ADA
POSITION STATEMENT

A Call to Action on Coverage of Hearing Care: Principles for Public Policies that Optimize Patient Outcomes

ACADEMY *of* DOCTORS *of* AUDIOLOGY®

WE MEAN BUSINESS

Background and Problem

Hearing health is essential for overall health and wellbeing. Approximately 15% of adults in the United States report difficulty hearing[1]. Disabling hearing loss affects about 5% of adults aged 45-54 years, 10% of adults aged 55-64 years, and 22% of those aged 65-74 years. Approximately 55% of those aged 75 years and older have disabling hearing loss[2]. Hearing loss is associated with diabetes, cardiovascular disease, cognitive decline and other serious health conditions[3]. Yet, coverage for audiology and hearing healthcare services is limited and deficient.

During the development of the Audiology 2050 Roadmap[4], ADA conducted a thorough analysis of the audiology and hearing healthcare coverage landscape. ADA identified coverage policies that impede beneficiary access to audiologic care and assessed state and federal laws and regulations to identify policy gaps. Some of ADA's key findings were presented to the Centers for Medicare and Medicaid Services (CMS) through the following comments:

- ADA January 5, 2024 comment on: Medicare Program: Contract Year 2025 Policy and Technical Changes to the Medicare Advantage Program, Medicare Prescription Drug Benefit Program, Medicare Cost Plan Program, and Programs of All-Inclusive Care for the Elderly; Health Information Technology Standards and Implementation Specifications (CMS-4205-P)[5], and
- ADA May 29, 2024 comment on: Request for Information on Medicare Advantage Data[6].

Upon further analysis, ADA has identified significant disparities in public policies impacting coverage of hearing services, as compared with state and federal laws and regulations governing vision and dental coverage. Audiology can only achieve its potential as a clinical doctoring profession and primary access point for hearing and balance care, when coverage parity can be established and maintained.[7,8,9] The only way to assure coverage parity for consumers, is to ensure parity in public policies that regulate insurance, benefit plans, and third-party administrators (TPAs) that currently control the delivery of hearing healthcare services.

Hearing benefit plans, supported by TPAs, aim to create national hearing aid sales and service delivery models to bolster their own products and networks, and to manage the hearing benefit plans and programs outsourced by insurers, employers, managed care organizations, and others. Most hearing benefit plans and programs are constructed to support the following assumptions:

1. That every individual who requests a hearing test is a traditional, prescription hearing aid candidate;
2. That every hearing aid candidate has the same characteristics, needs, and challenges;
3. That every hearing aid fitting, orientation, and follow-up requires the same level of effort, expertise, and time;
4. That hearing aid performance, satisfaction, and communication outcomes are solely dependent on the hearing aid product (not services such as counseling and auditory rehabilitation, for example); and
5. That every "hearing healthcare professional" has the same value and utility.

Because of their sole focus on the sale of hearing aids, hearing benefit plans and TPAs place little value on diagnostic audiologic testing, cerumen management, verification and validation, communication and functional needs assessments, and treatment services such as tinnitus management and auditory

1. https://www.nidcd.nih.gov/health/statistics/quick-statistics-hearing
2. See 1 above.
3. Jana Besser, Maren Stropahl, Emily Urry, Stefan Launer, Comorbidities of hearing loss and the implications of multimorbidity for audiological care, Hearing Research, Volume 369, 2018, Pages 3-14, ISSN 0378-5955, https://doi.org/10.1016/j.heares.2018.06.008.
4. https://audiologist.org/resources/advocacy/audiology-2050
5. https://www.regulations.gov/comment/CMS-2023-0187-3003, January 5, 2024, accessed on March 3, 2025
6. https://www.regulations.gov/comment/CMS-2024-0008-0268, May 29, 2024, accessed on March 3, 2025
7. https://glance.eyesoneyecare.com/stories/2024-01-19/aoa-town-hall-addresses-vision-plan-policy-concerns-and-future-advocacy-initiatives/
8. https://www.aoa.org/news/advocacy/state-advocacy/vsp-policy-change-may-violate-states-patient-protection-laws
9. https://www.ada.org/advocacy/legislative-action-center/dental-and-optometric-care-access-act

rehabilitation, despite the fact that these services are often crucial for optimal clinical outcomes, and most importantly, improved quality of life.[10]

Approximately 10% of adults experiencing hearing loss have a condition that can be remedied with medical or surgical intervention. Approximately 13% of adults with hearing loss are candidates for osseointegrated auditory device or a cochlear implant.[11,12] Others have auditory and communication difficulties that can be treated effectively with over-the-counter hearing aids, tinnitus maskers, assistive listening devices, and/or auditory rehabilitation.

Typically, hearing benefit plans and TPAs do not provide coverage for diagnostic and treatment services, and instead focus solely on routine hearing tests and services related to the selection and fitting of a hearing aid, incorrectly assuming those over a certain age only need hearing aids. These plans generally offer no coverage mechanism for addressing a beneficiary's complex diagnostic or rehabilitative needs, and, unfortunately, most of the plans also prohibit beneficiaries from contracting with audiologists privately for the services that are not covered. Beneficiaries are often left without the help, support, and treatment services that they need--and all too often even after having purchased hearing aids that they are unable to effectively use.[13]

Audiologists frequently receive no reimbursement at all from the hearing benefit plans or the beneficiary, unless the beneficiary purchases a hearing aid. Further, since most hearing benefit plans have no protocol for separating the diagnostic service fees, audiologists are often required to provide free hearing testing services, *even if the beneficiary does not proceed with amplification*. This practice will likely violate Medicare rules and ethical standards, depending on the audiologist's overall service fee protocols, putting them in a potentially non-compliant position ethically and legally.

Conversely, for audiologists who are contracted with the medical insurer, but not the hearing benefit plan, it is often the insurer who either denies coverage for diagnostic services or assigns responsibility for payment to the beneficiary. This is likely due to the inclusion of CPT® codes (92557, comprehensive audiometry, threshold evaluation and speech recognition, for example) into the fees paid to the TPA for administering the plan. Under current practices, simply bundling the billing code into a broader, non-transparent payment scheme seemingly absolves the insurer from covering and reimbursing for medically necessary services separately from the hearing benefit plan. This practice creates a complicated, confusing, and costly situation for both the audiologist and their patient. Even more so when the beneficiary has a Medicare Advantage plan and the testing is medically necessary (not for the purpose of fitting a hearing aid). In this case, the insurer may be legally required to cover the diagnostic service, since Medicare rules require Medicare Advantage plans to provide coverage for all services that are covered under Medicare Part B.

The Path Forward: Public Policy Solutions

The Audiology 2050 Roadmap provides a clear directive to address public policy deficiencies undercutting meaningful access to audiologic care for millions of consumers.[14] ADA has taken bold steps to develop legislative and regulatory strategies that promote parity in insurance laws for audiology and hearing healthcare services, and to advocate for affordable, accessible, audiologic care for all Americans.

10. https://pmc.ncbi.nlm.nih.gov/articles/PMC6132942/
11. MT, Pillsbury HC (2020) Cochlear Implantation in Older Adults: Effectiveness and Expanded Indications. J Geriatr Med Gerontol 6:098. doi.org/10.23937/2469-5858/1510098
12. Nassiri AM, Sorkin DL, Carlson ML. Current Estimates of Cochlear Implant Utilization in the United States. Otol Neurotol. 2022 Jun 1;43(5):e558-e562. doi: 10.1097/MAO.0000000000003513. Epub 2022 Mar 8. PMID: 35261379.
13. https://pmc.ncbi.nlm.nih.gov/articles/PMC3665209/
14. See 4

ADA has identified the following key public policies that need to be codified at the state and federal level:

1. Hearing benefit plans and third-party administrators should be classified as "health benefit plans" or a similar classification that requires them to register with the state and be subject to the purview of the State Insurance Commission or similar entity.
2. Insurers, insurance brokers, hearing benefit plan administrators, and third-party administrators should be prohibited from misrepresenting the elements of a hearing benefits plan when selling the plan or communicating the "benefits" to enrollees, or from misleading enrollees about what services are covered and funded.
3. If the hearing benefits plan is merely a hearing discount plan with a high co-payment option, the hearing benefit plan administrators and third-party administrators should be required to clearly identify and present to consumers, in plain language, what items and services are covered benefits (subject to applicable deductibles and co-insurance and reasonable co-payments), what items and services are capitated and/or discounted, and what items and services are non-covered.
4. The term co-payment should only be allowed to be used to describe a meaningful cost-sharing structure, consistent with other covered items and services within the health plan, where the insured pays a fixed fee for medical expenses and where the insurer pays the remainder.
    a. In order to use the term "co-pay," the insurer's portion should be required to be more than a nominal expense.
    b. The term "co-pay" should not be allowed to be used to describe the beneficiary's responsibility for payment under a hearing discount program.
5. Insurers, hearing benefit plan administrators, and third-party administrators should be prohibited from requiring an audiologist/provider to purchase products from any source owned by or affiliated with the same entity that issued the hearing benefit plan as a condition of participation.
6. Insurers, hearing benefit plans, and third-party administrators should be prohibited from "steering" or piloting enrollees to one provider over another, to any retail establishment affiliated with the insurer, hearing benefit plan, or third-party administrator, or to any internet or virtual provider affiliated with the insurer, hearing benefit plan, or third-party administrator.
7. Insurers, hearing benefit plans and third-party administrators, should be prohibited from "tiering" providers based on non-covered service discounts or the brands of products or hearing instruments that they carry.
8. Insurers, hearing benefit plans, third-party administrators, affiliated clinics, and providers should be required to disclose to beneficiaries when they are affiliated with or have an ownership stake in each other or with a hearing aid manufacturer.
9. Insurers and hearing benefit plans should be prohibited from offering audiologists/providers service fee differentials that would create a real or perceived conflict of interest, undermine clinical judgment, or "steer" or incentivize providers towards specific types, styles, brands, or tiers of hearing aid/amplification products.
10. Insurers, hearing benefit plans, and third-party administrators should be required to publicly publish accurate and comprehensive contact information for all providers in their network, including provider type and credentials. Provider contact information should be required to be readily accessible to the member during the open enrollment process, and should be required to be updated monthly.
11. Insurers, hearing benefit plans, and third-party administrators should be required to list the brand, type, and tier of hearing aids in their formulary, and to make this information available to the enrollee. They should be required to update that list at least annually during the open enrollment period.

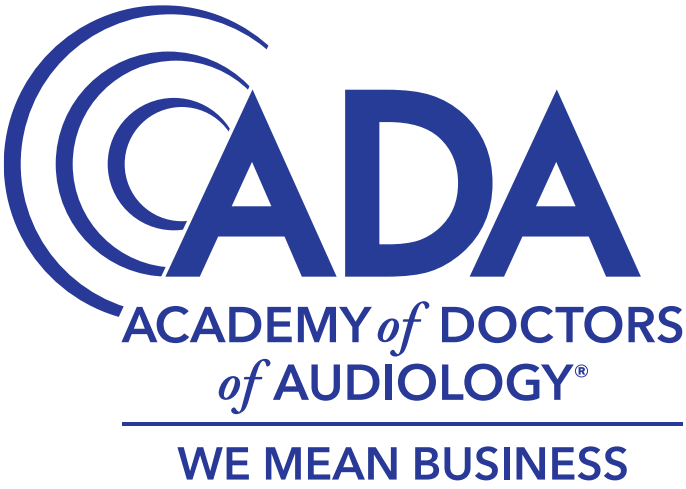
12. Patients should be allowed, by law, to combine and coordinate hearing benefit plan, discount, and medical benefits to maximize their coverage.
13. An insurer should be prohibited from requiring an audiologist to contract with a hearing benefit plan as a condition for participation in the insurer's health care network or to provide covered medical services to its enrollees.
14. An audiologist, with written informed consent of the patient, should be allowed to charge a patient privately for services that are not covered under an insurance policy or health benefit plan.
15. Insurers, hearing benefit plan administrators, and third-party administrators should be prohibited from setting or determining fees for any non-covered audiology or hearing service.
16. Reimbursement rates and required co-pays (if applicable) for each covered service product, and material, should be required to be clearly communicated and itemized in the provider contract. Services that the insurer or hearing benefit plan fails to include as covered services should be treated as non-covered services, for which the beneficiary may be responsible.
17. Covered services should include services for which reimbursement is available under an enrollee's medical insurance contract or health benefit plan, or for which a reimbursement would be available but for the application of contractual limitations, such as a deductible, copayment, coinsurance, waiting period, annual or lifetime maximum, frequency limitation, alternative benefit payment, or any other limitation.
18. Hearing benefit plans should be prohibited from issuing a contract that requires an audiologist, as a condition of participation, to offer services at a set fee or a discount from their reasonable and customary fee, when those services, materials, and products are not covered under the plans.
19. Hearing benefit plans should be prohibited from establishing nominal payments for otherwise non-covered services in an effort to have such services considered covered inappropriately.
    a. An item or service should be considered, with respect to a plan or coverage, to be covered under the plan or coverage only if the item or service is an item or service with respect to which the plan or coverage is obligated to pay an amount that is reasonable and is not nominal or "de minimis".
20. Insurers and hearing benefit plans should be prohibited from using "bundling" to render uncovered services nonbillable to the patient and inclusive to a professional fee.
21. Insurers and hearing benefit plan administrators should be prohibited from implementing a plan that uses "downcoding" to prevent an audiologist from collecting the fee for actual services performed either from the insurer, hearing benefit plan or the patient.
22. Insurers and third-party administrators should be prohibited from denying claims for procedures included in a prior authorization unless the patient has exceeded their annual maximum (in which case the patient should be able to be billed privately), or the prior authorization was based on information that was fraudulent or erroneous.
23. Insurance carriers, hearing benefit plans, and third-party administrators should be required to provide contact information for each entity involved in their claims process along with detailed explanations for any coverage denials when requested, including an explanation for the reasoning used to determine care was not medically necessary.
24. Any audiologist that is a party to the provider network contract must be allowed to choose not to participate in the third-party network access (network leasing). Insurers should not be allowed to change, diminish, or cancel an audiologist's rights, status, or participation in a health plan or contract because of the audiologist's decision to not participate in a network leasing arrangement. Further, the third party being granted access to hearing care insurance network must agree to comply with all terms of the provider network contract.

25. Insurers should be required to directly pay the participating/assigned audiologist/provider the amount of any claim under the same criteria and payment schedule under which the insurer would have reimbursed the insured.
26. The terms, fees, discounts, or reimbursement rates in a provider contract should not be able to be changed until the expiration of the contract, unless mutually agreed to in writing by the audiologist/provider and the insurer.
27. An insurer shall not require an audiologist to meet terms and conditions that are not required of a physician or osteopath as a condition for participation in its provider network for the provision of services that are within the scope of practice of an audiologist.
28. In accordance with Centers for Medicare and Medicaid Services (CMS) regulations, an insurer, hearing benefit plan administrator, or third-party administrator shall not require a qualified, enrolled audiologist to provide diagnostic audiologic evaluations to Medicare, Medicare Advantage, or Medicaid beneficiaries for no separate, distinct fee or for free. The charges for these medically reasonable and necessary diagnostic services cannot be bundled in or made inclusive to the hearing aid dispensing professional fee and should be the financial responsibility of the insurer, hearing benefit plan, third-party administrator, or beneficiary.
29. Enrollees should have the right, as outlined in the Health Insurance Portability and Accountability Act (HIPAA) Omnibus Rules of 2013, to waive their insurance, hearing benefit plan, or third-party administrator discounts, coverage and/or benefits and seek treatment from a licensed audiologist even if the enrollee was referred by the plan.
30. When the enrollee or beneficiary is purchasing (submitting payment directly to) the hearing aid from the hearing benefit plan or third-party administrator, the hearing benefit plan or third-party administrator should be deemed the seller and be solely responsible for compliance with applicable state hearing aid dispensing and consumer protection laws. The audiologist who fit and oriented the enrollee or beneficiary on the hearing aid should be held harmless as the enrollee or beneficiary did not purchase the hearing aid from them or their practice. This should be clearly communicated, in plain language, to the purchaser at the outset of the relationship.

Conclusion and Call to Action

ADA seeks volunteer AuDvocates to advance these public policy initiatives at the state and federal levels. Volunteer input is critical for policy development, media and public awareness, outreach to policymakers, coalition building, and education. Your voice matters and your vote matters! Please contact Stephanie Czuhajewski at sczuhajewski@audiologist.org or at (859) 321-1595 for more information. Please use the QR code to volunteer now to advance public policy initiatives that advance optimal patient care!

ADA
ACADEMY *of* DOCTORS *of* AUDIOLOGY®
WE MEAN BUSINESS



WE MEAN BUSINESS

The Academy of Doctors of Audiology (ADA) is dedicated to the advancement of practitioner excellence, high ethical standards, professional autonomy and sound business practices in the provision of quality audiologic care.

AUDIOLOGIST.ORG • AUDIOLOGYPRACTICES.ORG