REPORT OF THE
SPECIAL ADVISORY COMMISSION ON MANDATED
HEALTH INSURANCE BENEFITS

# SENATE JOINT RESOLUTION 426 STUDY OF HEARING AID COVERAGE FOR SMALL CHILDREN

TO THE GOVERNOR AND
THE GENERAL ASSEMBLY OF VIRGINIA

COMMONWEALTH OF VIRGINIA
RICHMOND
2004

January 6, 2004

To: The Honorable Mark R. Warner
Governor of Virginia
and
The General Assembly of Virginia

The report contained herein has been prepared pursuant to §§ 2.2-2504 and 2.2-2505 of the Code of Virginia.

This report documents a study conducted by the Special Advisory Commission on Mandated Health Insurance Benefits to assess the social and financial impact and the medical efficacy of Senate Joint Resolution 426 regarding a study of mandated hearing aid coverage for small children.

Respectfully submitted,

Stephen H. Martin
Chairman
Special Advisory Commission on
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## INTRODUCTION

The 2003 Senate Committee on Rules referred Senate Joint Resolution 426 to the Special Advisory Commission on Mandated Health Insurance Benefits (Advisory Commission). Senate Joint Resolution 426 is patroned by Senator Patricia S. Ticer.

The Advisory Commission held a public hearing on August 4, 2003 in Richmond to receive public comments on Senate Joint Resolution 426. In addition to the bill's chief patron, two interested parties spoke in favor of Senate Joint Resolution 426. One of the speakers was representing the interests of the Virginia Association of Speech-Language-Pathologists. Another speaker, who is hearing impaired and is involved in many hearing associations, provided testimony. The final speaker represented the Virginia Association of Health Plans (VAHP) and was opposed to the proposed legislation.

Additional public testimony was received at the November 17, 2003 meeting of the Advisory Commission. Six speakers provided testimony in support of Senate Joint Resolution 426. Two speakers were parents of children with hearing impairments. Two were audiologists providing a perspective of helping children with hearing aids. The fifth speaker was a member of the hearing impaired community who is also involved in many hearing associations. The final proponent was a physician. One speaker, representing VAHP, spoke in opposition of Senate Joint Resolution 426.

In addition, three letters were received by the Advisory Commission addressing Senate Joint Resolution 426. Information in the form of a letter was presented to the Advisory Commission that supported Senate Joint Resolution 426. Another letter was received that stated its overall opposition of mandates, including Senate Joint Resolution 426. A letter from the State Health Commissioner outlined the state programs that provide hearing aid assistance.

## SUMMARY OF PROPOSED LEGISLATION

The resolution requires the Advisory Commission to examine the cost of providing hearing aids to children under age 5. The resolution specified that the Advisory Commission consider the effect of providing hearing aids on health insurance premiums; the effects on the speech, language, and emotional development of children who have not had hearing aids before age 5; the costs of providing special services to children who are deaf and hard-of-hearing; the additional costs of educating children who are deaf and hard-of-hearing; and any other matter the Commission deems relevant to a cost/benefit analysis of providing hearing aids to children.

## HEARING LOSS

The National Institute on Deafness and Other Communication Disorders (NIDCD) reports that there are approximately 28 million Americans who have a hearing impairment. Hearing loss is one of the most prevalent chronic health conditions in the United States, affecting those of all ages, in all segments of the population, and across all socioeconomic levels. Hearing loss affects approximately 17 in 1,000 children under age 18.[i] Information provided to staff by the Virginia Department for the Deaf and Hard of Hearing indicated that there are approximately 615,000 people with some degree of hearing loss in Virginia. Approximately 1% of these 615,000 are considered to be profoundly deaf, and 7.7% are considered to be hard of hearing. The rest are considered to have mild to moderate hearing loss.[ii]

Hearing loss and deafness affect individuals of all ages and may occur at any time from infancy through old age. The U.S. Department of Education (2001) reports that, during the 1999-2000 school year, 71,671 students aged 6 to 21 (or 1.3% of all students with disabilities) received special education services under the category of "hearing impairment." However, the number of children with hearing loss and deafness is undoubtedly higher, since many of these students may have other disabilities as well and may be served under other categories. [iii]

Hearing loss or deafness does not affect a person's intellectual capacity or ability to learn. However, children who are either hard of hearing or deaf generally require some form of special education services in order to receive an adequate education. Such services may include:

- regular speech, language, and auditory training from a specialist;
- amplification systems;
- services of an interpreter for those students who use sign language;
- favorable seating in the class to facilitate lip reading;
- captioned films/videos;
- assistance of a note-taker, for the student with a hearing loss, so that the student can fully attend to instruction;
- instruction for the teacher and peers in alternate communication methods, such as sign language; and
- counseling. [iv]

Children who are hard of hearing will find it much more difficult than children who have normal hearing to learn vocabulary, grammar, word order, idiomatic expressions, and other aspects of verbal communication. For children who are deaf or have severe hearing losses, early, consistent, and conscious use of visible communication modes (such as sign language, finger spelling, and Cued Speech) and/or amplification and aural/oral training can help reduce this language delay. By age four or five, most children who are deaf are enrolled in school on a full-day basis and do special work on communication and language development.[v]

### ADDITIONAL HEARING FACTS

- Everyday in the United States, approximately 1 in 1,000 newborns (or 33 babies every day) is born profoundly deaf with another 2-3 out of 1,000 babies born with partial hearing loss, making hearing loss the number one birth defect in America.

- Newborn hearing loss is 20 times more prevalent than phenylketonuria (PKU), a condition for which all newborns are currently screened.

- Of the 12,000 babies in the United States born annually with some form of hearing loss, only half exhibit a risk factor – meaning that if only high-risk infants are screened, half of the infants with some form of hearing loss will not be tested and identified. In actual implementation, risk-based newborn hearing screening programs identify only 10-20% of infants with hearing loss. When hearing loss is detected beyond the first few months of life, the most critical time for stimulating the auditory pathways to hearing centers of the brain may be lost, significantly delaying speech and language development.

- Only 69% of babies in the U.S. are now screened for hearing loss before 1 month of age (up from only 22% in 1998). Of the babies screened, only 56% who needed diagnostic evaluations actually received them by 3 months of age. Moreover, only 53% of those diagnosed with hearing loss were enrolled in early intervention programs by 6 months of age. As a result, these children tend to later re-emerge in our schools' special education (Individuals with Disabilities Education Act, Part B) programs.

- When children are not identified and do not receive early intervention, special education for a child with hearing loss costs schools an additional $420,000, and has been estimated to have a lifetime cost of approximately $1 million per individual.[vi]

### MEDICAL EFFICACY

The Virginia Department of Health (VDH) explained what sounds a child can and cannot hear without amplification based on the degree of hearing loss. A resource guide from VDH explained how amplification may benefit a child and the potential effects on a child's speech and language development. The child's audiologist, speech-language pathologist, teacher, or other trained professional would be able to provide more detailed information.[vii]

A child with a loss of 16-25dB is considered to have minimal hearing loss. The child may have difficulty hearing quiet or distant speech in noisy environments. A child with a loss of 26-40dB is considered to have mild hearing loss, which means he hears most sounds, but misses fragments of words, like those that contain “s”, “f”, and “th”. A child with mild hearing loss may be helped, with proper amplification, to understand spoken communication at close distances. Moderate hearing loss children are those with 41-55dB hearing loss. With adequate amplification, these children should be able to hear and discriminate all sounds. Without the amplification, 50-100% of sounds may be missed and can affect speech development.[viii]

A loss of 56-70dB is considered moderately severe, and the child cannot understand conversation, unless the intensity is very loud. Severe hearing loss for children is at 71-90dB loss and without amplification, these children may be aware of loud voices near the ear. Spoken language for these children will not develop unless modifications and interventions are taken. With optimal amplification, these children should be able to detect all sounds of speech and environmental sounds. Profound hearing loss exists for children with loss at 91dB or greater. These children are aware of vibrations more than tonal pattern, and rely on vision rather than hearing as their primary avenue of communication and learning. Their speech and oral language will not develop without amplification and intervention, and their speech intelligibility is often greatly reduced and atonal voice quality is likely.[ix]

The following paragraphs are excerpts from the Consensus Statement of the National Institutes of Health (NIH) for Early Identification of Hearing Impairment in Infants and Young Children (1993):

## Early Testing

> The earlier that deafness or hearing loss is identified, the better the chances a child will acquire language, whether spoken or signed. A hearing screening can be an important indicator of deafness or hearing loss in a child. For this reason, all infants should be screened while still in the hospital or within the first month of life. But, children who do not pass their screening need to go for a follow-up examination.[x]
>
> The follow-up examination includes precise audiological testing that confirms the extent and type of hearing loss. It also allows parents, health professionals, and teachers to determine the best intervention strategy for the child. The term intervention refers to the different steps that families can take to overcome

communication barriers caused by a hearing loss. When intervention is introduced early, the child can take advantage of the unique window of opportunity during the first few years of life when a person acquires language, whether spoken or signed.[xi]

The primary justification for early identification of hearing impairment in infants relates to the impact of hearing impairment on speech and language acquisition, academic achievement, and social/emotional development. The first 3 years of life are the most important for speech and language acquisition. Consequently, if a child is hard of hearing or deaf at birth or experiences hearing loss in infancy or early childhood, it is likely that child will not receive adequate auditory, linguistic, and social stimulation requisite to speech and language learning, social and emotional development, and that family functioning will suffer. The goal of early identification and intervention is to minimize or prevent these adverse effects.[xii]

## Consequences of Non-Testing

The consequences of hearing impairment are many. Animal studies show that early auditory deprivation interferes with the development of neural structures necessary for hearing. Human infants with hearing loss, particularly those with sensorineural impairments, may experience similar disruptions that will have a direct impact on language acquisition. Significant hearing loss interferes with the development of phonological and speech perception abilities needed for later language learning, e.g., meaningful language at the word, phrase, and sentence levels. These impairments in communication skills can lead to poor academic performance (especially reading), and ultimately, to limitations in career opportunities.[xiii]

The degree and type of hearing impairment impact a child's development. Other factors can further exacerbate the consequences of hearing impairment. For example, some children have additional sensory disabilities and/or associated neurological disorders that further interfere with perceiving and processing information. Environmental factors, such as the quality of language input provided by the parents, can either facilitate or impede communication skills. Socioeconomic-related factors, such as the lack of access to health care, other associated health problems, high-risk populations, and social stresses, also may exacerbate the consequences of deficits. Early identification and intervention can address these factors, thus minimizing their effects.[xiv]

## When Children Should Be Screened

It is clear that the earliest possible identification of hearing-impaired infants is optimal for effective intervention to improve communication skills, language development, and behavioral adjustment. Identification of all children with hearing impairment at birth is ideal. As a practical matter, the cost of universal screening has been prohibitive. Attempts have been made to limit costs by focusing neonatal testing on those at highest risk. Unfortunately, research shows that this approach misses 50 percent of children who are eventually diagnosed with severe to profound hearing impairment. In spite of current screening programs, the average diagnosis of hearing impairment remains constant at about 2-1/2 years of age. In order to meet the goal of the Joint Committee on Infant Hearing to identify and initiate treatment by 6 months of age and to more completely identify hearing-impaired infants, we must dramatically change our approach to screening.[xv]

Some changes can be made in auditory screening procedures that would have a minimal effect on cost but would increase identification rate. Data has shown that infants admitted to the neonatal intensive care unit (NICU) have an increased risk of significant bilateral sensorineural hearing loss (1-3 percent); the addition of other neonatal high-risk factors does not add significantly to the identification of hearing loss. *Consequently, we recommend that all infants admitted to the NICU be screened for hearing loss prior to discharge*. To improve the accuracy and efficiency of the test, screening should take place as close to discharge as possible. Infants in the well-baby nursery with diagnoses of craniofacial anomalies, family history of hearing loss, and diagnosis of intrauterine infection comprise a special high-risk category. Thus, they should be screened using the same protocol and follow-up vigilance as the NICU population.[xvi]

*In addition to screening all NICU babies, we strongly recommend that universal screening be implemented for all infants within the first 3 months of life*. Recent data suggest that this will virtually complete our identification of newborns with hearing impairment. Even though we recommend universal screening within the first 3 months, as a practical matter this is most efficiently achieved by screening prior to discharge from the well-baby nursery. The disadvantages of hospital well-baby screening, such as missed screening because of early discharge and the possibility of higher false-positive rate, are outweighed by the accessibility of all newborns to testing at this time. The addition of screening in the well-baby nursery and as a part of well-baby care will increase cost. The benefit, however, is likely to be high. For well-baby screening

> to be cost effective, we recommend techniques that are rapid, reliable, highly sensitive, specific, and easily administered by trained and supervised personnel. Infants who are not screened in the hospital should be screened by 3 months of age.[xvii]

## The Best Screening Methods

> The panel identified two techniques -- EOAE and ABR -- as showing maximal promise as universal screening tools for the newborn. As noted earlier, each has its unique advantages and disadvantages. Weighing the evidence presented, the panel felt that EOAE shows best promise as a rapid, cost-effective means of quickly discharging all babies with normal auditory systems. In keeping with its high sensitivity, however, the EOAE lacks adequate specificity. It fails a relatively large number of babies whose hearing sensitivity is, in fact, normal. In order to prevent the majority of these "false alarms" from burdening the system for follow-up diagnostic evaluation, a second or confirmatory screen seems desirable. The panel felt that this goal would be best achieved by a second-stage ABR screen of all babies who fail the EOAE screen. Thus the preferred model for universal screening begins with an initial screen by EOAE. All babies who pass this screen are discharged. All babies who fail, however, are rescreened by ABR. Babies who pass the ABR screen are discharged but should be flagged for rescreen at 3-6 months. Babies who fail the ABR screen are referred for diagnostic evaluation. The purpose of the follow-up diagnostic evaluation is twofold: (1) to verify the existence and to determine the type and severity of hearing impairment and (2) to initiate a remediation program for the child and family.[xviii]
>
> It should be emphasized that only a small percentage of the total number of babies screened experiences both stages of the total screening process. If the specificity of the EOAE screen is taken as 90 percent, then 90 percent of the babies screened are discharged after the first (EOAE) stage. Only the 10 percent who fail the EOAE stage will undergo the second, ABR, stage. The roles of the two stages, EOAE and ABR, are viewed as complementary. The first, EOAE, rapidly and inexpensively rules out significant hearing impairment (99.9 percent of all babies), but has limited specificity. The second, ABR, appears to require more time and effort, but has the potential to identify failure with better specificity.[xix]

## VIRGINIA'S NEWBORN HEARING SCREENING PROGRAM

The Virginia Department of Health (VDH) has the responsibility to identify hearing loss in infants in the Commonwealth of Virginia. Section 38.2-3411.4 of the Code of Virginia requires all infants born in Virginia hospitals to be given a hearing screening before discharge from the hospital, and for the results to be disclosed to the parents, the child's primary health care provider, and the VDH. This requirement was imposed in furtherance of the belief that when children are identified early on with hearing loss and receive intervention services to develop signed or spoken word, they have the best chance to learn.

Below is a summary of statistics for infants born in Virginia between January 1, 2001 and December 31, 2001.

- Number of Live Births: 96,535

- Number of Infants Screened: 91,849(95.1%)

- Number of infants who did not pass the screening: 3,472(3.8%)
  Number receiving follow-up:2,459(70.8% of referred babies)

- Number who passed screening, but at-risk for progressive late-onset hearing loss: 2,381(2.6%)Number receiving follow-up:187(7.8% of all at-risk babies)

- Number of children born in 2001 who have been identified with hearing loss: 55

  54 of these children were screened through a Newborn Hearing Screening Program
  Average age at diagnosis: 5.1 months
  Median age at diagnosis*: 4.75 months
  Minimum age at diagnosis: 0.25 months
  Maximum age at diagnosis: 11.0 months [xx]

## REGULATIONS AFFECTING THE HEARING AID INDUSTRY

In Virginia, Hearing Aid Specialists are regulated by The Virginia Department of Professional and Occupational Regulation, Board for Hearing Aid Specialists (The Board). The Board defines a hearing aid specialist as "a person who engages in the practice of fitting and dealing in hearing aids or who advertises or displays a sign or represents himself as a person who practices the fitting and dealing of hearing aids." A licensee means "any person holding a valid license issued by the Board for Hearing Aid Specialists for the practice of fitting and dealing in hearing aids, as defined in § 54.1-1500 of the Code of Virginia." As of July 1, 2003, the Board reported there were 438 licensed hearing aid specialists in Virginia.[xxi]

The Virginia Department of Health Professions (The Department) regulates audiologists and speech-language pathologists. The Department defines an audiologist as one who practices "conducting measurement, testing and evaluation relating to hearing and vestibular systems, including audiologic and electrophysiological measures, and conducting programs of identification, hearing conservation, habilitation, and rehabilitation for the purpose of identifying disorders of the hearing and vestibular systems and modifying communicative disorders related to hearing loss including but not limited to vestibular evaluation, electrophysiological audiometry and cochlear implants."[xxii]

Speech-language pathologists are defined as those who "practice the facilitating development and maintenance of human communication through programs of screening, identifying, assessing and interpreting, diagnosing, habilitating and rehabilitating speech-language disorders, including but not limited to:

1. Providing alternative communication systems and instruction and training in the use thereof;

2. Providing aural habilitation, rehabilitation and counseling services to hearing-impaired individuals and their families;

3. Enhancing speech-language proficiency and communication effectiveness; and

4. Providing audiologic screening.

As of July 1, 2003, the Virginia Department of Health Professions reported there were 405 audiologists, 2,176 speech-language pathologists, and 76 speech-language pathologists in public schools in the Commonwealth of Virginia.[xxiii]

## CURRENT INDUSTRY PRACTICES

The State Corporation Commission's Bureau of Insurance surveyed sixty of the top writers of accident and sickness insurance in Virginia in April 2003, regarding the bills to be reviewed by the Advisory Commission in 2003. Fifty companies responded by the deadline. Thirteen companies indicated that they have little to no, applicable health insurance business in force in Virginia. These thirteen companies write few, if any, policies that are subject to insurance mandates. Of the remaining 37 companies, only 4 companies reported that they provided the coverage required by Senate Joint Resolution 426, under their standard benefit package. Thirty-three companies said they did not provide the coverage. Eight companies responded that they could provide the coverage on an optional basis to group policyholders.

Fourteen companies provided cost estimates of premium prices for providing the coverage for Senate Joint Resolution 426. Respondents to the survey provided cost figures of between $.09 and $.97 per month per standard individual policy. One company reported the cost to be .1%. Cost figures were between $.20 and $3.00 per month per standard group certificate, to provide the coverage required by Senate Joint Resolution 426. Again, one company reported the cost to be .1%. Seven companies providing cost figures for coverage on an optional basis estimated from $.02 to $2.23 per month per standard individual policy, and twelve companies estimated between $.02 to $3.00 per month per standard group certificate.

## FINANCIAL IMPACT

The Virginia Department of Education provided an analysis on the costs of educating students with hearing impairment. The latest figures, from the 2000-2001 school year, showed that there were 1,372 students statewide that were considered deaf or hard of hearing in Virginia public schools. The added cost for special education services for the deaf and hard of hearing children was a total of $20,315,757. That figure averages down to $14,807 per pupil for the added cost of instruction. That figure also averages down to $1,120 per pupil for the added cost support.[xxiv]

The average added cost per Special Education Student for those that were deaf or hard of hearing was $15,927. The average total cost for education for non-special education students was $6,632. The total average cost reported, per pupil, for special education students was $22,559. And the multiple or ratio of special education dollars to non-special education dollars spent was 3.40. The above-mentioned data does not include special education expenditures under the Comprehensive Services Act. The data is representative of all Virginia school divisions.[xxv]

Staff obtained information on hearing aid prices from the Department of Audiology at the Medical College of Virginia. The body aid style of hearing aid costs approximately $1,100. The range of prices for a Behind-the-Ear style is approximately $700 to $2,800. The In-the-Ear hearing aid prices are approximately $700 to $3,000. The In-the-Canal hearing aids costs range from $800 to $3,200. The Completely-in-Ear hearing aid costs range from $1,300 to $3,600. [xxvi]

The figures above are cost estimates that represent the prices for a single hearing aid. The audiologist explained that the costs of hearing aids vary depending upon the style of the hearing aid, the make of the hearing aid, and the circuitry inside the hearing aid. A discount of $100-$500 can often be obtained on these prices, when a second hearing aid is ordered at the same time.

## SIMILAR LEGISLATION IN OTHER STATES

According to information available to staff from the National Insurance Law Service and the National Association of Insurance Commissioners, 4 states currently have a mandate for hearing aids for those under age 18. Oklahoma requires group plans to cover audiological services and hearing aids for children up to 18 years of age. The benefit is limited to one hearing aid per hearing impaired ear every 4 years. Maryland requires insurers to cover “hearing aids for a minor child who is covered under a policy or contract, if the hearing aids are prescribed, fitted, and dispensed by a licensed audiologist.” Maryland’s coverage extends to $1,400 per hearing aid for each hearing impaired ear, every 36 months.

Connecticut requires insurers to provide coverage for hearing aids for children twelve years of age or younger. The coverage is considered durable medical equipment under the policy, and the policy may limit the hearing aid benefit to one thousand dollars within a twenty-four month period. Kentucky requires coverage for cochlear implants for people with profound hearing impairment. The coverage is limited to one hearing aid per hearing impaired ear, every 36 months. Rhode Island requires the offer of an optional rider to add hearing aid coverage to group policies. Also, 38 states provide infant hearing screenings for hearing loss.[xxvii]

## RECOMMENDATION

The Advisory Commission members unanimously (10-0) agreed to forward the study to the General Assembly.

## CONCLUSION

The Advisory Commission members believe that the report meets the requirements of the study resolution. The findings provide pertinent information on the social impact, medical efficacy, and financial impact of requiring insurers to provide coverage for hearing aids for children under age 5. The Advisory Commission members believe the report will be beneficial to the Commonwealth and should be forwarded to the General Assembly.

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[vii] Information for Parents of Children with Hearing Loss. May 2003. Virginia Department of Health, Virginia Department of Education, Virginia Department for Deaf and Hard of Hearing.

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[x] Consensus Statement for Early Identification of Hearing Impairment in Infants and Young Children. March 1993. National Institutes of Health.

[xi] Consensus Statement for Early Identification of Hearing Impairment in Infants and Young Children. March 1993. National Institutes of Health.

[xii] Consensus Statement for Early Identification of Hearing Impairment in Infants and Young Children. March 1993. National Institutes of Health.

[xiii] Consensus Statement for Early Identification of Hearing Impairment in Infants and Young Children. March 1993. National Institutes of Health.

[xiv] Consensus Statement for Early Identification of Hearing Impairment in Infants and Young Children. March 1993. National Institutes of Health.

[xv] Consensus Statement for Early Identification of Hearing Impairment in Infants and Young Children. March 1993. National Institutes of Health.

[xvi] Consensus Statement for Early Identification of Hearing Impairment in Infants and Young Children. March 1993. National Institutes of Health.

[xvii] Consensus Statement for Early Identification of Hearing Impairment in Infants and Young Children. March 1993. National Institutes of Health.

[xviii] Consensus Statement for Early Identification of Hearing Impairment in Infants and Young Children. March 1993. National Institutes of Health.

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