VIEWPOINT

Hearing Care Access?
Focus on Clinical Services, Not Devices

Nicholas S. Reed, AuD
Cochlear Center for Hearing and Public Health, Johns Hopkins University Bloomberg School of Public Health, Baltimore, Maryland; and Department of Otolaryngology–Head and Neck Surgery, Johns Hopkins University School of Medicine, Baltimore, Maryland.

Frank R. Lin, MD, PhD
Cochlear Center for Hearing and Public Health, Johns Hopkins University Bloomberg School of Public Health, Baltimore, Maryland; and Department of Otolaryngology–Head and Neck Surgery, Johns Hopkins University School of Medicine, Baltimore, Maryland.

Amber Willink, PhD
Cochlear Center for Hearing and Public Health, Johns Hopkins University Bloomberg School of Public Health, Baltimore, Maryland; and Department of Health Policy and Management, Johns Hopkins University Bloomberg School of Public Health, Baltimore, Maryland.

Corresponding Author: Nicholas S. Reed, AuD, Cochlear Center for Hearing and Public Health, Johns Hopkins University Bloomberg School of Public Health, 2024 E Monument St, Baltimore, MD 21205 (nreed9@jhmi.edu).

Hearing loss, the third most common chronic condition among older adults,[1] has suddenly been thrust into the legislative spotlight following the emergence of research that found an association between hearing loss and important health care outcomes, including cognitive decline and dementia.[1] Hearing loss and hearing care access have received attention from the White House,[2] US Congress,[3] and major scientific institutions.[1] Following recent legislation, hearing aids to address mild to moderate hearing losses are set to become available over-the-counter (OTC) by 2020, disentangling the purchase of hearing aids from the hearing rehabilitative services that support them.

For older Medicare beneficiaries, this change will likely result in greater access to more affordable hearing aids, as distribution models change and competition in the market reduces cost. However, financial barriers to hearing rehabilitative services, including customization and counseling, remain because Medicare policy does not cover these services.[4] Hence, although passage of the Over-the-Counter Hearing Aid Act of 2017 (passed as part of the FDA [US Food and Drug Administration] Reauthorization Act [HR 2430, §934] of 2017) was a critical step toward ensuring that individuals with hearing loss can purchase affordable and low-cost hearing aids, these same individuals may not be able to afford the additional hearing rehabilitative services that may be needed to ensure maximum benefit from hearing aids. To ensure that Medicare beneficiaries benefit from OTC access to hearing aids policy, efforts should now focus on ensuring that older adults also have access to affordable hearing care services.

Hearing Loss in the United States

Approximately 38 million Americans have hearing loss, and prevalence increases with age, such that two-thirds of adults older than 70 years have a mild or greater hearing loss.[1] Given current demographic trends, the number of persons with hearing loss in the United States is projected to double by 2060.[5] Hearing loss has often been viewed historically as an unfortunate but accepted inconvenience of aging. However, recent epidemiologic data have revealed the broader public health consequences of untreated hearing loss. The literature documents an independent association between hearing loss and more costly health outcomes, such as cognitive decline, incident dementia, social isolation, falls, and an increased rate of hospitalization.[1] These outcomes contribute to significantly higher health care costs among persons with hearing loss compared with their peers. However, less than 20% of persons with hearing loss in the United States use hearing aids, with variation in access by income.[1]

Hearing aids are regulated by the FDA, and until the recently passed OTC hearing aid legislation becomes effective in 2020, hearing aids can still only be sold by licensed professionals.[1] Hearing aids are generally sold to the patient along with hearing rehabilitative services as a bundled model. These services are typically bundled together with the cost of the hearing aid, leading to poor transparency in the relative costs of the device vs services. The mean price to consumers for a pair of hearing aids is $4700 but can range from $1000 to more than $8000.[1]

Significant Gains in Hearing Care Policy With an Important Caveat

The availability of OTC hearing aids will improve access by removing clinical barriers and likely spur the entrance of consumer technology companies into the hearing care marketplace, hence resulting in increased competition and lower prices. However, although many individuals with hearing loss will benefit from being able to access affordable hearing aids, other individuals may not benefit without access to a hearing professional and hearing rehabilitative services to guide them through the process and help individuals customize and learn how to use the technology for their individual needs.

Evidence supports that some individuals are able to self-adjust and manipulate their hearing aids to their needs and desires quite well, but there may be room for improvement. A recent randomized clinical trial (n = 163) of conventional (n = 53), OTC (n = 51), and placebo (n = 50) hearing care models demonstrated that even though patients benefited from an OTC model of hearing care, those who received best practice care that included counseling and communication strategies experienced greater perceived benefit based on a validated self-report questionnaire (Profile of Hearing Aid Benefit).[6] Other persons may not be able to self-adjust and self-manage their hearing care. Previous research suggests that persons with cognitive impairment, with low health literacy, and without previous hearing care experience or interaction may be especially at risk for the inability to self-manage.[7]

Evolution of Hearing Policy in the United States

Barriers to hearing care services exist for Medicare recipients because hearing testing (unless ordered by a physician), hearing aids, and hearing care services (ie, programming, repairs) are excluded in the Medicare Act as routine rather than medically necessary care.[1,4] The Over-the-Counter Hearing Aid Act of 2017 will attempt to address the access gap and provide cost-effective devices; however, Medicare beneficiaries will still lack access to support services.

© 2018 American Medical Association. All rights reserved.

Downloaded From: https://jamanetwork.com/ by a Johns Hopkins University User on 11/20/2019

Over time, multiple bills have attempted to improve access and affordability of hearing care for Medicare recipients. In the current US Congress, the Audiology Patient Choice Act has been introduced to committee in the US Senate (S 2575, 115th [2017-2018] Cong) with an accompanying US House of Representatives Bill (HR 2276, 115th [2017-2018] Cong). This bill does not specifically address the statutory exclusion of services related to hearing aids and hearing aid–related services in its current state; however, it may lay the groundwork for future coverage of services under limited license physician status.

Reimbursement Issues

In the context of future OTC hearing aids, one reasonable approach may be to leverage existing hearing rehabilitation *Current Procedural Terminology* (*CPT*)–coded (titled *aural rehabilitation*) reimbursement practices for speech-language pathologists as a benchmark for audiologists. The *CPT* codes for time-based aural rehabilitation (92626 for the first hour, 92627 for each additional 15-minute increment) already exist for audiologists, but these practices are not reimbursed by Medicare. In addition, Medicare reimburses speech-language pathologists for aural rehabilitation (*CPT* code 92507 at $79.92) under Medicare Part B; however, speech-language pathologists do not provide these services in relation to hearing aids and generally focus only on the communication counseling aspect. Audiologists could use the same *CPT* code (92507) for aural rehabilitation under Medicare Part B to provide communication counseling and auditory training, which would require hearing care to be redefined in the Medicare Act as medically necessary. Although these *CPT* codes would not necessarily support activities related directly to hearing aids (ie, programming and customization), these codes could support counseling to maximize benefit of OTC hearing aids among Medicare beneficiaries. Currently, no value-based cost-benefit study has specifically distinguished the use of hearing care services and devices. Future analyses will be necessary to support this policy.

Conclusions

Hearing care in the United States has already advanced with the signing of the Over-The-Counter Hearing Aid Act of 2017.[3] To help ensure that the benefits of this change are realized by the millions of Medicare beneficiaries with hearing loss regardless of income, 2 important policy changes may be necessary to increase access to aural rehabilitation services. First, current reimbursement policy could be changed to allow existing *CPT* codes to be used and reimbursed by audiologists under Medicare Part B to address the immediate policy change. Second, redefining hearing aids and hearing services as medically necessary would render comprehensive hearing care eligible for coverage by Medicare. With these changes, the Centers for Medicare & Medicare Services could safely support transitioning the state of hearing care in the United States from being high cost and low access to low cost and high access, thereby potentially leading to downstream savings and improved health outcomes among older adults.

ARTICLE INFORMATION

Published Online: September 13, 2018. doi:10.1001/jama.2018.11649

Conflict of Interest Disclosures: All authors have completed and submitted the ICMJE Form for Disclosure of Potential Conflicts of Interest. Dr Lin reported being a consultant to Cochlear, Amplifon, and Boehringer Ingelheim. Dr Reed reported being an adviser to Clearwater Clinical. No other disclosures were reported.

Funding/Support: This study was funded in part by the Eleanor Schwartz Charitable Foundation and the Cochlear Center for Hearing and Public Health at Johns Hopkins University Bloomberg School of Public Health and supported by grants R33DC015062 (Dr Lin) and NIH KL2TR001077 (Dr Reed) from the National Institutes of Health.

Role of the Funder/Sponsor: The Eleanor Schwartz Charitable Foundation, the Cochlear Center for Hearing and Public Health, National Institutes of Health, and US Department of Health and Human Services had no role in the design and conduct of the study; collection, management, analysis, and interpretation of the data; preparation, review, or approval of the manuscript; and decision to submit the manuscript for publication.

REFERENCES

1. Lin FR, Hazzard WR, Blazer DG. Priorities for improving hearing health care for adults: a report from the National Academies of Sciences, Engineering, and Medicine. *JAMA*. 2016;316(8):819-820. doi:10.1001/jama.2016.7916

2. President's Council of Advisors on Science and Technology. *Aging America & Hearing Loss: Imperative of Improved Hearing Technologies*. Washington, DC: Executive Office of the President of the United States; September 2015.

3. Warren E, Grassley C. Over-the-counter hearing aids: the path forward. *JAMA Intern Med*. 2017;177(5):609-610. doi:10.1001/jamainternmed.2017.0464

4. Willink A, Schoen C, Davis K. Consideration of dental, vision, and hearing services to be covered under Medicare. *JAMA*. 2017;318(7):605-606. doi:10.1001/jama.2017.8647

5. Goman AM, Reed NS, Lin FR. Addressing estimated hearing loss in adults in 2060. *JAMA Otolaryngol Head Neck Surg*. 2017;143(7):733-734. doi:10.1001/jamaoto.2016.4642

6. Humes LE, Rogers SE, Quigley TM, Main AK, Kinney DL, Herring C. The effects of service-delivery model and purchase price on hearing-aid outcomes in older adults: a randomized double-blind placebo-controlled clinical trial. *Am J Audiol*. 2017;26(1):53-79. doi:10.1044/2017_AJA-16-0111

7. Convery E, Hickson L, Meyer C, Keidser G. Predictors of hearing loss self-management in older adults [published online March 28, 2018]. *Disabil Rehabil*.

© 2018 American Medical Association. All rights reserved.

Downloaded From: https://jamanetwork.com/ by a Johns Hopkins University User on 11/20/2019