Beyond the Individual Practice
ACA Impact on State Insurance Mandates for Audiological Care
By Jessica J. Messersmith and Lindsey Jorgensen

The Affordable Care Act (ACA) is here, and it will change the landscape of the world of health care drastically from how we recognize it today. We’ve heard much about the impact of the ACA on audiology (for further information see Audiology Today March/April 2014). There have been presentations and publications in nearly every media outlet in our field. Most of these commonly present the ACA as an opportunity for audiologists to expand insurance coverage to hearing health care. So we have armed ourselves, prepared to face these changes and opportunities, and we continue to change, learn, and adapt as new challenges and opportunities emerge. One such emerging challenge could have a significant impact on audiology, specifically in those states without a mandate requiring insurance coverage of audiological services and equipment. While this may not initially have a direct impact for audiologists, it does have a large impact on our future and our ability to fight for our services and equipment to be covered by insurance.

When the ACA came into effect in 2014, minimum coverage guidelines were established. These guidelines are referred to as Essential Health Benefits (EHB) and include ten categories of benefits.

1. Ambulatory patient services
2. Emergency services
3. Hospitalization
4. Maternity and newborn care
5. Mental health and substance abuse services, including behavioral health treatment
6. Prescription drugs
7. Rehabilitative and habilitative services and devices
8. Laboratory services
9. Preventive and wellness services and chronic disease management
10. Pediatric services, including oral and vision care

For 2014 and 2015, the responsibility of defining the EHB within these categories falls to the states as they establish their “benchmark plan.” Through regulations established in the ACA, the benchmark plan should be equal to a “typical” employer health plan, with the level of the employer being selected by the state (largest small group plan, largest state employee plan, largest federal employee plan, or largest HMO offered in the commercial market). Although the coverage
benefits include the benchmark plan, the states interpret the EHB specified in the ACA.

Though the American Academy of Audiology, as well as other audiology and hearing health-care advocacy groups, actively lobbied for the inclusion of hearing care as part of the EHB, hearing care is not specified as an essential health service; this is in contrast to oral and vision care, which are specifically mentioned as EHB covered services. Further, hearing aids and services provided by audiologists for the purpose of dispensing hearing aids are not commonly covered by most insurance policies except in those states with a mandate requiring the coverage of hearing health care. As of 2013, 31 states had implemented some type of legislation mandating coverage of hearing assistive technology (HAT) through health insurance policies (Messersmith et al, 2014), most of them requiring services for the pediatric population. Due to these factors, hearing health care is not being included in most benchmark plans. Audiology care will be considered part of a state’s benchmark plan in those states with mandates in place prior to 2011. This is of concern for all audiologists.

For those 20 states without mandated coverage, the road toward passing a mandate becomes even more difficult. Because of efforts in the ACA to limit increases in premium costs for consumers, states now have a financial responsibility when they, at the state level, mandate insurance coverage benefits beyond those specified in the ACA. Under section 1311(d) of the ACA, states are required to defray the cost for benefits beyond the EHB in qualified health plans. This is where the primary problem lies with ACA in the coverage of audiology services and products.

The use of the term defray in section 1311(d) of the ACA, at the current time, appears to be interpreted to mean that the state must directly pay for the costs of any coverage mandates it requires that exceed those specified through the EHB. Determination of the costs of these additional coverage requirements falls to the plan carriers, as the exchanges are responsible for determining what, if any, state-required benefits exceed the EHB; plans then calculate the costs of providing those benefits, and the state would be responsible for paying either the plan or the enrollee for those costs. Therefore, if a state begins a new mandate after the implementation of ACA, they are conceding that they will pay for all costs associated with things that are not EHBs—this includes audiology services and equipment.

As we course this new road of insurance coverage of hearing health care it is important to note that some insurance companies are exempt from mandates. Section 1302(b) of the ACA delineates which plans are and are not exempt. Medicaid benchmark and benchmark-equivalent, nongrandfathered plans in the individual and small group markets both inside and outside of the exchanges, and Basic Health Programs must cover the EHB. Self-insured group health plans, health insurance offered in the large group market, and grandfathered health plans are
exempt. Therefore, plans that are (1) self-insured group, (2) offered in the large group market, or (3) grandfathered would not be subject to cost defrayment under 1311(d) for a state-mandated benefit since they are not subject to the EHB requirements of section 1302(b). The state would be responsible for defraying the cost for all plans offered through the exchange and all plans outside of the exchange that do not fit into one of these three categories.

Consider the following example. It has been estimated by the American Speech-Language-Hearing Association (2014) that the inclusion of speech-language pathology and audiology benefits would cost less than 35 cents per member per month. Although this estimated premium increase is reflective of adding both speech-language pathology and audiology coverage, this value will be assumed for the current example because an estimate for the addition of only audiology services could not be found. An increase of 35 cents per month would translate to $4.20 per member per year. If a state with a moderate population size is assumed, two million people, the total cost to introducing the mandate would be in excess of $8 million. Even if a population of one million people were assumed to account for those persons covered under plans that do not fall into the category that requires the state to defray the cost, the cost to the state for introducing the mandate would exceed $4 million. Ultimately, because of section 1311(d) the state now holds a rather large financial responsibility for any increase in premium that occurs as the result of a state mandate.

For those states who did not have legislation mandating insurance coverage of HAT or audiology services in place prior to 2011, it is now going to be an uphill battle to realize such a mandate. Previously, the fight for covered services was difficult. However, the individuals in the states without a mandate now not only have to combat the idea of a mandate and the insurance lobby, but they also have to combat the state itself and the state’s desire to avoid the financial repercussions of a mandate. State mandates, when implemented, serve as a guideline for insurance coverage of hearing aids and HAT. Unfortunately, these mandates often become necessary for patients and parents of children with hearing loss to obtain appropriate hearing health care. Due to the financial charges to the state through the ACA, though, it’s reasonable to expect that mandates will fall even more out of favor and alternate courses of action will become necessary for ensuring proper coverage of health care.

It is expected that in 2016 the ACA will be refined. Specifically, it has been indicated that the federal government will review the implementation of the ACA at the state level and provide more specific guidelines for benchmark plans. A definition of “habilitative services” is also expected since it is not yet defined by the Department of Health and Human Services. As the ACA is revised across the next several years, the EHB will be more clearly defined, and the inclusion of audiology services in the EHB of the ACA is possible in the future. Therefore, it is our duty to continue to fight for the inclusion of audiology services and equipment in the EHB. The current status of audiology in the ACA places audiologists and persons requiring the services of audiologists at a disadvantage in those states without a mandate requiring audiology benefits. The battle that has been waged in the 2014 session of South Dakota legislature as we have fought for insurance coverage of audiology services has taught us these aspects of the ACA.

Although we did not achieve what we set out to accomplish, we were, through negotiation, successful in securing insurance coverage of services provided by an audiologist. As we move forward we will continue to navigate these uncharted waters, working toward the inclusion of comprehensive hearing health-care benefits through means other than a mandate. Similar battles are likely to be waged in other states as well, as our profession strives for the coverage of audiological care.

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Notes
1. State refers to all 50 states and the District of Columbia.
2. South Dakota legislature meets one time per year at the beginning of the calendar year.

References