children up through age 26, they expect an increase in total expected claims of 0.05% to 0.1%. Additional expenses to administer this would be negligible.

Harvard Pilgrim has limited data for the state of Maine. Using data from other states, it estimated that the premium impact of extending the hearing aid mandate to age 26 would be minimal; about \$0.02 to \$0.04 PMPM or \$0.24 to \$0.48 PMPY. The impact to individual, small group and large group would be the same. The estimated impact to administrative expenses and indirect costs would be negligible.

The carriers’ estimates of premium increases are included in the following table:

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Premium Increase PMPM		
Carrier	To Age 26	Unlimited Age
Aetna	\$0.00	\$0.21
Harvard Pilgrim	\$0.03	
United Healthcare	\$0.00	\$0.00
Cigna		\$0.22
Anthem		\$0.75

NovaRest, Inc. estimates that the premium impact of increasing coverage of hearing aids to an unlimited age would range from \$0.00 for UnitedHealthcare members to \$0.57 PMPM for other carrier members. If the bill was amended to only cover insured up to age 26, the impact on premium for non-UnitedHealthcare members would be \$0.04 PMPM.

7. *The impact of indirect costs, which are costs other than premiums and administrative costs, on the question of the cost and benefits of coverage.*

There would not be any additional cost effect beyond benefit and administrative costs.

8. *The impact on the total cost of health care.*

The cost of health care would increase if the utilization of hearing aids is increased due to their being covered by insurance. We were unable to quantify that cost.

9. *The effects of mandating the benefit on the cost of health care particularly the premium and administrative expenses and indirect costs, to employers and employees, including the financial impact on small employers, medium-sized employers and large employers.*

The impact on premium would be the same for the small and large employers impacted by this act (see question number 6 above). This act will not apply to self-insured groups.

10. *The effect of the proposed mandates on cost-shifting between private and public payers of health care coverage and on the overall cost of the health care delivery system in this State.*

MaineCare provides for hearing aids to age 21. Given the current mandate of coverage to age 18, for private insurance, there may be some minimal cost-shifting for individuals between the ages of 18 and 21 if these mandates go into effect. This cost has not been quantified.

V. Medical Efficacy

C. The Medical Efficacy of Mandating the Benefit.

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

People with hearing loss may:

- Tire easily or suffer from increased stress from trying to hear
- Find it necessary to see a speaker's face in order to understand their words
- Frequently have to ask others to repeat themselves
- Increase television or radio volume to a point that others complain
- Have difficulty understanding speech in noisy places like cars, restaurants and theaters
- Fail to understand doctor's instructions about medications
- Make inappropriate responses to conversations that are not clearly heard
- Miss essential sounds such as doorbells, alarm clocks, and smoke alarms
- Have trouble hearing conversations on the telephone

Life without hearing can have devastating effects. It can leave people feeling isolated or depressed and may lead to serious illnesses like dementia. Hearing loss may even put an individual's immediate safety at risk.¹⁶

Hearing aids have experienced dramatic improvements in the technology, or circuitry, used to amplify sound and in how the aid is modified to the person's hearing needs. Conventional analog hearing aids amplify speech and noise alike, although they may have features and adjustments that can modify the sounds differentially. Until recently, this was the basic technology of hearing aids. This type of aid is generally the least expensive, but it may not be reprogrammed if a person's hearing changes over time. Digital Programmable (DSP or digitized sound processing) hearing aids convert sound waves into digital signals. A computer chip in the aid can tell if the incoming sound has the sound wave pattern of noise or of speech. It blocks out continuous background noise, while selectively amplifying the sound patterns of speech. DSP allows for more flexibility in programming and reprogramming the aid so the sound it transmits matches the user's specific pattern of hearing loss. This is typically the more expensive design, although sales of DSP accounted for over 90 percent of all hearing aid sales in 2006.¹⁷

¹⁶ Jen Christensen, CNN "Hearing Loss an 'invisible,' and widely uninsured, problem," www.cnn.com/2012/07/10/health/hearing-aid-insurance/index.html.

¹⁷ AARP, "Consumer Guide to Hearing Aids," 2007 AARP.

2. *If the legislation seeks to mandate coverage of an additional class of practitioners;*
 - a. *The results of any professionally acceptable research demonstrating medical results achieved by the additional practitioners relative to those already covered.*

LD 523 will not require an additional class of practitioners.

- b. *The methods of the appropriate professional organization that assure clinical proficiency.*

LD 523 will not require an additional class of practitioners.

VI. Balancing the Effects

D. The Effects of Balancing the Social, Economic, and Medical Efficacy Considerations.

1. *The extent to which the need for coverage outweighs the cost of mandating the benefit for all policyholders.*

Although not all hearing problems can be solved with hearing aids, many can. It is estimated that only 23%¹⁸ of individuals that need a hearing aid have one. There are many reasons why individuals may not want a hearing aid. The biggest is the perceived stigma attached with wearing a hearing aid, but another is the cost of the device. This act would help those that would benefit from a hearing aid and who could not afford to purchase one without insurance.

There are other agencies and foundations that offer financial assistance for the purchase of hearing aids to those individuals that cannot afford them. Organizations that provide assistance to adults include: Alpha One,¹⁹ HEAR NOW, Lion's Club,²⁰ and Maine Vocational Rehab.²¹

2. *The extent to which the problem of coverage can be resolved by mandating the availability of coverage as an option for policyholders.*

¹⁸ AARP, "Consumer Guide to Hearing Aids," 2007 AARP.

¹⁹ alphaonenow.org.

²⁰ <http://www.hearingloss.org/content/financial-assistance-programs-foundations>.

²¹ Maine.gov/rehab.

It is likely that only those who would benefit from the services would purchase the coverage. This would result in an alternative coverage that would cost more than the additional cost of services because of the administrative charges that would be added to benefit costs. This cost would be reduced if the option was only available when the coverage was initially purchased, but it would then be less effective because many individuals would not anticipate needing the coverage and, therefore, would not purchase it.

3. *The cumulative impact of mandating this benefit in combination with existing mandates on costs and availability of coverage.*

NovaRest, Inc. estimates that the premium impact of increasing coverage of hearing aids to an unlimited age would range from \$0.00 for UnitedHealthcare members to \$0.57 PMPM (less than 0.2%) for other carrier members.

The estimated cost of current Maine mandates is detailed in Appendix C. For most of these mandates, our estimate is based on the net impact on premiums as estimated at the time the mandate was enacted. Four of the mandates – mental health, substance abuse, chiropractic, and screening mammograms – require carriers to report annually the amount of claims paid for these benefits and the estimates are based on that data. The true cost for the Maine mandates are impacted by the fact that:

1. Some services would be provided and reimbursed in the absence of a mandate.
2. Certain services or providers will reduce claims in other areas.
3. Some mandates are required by Federal law.

VII. Appendices

LD 523, 126th Maine State Legislature
An Act to Require Health Insurance Coverage for Hearing Aids for Adults

Appendix A: Letter from the Committee on Insurance and Financial Services with Proposed Legislation

SENATE

GEOFFREY M. GRATWICK, District 32, Chair
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State of Maine
ONE HUNDRED AND TWENTY-SIXTH LEGISLATURE
COMMITTEE ON INSURANCE AND FINANCIAL SERVICES

May 23, 2013

Marti Hooper
Senior Insurance Analyst
Life and Health Division
Bureau of Insurance
34 State House Station
Augusta, Maine 04333

Dear Ms. Hooper:

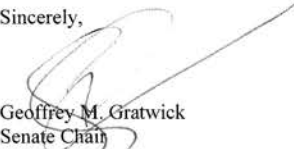
Title 24-A Maine Revised Statutes Annotated, Section 2752 requires the Joint Standing Committee on Insurance and Financial Services to submit legislation proposing health insurance mandates to the Bureau of Insurance for review and evaluation if there is substantial support for the mandate among the committee after a public hearing on the proposed legislation. Pursuant to that statute, we request that the Bureau of Insurance prepare a review and evaluation of **LD 523, An Act to Require Health Insurance Coverage for Hearing Aids for Adults**.

A copy of the bill is enclosed. Please prepare the evaluation using the guidelines set out in Title 24-A § 2752. In addition, we ask that the Bureau provide an analysis of the following issues:

- The extent to which coverage of hearing aids is included in the State's essential benefits package and the manner in which the bill may expand this coverage; and
- If the bill expands coverage beyond the essential benefits package, the estimated costs to the State to defray the costs of including the coverage in qualified health plans;
- The impact of amending LD 523 to require coverage for adults up to age 26; and
- The impact of the federal Affordable Care Act's provisions for cost-sharing in qualified health plans on existing coverage of hearing aids and the expanded coverage required by the bill.

Please submit the report to the committee before January 1, 2014. If you have any questions, please do not hesitate to contact us or our legislative analyst, Colleen McCarthy Reid.

Sincerely,


Geoffrey M. Gratwick
Senate Chair


Sharon Anglin Treat
House Chair

cc: Rep. Linda Valentino

100 STATE HOUSE STATION, AUGUSTA, MAINE 04333-0100

TELEPHONE 207-287-1314

An Act To Require Health Insurance Coverage for Hearing Aids for Adults

Be it enacted by the People of the State of Maine as follows:

Sec. 1. 24-A MRSA §2762, sub-§3, as enacted by PL 2007, c. 452, §2, is amended to read:

3. Application of coverage. The requirements of subsection 2 apply to an individual:

- A. From birth to 5 years of age, who is covered under a policy or contract that is issued or renewed on or after January 1, 2008;
- B. From 6 to 13 years of age, who is covered under a policy or contract that is issued or renewed on or after January 1, 2009; ~~and~~
- C. From 14 to 18 years of age, who is covered under a policy or contract that is issued or renewed on or after January 1, 2010; and
- D. Over 18 years of age, who is covered under a policy or contract that is issued or renewed on or after January 1, 2014.

Sec. 2. 24-A MRSA §2847-O, sub-§2, as reallocated by PL 2007, c. 695, Pt. A, §29, is amended to read:

2. Required coverage. In accordance with the application of coverage set forth in subsection 3, all group health insurance policies, contracts and certificates must provide coverage for the purchase of a hearing aid for each hearing-impaired ear for an individual covered under the policy, contract or certificate ~~who is 18 years of age or under~~ in accordance with the following requirements.

- A. The hearing loss must be documented by a physician or audiologist licensed pursuant to Title 32, chapter 77.
- B. The hearing aid must be purchased from an audiologist licensed pursuant to Title 32, chapter 77 or a hearing aid dealer licensed pursuant to Title 32, chapter 23-A.
- C. The policy, contract or certificate may limit coverage to \$1,400 per hearing aid for each hearing-impaired ear every 36 months.

Sec. 3. 24-A MRSA §2847-O, sub-§3, as reallocated by PL 2007, c. 695, Pt. A, §29, is amended to read:

3. Application of coverage. The requirements of subsection 2 apply to an individual:

- A. From birth to 5 years of age, who is covered under a policy, contract or certificate that is issued or renewed on or after January 1, 2008;
- B. From 6 to 13 years of age, who is covered under a policy, contract or certificate that is issued or renewed on or after January 1, 2009; ~~and~~
- C. From 14 to 18 years of age, who is covered under a policy, contract or certificate that is issued or renewed on or after January 1, 2010; and
- D. Over 18 years of age, who is covered under a policy, contract or certificate that is issued or renewed

on or after January 1, 2014.

Sec. 4. 24-A MRSA §4255, sub-§2, as reallocated by PL 2007, c. 695, Pt. A, §30, is amended to read:

2. Required coverage. In accordance with the application of coverage set forth in subsection 3, all health maintenance organization individual and group health insurance contracts must provide coverage for the purchase of a hearing aid for each hearing-impaired ear for an individual covered under the policy, contract or certificate ~~who is 18 years of age or under~~ in accordance with the following requirements.

A. The hearing loss must be documented by a physician or audiologist licensed pursuant to Title 32, chapter 77.

B. The hearing aid must be purchased from an audiologist licensed pursuant to Title 32, chapter 77 or a hearing aid dealer licensed pursuant to Title 32, chapter 23-A.

C. The policy, contract or certificate may limit coverage to \$1,400 per hearing aid for each hearing-impaired ear every 36 months.

Sec. 5. 24-A MRSA §4255, sub-§3, as reallocated by PL 2007, c. 695, Pt. A, §30, is amended to read:

3. Application of coverage. The requirements of subsection 2 apply to an individual:

A. From birth to 5 years of age, who is covered under a contract that is issued or renewed on or after January 1, 2008;

B. From 6 to 13 years of age, who is covered under a contract that is issued or renewed on or after January 1, 2009; ~~and~~

C. From 14 to 18 years of age, who is covered under a contract that is issued or renewed on or after January 1, 2010; and

D. Over 18 years of age, who is covered under a contract that is issued or renewed on or after January 1, 2014.

Sec. 6. Exemption from review. Notwithstanding the Maine Revised Statutes, Title 24-A, section 2752, this Act is enacted without review and evaluation by the Department of Professional and Financial Regulation, Bureau of Insurance.

Sec. 7. Application. The requirements of this Act apply to all policies, contracts and certificates executed, delivered, issued for delivery, continued or renewed in this State on or after January 1, 2014. For the purposes of this Act, all contracts are deemed to be renewed no later than the next yearly anniversary of the contract date.

SUMMARY

This bill requires health insurance coverage of hearing aids for persons over 18 years of age.

Appendix B: State Hearing Health Insurance Mandates

US State:	Limit	Covered Age	Note
Arkansas	\$1,400 per aid, every 3 years	All Ages	Does not mandate coverage of the cost of hearing aids but rather requires insurance companies to offer coverage to employers in the state.
Colorado	1 hearing aid per ear every 5 years, no limit on cost but deductibles and co-pays may apply	Children under 18	
Connecticut	\$1,000 total, every 24 months	Children under 12	
Delaware	\$1,000 per aid, 1 hearing aid per ear every 36 months	Children under 18	
Kentucky	\$1,400 per aid, every 36 months	Children under 18 and state employees	State employees were added to the coverage list as of last legislative session
Louisiana	\$1,400 per aid, every 36 months	Children under 18	
Maine	\$1,400 per aid, every 36 months	Children 5 and under took effect Jan. 1, 2008, children 6-13 took effect Jan. 1, 2009, children 14-18 took effect Jan. 1, 2010	
Maryland	\$1,400 per aid, every 36 months	Children under 18	
Massachusetts	Up to \$2,000 per hearing aid every 36 months.	Children 21 years old and younger	In effect 1/2013
Minnesota	1 hearing aid per ear, every 36 months, no limit on cost and no additional deductible or similar restriction	Children under 18	In effect 8/2003

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Missouri	Coverage amount varies per need of newborn	Newborns coverage for screening, audiological assessment and hearing aid purchases	In effect 2004
New Hampshire	\$1,500 per hearing aid, per ear, once every 60 months	No age restrictions	In effect 1/2011
New Jersey	Coverage for \$1,000 per aid, once every 2 years	Children 15 years old and younger	In effect 4/2009
New Mexico	\$2,200 per ear, once every 36 months	Children under 18, or those under 21 if still enrolled in high school	
North Carolina	\$2,500 per hearing aid, per ear, once every 36 months	Children under the age of 22	In effect 1/2011
Oklahoma	No limit for hearing aid cost, once every 48 months	Children under 18	In effect 11/2002
Oregon	\$4,000 per aid, once every 48 months	Children under 18, dependents	In effect 1/2010
Tennessee	\$1000 per hearing aid per ear every 3 years	Children under 18	
Rhode Island	Increased in 2006 from \$400 to \$2,000, per hearing aid for those under 19. For all others, increased from \$400 to \$800, per hearing aid. Once every three years for both groups.	All Ages	In effect 1/2002
Wisconsin	No limit, covers the cost of one hearing aid per ear (once every 3 years), cochlear implants, and related therapy	Children under 18	Hearing aids <u>and</u> cochlear implants

Appendix C: Cumulative Impact of Mandates in Maine

Bureau of Insurance

Cumulative Impact of Mandates in Maine

Report for the Year 2012

This report provides data for medical insurance coverage of mandates as required by 24-A M.R.S.A. §2752 and compiled by the Bureau of Insurance. While some data was provided through annual mandate reports by insurers, other figures were estimated as a part of the proposed mandates study. The following provides a brief description of each state mandate and the estimated claim cost as a percentage of premium. Many of these mandates are now required by the federal Affordable Care Act (ACA). In addition, the ACA requires benefits covered by the benchmark plan which includes all state mandates to be covered by all individual and small group plans effective January 1, 2014. A summary chart is provided at the end of this report.

- ♦ **Mental Health** (Enacted 1983)

Mental health parity in Maine for listed conditions became effective July 1, 1996, and was expanded effective October 1, 2003. The percentage of mental health claims paid has been tracked since 1984 and has historically been between 3% and 4% of total group health claims and was reported as 3.3% in 2012. Mental health claims stayed below 3.5%, despite the fact that an expansion of the list of conditions for which parity is required was fully implemented in 2005. Mental health coverage is included in the essential health benefits for individual and small group plans beginning 2014. This report includes claims as paid under the law requirements for 2012. Individual mental health claims were only 1.9% in 2012 as a mandated offer. We have assumed that individual mental health claims will increase under ACA and will be similar to group claims in 2014.

- ♦ **Substance Abuse** (Enacted 1983)

The state mandate required the provision of benefits for alcoholism and drug dependency and applied only to groups of more than 20. Effective October 1, 2003, substance abuse was added to the list of mental health conditions for which parity is required. Effective on January 1, 2014 the federal Affordable Care Act requires substance abuse treatment benefits for individual and small group plans as part of the essential health benefits.

The percentage of claims paid has been tracked since 1984. For 2012, substance abuse claims paid were 0.7% of the total group health claims. Despite implementation of the parity requirement, there was a long-term decrease in the percentage, likely due to utilization review, which sharply reduced the incidence of inpatient care. We estimate substance abuse claims will remain at the current levels going forward.

- ♦ **Chiropractic** (Enacted 1986)

This mandate generally requires coverage for the services of chiropractors to the extent that the same services would be covered if performed by a physician. Using annual experience reports from the carriers, the percentage

of claims paid has been tracked since 1986 and, in 2012, was 1.0% of total health claims. The level has typically been lower for individual than for group. We estimate the current levels going forward. Although it is likely that some of these costs would have been covered even in the absence of a mandate, we have no basis for estimating how much. We have included the entire amount, thereby overstating the impact of the mandate to some extent.

- ♦ **Screening Mammography** (Enacted 1990)

This mandate requires that benefits be provided for screening mammography. The U.S. Preventive Services Task force has recommended that screening mammograms begin at a later age and be done less frequently. While it is possible this will lead to reduced utilization, the American Cancer Society, The American College of Obstetricians and Gynecologists, and many oncologists have not accepted these recommendations. We, therefore, estimate the current level of 0.71% in all categories going forward. Coverage is required by ACA for preventive services.

- ♦ **Dentists** (Enacted 1975)

This mandate requires coverage for dentists' services to the extent that the same services would be covered if performed by a physician. It does not apply to HMOs. A 1992 study done by Milliman and Robertson for the Mandated Benefits Advisory Commission estimated that these claims represent 0.5% of total health claims and that the actual impact on premiums is "slight." It is unlikely that this coverage would be excluded in the absence of a mandate. We include 0.1% as an estimate.

- ♦ **Breast Reconstruction** (Enacted 1998)

This mandate requires coverage for reconstruction of both breasts to produce a symmetrical appearance after a mastectomy. At the time this mandate was being considered in 1995, one carrier estimated the cost at \$0.20 per month per individual. We do not have a more recent estimate. We include 0.02% in our estimate of the maximum cumulative impact of mandates.

- ♦ **Errors of Metabolism** (Enacted 1995)

This mandate requires coverage for metabolic formula and up to \$3,000 per year for prescribed modified low-protein food products. At the time this mandate was being considered in 1995, Blue Cross estimated the cost at \$0.10 per month per individual. We do not have a more recent estimate. We include 0.01% in our estimate.

- ♦ **Diabetic Supplies** (Enacted 1996)

This mandate requires that benefits be provided for medically necessary diabetic supplies and equipment. Based on data collected in 2006, most carriers reported that there would be no cost increase or an insignificant cost increase because they already provide this coverage. Based on our report we estimate 0.2%.

- ♦ **Minimum Maternity Stay** (Enacted 1996)

This mandate requires that if a policy provides maternity benefits, the maternity (length of stay) and newborn care benefits must be provided in accordance with "Guidelines for Prenatal Care." Based on carrier responses indicating that they did not limit maternity stays below those recommended, we estimate no impact.

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An Act to Require Health Insurance Coverage for Hearing Aids for Adults

- ♦ ***Pap Smear Tests*** (Enacted 1996)

This mandate requires that benefits be provided for screening Pap smear tests. HMOs would typically cover these costs and, for non-HMO plans, the relatively small cost of this test would not in itself satisfy the deductible, so there would be no cost unless other services were also received. We estimate a negligible impact of 0.01%. Coverage is required by ACA for preventive services.

- ♦ ***Annual GYN Exam Without Referral*** (Enacted 1996)

This mandate only affects HMO plans and similar plans, and it requires the provision of benefits for annual gynecological exams without prior approval from a primary care physician. To the extent the Primary Care Physician (PCP) would, in absence of this law, have performed the exam personally rather than referring to an OB/GYN, the cost may be somewhat higher; therefore, we include 0.1%.

- ♦ ***Breast Cancer Length of Stay*** (Enacted 1997)

This mandate requires that benefits for breast cancer treatment be provided for a medically appropriate period of time as determined by the physician in consultation with the patient. Our report estimated a cost of 0.07% of premium.

- ♦ ***Off-label Use Prescription Drugs*** (Enacted 1998)

This mandate requires coverage of off-label prescription drugs in the treatment of cancer, HIV, and AIDS. Our 1998 report stated a "high-end cost estimate" of about \$1 per member per month (0.6% of premium) if it is assumed there is currently no coverage for off-label drugs. Because the HMOs claimed to already cover off-label drugs, in which case there would be no additional cost; and, providers testified that claims have been denied on this basis, we include half this amount, or 0.3%.

- ♦ ***Prostate Cancer*** (Enacted 1998)

This mandate requires prostate cancer screenings if recommended by a physician, at least once a year for men 50 years of age or older until a man reaches the age of 72. No increase in premiums should be expected for the HMOs that provide the screening benefits currently as part of their routine physical exam benefits. Our report estimated additional claims cost for non-HMO plans would approximate \$0.10 per member per month. With the inclusion of administrative expenses, we would expect a total cost of approximately \$0.11 per member per month, or approximately 0.07% of total premiums.

- ♦ ***Nurse Practitioners and Certified Nurse Midwives*** (Enacted 1999)

This law mandates coverage for nurse practitioners and certified nurse midwives and allows nurse practitioners to serve as primary care providers. This mandate is estimated to increase premium by 0.16%.

- ♦ ***Coverage of Contraceptives*** (Enacted 1999)

This mandate requires health plans that cover prescription drugs to cover contraceptives. Our report estimated an increase of premium of 0.8%.

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- ♦ ***Registered Nurse First Assistants*** (Enacted 1999)

This mandate requires health plans that cover surgical first assistants to cover registered nurse first assistants if an assisting physician would be covered. No material increase in premium is expected.

- ♦ ***Access to Clinical Trials*** (Enacted 2000)

This mandate requires that coverage be provided for an eligible enrollee to participate in approved clinical trials. Our report estimated a cost of 0.19% of premium.

- ♦ ***Access to Prescription Drugs*** (Enacted 2000)

This mandate only affects plans with closed formularies. Our report concluded that enrollment in such plans is minimal in Maine and therefore the mandate will have no material impact on premiums.

- ♦ ***Hospice Care*** (Enacted 2001)

No cost estimate was made for this mandate because the Legislature waived the requirement for a study. Because carriers generally covered hospice care prior to the mandate, we assume no additional cost.

- ♦ ***Access to Eye Care*** (Enacted 2001)

This mandate affects plans that use participating eye care professionals. Our report estimated a cost of 0.04% of premium.

- ♦ ***Dental Anesthesia*** (Enacted 2001)

This mandate requires coverage for general anesthesia and associated facility charges for dental procedures in a hospital for certain enrollees for whom general anesthesia is medically necessary. Our report estimated a cost of 0.05% of premium.

- ♦ ***Prosthetics*** (Enacted 2003)

This mandate requires coverage for prosthetic devices to replace an arm or leg. Our report estimated a cost of 0.03% of premium for groups over 20, and a cost of 0.08% of premium for small employer groups and individuals.

- ♦ ***LCPCs*** (Enacted 2003)

This mandate requires coverage of licensed clinical professional counselors. Our report on mental health parity indicated no measurable cost impact for coverage of LCPCs.

- ♦ ***Licensed Pastoral Counselors and Marriage & Family Therapists*** (Enacted 2005)

This mandate requires coverage of licensed pastoral counselors and marriage & family therapists. Our report indicated no measurable cost impact for this coverage.

- ♦ ***Hearing Aids*** (Enacted 2007)

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An Act to Require Health Insurance Coverage for Hearing Aids for Adults

This mandate requires coverage for \$1,400 for each ear every 36 months for children age 18 and under. The mandate was phased-in between 2008 and 2010, and our report estimated a cost of 0.1% of premium.

- ♦ ***Infant Formulas*** (Enacted 2008)

This mandate requires coverage for amino acid-based elemental infant formulas for children two years of age and under, regardless of delivery method. This mandate is effective January 2009, and our report estimated a cost of 0.1% of premium.

- ♦ ***Colorectal Cancer Screening*** (Enacted 2008)

This mandate requires coverage for colorectal cancer screening for persons fifty years of age or older, or less than 50 years of age and at high risk for colorectal cancer according to the most recently published colorectal cancer screening guidelines of a national cancer society. This mandate is effective January 2009. No carriers stated they denied coverage prior to this mandate; therefore, our report estimated no impact on premium.

- ♦ ***Independent Dental Hygienist*** (Enacted 2009)

This mandate requires individual dental insurance or health insurance that includes coverage for dental services to provide coverage for dental services performed by an independent practice dental hygienist. This mandate applies only to policies with dental coverage; therefore, there is no estimated impact on medical plan premiums.

- ♦ ***Autism Spectrum Disorders*** (Enacted 2010)

This mandate requires all contracts to provide coverage for the diagnosis and treatment of autism spectrum disorders for individuals five years of age or under. Coverage may be limited for applied behavior analysis to \$36,000 per year. This mandate is effective January 2011, and our 2009 report estimated a cost of 0.7% of premium once the mandate is fully implemented if it included those under age 21. Because the current mandate only applies to those up to age five, the estimate was reduced to 0.3% of premium.

- ♦ ***Children's Early Intervention Services*** (Enacted 2010)

This mandate requires all contracts to provide coverage for children's early intervention services from birth to 36 months for a child identified with a developmental disability or delay. Benefits may be limited to \$3,200 per year. This mandate is effective January 2011, and our report estimated a cost of 0.05% of premium.

COST OF EXISTING MANDATED HEALTH INSURANCE BENEFITS

Year Enacted	Benefit	Type of Contract Affected	Est. Maximum Cost as % of Premium
1975	Must include benefits for dentists' services to the extent that the same services would be covered if performed by a physician.	All Contracts	0.10%
1983	Benefits must be included for treatment of alcoholism and drug dependency .	All Contracts	0.70%
1975 1983 1995 2003	Benefits must be included for Mental Health Services , including psychologists and social workers.	Groups	3.30%
		Individual	3.30%
1986 1994 1995 1997	Benefits must be included for the services of chiropractors to the extent that the same services would be covered by a physician. Benefits must be included for therapeutic, adjustive and manipulative services. HMOs must allow limited self-referred for chiropractic benefits.	Group	1.0%
		Individual	0.50%
1990 1997	Benefits must be made available for screening mammography .	Group	0.71%
		Individual	0.71%
1995	Must provide coverage for reconstruction of both breasts to produce symmetrical appearance according to patient and physician wishes.	All Contracts	0.02%
1995	Must provide coverage for metabolic formula and up to \$3,000 per year for prescribed modified low-protein food products.	All Contracts	0.01%
1996	If policies provide maternity benefits, the maternity (length of stay) and newborn care benefits must be provided in accordance with "Guidelines for Prenatal Care."	All Contracts	0
1996	Benefits must be provided for medically necessary equipment and supplies used to treat diabetes and approved self-management and education training.	All Contracts	0.20%
1996	Benefits must be provided for screening Pap tests .	All	0.01%
1996	Benefits must be provided for annual gynecological exam without prior approval of primary care physician.	Group managed care	--
1997	Benefits provided for breast cancer treatment for a medically appropriate period of time determined by the physician in consultation with the patient.	All Contracts	0.07%
1998	Coverage required for off-label use of prescription drugs for treatment of cancer, HIV, or AIDS.	All Contracts	0.30%
1998	Coverage required for prostate cancer screening .	All Contracts	0.07%

1999	Coverage of nurse practitioners and nurse midwives and allows nurse practitioners to serve as primary care providers.	All Managed Care Contracts	--
1999	Prescription drug must include contraceptives .	All Contracts	0.80%
1999	Coverage for registered nurse first assistants .	All Contracts	0
2000	Access to clinical trials .	All Contracts	0.19%
2000	Access to prescription drugs .	All Managed Care Contracts	0
2001	Coverage of hospice care services for terminally ill.	All Contracts	0
2001	Access to eye care .	Plans with participating eye care professionals	0
2001	Coverage of anesthesia and facility charges for certain dental procedures.	All Contracts	0.05%
2003	Coverage for prosthetic devices to replace an arm or leg	Groups >20	0.03%
		All other	0.08%
2003	Coverage of licensed clinical professional counselors	All Contracts	0
2005	Coverage of licensed pastoral counselors and marriage & family therapists	All Contracts	0
2007	Coverage of hearing aids for children	All Contracts	0.1%
2008	Coverage for amino acid-based elemental infant formulas	All Contracts	0.1%
2008	Coverage for colorectal cancer screening	All Contracts	0
2009	Coverage for independent dental hygienist	All Contracts	0
2010	Coverage for autism spectrum	All Contracts	0.3%
2010	Coverage for children's early intervention services	All Contracts	0.05%
	Total cost for groups larger than 20:		8.11%
	Total cost for groups of 20 or fewer:		8.16%
	Total cost for individual contracts:		7.66%