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Fiscal Impact Report – BR82/SB93 HCS1

Coverage for Hearing Aids for Children, Cochlear Implants and Feeding & Eating Disorder Treatment Coverage

PREPARED FOR THE KENTUCKY DEPARTMENT OF INSURANCE

MARCH 13, 2025

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Introduction

Lewis & Ellis, LLC (L&E) was engaged by the Kentucky Department of Insurance (KY DOI) to perform a fiscal impact analysis of BR82/SB93 HCS1, which would:

- Mandate that health benefit plans provide coverage for hearing aids for children regardless of degree of hearing loss subject to a minimum coverage amount of no less than $2,500 as determined by the commissioner, with no cost-sharing to the insured member, although a maximum coverage limit may be applied;
- Mandate that health benefit plans provide coverage for cochlear implants, with no cost-sharing to the insured member, although a coverage limit may be applied;
- Mandate that health benefit plans provide coverage for treatment of a diagnosed feeding and eating disorders; and
- Prohibit a health plan from utilizing body mass index, ideal body weight, or any other standard requiring an achieved weight, when determining medical necessity for treatment of feeding and eating disorders.

Kentucky Revised Statute (KRS) 6.948[a] mandates that the sponsor of any bill proposing a health benefit mandate must request a financial impact statement from the Kentucky Department of Insurance (DOI). This statement must be completed within 30 days of the request and should include the following:

1. An assessment of the impact of the mandated health benefit on administrative expenses, premiums, and the overall cost of healthcare including any potential future cost savings.
2. Supporting documentation, including studies, written opinions, calculations, and citations that validate the findings and conclusions.
3. An estimate of any potential cost savings in the future, along with an explanation of why the bill would or would not lead to such savings, and
4. A certification confirming the accuracy of the information provided.

Additionally, KRS 6.948 mandates that the sponsor of any bill proposing a health benefit mandate must also request a federal cost defrayal impact statement from the Kentucky DOI. This statement must be completed within 30 days of the request. The federal defrayal cost impact statement shall:

1. Indicate whether a bill or amendment that contains a mandated health benefit may result in the state being required to make payments to defray costs.
2. If applicable, indicate which provision(s) of the bill or amendment may trigger the requirement to make payments to defray the costs.
3. If applicable, include an estimate of the payment amount that the state may be required to make if the bill or amendment is enacted into law.

L&E is tasked with performing the health mandate fiscal impact and federal cost defrayal impact analyses for the Kentucky insurance market, excluding the Kentucky Employee Health Plan (KEHP) and the Kentucky Medicaid programs. The fiscal impact analyses for these programs are

[a] As amended by 2024 House Bill 635.

performed by other entities. For this analysis, L&E reviewed literature, gathered statistics from public sources[b], and used data from the KY DOI's 2023 Insurer Annual Data report.

Administrative Expense Impact Analysis

The proposed bill is estimated to have **an immaterial (within +/- 0.05%) impact on administrative expenses** as a percentage of premium, based upon our analysis of the proposed mandate and our experience with similar health insurance benefits. It is our assumption that insurers either already provide coverage for the mandated benefits or the additional administrative requirements imposed by this mandate would not significantly impact the administrative costs relative to current levels.

Premium Impact Analysis

To estimate BR82/SB93 HCS1's premium impact, L&E evaluated data from KY DOI's 2023 Insurer Annual Data report and publicly available sources. L&E used the collected information and data to estimate low-end and high-end assumptions for each variable that could impact cost or utilization. The ranges for each variable were then used to estimate the aggregate premium impact range.

While L&E selected specific assumptions to develop a range for the estimated premium impact, it is not intended to represent only the low- and high- scenarios illustrated. Each assumption range is intended to capture the various uncertainties inherent in each assumption and to provide an estimated range of resulting potential outcomes. Therefore, the final estimated aggregate premium impact range implicitly captures a wide range of scenarios and assumptions.

Each of the following sections discuss the data used to inform each assumption evaluated by L&E.

HEARING AID AND COCHLEAR IMPACT COVERAGE

HEARING AID AND COCHLEAR IMPLANT UTILIZATION PRE-MANDATE

Utilization data was reviewed from several publicly available sources.[1] [2] [3] [4] Based on this data, L&E selected the following range for the hearing aid and cochlear implants utilization percentages pre-mandate:

Hearing Aid and Cochlear Implant Utilization Pre-Mandate	Low	High
Children – Hearing Aids	0.50%	3.00%
Children – Cochlear Implants	0.006%	0.013%
Adults – Cochlear Implants	0.003%	0.007%

[b]Including reports for other states who have considered or passed similar legislation.

L&E notes that the hearing aid utilization assumptions are based on a combination of assumed prevalence of hearing loss to be covered and an assumed percentage of that will elect to utilize hearing aids, both selected based on information from the cited sources.

HEARING AID AND COCHLEAR IMPLANT COVERAGE CHANGE INDUCED UTILIZATION

There is little data available regarding induced utilization[c] resulting from eliminating cost sharing for hearing aids and cochlear implants. However, L&E believes it is reasonable to assume that there is potential for increased utilization because the insured's financial responsibility would decrease if cost sharing were eliminated. Based on L&E's similar experience with cost-sharing eliminations, the following induced utilization assumption range was selected:

Assumed Induced Utilization	
Low	**High**
0.0%	3.0%

HEARING AID AND COCHLEAR IMPLANT UNIT COST

Based on the information available from publicly available research[5] [6], L&E selected the following assumptions for the average cost for hearing aids and cochlear implants.

Hearing Aid/Cochlear Implant Unit Cost		
	Low	**High**
Hearing Aids Unit Cost	$2,500	$3,500
Cochlear Implant Unit Cost	$30,000	$60,000

HEARING AID AVERAGE LIFESPAN

Based on the information available from publicly available research[7] [5], L&E selected the following assumptions for the average lifespan for hearing aids.

Hearing Aid Average Lifespan		
	Low	**High**
Hearing Aids Lifespan	8 years	4 years

L&E notes that a longer lifespan results in a lower premium impact. Therefore, the longer lifespan is listed for the low end. Further, a lifespan assumption for cochlear implants is not needed because assumed procedure utilization is already on a per-year basis.

HEARING AID AND COCHLEAR IMPLANT AVERAGE NUMBER OF DEVICES PER INSURED

Based on L&E experience and information available from publicly available research[8], approximately 60 to 65 percent of those experiencing hearing loss have hearing loss in both ears. Based on this information, the assumed average number of devices per insured for hearing aids and cochlear implants to be 1.6 devices.

[c] An increase in demand for and utilization of health care services caused by a decrease in the level of cost-sharing that insured's are required to pay under their insurance coverage.

HEARING AID AND COCHLEAR IMPLANT INSURER COST-SHARING PRE- AND POST-MANDATE

Based on the KY DOI's Annual data report, L&E selected the following assumptions for the Insurer Cost-Sharing Pre- and Post-Mandate:

Assumed Insurer Cost-Sharing	Low	High
Hearing Aid/Cochlear Implant Insurer Cost-Share Pre-Mandate	70%	50%
Hearing Aid/Cochlear Implant Insurer Cost-Share Post-Mandate	100%	100%

L&E notes that a higher level of pre-mandate insurer cost-share results in a lower premium impact. Therefore, the higher pre-mandate cost-share percentage is listed for the low end.

HEARING AID AND COCHLEAR IMPLANT RESULTING PREMIUM IMPACT ESTIMATE

The following tables illustrate the range of assumptions selected by L&E and the resulting estimated premium impact range. The first three tables below show three calculations for each of the three components of the mandate with a pricing impact: Children Hearing Aids, Children Cochlear Implants, and Adult Cochlear Implants. The final table aggregates these components to show the final premium impact estimate for the mandate.

Children - Hearing Aid: Claim Cost Impact Calculation Assumption	Low	High
Children – Hearing Aid Utilization Pre- Mandate (a)	0.50%	3.00%
Induced Utilization (b)	0.0%	3.0%
Children – Hearing Aid Utilization % Post- Mandate (c)=(a)*(1+b)	0.50%	3.09%
Unit Cost per Hearing Aid (d)	$2,500	$3,500
Hearing Aids Lifespan (e)	8	4
Average # of Devices per Insured (f)	1.6	1.6
Hearing Aid Insurer Cost-Share Pre- Mandate (g)	70%	50%
Hearing Aid Insurer Cost-Share Post- Mandate (h)	100%	100%
Children – Hearing Aid Claim Cost Impact PMPY (i)=[(c*d*f*h)/e]-[(a*d*f*g)/e]	$0.76	$22.61
Children – Hearing Aid Claim Cost Impact PMPM (j)=(i)/12	$0.06	$1.88

Children – Cochlear Implants: Claim Cost Impact Calculation		
Assumption	**Low**	**High**
Children – Cochlear Implants Utilization Pre- Mandate (a)	0.006%	0.013%
Induced Utilization (b)	0.0%	3.0%
Children – Cochlear Implants Utilization % Post- Mandate (c)=(a)*(1+b)	0.006%	0.014%
Unit Cost per Cochlear Implant (d)	$30,000	$60,000
Average # of Devices per Insured (e)	1.6	1.6
Cochlear Implant Insurer Cost-Share Pre- Mandate (f)	70%	50%
Cochlear Implant Insurer Cost-Share Post- Mandate (g)	100%	100%
Children – Cochlear Implant Claim Cost Impact PMPY (h)=(c*d*e*g)-(a*d*e*f)	$0.88	$6.93
Children – Cochlear Implant Claim Cost Impact PMPM (i)=(h)/12	$0.07	$0.58

Adult – Cochlear Implants: Claim Cost Impact Calculation		
Assumption	**Low**	**High**
Adult – Cochlear Implants Utilization Pre- Mandate (a)	0.003%	0.007%
Induced Utilization (b)	0.0%	3.0%
Adult – Cochlear Implants Utilization % Post- Mandate (c)=(a)*(1+b)	0.003%	0.007%
Unit Cost per Cochlear Implant (d)	$30,000	$60,000
Cochlear Implant Lifespan (e)	30	10
Cochlear Implant Insurer Cost-Share Pre- Mandate (f)	70%	50%
Cochlear Implant Insurer Cost-Share Post- Mandate (g)	100%	100%
Adult – Cochlear Implant Claim Cost Impact PMPY (h)=(c*d*e*g)-(a*d*e*f)	$0.44	$3.50
Adult – Cochlear Implant Claim Cost Impact PMPM (i)=(h)/12	$0.04	$0.29

The three calculations above were weighted based on the child and adult populations to arrive at the total claim cost impact of the mandate shown below:

Hearing Aid and Cochlear Implant Premium Impact Calculation		
Assumption	**Low**	**High**
Hearing Aid and Cochlear Implant Claim Cost Impact PMPM (l)	$0.06	$0.77
Projected 2025 Total Claims Costs PMPM (m)	$636.55	$636.55
Projected 2025 KY Average Loss Ratio (n)[d]	89.5%	89.5%
Projected 2025 KY Average Premium PMPM (o)=(m)/(n)	$711.60	$711.60
Hearing Aid and Cochlear Implant Premium Impact PMPM (p)=(l)/(n)	**$0.07**	**$0.86**
Hearing Aid and Cochlear Implant Premium % Impact (q)=(p)/(o)	**0.0%**	**0.1%**
Projected 2025 KY Insured Members[e] (r)	351,797	351,797
Hearing Aid and Cochlear Implant Premium Total Annual Impact (s) = (p)*(r)*12	**$277K**	**$3.6M**

FEEDING AND EATING DISORDER TREATMENT COVERAGE

FEEDING AND EATING DISORDER TREATMENT UTILIZATION

Eating disorder prevalence and utilization data was reviewed from a study for the Academy for Eating Disorders.[9] Based on this data, L&E selected the following range for the eating disorder treatment utilization percentage:

Feeding and Eating Disorder Treatment Utilization		
	Low	**High**
Feeding and Eating Disorder Treatment Utilization %	0.8%	1.7%

[d] Based on 2023 Insurer Annual Data report provided by the KY DOI. Excludes KEHP and Medicaid.

[e] Excluding the Kentucky Employee Health Plan (KEHP) and the Kentucky Medicaid programs.

FEEDING AND EATING DISORDER TREATMENT CHANGE IN DENIAL RATES

This bill mandates that when determining medical necessity, a health plan cannot utilize body mass index, ideal body weight, or any other standard requiring an achieved weight. There is little data available regarding how often and why eating disorder treatment is denied. However, L&E believes it is reasonable to assume that there are currently some denials under current practices that could no longer be denied with this mandate. Based on L&E's research[10] [11] and judgment, the following denial rates were assumed pre- and post- mandate:

	Low	High
Assumed Denial Rate Pre-Mandate (a)	17.0%	27.0%
% of Denials now Covered after Mandate (b)	10.0%	75.0%
Assumed Change in Denials as a Result of Mandate (c = a*b)	1.7%	20.3%

FEEDING AND EATING DISORDER TREATMENT AVERAGE COST

Based on the information available from publicly available research[9] L&E selected the following assumptions for the average annual cost per year for eating disorder treatment.

Eating Disorder Treatment Average Annual Cost		
	Low	**High**
Average Cost of Feeding and Eating Disorder Treatment	$400	$1,200

FEEDING AND EATING DISORDER TREATMENT INSURER COST-SHARING

Based on the KY DOI's Annual data report, the average insurer-paid claims costs for behavioral health services as a percentage of total claims costs were determined to be 68.4%. Based on the information available, L&E selected the following assumptions for the insurer cost-sharing for eating disorder treatments:

Assumed Insurer Cost-Sharing		
	Low	**High**
Feeding and Eating Disorder Treatment Insurer Cost-Share	60.0%	80.0%

FEEDING AND EATING DISORDER TREATMENT RESULTING PREMIUM IMPACT ESTIMATE

The following table illustrates the range of assumptions selected by L&E and the resulting estimated premium impact range.

Feeding and Eating Disorder Treatment Claim Cost Impact Calculation		
Assumption	**Low**	**High**
Assumed Denial Rate Pre-Mandate (a)	17.0%	27.0%
% of Denials now Covered after Mandate (b)	10.0%	75.0%
Assumed Change in Denials as a Result of Mandate (c = a*b)	1.7%	20.3%
Eating Disorder Treatment Utilization % (d)	0.8%	1.7%
Eating Disorder Treatment Average Annual Cost (e)	$400	$1,200
Eating Disorder Treatment Insurer Cost-Share (f)	60.0%	80.0%
Feeding and Eating Disorder Treatment Claim Cost Impact PMPY (g)=c*d*e*f	$0.03	$3.23
Feeding and Eating Disorder Treatment Claim Cost Impact PMPM (h)=(g)/12	$0.00	$0.27
Projected 2025 Total Claims Costs PMPM (i)	$636.55	$636.55
Feeding and Eating Disorder Treatment Claim Cost % Impact (j)=(h)/(i)	0.0%	0.0%

Feeding and Eating Disorder Treatment Premium Impact Calculation		
Assumption	**Low**	**High**
Projected 2025 KY Average Loss Ratio (k)[f]	89.5%	89.5%
Projected 2025 KY Average Premium PMPM (l)=(i)/(k)	$711.60	$711.60
Feeding and Eating Disorder Treatment Premium Impact PMPM (m)=(h)/(k)	**$0.00**	**$0.30**
Feeding and Eating Disorder Treatment Premium % Impact (n)=(m)/(l)	**0.0%**	**0.0%**
Projected 2025 KY Insured Members[g] (o)	351,797	351,797
Feeding and Eating Disorder Treatment Premium Total Annual Impact (p) = (m)*(o)*12	**$13K**	**$1.3M**

BR82/SB93 HCS1 TOTAL RESULTING PREMIUM IMPACT ESTIMATE

The total premium impact estimate for BR82/SB93 HCS1 is equal to the sum of the premium impact estimate for hearing aid and cochlear implant coverage and the premium impact estimate for feeding and eating disorder treatment. This is illustrated in the table below.

[f] Based on 2023 Insurer Annual Data report provided by the KY DOI. Excludes KEHP and Medicaid.

[g] Excluding the Kentucky Employee Health Plan (KEHP) and the Kentucky Medicaid programs.

Total BR82/SB93 HCS1 Premium Impact Calculation		
Assumption	**Low**	**High**
Hearing Aid and Cochlear Implant Premium Impact PMPM (a)	**$0.07**	**$0.86**
Feeding and Eating Disorder Treatment Premium Impact PMPM (b)	**$0.00**	**$0.30**
Total BR82/SB93 HCS1 Premium Impact PMPM (c)=(a)+(b)	**$0.07**	**$1.16**
Projected 2025 KY Average Premium PMPM (d)	$711.60	$711.60
Feeding and Eating Disorder Treatment Premium % Impact (e)=(c)/(d)	**0.0%**	**0.2%**
Projected 2025 KY Insured Members[h] (f)	351,797	351,797
Feeding and Eating Disorder Treatment Premium Total Annual Impact (g) = (c)*(f)*12	**$290K**	**$4.9M**

Total Cost of Health Care Impact Analysis

L&E defines 'Total Cost of Health Care' as being equal to the sum of the Allowed Cost (i.e., the amount paid by the insurer plus the amount paid by the insured) and the insurer Non-Benefit Expenses. Additionally, as required by KRS 6.948, L&E considered the impact of potential future cost savings.

HEARING AID AND COCHLEAR IMPLANT POTENTIAL FOR FUTURE COST SAVINGS

L&E recognizes the potential for long-term savings through enhanced affordability and accessibility of hearing loss treatment. There is published research[12] showing that untreated hearing loss is associated with other costly comorbidities, including higher risk of emergency department visits, higher rate of hospitalization, and longer stay when hospitalized. However, available research does not define the magnitude of potential cost savings, particularly regarding the relationship between cost savings and incremental coverage increases. Based on experience and actuarial judgment, L&E estimates the impact of potential future savings as a result of the BR82/SB93 HCS1 to be immaterial (within +/- 0.05%).

FEEDING AND EATING DISORDER TREATMENT POTENTIAL FOR FUTURE COST SAVINGS

L&E recognizes the potential for long-term savings through enhanced accessibility of eating disorder treatments. Improved access by limiting denials can lead to prompt diagnosis and treatment, reducing the need for higher-cost interventions in the future. For example, shifting the mix of services from higher-cost settings, such as inpatient facilities or emergency rooms, to lower-cost alternatives like outpatient visits, may yield savings. However, quantifying these savings is challenging, as it requires estimating the counterfactual scenario—what would have occurred without early intervention. Moreover, any cost reductions could be partially offset by induced utilization, where the increased availability of services results in higher-than-expected use.

[h] Excluding the Kentucky Employee Health Plan (KEHP) and the Kentucky Medicaid programs.

While there is limited research suggesting eating disorder treatment is cost effective in some specific settings (such as college students), further research is needed to estimate the overall costs that may be prevented through early intervention and prevention. The limited research available does not define the magnitude of cost savings, particularly regarding the relationship between cost savings and incremental coverage increases. Based on experience and actuarial judgment, L&E estimates the impact of potential future savings as a result of the BR82/SB93 HCS1 to be immaterial (within +/- 0.05%).

RESULTING TOTAL COST OF HEALTH CARE IMPACT ESTIMATE

The proposed bill is estimated to have **an immaterial (within +/- 0.05%) impact on total cost of health care**, including potential future cost savings, based upon our analysis of the proposed mandate and our experience with similar health insurance benefits. This estimate differs from the premium estimate above because shifting cost sharing from the insured to the insurer does not impact the total cost of care. In this case, the only impact to the total cost of care is the induced utilization, which has an immaterial impact.

Cost Defrayal Impact Analysis

Based on L&E's research and actuarial judgment, L&E determined that this bill contains a mandated health benefit that may result in the state being required to make payments to defray costs under 42 U.S.C sec 18031(d)(3) and 45 C.F.R. sec 155.170, as amended. The provision of the bill that may trigger the requirement is on page 6, lines 7-8 as the mandated coverage of "any treatment" may increase coverage beyond what is currently required by the benchmark plan such that defrayal would be required.

The estimated annual cost defrayal payment that the state may be required to make is between $4K and $390K, which is based on the portion of the mandate claims cost estimate that is attributed to the individual and small group markets. The hearing aid and cochlear implant impact is excluded from the estimated defrayal payment based on the understanding that hearing aids and cochlear implants are already covered under the state's benchmark plan as an essential health benefit.

L&E has disclosed its defrayal determination based on its earnest interpretation of federal guidance available as of the date of this report. However, determination of defrayal is ultimately under the regulatory purview of Centers for Medicare and Medicaid Services (CMS).

Certification of Accuracy

L&E believes the estimates are accurate based on the information disclosed in the report. To the extent that there are material inaccuracies, misrepresentations, or lack of adequate disclosure in the data, the results may be accordingly affected. Several of the assumptions made in this analysis are subject to uncertainty and it is expected that actual results could differ from the calculated estimates.

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3/13/2025
(Signature of Commissioner/Date)

ASOP 41 Disclosures

The Actuarial Standards Board (ASB), vested by the U.S.-based actuarial organizations[i], promulgates actuarial standards of practice (ASOPs) for use by actuaries when providing professional services in the United States.

Each of these organizations requires its members, through its Code of Professional Conduct[j], to observe the ASOPs of the ASB when practicing in the United States. ASOP 41 provides guidance to actuaries with respect to actuarial communications and requires certain disclosures which are contained in the following.

Identification of the Responsible Actuary

The responsible actuaries are:

- Traci Hughes, FSA, MAAA, Vice President & Principal
- Brian Stentz, ASA, MAAA, FCA Vice President & Principal
- Bobby Dorman, ASA, MAAA, Vice President & Consulting Actuary

These actuaries are available to provide supplementary information and explanation.

Identification of Actuarial Documents

The date of this document is March 13, 2025. The date (a.k.a. "latest information date") through which data or other information has been considered in performing this analysis is March 13, 2025.

Disclosures in Actuarial Reports

- The contents of this report are intended for the use of the Kentucky Department of Insurance. The authors of this report are aware that it may be distributed to third parties. Any third party with access to this report acknowledges, as a condition of receipt, that they cannot bring suit, claim, or action against L&E, under any theory of law, related in any way to this material.
- Lewis & Ellis, LLC is financially and organizationally independent from the health insurers and providers involved in this analysis. There is nothing that would impair or seem to impair the objectivity of the work.
- The purpose of this report is to assist the Kentucky Department of Insurance in assessing the financial impact and federal cost defrayal impact of proposed legislation that includes a proposed health benefit mandate.
- The responsible actuaries identified above are qualified as specified in the Qualification Standards of the American Academy of Actuaries.
- L&E has reviewed the data provided by the insurers and Kentucky Department of Insurance for reasonableness, but the data has not been audited. L&E nor the responsible actuaries assume responsibility for these items that may have a material impact on the analysis. To the extent that there are material inaccuracies in, misrepresentations in, or lack of adequate disclosure by the data, the results may be accordingly affected.

[i] The American Academy of Actuaries (Academy), the American Society of Pension Professionals and Actuaries, the Casualty Actuarial Society, the Conference of Consulting Actuaries, and the Society of Actuaries.

[j] These organizations adopted identical *Codes of Professional Conduct* effective January 1, 2001.

- Several of the assumptions made in this analysis are subject to uncertainty and it is not unexpected that actual results could differ from the calculated estimates.
- L&E is not aware of any subsequent events that may have a material effect on the findings.
- There are no other documents or files that accompany this report.

Actuarial Findings

The actuarial findings of the report can be found in the body of this report.

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