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“Can you hear me now?”: Insurance Coverage for Hearing Benefits in the United States

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Can you hear me now?



By: Reegan Whipple

Dr. Hackey

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Marcia Angell, Editor-in-Chief of the *New England Journal of Medicine*, once said, "...our health care system creates ethical dilemmas that no health care system should create" (Angell). One of these ethical dilemmas is the lack of insurance coverage for hearing assistance devices and surgeries, which add to the quality of a person's life. Hearing is one of the five major senses, but millions of Americans are hearing impaired throughout the U.S. The largest populations in the United States affected by hearing loss are the elderly and the aging generation of baby boomers. In fact, 25% of adults over age 65 experience disabling hearing loss (Quick Statistics). Recent studies demonstrate that, "Severity of hearing loss is associated with reduced quality of life in older adults" (Dalton). Another study, the Blue Mountain Hearing Study, also identified the "disease burden of age-related hearing impairment on health-related quality of life in a population-based cohort of older persons" (Chia). The lack of coverage for services to aid in the restoration or partial-restoration of hearing should be considered a gross inequity in the world's most medically advanced country.

The elderly may often take center stage on this issue but the effects of hearing loss are widespread and can be found in all age groups and socio-economic classes. According to the U.S. Department of Health and Human Services, "About 2 to 3 out of every 1,000 children in the United States are born with a detectable level of hearing loss in one or both ears" (Quick Statistics). In addition, 90% of children born with hearing loss are born to hearing parents who do not understand their child's condition fully because they have not experienced it themselves. One in eight Americans twelve years of

age or older suffer from hearing loss in one or both ears. This statistic constitutes 13% of the population of the U.S. or 30 million Americans. (Quick Statistics). In addition a recent study by Dr. Judith E. Cho Lieu, noted among children and youth grade failure as well as speech impairment and delays are negative results of childhood hearing loss, which negatively affect social skill development, often resulting in behavioral problems (Cho Lieu).

There are three types of hearing loss, which are responsible for these statistics. Conductive hearing loss is due to problems with the ear canal, eardrum, or the middle ear, which is home to many small bones. Sensorineural hearing loss is due to inner ear problems and nerve problems. Mixed hearing loss is a combination of the two types previously mentioned (Types, Causes, Treatments). There are also various levels to each of these types of loss: mild, moderate, severe, or profound. Mild hearing loss means that the individual will have some trouble keeping up with conversations, especially in noisy environments. Moderate hearing loss means an individual will have trouble keeping up with conversations without the use of a hearing aid. Severe hearing loss sufferers greatly benefit from hearing aids but often rely heavily on lip reading even when they do use them. Many people with severe loss sign as well. Profound hearing loss means that the person relies almost completely on lip reading and sign language but occasionally they can hear very loud sounds (What are the different degrees of hearing loss?).

There are various treatment options for each type of hearing loss. The most common treatment is wearing hearing aids, which are used in cases where medicine and surgery are not suitable for the patient or are too expensive. Many factors such as listening needs, lifestyle, and individual hearing loss impact which kind of hearing aids

will best suit a patient. Hundreds of different makes and models of external hearing aids can be found in the U.S. market today. Patients can expect to pay anywhere from \$1,000 to \$8,000 for a pair of custom hearing aids, most of which are not covered by insurance. A single hearing aid can cost up to \$600 (Hearing Aid Buying Guide). Hearing aid purchases reached a peak in 2008 when the binaural purchase rate increased 78.8% for all users. New hearing aid owners, however, decreased by 39.9% as the price of hearing aids rose (Kochkin). Hearing aids are the third most widely used assistive medical device in this country after canes and eyeglasses. Nevertheless, most Americans with hearing loss do not use hearing aids; “Of the estimated 23.5 million Americans with hearing loss, only about 3.78 to 5 million own hearing aids” (Adams 1).

Cochlear implants are another device that can improve the condition of people with severe and irreparable hearing loss. These small devices surgically implanted in the ear can help a person to hear and understand more speech than is possible with even the best external hearing aid (Hearing Loss Treatment). Cochlear implants consist of an external portion, which sits behind the recipient’s ear and an internal portion, which is surgically implanted under the recipient’s skin. This one small device consists of a microphone to amplify environmental sounds, a speech processor, which arranges sounds picked up by the microphone, a transmitter, which converts the sounds into electrical impulses, and an electrode array, which collects the impulses and sends them to the auditory nerves. As of December 2012, about 58,000 adults and 38,000 children had received this type of implant in the United States. Some insurance companies may cover the expense of this surgery or a portion, but not always (Cochlear Implants). The average

cost for the entire procedure including post-operative rehabilitation often exceeds \$40,000 (Cochlear Implant Frequently Asked Questions).

An examination of current standard health insurance policies on hearing problems illuminates the commoditization of this portion of healthcare. The treatment of hearing aids as market commodities means the devices are only available to those who can pay for them out of their own pockets. The best example from the insurance sector to use here is the case of Medicaid. Medicaid provides assistance for low-income individuals who qualify. The new terms of qualification set out by the Affordable Care Act expand Medicaid coverage to every American under age 65 with an income below 138% of the federal poverty line unless they receive insurance through another source, such as an employer (Ezekiel pp. 207). Both the state and federal governments jointly fund the program. Each state has flexibility under the broad guidelines set out for Medicaid. Remarkably, hearing health services are optional under the Federal guidelines for minimum coverage set out for Medicaid. As a result, many states do not cover adult hearing health services, even though a federally mandated program covers children until the age of 18 in all fifty states through a program known as EPSTD or Early and Periodic Screening, Diagnosis, and Treatment Program (Medicare Coverage of Hearing Aids). In recent years coverage, specifically for cochlear implants has expanded. Medicare and the Veteran's Administration offer at least partial coverage and federal law mandates that Medicaid cover the procedure for any child under 21 who qualifies (Cochlear Implant Frequently Asked Questions). The coverage for private insurance varies greatly depending on each independent provider but many private health insurance companies consider hearing aids and cochlear implants "exclusions," which a term insurance

companies use for the conditions and treatments that are not covered by a policy (Hoffman 98).

The health care system in the U.S. suffers from perverse incentives, that send contradictory messages to both the public and health care professionals. The commoditization of American health insurance was perpetuated by the social conditions created by World War II. During the war President Franklin Delano Roosevelt froze the wages of workers. In order to recruit and retain workers, employers turned to enhancing fringe benefits, such as healthcare coverage. Private insurers were already on the scene in the forms of both Blue Cross and Blue Shield and were very successful. During such a tumultuous time major reform in a system that was working perfectly fine seemed to be a waste of resources. In the opinion of some, America missed her chance to implement universal coverage during FDR's presidency when Britain was accepting the Beveridge Report and using FDR's own terminology to make it a success. Britain came out with a "cradle to grave" coverage system; America came out with an intricate system of confusion (Blumenthal & Morone pp.21-56). Many small decisions in the health care sector added up to produce today's predicament where people who cannot afford insurance are left without and even those who can are left without coverage for certain medical procedures. As Beatrix Hoffman writes, since 1930 "The gap between public expectations and the reality of the limited coverage led to discontent..." (90). Hearing loss is a widespread example of this. The ability to hear is intrinsic to being human, however, in the U.S. the hearing aid sector of the healthcare industry is treated mainly as a commodity. Insurance companies are willing to pay for testing to determine if a person suffers from hearing loss, however, they will not pay for hearing aids or surgery to fix the

problem. Within in the framework of the world of those hard of hearing, a major problem within the health sector is highlighted; is healthcare really a commodity or a right in the United States?

According to the Robert Wood Johnson Foundation, “Four in five physicians say patients’ social needs are as important to address as their medical conditions...” (Fenton). Hearing loss is clearly classified as a medical condition but it seriously affects a patient’s social needs as well augmenting the importance of preserving each individual’s ability to hear. Multiple aforementioned studies have found negative social effects on both the elderly and the young who are afflicted with such impairments. The ability to adequately communicate and be communicated with is essential to the health, safety, and social well being of patients. Why then is something that is so basic to being human commoditized in the U.S. healthcare system? The answer is American values.

In order to understand the mixed incentives of the current U.S. system, where some aspects of health are treated as rights while others are treated as commodities, one must understand the values that resulted in this system. The United States prides itself on democracy, liberty, freedom, and free markets. American skepticism of anything that can be labeled as socialist or has too much government involvement runs very deep. America was born on the principle that this country would forever be a place where freedom resides, as recorded by our founding fathers in the Constitution. Universal health coverage, which would treat healthcare as a right for all, has been given the label “socialized medicine” and is therefore seen as a threat to these American ideals. President Dwight D. Eisenhower solidified the American values of competition, free markets, and limited government involvement when he signed into law the employer-based health

insurance system that is still the basis of the healthcare system in the U.S. today.

Eisenhower acted out of necessity to soothe public upheaval during a tumultuous time for both foreign and domestic affairs during his presidency (Blumenthal & Morone 99-130).

Fear of government control, however, does not mean that America completely lacks compassion and human sentiment. This is where the confusion begins.

Since the U.S. system is based on private health insurance plans, one would assume that a person must purchase insurance, or receive it through their employer, in order to access medical care at all. In a market system this is usually the case, however, in the healthcare system it is not. Healthcare is treated as a commodity for the majority of Americans, but what about a person who just got into a nearly fatal car accident and has no insurance? The emergency medical response team is not going to leave that man to die in the street, insurance or not. America possesses the most advanced healthcare in the world and as the current world superpower it would be beyond barbaric to let citizens die in the street because they could not afford coverage. That person will be taken to the hospital and stabilized, regardless of cost to the hospital and providers. Similarly, to this situation, if the same uninsured person were to walk into the ER after an accident, he or she would be treated then as well. Written into laws, such as the Emergency Medical Treatment and Labor Act or EMTALA, America provides safeguards for the uninsured (EMTALA). The statutory provisions of EMTALA "...impose specific obligations on certain Medicare-participating hospitals and critical access hospitals..." and "These obligations concern individuals who come to hospitals "dedicated emergency departments" and request examination or treatment for a medical condition and apply to all of these individuals regardless of whether they are beneficiaries of any program under

the act”(Medicare Program; EMTALA: Applicability to Hospital Inpatients and Hospitals With Specialized Capabilities).

In Thomas Murray’s article, *American Values and Health Care Reform* he discusses the implications of these American values. He writes, “Stewardship requires us to be mindful of the basic needs of others and of the power and responsibility we have to use the resources in our control to meet those needs” (Murray). Hearing is one of the five basic senses, yet Americans are not mindful of this basic need and the cost of financing it. Murray believes that the work of reforming the healthcare system must be accompanied by a dialogue about what values should form the foundation of the system. These values must be understood and reinforce one another in order to be successful (Murray). The lesson here is a confusing one; America does not have formal universal healthcare coverage, but in reality an informal system, or safety net, does exist.

Now we need to exam this issue in three different settings to underscore the importance of the ability to hear and the impact that the lack of coverage due to the commoditization of this sector of the healthcare industry has on everyday people. Let’s consider three cases that underscore how hearing treatments are a commodity in the U.S.

Paul

My father watches the television on mute. Most people take advantage of the volume settings on television sets, but it does not matter all that much if the person watching it cannot hear. His hearing loss was gradual, and deteriorated little by little over time. Years of farm work with heavy machinery, hunting with high-powered rifles, and battling sinus infections due to environmental allergies took their toll. When my dad watches television volume is a moot point; he reads lips or risk blowing the speakers completely. Hearing aids have been around for decades and are easily accessible in this affluent country that we reside in, so why didn’t my father purchase a set the moment his hearing started to fail? The answer is simple: money. My father has six children and, as a byproduct, more

financial responsibilities than most. Hearing aides, whether surgically implanted (cochlear implants) or external amplifiers are not covered by health insurance in the United States. Like many parents, my father put the needs of his children before his own needs for many years until his hearing loss interfered in his day-to-day activities. My father now owns Beltone Promise hearing aids, which cost him \$8,000 out of pocket. As a farmer, his ability to hear is vital to his safety on the job while he is working with heavy machinery and communicating with labor teams. My father suffers from severe hearing loss in his left ear and his right ear suffers from moderate hearing loss.

As Jen Christensen notes, “Hearing loss is an ‘invisible,’ and widely uninsured problem.” If a person loses a limb, insurance usually covers the cost of a prosthetic limb; individuals with ED can obtain Viagra or other drugs through their insurance company. This generous approach to coverage for disabilities does not extend to hearing; in fact, hearing loss is not categorized as a disability. If it were, however, hearing loss would rank as the number one disability class in the country. Hearing aids, therefore, are considered an elective purchase. Only 19 states out of 50 require health plans to cover hearing aids; only 3 out of those 19 states extend coverage to adults as well as children. Even when private insurance does pay the only aspect private insurers typically cover is the hearing exams that assess the level of loss. A recent study conducted by Virginia Ramachandran who is a senior staff audiologist in the Division of Audiology of the Henry For Hospital in Detroit, MI, showed that 75% to 80% of adults with hearing loss do not invest in hearing aids. The study showed that the only group that consistently obtained hearing aids were those individuals whose insurance paid for them in full (Christensen).

Coverage for prosthetic limbs is much more expansive. Just as prostheses, hearing aids and cochlear implants help to return a body to its fully functioning state as best as possible, so why then do these devices not receive equal coverage?

Medicare Part B covers prosthetics limbs (Orthotics & Artificial Limbs). All 50 states have at least partial coverage for prosthetic limbs under Medicaid (Medicaid Benefits: Prosthetic and Orthotic Devices). Private insurance coverage varies though most private insurance companies cover prostheses. This coverage may be capped or have a lifetime limit (Financial Assistance for Prosthetic Services, Durable Medical Equipment, and Other Assistive Devices).

My father's case illustrates the plight of most American adults with a hearing impairment. At 62 years old he is not yet eligible for Medicare, however, the situation would not change much even if he were because Medicare also does not cover most hearing aids. In order to examine the coverage, or lack thereof, for hearing services an examination of the Medicare, Medicaid, and private insurance policies is necessary. Medicare Part B will cover diagnostic hearing tests and balance exams if ordered by a health care provider in order to determine if treatment is necessary. Medicare Part B will not cover routine hearing exams, fitting for hearing aids, or hearing aids. Even for the covered exams the patient is still responsible for their Part B deductible and 20% of the "Medicare approved amount" for the doctor's services (Hearing and balance exams & hearing aids).

Cochlear implant coverage under Medicare is different. CMS issued a decision that "The evidence is adequate to conclude that cochlear implantation is reasonable and necessary for treatment of bilateral pre-or-postlinguistic, sensorineural, moderate-to-

profound hearing loss in individuals who demonstrate limited benefit from amplification” (Decision Memo for Cochlear Implantation). However, hearing loss is so specific to each individual and the various models of cochlear implants, which the FDA has approved, made deciding how much to reimburse difficult for CMS. With regards to reimbursement CMS concluded “Although we do not find sufficient evidence to support across the board coverage of cochlear implantation for all persons who have hearing loss scores $\leq 60\%$ correct, a sufficient inference of benefit can be drawn to support limited coverage in the context of a clinical trial that provides rigorous safeguards for patients” (Phurrough).

There is some hope for the private insurance sector to take on more coverage since the ACA lists hearing aids as a standard health benefit. Hearing aids are listed number 36 on HHS’s benchmark plan format for each state. Unfortunately, each state is only required to meet the first ten essential benefits set out by the ACA. HHS clearly seems to recognize that hearing aid coverage should be considered a standard component of health insurance plans (Hearing Aids and the Affordable Care Act).

The commoditization of hearing has led to a complex and competitive market for hearing aids and other assistive devices. It is important to remember that most people purchasing hearing aids are age 65 or older. Elderly consumers are more susceptible to high-pressure sales tactics and more trusting than the average consumer. A study conducted by Eun-Jin Kim and Loren Geistfeld shows that elderly vulnerability is a three dimensional phenomenon encompassing their health status, cognitive ability, and social network, which all tend to degenerate with age (Geistfeld & Kim). Door-to-door hearing aid dispensers take full advantage of this

susceptibility and augment it by making sales within people's homes. The manufacturing, sale, and distribution of hearing aids is regulated by three bodies of law that overlap: federal laws, state laws, and state licensing boards. Federal regulations state that hearing dispensers are not permitted to sell hearing aids to an individual who has not produced a statement signed by a licensed physician stating that the patient has been medically evaluated and is a candidate for hearing aids. Individuals can sign a waiver of the medical examination as long as the dispenser notifies the client that the evaluation is in their best interest medically (Adams). Signing this medical waiver can be extremely dangerous as Dr. Dennis Colucci, a forensic audiologist from a private practice in Laguna Hills, CA, explains, "Ill-fitted hearing aids come in all sizes and circuits from people who manufacture devices or are licensed to fit and sell them. Blurry hearing aids not only worsen patients' social isolation and deprivation, but they also result in public confusion and distrust."

Licensing boards differ from state to state but they all serve the same basic purpose, which is to "set standards for minimum competency, licensure, and practice; investigate complaints; and discipline practitioners" (Adams). These boards lack funding to be proactive and, therefore, often act retroactively when a complaint has been filed. State to state differences for licensing hearing aid dealers make the system complicated but an individual who fits the minimal requirement is generally someone with a high school diploma or GED who is 18 years of age or older (Adams).

False or misleading advertisement is a huge impediment to the effective use of hearing aids within the U.S. Dispensers abuse the regulations under which consumers can waive their medical evaluation and misrepresent the benefits received from using hearing

aids. In April of 1993 the FDA warned six manufacturers about misrepresenting the capabilities of hearing aids (i.e. such as claiming that hearing aids could eliminate background noise). Beltone, the company my father purchased his hearing aids from, was one of the six companies cited by the FDA. In 1976 these six companies were also issued consent orders against them by the Federal Trade Commission, which instructed them to cease making “unreasonable” claims about their products’ abilities. Waiving one’s medical examination may lead to the purchase of an ineffective or inappropriate model for their type of hearing impairment (Adams).

Quality of life is at stake for my father and millions of other Americans who suffer from hearing loss. Like my father, many hearing loss sufferers, especially the elderly, take shame in undergoing the process for and making the purchase of assistive devices. In 2010 -2011 the Ida Institute held a series of seminars on the theme *Living Well With Hearing Loss* with their distinguished faculty Leslie Jones, PhD, Patricia McCarthy, PhD, Christopher Lind, PhD, and Jean-Pierre Gagné, PhD. During the seminar, the faculty highlighted the importance of recognition and acceptance of hearing impairment. Once acceptance is achieved then audiological rehabilitation goals can begin to be reached (*Living Well With Hearing Loss*). My father has financial concerns about his hearing aids but admitting that he needed them was just as hard as handing over \$8,000. My father could easily recognize he had a problem but accepting that problem and allowing others to see a physical sign that he is hard of hearing took about two years for him to cope with.

Janet

My Aunt Janet, suffers from hearing loss of a different nature. Janet is a breast cancer survivor who had a double mastectomy about 15 years ago and then

survived lung cancer about 8 years ago by undergoing chemotherapy as well as the partial removal of her left lung. The months of rigorous chemotherapy not only caused my aunt to lose her hair and copious amounts of weight, but it also caused her to lose much of her hearing. The University of Arizona Cancer Centers notes, "Hearing loss has become one of modern cancer therapy's most prevalent side effects. In fact, hearing loss is among the most underreported, yet potentially devastating, side effects endured by many chemotherapy patients" (Prevenas). Patients often do not think about the fact that they could lose their hearing from cancer treatment, nor do most of them care during such a pivotal time. Patients also rarely recognize that they are losing their hearing until it is too late for treatment because the loss first impacts higher frequencies, which are far above the range of normal speech recognition (Prevenas). Janet is an elementary level special needs teacher; the ability to hear is essential to her profession. Should hearing aids not be covered as part of her full cancer treatment since they would be a direct result of it?

Cancer treatment is very costly investment and the amount that patients will pay out-of-pocket depends on their insurance plan, if they have any at all. Both public and private insurance cover at least a portion of treatment costs and the uninsured can usually gain assistance from public and private programs, such as the TANF program (Temporary Assistance for Needy Families). The potential financial burden that comes with a cancer diagnosis seems insignificant in the face of death. Although, cancer treatments have made huge strides and more people are surviving various types of cancer than ever before, there is a lurking threat of losing one's hearing due to life saving treatment and reducing the quality of the life they are trying so desperately to save. The likelihood of a patient rejecting chemotherapy or radiology based on the risk of hearing loss is so minimal that this problem has essentially been swept under the rug.

How do chemotherapy and radiation contribute to hearing loss? As Dr. Paul Gidley explained, toxicities from chemotherapy treatment cause nerve damage, which

results in the loss of hearing, or ototoxicity. Gidley's subspecialty is otology and neurotology, which means he specializes in the care of chronic ear disease (Q&A: Cancer and Hearing Loss). This type of hearing loss is sensorineural and is most often permanent. High doses of radiation near the ear or to the brain can cause inflammation and subsequent wax build up in the outer ear, fluid build up in the inner ear, or stiffness within the middle ear bones or eardrum. These problems can result in conductive hearing loss, which may improve over time but may also be permanent (Hearing Loss, Vanderbilt-Ingram Cancer Center). A study on sensorineural hearing loss after chemotherapy and radiation was published in the Clinical Journal of Oncology and found that patients who received radiotherapy and chemotherapy suffered from greater sensorineural hearing loss than those who only received radiotherapy. High frequency sounds in the speech range were especially impacted. (Kein Low).

Prior to treatment the University of Arizona Cancer Center strongly suggests that patients undergo a baseline audiogram that focuses on high frequencies, Distortion Product Otoacoustic Emissions (to test inner ear cell hair function), and videonystagmography (to evaluate balance function). Patients should have follow up tests done at pre-determined intervals by an audiologist and should also make contact with neurotologist or inner specialist in case hearing is impacted throughout treatment (Chemotherapy-Induced Hearing Loss). The two main detriments to cancer patients' hearing during treatment is radiation to the head or ear and chemotherapy from the "platinum" group like cisplatin or carboplatin. The physical effects of this hearing loss are balance issues, which means a greater likelihood for dangerous falls. Hearing loss has also been linked to the development of certain forms of dementia. Psychologically

depression, isolation, and anxiety are all results. Economically, there is a higher rate of unemployment, an overall lower standard of living, and difficulty advancing in one's career. Although little statistical data is currently available, a landmark study of 67 chemotherapy patients between the ages 8-23 years old found that 61% of them developed hearing loss after treatment. Most of the hearing loss experienced was high-frequency loss. These treatments that save lives depreciate that same life's value (Klop).

External and internal breast prostheses and post-surgical bras for breast cancer patients who undergo mastectomies are covered by both public and private insurance. Prosthetic breasts are merely an aesthetic or cosmetic surgery, which aims to restore how the woman's appearance before her mastectomy. Is the purpose of hearing aids not to achieve the same goal? To return a person who is missing some feature to as close to whole and functioning properly as possibly? Once again, prosthetic coverage raises the question about why hearing aids and services are not covered. All women with Medicare are covered for these procedures. Part B covers external prosthetic, post-surgical bras, and breast reconstruction surgery performed in an outpatient setting. Part A covers surgically implanted breast prostheses after a mastectomy in an inpatient setting (Breast Prostheses). Private insurance coverage varies, however; generally external breast prostheses are covered subject to specifications. For instance, some private insurance companies do not cover custom breast prostheses because there is a standard model available, which meets the medically necessary criteria. Prosthetic replacements due to changes in size are usually covered by insurance as long as a prescription with reasoning for the replacement is provided by a doctor (Breast Prosthesis).

As was the case with my aunt, many women feel that procuring prostheses after mastectomies helps them cope with such a drastic change and permanent bodily change. The prostheses essentially raise the quality of the patients' life by keeping their self-esteem intact after such a hard fought battle. If purely cosmetic surgical and non-surgical coverage is extended to cancer patients as part of their care then why shouldn't hearing aids and cochlear implants also be covered? There are ample studies that show the improved quality of life that these devices provide to their users. To give a patient a new lease on life only to have her faced with the great physical and financial burden of hearing loss is counterproductive.

Jamison –age four-

Jamison suffers from moderate hearing loss and underwent two surgeries to have tubes surgically implanted in his ears to improve his hearing. Tube implantation requires small tubes to be placed in the eardrums to help ventilate the area behind the eardrum. This equalizes pressure as well as drains fluid to keep the middle ear pressure closer to atmospheric pressure (Middle Ear Infections and Ear Tube Surgery). Jamison is a wonderful little boy, but his frustration over not being able to hear well manifests itself in his behavior. Before his second surgery to replace his original tubes, Jamison began having uncharacteristic and frequent tantrums. His speaking voice became more childish and his pronunciation less clear. Jamison may not have a profession that his hearing impairment can negatively effect but his fundamental language and social skills are mostly definitely impacted by his loss and in jeopardy of being underdeveloped if he does not receive the proper treatment and intervention.

As previously mentioned children have a much wider range of coverage for hearing benefits than do adults. Medicaid coverage of hearing benefits is an extremely complex system in terms of adult coverage because each state sets its own standards and there is not requirement within the federal guidelines that mandates each state to cover

hearing benefits. Services are mandated, however, for children from birth until age 21. The federal government requires that Medicaid cover audiological assessments, hearing aid evaluations, and medically necessary hearing aid services, which includes hearing aids, hearing accessories, and services (Medicaid Regulations). Although these benefits are available the system is not perfect. A study on Medicaid reimbursement of children's hearing services published in the *Official Journal of the American Academy of Pediatrics* found that Medicaid reimbursements are falling short. The study looked at 15 states in which Medicaid, Medicare, and private insurance have comparable coverage for hearing services and found that Medicaid reimbursement rates have been steadily declining and that many states do not even have billing codes for a significant number of hearing services need by children. The expansion of newborn hearing screening has added a significant number of children to the pool of those who need these services. This study raises questions about how well states are meeting federal guidelines because many children cannot access the services they need (McManus).

Medicaid is also required to cover all children for cochlear implants up to age 21. Research studies found that cochlear implants can result in net saving of \$53,000 per child, in stark contrasts to the more than \$1 million average expected lifetime cost that each child with profound hearing loss prior to language development will likely incur. With the operation costing in total about \$40,000 these savings are significant (Cochlear Implant Frequently Asked Questions).

Jamison's family is too affluent to qualify for Medicaid, so his family relies on private insurance coverage. Cochlear implants are in his future within the next two years. Most private health insurance companies provide cochlear implant coverage because the

implants have been recognized as a standard treatment for severe to profound hearing loss due to nerve deafness. It is important to note, however, that repairs and updates for cochlear implants are not always covered by insurance (Cochlear Implant Frequently Asked Questions). More than 90% of all the commercial health insurance plans in the country cover cochlear implants. Managed care plans may be more restrictive about their coverage. Additional warranties and insurance on the actual devices themselves can be obtained from manufacturers but not private insurance companies (Nussbaum) Over 40,000 adults and 30,000 children in the United States are cochlear implant recipients, however, only 7% of the people in this country who qualify for the implants are hearing with this technology today (Hearing Loss Stats).

Hearing aids are widely accepted so policy changes on adding coverage will most likely face opposition solely from the insurance companies who will have to pay the bills. The hearing world may not realize, however, the amount of controversy that cochlear implants, specifically, create within the deaf community of this country. In the world of those who can hear or gradually lose their hearing, some hearing is considered better than non at all. In the deaf world, the sentiment is exactly the opposite; the deaf would rather be completely deaf rather than hard of hearing. Deaf children with deaf people do not see their circumstances as a tragedy like hearing parents often do. Deaf parents of deaf children see their child's impairment as a blessing of sorts, because it will allow their child to grow up fully immersed in deaf culture. The deaf community warns against the surgeries potential risks, which include "anesthesia complications, facial nerve damage, skin flap necrosis, meningitis, and permanent dizziness" (Gaines). The deaf community also points out the variability of success with the devices.

The ethical debate this causes brought both medical and legal biomedical ethics considerations to cochlear implant policies. The medical community has verified that cochlear implants are the best therapeutic option for people with profound hearing loss. By biomedical ethics standards, cochlear implants have also been found to be valid as long as implantations are analyzed on a case-by-case basis. This stipulation means that ENT (ears, nose, and throat) physicians bear the ethical responsibility to properly assess each child as well as provide the child's parent/guardian with all the material information or information pertinent to the procedure and receive formal written consent (Ortohinolaryngol).

Cochlear implants were first marketed in 1972 and more than 1,000 of the primitive models of these devices were implanted between 1972 and the mid 1980's. The FDA formally approved this model of the implant in November of 1984 and several hundred children received the devices. By the end of the late 1980's, most concerns about long-term success and the safety of the implants had been resolved. Since then, the technology for these implants increases with every passing year. Cochlear implants today have much higher performance levels. Acceptance of the implants as assistive devices grew rapidly throughout the 90's and continues to do so today. Implants are increasingly recommended by medical professionals and chosen by patients as well. There are two major corporations that produce cochlear implants in the United States, which are Cochlear Corporation and Advanced Bionics Corporation (History of Cochlear Implants).

A study conducted on the effects of having cochlear implants in a world of hearing people identified four principle conclusions about the devices' long-term effects for children. First, students with cochlear implants often experience great academic

success but may still experience difficulties in a classroom setting. Second, the children have strong and healthy relationships with hearing peers rather than hard of hearing peers. Third, adolescents' hearing-deaf identity was heterogeneous and ranged from hearing to deaf. Finally, some adolescents with the implants may simultaneously have more than one personal identity, which may be expressed at different intensities according to their level of functioning and their circumstances (Adelman).

Time for Change

Congress is considering proposed legislation that would make hearing aids and hearing healthcare part of the services and benefits covered by the federal Medicare program. A Florida Republican, Mark Foley, introduced the bill last fall. Although predictions that it will take years for Congress to pass any meaningful legislation on hearing benefits may prove to be true, four state legislators have passed laws requiring hearing benefits be covered for specific sectors of the population, mostly children, and six other states are starting to follow suit. The private sector is also being pushed by consumer demand to expand coverage. The hearing industry and manufacturers also support an expansion in coverage for obvious reasons. Most campaigns, even before the Foley Bill, are targeted at expanding coverage for children. James Potter, the director of government relations and public policy at the American Speech-Language-Hearing Association, points out that coverage for children is the logical sequel to the nationwide campaign for newborn for newborn hearing screening, which made great progress and won legislation mandating universal newborn hearing screening. As the baby boomers now begin to reach the age for Medicare eligibility, there will be an even larger push from that constituency.

The Foley Bill, formally known as H.R. 2934, the Medicare Aural Rehabilitation and Hearing Aid Coverage Act of 2001, would add hearing aids to the list of approved durable medical devices covered by Medicare. Beneficiaries would then be entitled to new hearing aids every three years if needed and patients would be billed personally if they exceed their amount of coverage provided by Medicare. Potter sees this bill as well intentioned but unlikely to pass, but will still be beneficial for raising awareness. The Hearing Industries Association (HIA), which is the trade association for suppliers and manufacturers of hearing products, support the Foley Bill but warn that reimbursement would have to be high enough to keep manufacturers dedicated to innovation that benefit the users of their products. HIA believes that the ability of patients to choose from a variety of devices will need to be a significant part of any bill passed (Nemes).

Since 2002, bills that would create a federal income tax credit for individuals who purchase hearing aids have been repeatedly introduced to Congress. This bill has never come up for a vote but constantly gains more and more support over time. The original version of the bill, known as the Hearing Aid Assistance Tax Credit or H.R. 1646, provides a \$500 tax credit per purchased hearing aid to by a hearing impaired person who is 55 years of age or older or for a dependent child 18 years or younger. Other family members who qualify as dependents for tax purposes are also covered by the act. The newest version of the bill requires that a person must have an annual income under \$200,000 to receive the tax credit. The basic idea of this revision is to bring the total cost of the act down by making those who can afford hearing aids pay for them. The bill has a wide range of support from organizations such as the Hearing Loss Association of America, HIA, ASHA, and the Academy of Doctors of Audiology. Tax credits are an

expansion of third-party coverage. The only opposition the bill faces is that the federal government would be losing revenue by allowing taxpayers to keep more of their money. The Joint Committee on Taxation estimated in 2005 that the bill would cost the federal government \$300 million in one year and about \$1.3 billion over five consecutive years (Hearing Aid Assistance Tax Credit). Therefore, cuts would have to be made elsewhere in the budget to make up for this benefit. The proposed tax credit would benefit many individuals who already have insurance coverage for hearing services. For instance, Blue Cross/Blue Shield FEHBP covers up to \$1,200 per device despite the fact that on average hearing aids cost \$1,800 per device. A federal employee who buys a pair of hearing aids for \$3,500 could use the FEHBP coverage of \$1,200 and also receive a \$1,000 tax credit. Some critics of the bill believe an insurance mandate on hearing benefits would be easier because the government would not have to pay the bills (Victorian).

The implementation of the ACA holds some major implications for the future of the hearing impaired percentage of the population. The enrollment of more individuals in health insurance will more likely than not lead to more patients being referred to audiologists for hearing-and-balance-related evaluations, which will increase the number of people interested in hearing-benefit reform. Also, the actual number of hearing impaired will statistically increase and reports will be more accurate. At present, 25 states have already taken advantage of the option to expand Medicaid eligibility written into the ACA and others may follow suit. The Medicaid eligibility expansion will result in expanded hearing aid sales in those states and hearing benefits. As aforementioned, the degree of covered care will vary in each state, however, the trend is to follow the Massachusetts or “Romneycare” example, which expands hearing benefits. With the

aging generation and expansion of hearing benefits audiologists are feeling pressure to increase the quality of their services as well as their capacity for service. Competition amongst audiologists through high-quality care at lower cost than other professionals in the hearing health care field may promote direct access to hearing services (Parker).

Other reforms in the hearing services sector of health care would help simplify the process and support coverage expansion with public and private insurers alike. One element of reform should be increasing the transparency of hearing aid pricing. True transparency would mean that practitioners would be expected to unbundle prices and make the actual price of the hearing aid obvious separate from any other related charges for professional services. Audiologists are often worried about sufficient reimbursement for their services and transparency of cost will allow for the negotiation of reasonable payment amounts. The development of better benchmarks and objective measurements of the benefits of hearing treatment would also help coverage expansion grow. For example, John Laftsidis, Alliances Manager of Beltone, believes that the hearing industry should conduct a study to show employers how covering hearing benefits will benefit them in the long run. Essentially, the main point of the study would be that employers should cover hearing costs because employees who can hear better will perform better (Victorian).

I believe a major reform that should be implemented is the removal of the option to waive the medical evaluation before the purchase of hearing aids. Removing the option to waive the medical evaluation would ensure that patients receive proper models and fittings when they make their purchase. The requirement that patients see a physician would also help data collection on this issue and more accurate statistics for the future.

The fact that the hearing aid dispenser must inform the consumer that waiving their medical evaluation is not in the best interest of his or her health is an indication to me that it should not be an option in the first place. In a high stress financial and emotional situation, people want to make the process as simple as possible, however, skipping the step of seeing a physician prior to being fitted for and purchasing hearing aids is counterproductive.

The best direction for this country to go in for expanding hearing benefit coverage is to remove the option to waive the medical evaluation, pass the Foley Bill, and to make hearing part of the new ACA benchmark essential benefits. A hearing aid assistance tax credit like the one proposed above would put a large burden on the federal government and leave private insurance companies unaccountable. Adding hearing benefits to the essential benefits that plans must cover to participate in the insurance market place under the ACA would acclimate private insurance to covering hearing benefits, which could be easily expanded to all plans from there. Removing the option to waive the medical evaluation will instantly increase the quality of services that each individual will receive and cut down on wasted expenses, like improperly fitted hearing aids. Expanding hearing coverage for adults to the level that children receive it is the next logical step for this country. All newborns receive screening for possible hearing impairment, all children have access to hearing coverage, now, adults need to be offered that same access.

As William M. Sage writes, “One person’s malady can harm families, workplaces, clubs, churches, and sometimes entire communities” (Sage). The loss of hearing is one of this country’s easily fixable maladies, which negatively impacts society, yet we chose to ignore it. My father’s hearing affected my entire family and makes his

job that much more dangerous. My aunt's hearing makes teaching special needs elementary school students even more of a challenge than it already is and Jamison's entire class of schoolmates is affected by his lack of hearing and subsequent behavior issues. Sage goes on to say that "Effective reform must connect individual services to population health at as many junctures as possible"(Sage). With increased hearing services coverage the overall population of the country will be significantly healthier. Mentally and physically, the impacts of hearing loss are all negative and the growing number of individuals who will face hearing problems in the near future should be of the utmost concern in the medical industry.

In a time of great change and reform for the health care sector of this country, efforts to correct this grievous coverage gap should be in the forefront of reformers' minds. Sage argues that "coordinated investment" is one of the aspects of American solidarity in health care. He insists, "Epidemics and disasters generate widespread willingness both to contribute funds and to submit to physical restrictions in order to prevent additional physical harm and to keep critical infrastructure functioning" (Sage). I would argue that hearing impairments are a pandemic in this country of ghastly proportions. The cause of much of the lack of accurate data and actual numbers for hearing loss is commoditization of hearing services and devices. Turning patients into solely consumers is a dangerous game to play when one of the person's five senses is at stake. Hearing device consumers are often under or uninformed, which leads to the purchase of incorrect devices. The option to waive the medical evaluation is even more precarious because it takes medical professionals out of the picture completely. Tax credits for hearing aids purchasers and greater transparency in price are good first steps to

integrating hearing coverage fully into the third-party payer system. However, I believe that full coverage of hearing services and devices by both public and private insurance is the direction this country should be headed in and is in fact, inevitable with the aging baby boomer generation and the vastly increasing number of newborns who will now be identified as hearing impaired through mandatory infancy screenings.

I know first hand how hearing loss impacts a relationship and an entire family. My mother's frustration at having to constantly raise her voice to have a normal conversation, my father's lack of participation in conversations at busy restaurants, and rarely getting a response when I'd say "Love you Dad," as he walked out the door to work in the morning, all brought stress into our home. The difference that his hearing aids make in his daily life is profound. Unfortunately for the hearing impaired treatment comes with a very high price. My father was fortunate enough to be able to pay this price, no matter how much anxiety the costly purchase caused him. The day after my father purchased his hearing aids he walked out the door to work and when I called, "Love you Dad," he actually called back, "Love you too Reeg, but you don't have to yell."

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