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Re*: **Request for Information on Medicare Advantage Data: CMS-4207-NC***

The American Academy of Audiology ("the Academy") is pleased to provide our observations and recommendations on increasing transparency and data insights into supplemental hearing benefits offered under the Medicare Advantage program. The Academy is the world's largest professional organization of, by and for audiologists. Representing the interests of audiologists in all practice settings, the Academy is dedicated to providing quality hearing care services through professional development, education, research, and increased public awareness of hearing and balance disorders.

Supplemental Hearing Benefits in Medicare Advantage Plans

A 2023 GAO report provides that hearing is the second most commonly offered supplemental benefit offered in Medicare Advantage (MA) plans with just over 94% of plans that offer at least one hearing benefit.[1] These hearing benefits are typically administered by a third-party administrator (TPA) that specializes in formulating and administering hearing care benefits. Most hearing health TPAs are owned, contracted or affiliated with major hearing aid manufacturers, retailers and/or distributors. MA plans or insurers choose to utilize these specialized TPAs precisely because these entities have more in-depth knowledge of the benefit and many times are able to create and deploy provider networks. However, this construct also creates a situation in which there is a distinct disconnect between the actual insurer/plan and the individual supplemental benefit.

[1] GAO-23-105527 Medicare Advantage Supplemental Benefits

Supplemental Hearing Benefits: Benefit Design and Cost to Consumer

Although the majority of MA plans do offer a hearing benefit, the amount and/or terms of that benefit may vary widely from plan to plan. Depending on the exact MA plan and the TPA that administers the benefit, the allocated amount per beneficiary for a hearing aid and related services may vary from 2K, 5K or $750 per annum. In addition, the coverage levels for fittings and maintenance services are also inconsistent and many times unclear to the beneficiary. In spite of the existence of coverage, significant out-of-pocket (OOP) costs may still remain. According to a 2021 report conducted by the Kaiser Family Foundation on hearing, vision and dental benefit offerings in Medicare Advantage, "the average annual out-of-pocket spending was $914 for hearing care."[2]

The existence of significant OOP costs for these beneficiaries in large part stems from terminology used by the insurer/TPA that causes consumer confusion. Some of the coverage offered in MA plans is not an actual funded benefit but rather a discount plan. Some MA plans provide members access to discounted prices on hearing aids and related services. The plan may not cover the entire cost of the hearing aid, and beneficiaries still need to pay for the discounted amount out of pocket. Many times, this OOP amount is mischaracterized by the insurer/TPA as a "co-pay" rather than a true out-of-pocket expense. Other MA plans offer a true funded benefit or more comprehensive offering that covers a portion or the full cost of hearing aids and related services up to a certain limit or maximum amount. A significant problem and example of a lack of transparency is the fact that most consumers do not recognize the difference between these types of benefit and do not fully appreciate the ramifications that this may have on OOP costs.

Limits on Patient Choice of Device and Provider

In many MA plans, consumers are limited to very specific types or brands of hearing aids. These restrictions may not be in the best interest of the consumer as different brands and models typically offer different technologies, functionalities and fit. In addition, in many MA plans, there is

[2] Dental, Hearing, and Vision Costs and Coverage Among Medicare Beneficiaries in Traditional Medicare and Medicare Advantage | KFF

no direct access to the benefit. A consumer is directed to access their hearing benefit but contacting the TPA and is then "referred" to a participating provider. It is unclear as to how this referral process is structured. This practice significantly limits patient choice of provider and also creates a situation in which there is little to no transparency into the actual makeup and extent of the provider network.

Supplemental Hearing Benefits: Restrictions on Audiologists/Providers

Many audiologists participate in Medicare Advantage plans as providers of hearing and vestibular healthcare. However, because of the fact that hearing aid benefits are administered by a TPA, there are audiologists that may be "in-network" with the insurer or MA plan but "out of network" with the TPA that administers the hearing aid benefit for the plan. This results in consumer confusion as well as fragmented patient care. The Academy understands that Medicare Advantage differs significantly from traditional Medicare in that the MA plan may use limited networks to contain costs. However, these hearing aid benefits that are administered by TPAs are a subset of an already limited provider network and many audiologists report difficulties in gaining access to some of these networks. These "micro" networks many times have a deleterious effect on patient access to their benefit.

Problematic Contractual Terms

Many TPA contracts include problematic contractual terms that have may have a negative impact on the provider as well as the patient. Many of these TPA contracts condition participation in one network with an obligation to participate in one or more additional networks with contractual terms that may not be advantageous. For example, there are certain TPA contracts that include verbiage that prohibits participating providers from even discussing devices or technologies or services that are not covered under the benefit offering. Finally, there are some TPA contracts that dictate what providers may charge for non-covered services (additional diagnostic tests) that may be in the best interest of the patient.

Discussion and Recommendations

The Academy has been pleased to note recent CMS efforts to obtain encounter data on supplemental benefits. Gaining additional information and data on the number of beneficiaries who avail themselves of supplemental hearing benefits will be valuable information that can be used to inform future policy proposals. In addition, the recent finalization of a proposal to require MA plans to send enrollees annual personalized notices regarding supplemental benefits they have not accessed in the first six months of the year as well as details on the scope of the benefit, cost sharing and instructions on how to access the benefit is a promising development.

Increasing Transparency

Most consumers do not clearly understand the parameters of their supplemental hearing benefit. As outlined earlier in these comments, the amount of the benefit and the plan design for supplemental hearing benefits vary widely from plan to plan. Beneficiaries do not understand the difference between a true funded benefit versus a discount plan and thus may be surprised by out-of-pocket costs that they may incur. MA plans/TPAs should be required to clearly outline the parameters of any hearing benefit including the nature of the benefit, and potential out-of-pocket costs, limits on types of devices offered and the extent of any maintenance/fitting services that may or may not be included. Provider network listings for supplemental hearing benefits should be readily available to beneficiaries and the TPA should not be allowed to serve as the only point of contact for beneficiaries to access their benefit. Audiologists that are in-network with the MA plan should also have the option to be included in the network for the hearing aid benefit as well. This would create greater integration and continuity between the MA plan/TPA and the provider.

Contractual terms binding the provider should not stifle the provision of professional advice and recommendations that are in the best interest of the patient. In addition, contractual terms should not “tie” providers to participation in other, non-advantageous contracts or networks nor dictate the cost or charge of non-covered services.

Proposal to Standardize Certain Supplemental Benefits

The Medicare Payment Advisory Commission (MedPAC) has recently started a discussion around the potential standardization of certain supplemental benefits (hearing, vision and dental) benefits in Medicare Advantage (MA). The initial proposal outlines (1) Separate standard and high options for hearing and vision; (2) Standard set of items and services; (3) Identical benefits: different provider network types (HMO and PPO) and (4) Standards set by regulation (flexible and could be revised). Requiring plans to provide standardized information regarding the hearing aid benefit design and value of the benefit would help consumers make an "apples to apples" comparison.

Conclusion

Increased transparency around the nature and amount of the hearing benefit and the professional services included is needed to provide consumers with the requisite information necessary to make an informed decision. In addition, provider network listings should be readily available and consumers should have the ability to choose their provider. TPA contracts should not constrain the professional judgement of the audiologist/provider in discussing appropriate clinical treatment options nor should they include provisions that unfairly bind the audiologist to participation in other contracts/networks. Finally, there should be greater connectivity between the insurer/plan and the TPA that is charged with administering the benefit. If you have any questions regarding any of the information included in these comments, please contact Susan Pilch, Senior Director of Government Relations at spilch@audiology.org.

Sincerely,

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