Implications of Hearing Care Policy for Nurses

Margaret I. Wallhagen, PhD; and Nicholas S. Reed, AuD

ABSTRACT

Hearing loss (HL) becomes increasingly common with age and can lead to multiple negative outcomes, including isolation, falls, depression, altered social relationships, and altered cognitive functioning. HL also can affect patient–provider communication and lead to misunderstandings. Despite the negative effects that HL has on multiple domains, less than 20% to 25% of individuals who might benefit from amplification devices and/or hearing aids own them. Barriers to use include stigma, cost, and access. Nurses can play a critical role in promoting appropriate care for individuals with HL and providing access for those who need hearing aids. The current article (a) briefly reviews how history and policies, especially Medicare and Medicaid, but also those defining the practice of audiology and dispensing of hearing aids, affect insurance coverage for hearing care; (b) reviews how a combination of forces brought the need for accessible and affordable hearing care to national attention and resulted in the Over-the-Counter (OTC) Hearing Aid Act; and (c) discusses the implications of the OTC Act for nurses and nursing practice.

Hearing connects us to others via communication and gives us an awareness of our surrounding environment, even warning us of potential dangers, as signaled by a siren or alarm. However, the sense of hearing is often taken for granted and hearing loss (HL) viewed as an unfortunate but benign side effect of aging. Despite this common perception, HL is far from benign. Research has revealed independent associations between HL and depression, isolation, decreased functional capacity, changes...
Despite the negative effects that hearing loss has on multiple domains, less than 20% to 25% of individuals who might benefit from amplification devices and/or hearing aids own them.
only a hearing aid rather than including the range of services comprising aural rehabilitation. This perception is reinforced today by a common bundled model of care in which services are included in the cost of the hearing aid purchase. In 1978, a Supreme Court decision that a professional society’s code of ethics could not prohibit competition essentially put an end to this separation. Over time, hearing care has moved from a solely diagnostic field to an incorporated diagnostic and aural rehabilitation field (Lowder, Paarlberg, & Harding, n.d.; NASEM, 2016).

Another important policy affecting hearing care is the signing of Medicare and Medicaid into law by President Johnson as Title XVIII and Title XIX of the Social Security Act in 1965. This enactment was the culmination of a long process that involved much debate about coverage and compromises, partly due to the opposition of organized medicine at the time. As designed, Medicare coverage focused on hospital-related expenses (Medicare Part A) with additional coverage (Medicare Part B) for some out-of-hospital expenses, such as physician visits, not covered by Medicare Part A and also exclude coverage of hearing aids and hearing services.

Unlike Medicare, Medicaid does not exclude coverage for hearing aids or hearing services, but they are not federally mandated defined benefits. Rather, coverage is state-specific (Arnold et al., 2017). Most states focus on hearing care for Medicaid-eligible children rather than adults. Only 28 states offer some coverage of hearing aids for adults older than 21 under Medicaid and policies differ greatly in eligibility criteria. Moreover, many state Medicaid policies allow for only one hearing aid rather than two. Importantly, all states that cover hearing aids focus on the device rather than the complementary services, such as aural rehabilitation, to maximize benefit.

As noted above, the multi-step process of diagnosis and prescription may be a further barrier to hearing aid uptake. Under state laws, hearing aids must be dispensed by a licensed individual. Under current FDA Federal Regulation Sec. 801.421:

a hearing aid dispenser shall not sell a hearing aid unless the prospective user has presented to the hearing aid dispenser a written statement signed by a licensed physician that states that the patient’s HL has been medically evaluated and the patient may be considered a candidate for a hearing aid. The medical evaluation must have taken place within the preceding 6 months. This regulation ensures no medical pathology requiring treatment is present. However, this regulation combined with the Medicare requirement for a physician referral limits direct access to hearing care and contributes to a system where multiple visits with multiple providers are required to obtain hearing aids. Notably, in December 2016, the FDA announced it would no longer enforce this policy; however, the requirement remains in place in regulatory documents, which has created some confusion among practicing audiologists (Warren & Grassley, 2017).

The combination of the history of hearing care and related policies created a somewhat complicated and cumbersome care delivery model that requires patients to navigate multiple providers and visits. Further, because the focus of current care is on the hearing aid itself, usual care does not include those services that maximize hearing capacity. Finally, the individual is burdened with the associated costs. These circumstances compromise the health and well-being of older adults with HL.

COALITION BUILDING TO CHANGE POLICY

Given the prevalence and impact of HL, one might believe that policy change to remove barriers to accessible and affordable hearing care should be straightforward. However, unsuccessful attempts to change Medicare coverage date back to the late 1970s when Senator Claude Pepper introduced several bills designed to cover the cost of hearing aids (Joyner, 2018). Further proposed legislative attempts over the years to either cover hearing aids or improve access never emerged from committee. At the time of the current article, the Audiology Patient Choice Act (S2573), which aims to improve direct access to care, would give audiologists limited-license physician status within Medicare. This bill was assigned to the Senate Committee on Finance in March 2018. As this legislation suggests, forces for change began to coalesce in recent years.

For years, personal sound amplification products (PSAPs) that amplify
sound have existed as unregulated devices available for direct consumer purchase. These devices range in cost from $19.99 to $400 but are not FDA approved and cannot be marketed as hearing aids or devices for HL (Reed, Betz, Lin, & Mamo, 2017). Although not promoted for this purpose, survey data suggest individuals with HL adopt PSAPs to treat their HL in lieu of traditional hearing care (Kochkin, 2010). Traditionally, these devices were of poor quality; however, in recent years, select PSAPs have proven more technologically capable and compare well to hearing aids on basic listening tasks (Reed, Betz, Kendig, Korczak, & Lin, 2017). The emergence of these more technologically advanced devices began to challenge hearing aid manufacturers and pressure the hearing care system to consider new models of care.

On another front, data supporting the association of HL with numerous negative health outcomes have grown significantly. This cumulative body of research was part of the catalyst for multiple scientific bodies to turn their attention to HL. In 2009, the National Institute on Deafness and Other Communication Disorders/ National Institutes of Health sponsored a working group focusing on accessible and affordable hearing health care (Donahue, Dubno, & Beck, 2010). An outgrowth of this effort was the call for research to develop, improve, and lower the cost of hearing aids. This effort ultimately led to the establishment of the Committee on Accessible and Affordable Hearing Healthcare in 2015 under the auspices of the NASEM, formerly the Institute of Medicine. In June 2016, the NASEM committee published its comprehensive consensus study, which made 10 major recommendations, including the call to further study the impact of HL across multiple conditions, educate practitioners and others, integrate hearing screening into primary care, and meet the needs of underserved populations.

Importantly, the report acknowledged the advanced PSAPs available and recommended consideration of an FDA–approved class of OTC wearable hearing devices for mild to moderate HL (NASEM, 2016).

Almost serendipitously at the 2015 White House Conference on Aging, technology in the context of age-related mild to moderate HL was investigated as part of a larger focus on technology for older adults. In October 2015, The President’s Council of Advisors on Science and Technology (PCAST; 2015) published a report in a letter to the President that included multiple recommendations to improve access to hearing care, including the creation of a distinct category of “basic” hearing aids that could be purchased OTC.

Media interest heightened with the combination of an increasingly technologically advanced PSAP market, HL research focused on negative health outcomes, and attention from major scientific and policy parties. This combination increased public awareness of the issues surrounding hearing care. In addition, as the population aged, more older adults with HL became aware of their lack of options and the fact that Medicare did not support HL treatment. In addition, consumer groups, such as the Hearing Loss Association of America and AARP®, were emboldened and stepped up their efforts to advocate for hearing health care services.

These NASEM and PCAST reports received a great deal of attention from industry, the public, and Congress. Subsequently, in March 2017, Senator Warren, along with Senator Grassley, introduced Senate Bill 670, titled “Over-the-Counter Hearing Aid Act of 2017.” The bill amended Section 520 of the Federal Food, Drug, and Cosmetic Act (21 U.S.C. 360j) to incorporate a category of OTC hearing aids for individuals with mild to moderate HL and mandated that facilitating regulations be developed in no more than 3 years (Warren & Grassley, 2017). The bill passed and was subsequently incorporated into H.R. 2430, the FDA Reauthorization Act of 2017, which was signed into law by the President on August 18, 2017. The FDA has until 2020 to prepare the standards and regulatory process for OTC hearing aids.

Although this new legislation does not address insurance coverage, the purpose of these OTC hearing aids is to alter and complement the current model of access. OTC hearing aids will provide enhanced accessibility while also easing entrance into the hearing aid market for new companies. Market forces should contribute to lower costs and increased awareness as manufacturers are challenged to compete and market their products. Further, this legislation may also help alter the practice of audiologists by allowing them to focus more on aural rehabilitation, assisting individuals with developing enhanced communication strategies and more effectively handling their HL overall, as the sale of hearing aids for many individuals will be separated from the provision of services.

**IMPLICATIONS OF THE OTC LEGISLATION FOR NURSES AND NURSING PRACTICE**

Changing policy involves far more than developing a policy statement or bill, even if the policy addresses an obvious need. Instead, policy changes with the coalescence of multiple forces. Importantly, the NASEM report, with its extensive analysis, brought the issue of HL to the fore as a public health issue. HL is a vital issue for nurses who care for older adults, as many older adults have some degree of HL. As advocates, nurses can play a critical role in promoting appropriate care and access for individuals with HL who need traditional hearing aids. Although OTC hearing aids may enhance access, health care professionals should continue to advocate for insurance coverage for hearing aids to completely remove cost as a barrier...
and improve services to maximize the benefit of hearing aids. Despite the fact that, dating back over 40 years, proposals for Medicare to cover hearing aids have failed due to concerns about the cost, advocates propose that hearing care provided by Medicare could be preventive in nature (i.e., reducing social isolation) and reduce long-term costs (Willink et al., 2017). More data are accumulating that support the cost-effectiveness of coverage to health care, but these data have been difficult to obtain and slow to produce. Concurrently, research exploring how hearing aid use impacts health outcomes, such as cognitive decline and other negative health effects, could alter Medicare’s stance on the medical necessity of hearing aids.

As frontline providers, nurses will play a key role in shaping the immediate future of hearing care, especially in the framework of OTC hearing aids. The Table provides a checklist for addressing hearing loss in the health care system. Nurses can contribute by screening for HL in all health care settings using simple methods such as asking questions related to difficulty hearing combined with either a standardized finger rub or whisper test (Strawbridge & Wallhagen, 2017). Upon screening, nurses are in a key position to help older adults navigate the new hearing care model. As noted above, OTC hearing aids will target individuals with mild and moderate HL. Further, comfort with technology and health literacy may be required to self-fit a device. Nurses are well-suited to help individuals discern whether this new category of hearing aid is appropriate for their HL and whether they would be comfortable using an OTC device or whether traditional services are a better route.

Screening has implications beyond identification and advising on next steps. HL has direct implications for patient–provider communication in the clinical setting. Poor communication and misunderstandings related to hearing impairment are associated...
with poor treatment adherence and can result in negative health outcomes (Zolnierek & DiMatteo, 2009). The Table outlines technological and communication strategies that nurses can use to help overcome HL in the health care setting. Moreover, nurses should take a lead role in championing the awareness of HL among all providers and staff to improve patient–provider communication.

We are entering a new era for hearing care. The importance of hearing to general as well as cognitive health is finally being acknowledged, and models of care are being challenged in ways that will allow a broader array of individuals with HL to obtain services. These changes bring important opportunities for nurses to understand the importance of hearing alone and also advance new models of care to enhance the quality and safety of care received by older adults and their families.

REFERENCES


