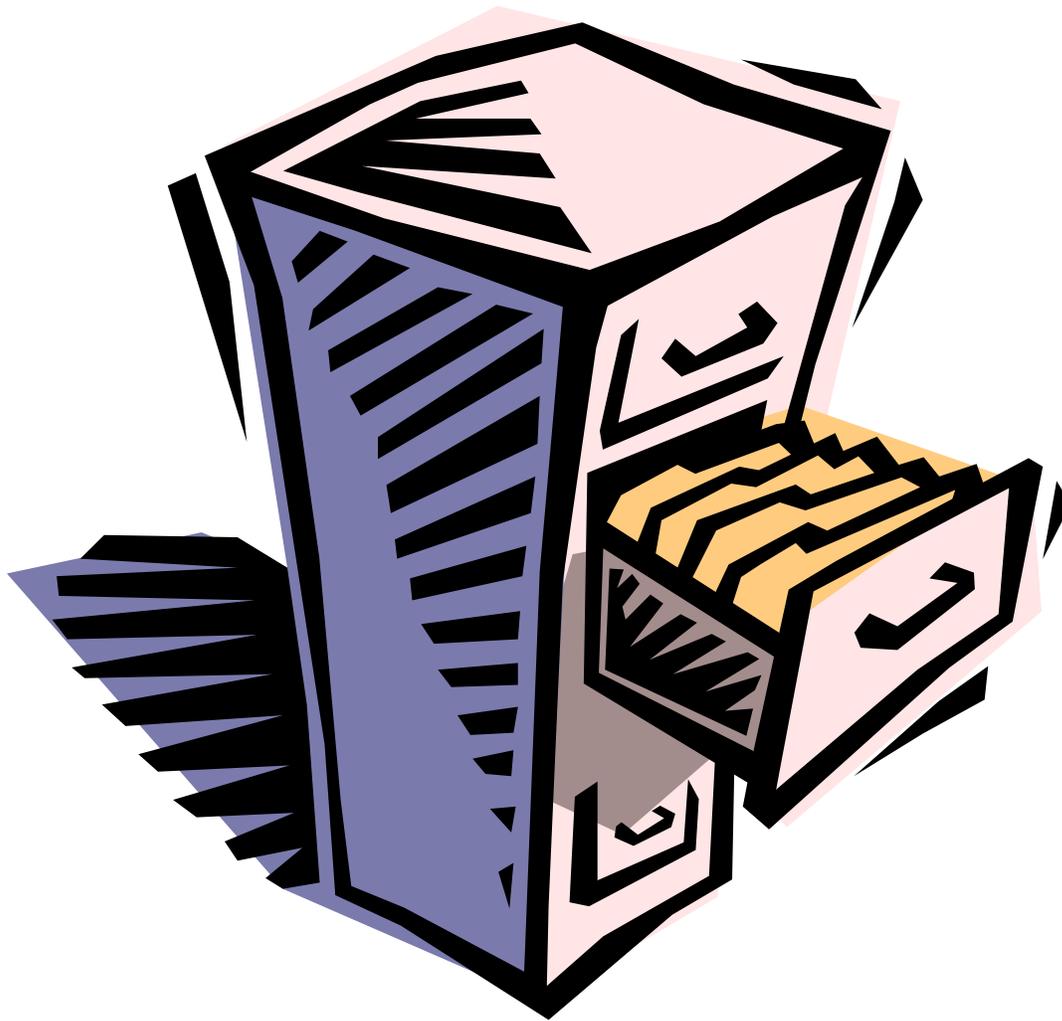


Hearing Aid Appeals Information Packet: Information for Parents with Self-insured Health Plans



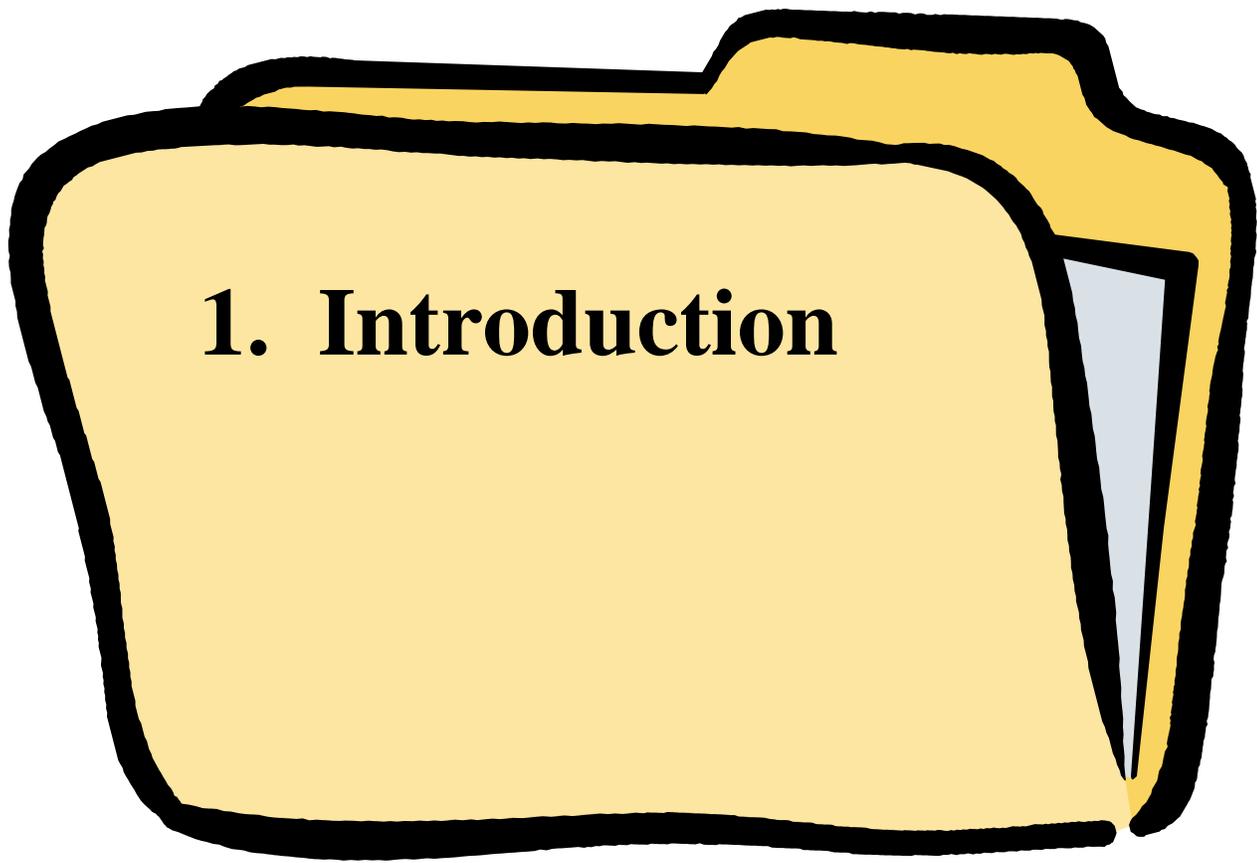
Minnesota Department of **Human**

Deaf and Hard of Hearing Services – Metro

Site Address: 85 East Seventh Place, Suite 105 downtown St. Paul *Mailing Address:* 444 Lafayette Road North, St. Paul, MN 55155-3814
651.431.5940 Voice 1.888.206.6513 TTY 651.431.7587 Fax

Equal Opportunity Employers

Updated Feb. 2011



1. Introduction



Minnesota Department of **Human Services**

Thank you for contacting Deaf and Hard of Hearing Services (DHHS) for the hearing aid appeals information packet. For six years the Minnesota Commission Serving Deaf and Hard of Hearing People (MCDHH) attempted to get a hearing aid bill passed in Minnesota. In 2003, with the help of parent advocates, the commission succeeded. The bill was then amended in 2007.

While this legislation has helped many parents obtain hearing aids for their children, ERISA (a federal law) excludes self-insured plans from following any state mandates for health coverage. As a result, parents who work for employers with self-insured health plans have received denial letters when requesting payment for their child's hearing aids. DHHS staff assembled materials that may assist parents who want to appeal the decision. Appealing does not guarantee that employers will add hearing aids to their plans, but at least parents know they've tried to make a change that will benefit not only their child, but perhaps a co-worker's child, too. DHHS thanks the people who graciously allowed us to use their materials in this information packet.

And now, a brief explanation about the contents of this information packet:

Minnesota Statute 62Q.675 (Updated 2007)

This law requires insurance companies that provide coverage in Minnesota to include hearing aids for children birth through 18.

Complaint Resolution Process

This document was prepared by the Minnesota Department of Commerce and summarizes the complaint resolution process for hearing aids.

Appeal Letters to Insurance Company

Written by parents and sent to their insurance company.

Requesting an Employer to Add Hearing Aid Benefits to Insurance Coverage

Written by parents whose employers are **self-insured**. In this situation it's the employers who make the final decision about adding hearing aids to their health plan. Appeals should be directed to them.

Letter to the First Lady

Just in case you wish to send a letter to the First Lady, here is a letter written by a parent. If you wish, this same type of letter could be sent to your Representatives and Senators in Washington, D.C.

Support Documents

These documents may help in explaining the impact of hearing loss and what *may* happen if corrective measures such as hearing aids are not provided. Please do not feel you have to include all of them – pick the ones you think will help support your letter.

Included are:

Deaf and Hard of Hearing Services – Metro

Site Address: 85 East Seventh Place, Suite 105, downtown St. Paul *Mailing Address:* 444 Lafayette Road North, St. Paul, MN 55155-3814
651.431.5940 Voice 1.888.206.6513 TTY 651.431.7587 Fax

Equal Opportunity Employers

- Testimonies given during the 2003 Legislative Session, *prior* to passing Minnesota Statute 62Q.675
- Audiogram (includes pictures of common environmental sounds and speech sounds)
- Audiogram (shows the speech banana)
- Cost of Hearing Aids vs. Education, Speech & Social Services
- Comparing the Cost of Hearing Aid Purchases vs. Speech Therapy Costs
- Possible Effects of Hearing Loss
- Effects of Hearing Loss
- Facts and Figures About Hearing Loss in Children
- Contacting Your State Legislator
- Websites (certainly not an all inclusive list, but will get you started)
- Impact of Varying Degrees of Hearing Loss.

Staff at Deaf and Hard of Hearing Services (DHHS) hope that you find the information packet helpful. If you have any questions, please contact your local Deaf and Hard of Hearing Services office.

DHHS - Metro

St. Paul
 651-431-5940 (VOICE)
 888-206-6513 (TTY)
dhhs.metro@state.mn.us

DHHS – Northwest

Moorhead
 800-456-7589 (VOICE)
 866-488-3829 (TTY)
dhhs.moorhead@state.mn.us

DHHS – Northeast

Duluth
 888-234-1322 (VOICE)
 866-488-3833 (TTY)
dhhs.duluth@state.mn.us

DHHS – Central

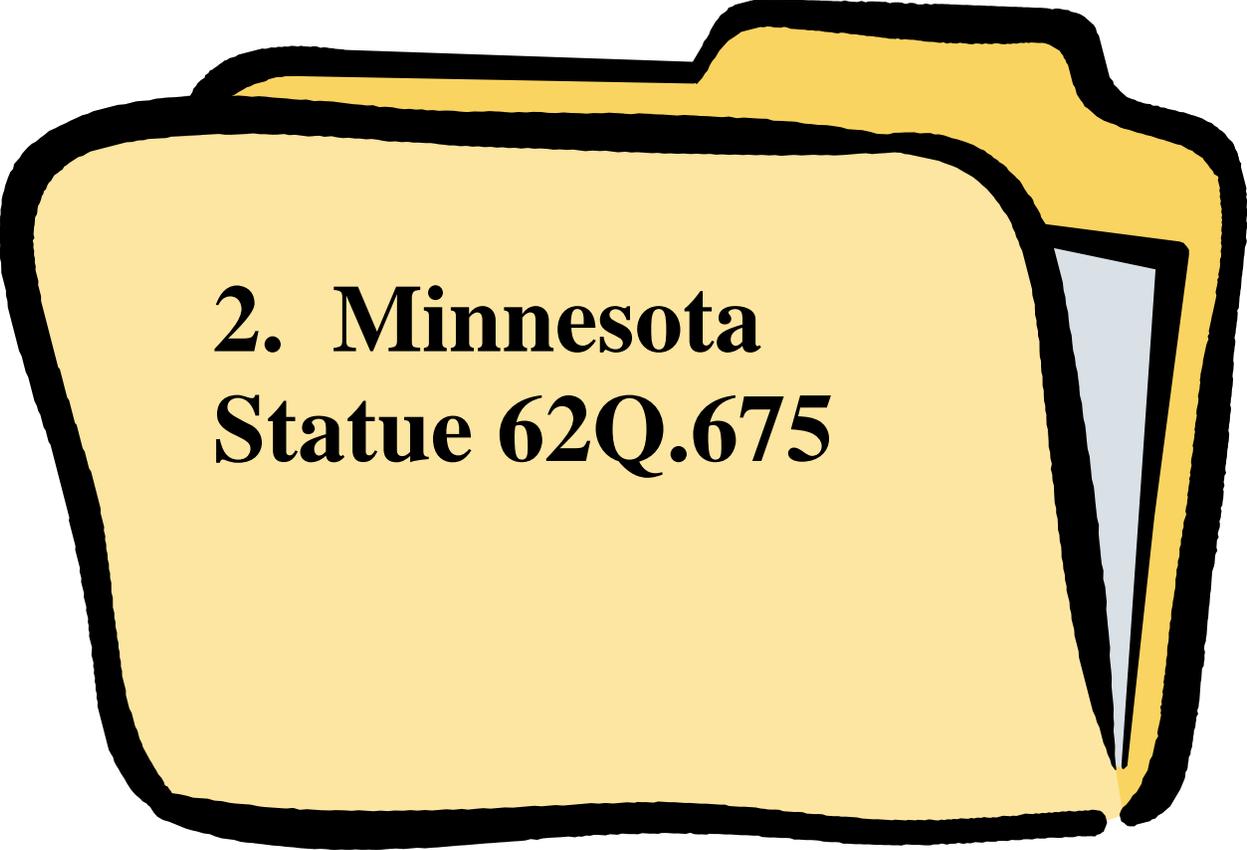
St. Cloud
 800-456-3690 (VOICE)
 866-488-3909 (TTY)
dhhs.stcloud@state.mn.us

DHHS – Northeast

Virginia
 888-234-1322 (VOICE)
 866-488-3997 (TTY)
dhhs.virginia@state.mn.us

DHHS - Southwest

Mankato
 800-311-1148 (VOICE)
 866-266-2461 (TTY)
dhhs.mankato@state.mn.us



**2. Minnesota
Statue 62Q.675**

62Q.675 of the Minnesota Statutes (amended in 2007)

This section is effective August 1, 2007, and applies to policies, contracts, and certificates issued or renewed on or after that date.

The number and language of the statute is as the followings:

[62Q.675] [HEARING AIDS; PERSONS 18 OR YOUNGER.] A health plan must cover hearing aids for individuals 18 years of age or younger for hearing loss that is not correctable by other covered procedures. Coverage required under this section is limited to one hearing aid in each ear every three years. No special deductible, coinsurance, co-payment, or other limitation on the coverage under this section that is not generally applicable to other coverages under the plan may be imposed.

NOTE:

It is important that you contact your human resource department to determine if your health plan is fully-insured or self-insured. A fully-insured health plan means the employer purchased health coverage from an insurance company or HMO. A self-insured health plan means the employer pays all of the health care costs themselves for employees and their dependents.

This legislation does NOT apply to employers who are self-insured. Most large employers in this country are self-insured. When an employer is self-insured, ERISA (a federal law) excludes them from state mandates for health coverage. ERISA was created to encourage employers to provide voluntary health coverage for employees. (**NOTE:** See Page 2 for more information about ERISA.)

If your employer is self-insured, you should request coverage for your child's hearing aids. Once you receive a letter that denies coverage, you have 90 days to appeal. In your appeal, use compelling arguments as to why your child should receive the coverage. The materials included in this packet will help you explain why hearing aids are so important for children.

If you talk to the insurance company or HMO, always get the name, title and phone number/extension of the person you talk to. If you decide to file a complaint or an appeal, it is important to have all conversations documented with the information mentioned above. You may also want to include the date and time you spoke to the individual.

The Minnesota Department of Commerce has contacts with all the insurance companies in this country, all Minnesota HMOs, and most of the Third Party Administrators (TPA) who administrate a self-insured employer's health plan. Department of Commerce is available to assist you. Their phone numbers are 651-296-2488 or 1-800-657-3602.

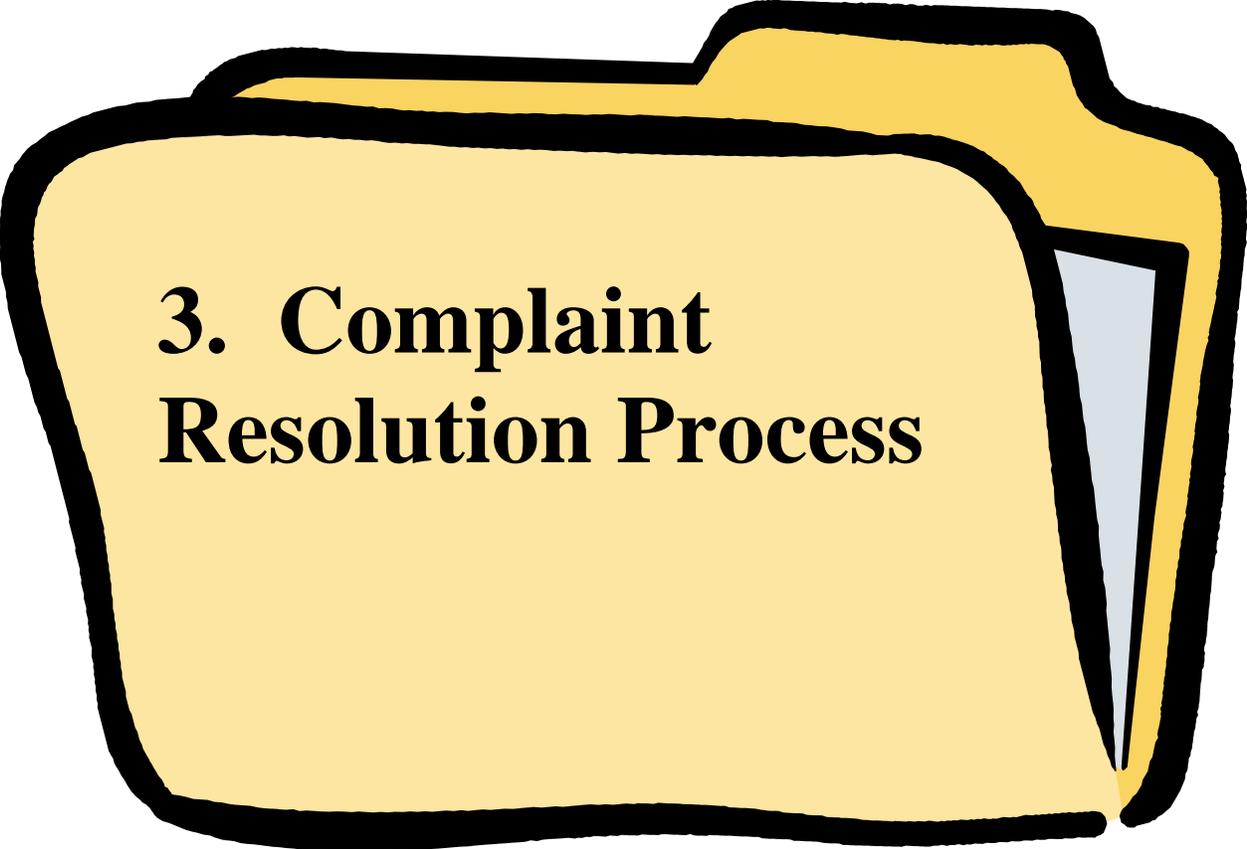
To view and/or print the statute directly from the Minnesota Statutes website, go to: www.revisor.mn.gov/ Type in **62Q.675** in the *Retrieve by number* field on the left, and then click on the *Retrieve* button.

The following was taken from the American College of Emergency Physicians (ACEP) website.

ERISA

Main Points

- The Employee Retirement Income Security Act of 1974 (ERISA) is a federal law that gives states the right to regulate insurance and exempts self-insured (or self-funded) health plans (any employee benefit plans) from state laws. It was designed to allow corporations operating in several states to have one set of rules to govern their health plans, rather than 50 separate sets of rules. It was enacted by Congress to address irregularities in the administration of large pension plans.
- Almost 40 percent of employees with health insurance are covered by self-insured plans and therefore are not protected by state laws.
- ERISA has had a major impact on emergency care by exempting plan participants from state patient protection laws, such as the prudent layperson standard.
- Efforts have been made in Congress to modify ERISA to allow states to develop and finance consumer protection reforms.
- Patients almost never know whether their plans are through ERISA, and it is seldom noted on their insurance cards. This can cause confusion as to whether state laws apply to them.



**3. Complaint
Resolution Process**

THE FOLLOWING WAS DEVELOPED IN 2003 AND WAS UPDATED SEPTEMBER 2004 BY JOHN GROSS, DIRECTOR OF HEALTH CARE POLICY, MINNESOTA DEPARTMENT OF COMMERCE. IT CONTAINS EXCELLENT INFORMATION THAT MAY HELP YOU IF YOU NEED TO FILE AN APPEAL OR COMPLAINT WITH YOUR INSURANCE COMPANY OR YOUR EMPLOYER.

SUMMARY OF THE COMPLAINT RESOLUTION PROCESS FOR HEARING AIDS FROM THE MINNESOTA DEPARTMENT OF COMMERCE

All health plans issued in Minnesota and all employers who self-insure their health coverage must provide a complaint resolution process. A complaint is any type of grievance including issues with coverage, denial or limitation of services, eligibility issues, administrative operations, quality, medical necessary decision, etc. The complaint includes the enrollee, provider or anyone acting on behalf of the enrollee.

Appeal Process for an Employer or Individual Who Purchased Health Coverage from an Insurance Company or HMO

If the employer or individual **purchased health coverage from a licensed health carrier**, that health carrier must provide an internal and external review process. Each health carrier must provide a description of their complaint resolution procedure to the enrollee, and this information when a claim is denied.

Who Makes the Decisions in the Internal Appeal Process?

For a medical appeal, a medical provider (physician, dentist or chiropractor) must be involved in the internal appeal process.

Criteria used for the basis of decision must be provided to the enrollee and the provider. **If the internal decision is adverse, the enrollee must be informed of the external appeal process.**

Who Makes the Decision on the External Appeal Process?

The external appeal process is performed by a neutral outside entity contracted by the State of Minnesota (currently providing similar services for Medicare and 36 other states), and costs the enrollee is \$25 (this can be waived for financial hardship). The decision is binding on the health carrier, but the enrollee can appeal.

Appeal Process for Self-Insured (Businesses that Pay the Claims Themselves)

If an employer is self-insured they must have an appeal process. The employee/dependent has **90 days to file an appeal** in writing with their employer. The employer might hire a Third Party Administrator (TPA) to process claims, but an appeal can be made to the TPA or directly to employer.

The state cannot regulate an employer who self-insures their health care benefits, however, we will attempt to assist and advise you of what to do. Remember, your employer makes the final decision, thus your final appeal should be to them.

Assistance Can Be Provided By:

Minnesota Department of Health, who regulates all MN Health Maintenance Organizations (HMOs) (651-282-5600 or 1-800-657-3916).

Minnesota Department of Commerce, who regulates all insurance companies. Blue Cross and Blue Shield of MN and Third Party Administrators (TPAs) (651-296-2488 or 1-800-657-3602).

U.S. Department of Labor – Employees Benefits Security Administration, who regulates all self-insured employers (1-866-275-7922).

Both the Departments of Commerce and Health will assist you on any questions or concerns you have about your health coverage.



**4. Appeal Letters to
Insurance Company**

Insurance Company Appeal Sample Letter #1

SEND THIS LETTER TO ALL PARTIES INVOLVED

April 3, 2XXX

Mr. X
Consumer Appeals Advisor
INSURANCE COMPANY X Customer Service
Route 123
PO Box 123
Minneapolis, MN 55440

Re: John Doe
INSURANCE COMPANY X #12345-123456789-12
Second Appeal

Dear Mr. X:

This letter is in reference to your denial letter dated December 7, 2XXX; this letter serves as our request for a second appeal process on behalf of my son, John Doe. In your above referenced letter you stated, "Recently, you appealed to *INSURANCE COMPANY X* regarding the denial of coverage for hearing aids that John would like to receive". I do not want to sound disrespectful, but would you ask a child that needed a wheelchair or a child that needed leg braces if they would "like" those needed items? No one with a birth defect would "like to receive" leg braces, a wheel chair, hearing aids, or such medically necessary items. John medically **needs** the hearing aids. Therefore, we are respectfully requesting a second appeal process.

John was born on July 11, 2XXX and a hearing test was administered on him in the nursery, he failed. We have learned through strenuous testing that he has a "Moderate-Severe Bilateral Sensorineural Hearing Loss". John is not a candidate for either the Otosclerosis Stapedectomy procedure or the Cochlear ear implant. Hearing aids are the only "medical solution to his birth defect" at this date and time. Enclosed is the actual data (Auditory Evoked Response Record) of what John can and can't hear. Also, I have enclosed an audiogram chart of which I have highlighted the frequencies John can't hear and some statistical information as to what a person with a Moderate-Severe Hearing Loss would encounter without hearing aids. We are quite surprised to learn *INSURANCE COMPANY X* is selective in what types of "birth defects" you are willing to help. If he had needed leg braces, *INSURANCE COMPANY X* would have helped in that instance.

In John's case the request for hearing aids is not one for cosmetic improvement, but is medically necessary and would drastically help our son to not only hear, but also be a "normal" child. Without the hearing aids John will not hear correctly, therefore will not learn correctly. Without

hearing aids John will be in special learning classes, speech therapy, etc. He will be unable to be outside playing with other kids because he cannot hear cars going by, unable to communicate clearly with friends and family. Would you let your child live this kind of life because *INSURANCE COMPANY X* insurance discriminates on what type of birth defects they deem “medically necessary”. My husband and I will not let our child be without hearing aids, but find it unjust that *INSURANCE COMPANY X* will not cover a medically needed item.

When I was pregnant with John, we took the tests offered at that time for birth defects and all indicated everything was normal. I (John’s Mother) practiced preventive health care by having the appropriate tests, exams, and immunizations recommended as well as eating a healthy nutritious diet, yet my son was still born with this handicap.

As stated above, this would be a serious travesty by *INSURANCE COMPANY X*’s to deny a six month old child the chance of hearing like you and I do. We wait to hear your final decision and hope our insurance carrier will make the correct decision.

Sincerely,

Jane Doe
John Doe’s Mother

Enclosures

Cc: Minnesota Insurance Commissioner
Minnesota Department of Commerce
Minnesota Department of Health
Minnesota State Representative for the House
Minnesota State Representative for the Senate
Ms. Laura Bush
Attorney General’s Office

Insurance Company Appeal

Sample Letter #2

August 12, 2XXX

INSURANCE COMPANY X
Member Services Department
123 45th Ave. S.
P.O. Box 123
Minneapolis, MN 55440

Re: John Doe *INSURANCE COMPANY X* Medical Record Number: 12345678

To Whom It May Concern:

John Doe was born on March 3, 2XXX. Before leaving the hospital, John was given a hearing test and failed. Finally at 4 months, he was diagnosed with a moderate bilateral sensorineural hearing loss by the audiologist, Dr. X at St. Paul Children's Hospital. This type of loss is permanent and if untreated will adversely affect John's ability to speak language.

John is not a candidate for either the Otosclerosis Stapedectomy procedure or the cochlear implant. Hearing aids are the only "medical solution to his birth defect" at this date and time. Enclosed is the actual data – ABR (auditory brainstem response) and OAE (otoacoustic emissions) of what John can and can't hear. Also, I have enclosed an audiogram on which I have highlighted the frequencies John can't hear and some statistical information as to what a person with a moderate hearing loss would encounter without hearing aids.

In John's case, the request for hearing aids is not one for cosmetic reason, but is medically necessary and would drastically help our son to not only hear, but also be a "normal" child. Without the hearing aids John will not hear correctly, therefore he will not speak or learn correctly. Without hearing aids John will cost an insurer more money and require special learning classes, speech therapy, etc. He will be unable to be outside playing without special supervision with other kids because he cannot hear cars going by. Without hearing aids John will be unable to communicate clearly with friends and family his needs.

We learned that our insurance covers prosthetics, and covers leg braces if the child was born needing them. We are quite surprised to learn *INSURANCE COMPANY X* is selective in what types of "birth defects" you are willing to cover as a necessary medical benefit when you cover prosthetics for other congenital defects. We believe it is unjust that *INSURANCE COMPANY X* will not cover a medically needed item, in this case – hearing aids, ear-molds and hearing evaluations for a child with congenital hearing loss.

Effective August 1, 2003 [and amended in 2007] the state of Minnesota requires insurance companies that provide coverage in Minnesota to add hearing aids for individuals 18 years of age or younger for hearing loss that is not correctable by other covered procedures of their benefit set when the policy is issued or renewed.

The number and language of the statute is as follows:

[62Q.675] [HEARING AIDS; PERSONS 18 OR YOUNGER.] A health plan must cover hearing aids for individuals 18 years of age or younger for hearing loss that is not correctable by other covered procedures. Coverage required under this section is limited to one hearing aid in each ear every three years. No special deductible, coinsurance, co-payment, or other limitation on the coverage under this section that is not generally applicable to other coverages under the plan may be imposed. This section is effective August 1, 2007, and applies to policies, contracts, and certificates issued or renewed on or after that date.

It would be a serious travesty, if you deny a 5 month old child the chance of hearing like you and I do.

Thank you for your prompt attention to this matter. I look forward to your return response.

Sincerely,

Mr. Doe
John's Father

Enclosures

Letter from Dr. X

Letter from Dr. Y

Letter from Dr. Z

Audiogram highlighting the frequencies (language) John can't hear

Postpartum discharge form

ABR hearing test report for left ear and failed OAE tests on 07/14/2004

ABR hearing test report for right ear and failed OAE tests on 05/10/2004

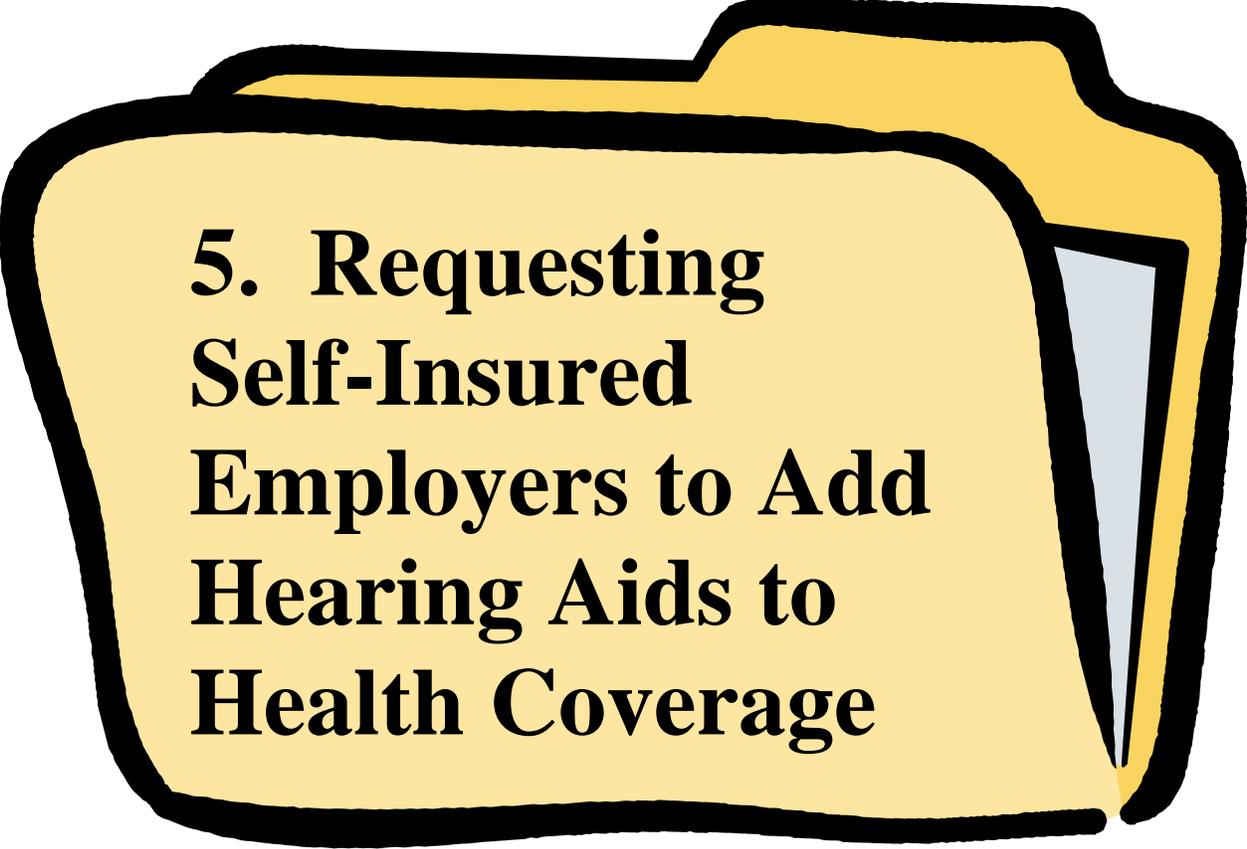
Testimony from Dr. Robert Margolis

Students with Moderate Hearing Loss

Hearing Loss in Children

Degrees of Hearing Impairment for Children

Cc: John Gross, Director Health Care Policy, Minnesota Department of Commerce
Dianne Mandernach, Commissioner, Minnesota Department of Health
Rep. X, Minnesota State Representative for the House
Senator X, Minnesota State Representative for the Senate
Mike Hatch, Attorney General's Office



**5. Requesting
Self-Insured
Employers to Add
Hearing Aids to
Health Coverage**

Self-Insured Plan Appeal

Sample Letter #1

August 12, 2XXX

COMPANY X Benefits Department
P O Box XXX
XXX, TX 77387

Re: John Doe *INSURANCE COMPANY X* Medical Record Number: XXXXXXXXX

To Whom It May Concern:

John Doe was born on March 3, 2XXX. Before leaving the hospital, John was given a hearing test and failed. Finally at 4 months, he was diagnosed with a moderate bilateral sensorineural hearing loss by the audiologist, Dr. X at St. Paul Children's Hospital. This type of loss is permanent and if untreated will adversely affect John's ability to speak language. Enclosed is the actual data – ABR (auditory brainstem response) and OAE (otoacoustic emissions) of what John can and can't hear. Also, I have enclosed an audiogram on which I have highlighted the frequencies John can't hear and some statistical information as to what a person with a moderate hearing loss would encounter without hearing aids.

John is not a candidate for either the otosclerosis stapedectomy procedure or the cochlear implant. Hearing aids are the only "medical solution to his birth defect" at this date and time. However, our medical insurance plan – *INSURANCE COMPANY X* Primary Clinic Plan (Group number XXXX) won't cover hearing aids, hearing evaluation or ear molds.

As a big and famous company, *COMPANY X* must be aware the importance of language and communication in our society. Children have their greatest capacity for learning language from ages 0-3 (or maybe even to age 5). If a child can't hear appropriately, how can he learn to communicate? Understanding this, you must appreciate the need of a child to have access to language in his most formative years. Giving our child this opportunity is important, not only to our child, but to society, in that it will ultimately decrease the costs to the school system in providing speech therapy and other services that our child will need if he cannot have quality access to speech and language. It also sets a good example for other employers with self-funded health plans to offer this important coverage to the children covered under our company's medical insurance plans.

Effective August 1, 2007 the state of Minnesota requires insurance companies that provide coverage in Minnesota to add hearing aids for individuals 18 years of age or younger for hearing loss that is not correctable by other covered procedures of their benefit set when the policy is issued or renewed.

The number and language of the statute is as follows:

[62Q.675] [HEARING AIDS; PERSONS 18 OR YOUNGER.] A health plan must cover hearing aids for individuals 18 years of age or younger for hearing loss that is not correctable by other covered procedures. Coverage required under this section is limited to one hearing aid in each ear every three years. No special deductible, coinsurance, co-payment, or other limitation on the coverage under this section that is not generally applicable to other coverages under the plan may be imposed. This section is effective August 1, 2007, and applies to policies, contracts, and certificates issued or renewed on or after that date.

Thank you for your prompt attention to this matter. I look forward to your return response.

Sincerely,

Mr. Doe
John's Father

Enclosures

Letter from Dr. X

Letter from Dr. Y

Letter from Dr. Z

Audiogram highlighting the frequencies (language) John can't hear

Postpartum discharge form

ABR hearing test report for left ear and failed OAE tests on 07/14/2004

ABR hearing test report for right ear and failed OAE tests on 05/10/2004

Testimony from Dr. Robert Margolis

Students with Moderate Hearing Loss

Hearing Loss in Children

Degrees of Hearing Impairment for Children

Self-Insured Plan Appeal Sample Letter #2

MEMORANDUM

TO: *Company X*

FROM: *Parent X*

DATE: August 28, 2XXX

RE: Self-insured plan hearing aid coverage

Until this year, many Minnesota insurance companies denied coverage for hearing aids as “cosmetic improvements”. The Minnesota legislature recently amended the bill requiring insurance companies to cover the cost of hearing aids for children. Effective August 1, 2007 the state of Minnesota requires insurance companies that provide coverage in Minnesota to add hearing aids for individuals 18 years of age or younger for hearing loss that is not correctable by other covered procedures or their benefit set when the policy is issued or renewed. The law, Minn. Stat. 62Q .675, requires the insurance company to provide (with applicable, but not special, co-pay or deductible) new hearing aid(s) once every three years until the child is 18 years old. I have attached a copy of the law, as well as testimony from parents and doctors in support of the bill. Because *Company X* is self-insured for its employees, this legislation does not impact our plan. The purpose of this memo is to ask *Company X* to consider adding hearing aid coverage to its self-insured plan.

The cost of an average hearing aid is about \$1800. The expected life is about 2-4 years. The benefit received from hearing aids varies, but in all cases, having one is better than not having one when it comes to children developing language skills. Consequently, it is estimated that the cost of speech therapy (which most insurance, including *Company X*'s, covers) is estimated to decrease by 40% when children with hearing problems receive early intervention through hearing aids. Because of this, the cost of providing hearing aids is nearly (or totally) paid for by the reduction in speech therapy costs.

In reality, with only a total of 90 Minnesota children identified as hearing impaired last year (this includes testing of 86% of newborns), it is unlikely that the *Company X* self-insured plan would be greatly impacted by adding this coverage. However, if you need more information, the Minnesota Commission Serving Deaf and Hard of Hearing People has offered to arrange for audiologists and other professions to speak to you on the importance of early intervention for permanent, congenital hearing loss in children.

As the sponsor of a self-insured plan, *Company X* can control, in many cases, which benefits its insurance plan will provide. While I do not believe this should be simply a matter of dollars and cents, I understand that nothing is free. Therefore, I urge you to look at the enclosed studies regarding *Company X*'s potential cost savings in speech therapy (as well as society's cost

savings in K-12 education and social services) from providing hearing aid coverage, and then determine if this is a benefit *Company X* can afford to provide its employees. Please let me know if there is any additional information you feel you need to help you make this decision.

Self-Insured Plan Appeal

Sample Letter #3

February 7, 2XXX

Company ABC Human Resources Support Center
Appeals
P.O. Box 1234
Anywhere USA

Re: XXX (Jane Doe – Employee 1234567)

To Whom It May Concern:

I would like Company A to add hearing aid coverage as a benefit to all of the health plans that are offered to employees. This would benefit Company A employees who have children born with a hearing loss; I have two children who are hard of hearing. Our kids need hearing aids so they reach their full potential and become responsible, contributing citizens and effective members of the workforce.

Up until 2003, many Minnesota insurance companies denied coverage for hearing aids as “cosmetic improvements”. The Minnesota legislature passed a bill requiring insurance companies to cover the cost of hearing aids for children with congenital hearing loss. The law, Minn. Stat. 62Q.675, [which was revised in 2007] requires the insurance company to provide (with applicable, but not special, co-pay deductible) new hearing aid(s) once every three years until the child is 18 years old. I have attached a copy of the law, as well as my parent testimony and other documentation from parents and doctors in support of the bill. Because Company A is self-insured for its employees, this legislation does not impact our plan. In my research, I have found other self-insured companies in the State of Minnesota that have hearing aid coverage on their health plans and those include 3M and Wells Fargo.

The average cost of a hearing aid is about \$1,800. The expected life is about 2-4 years. The benefit received from hearing aids varies, but in all cases, having two is better than not having any when it comes to children developing language skills. Consequently, it is estimated that the cost of speech therapy (which most insurance covers, including Company A) is estimated to decrease by 40% when children with hearing problems receive early intervention through hearing aids. Because of this, the cost of providing hearing aids is offset by the reduction of speech therapy costs.

In reality, with only a total of 90 Minnesota children identified as hearing impaired last year (this includes testing of 86% of newborns), it is unlikely that the Company A’s self-insured plan would be greatly impacted by adding this coverage.

However, if you need more information, the Minnesota Commission Serving Deaf and Hard of Hearing People has offered to arrange for audiologists and other professions to speak to you on the importance of early intervention for permanent, congenital hearing loss in children.

As the sponsor of a self-insured plan, Company A can control, in many cases, which benefits its insurance plan will provide. While I do not believe this should be simply a matter of dollars and cents, I understand that nothing is free. Therefore, I urge you to look at the enclosed studies and other pertinent information regarding the potential cost savings in speech therapy, as well as society's cost savings in K-12 education and social services that Company A would obtain from providing hearing aid coverage.

When taking this decision into consideration, please keep in mind that [my children] did not have a choice about their hearing impairment. Please let me know if there is any additional information you feel you need to help make this decision. Adding hearing aid coverage to Company A's health care plans would not only benefit my children, it would also benefit other Company A employees who have children suffering from hearing loss.

Your consideration in this matter would be greatly appreciated.

Kindest regards,

Jane Doe
Executive Assistant to John Smith

Enclosure(s)

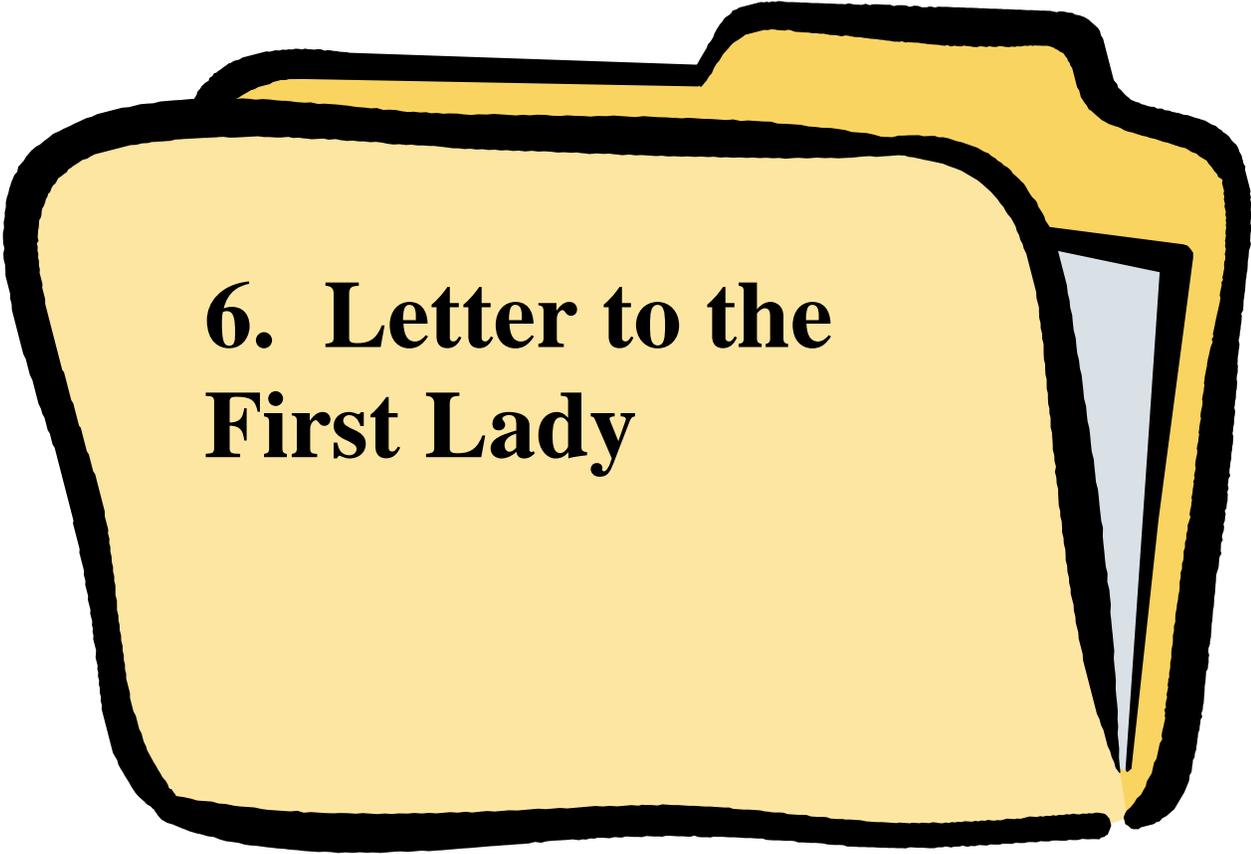
cc:

XXX
Vice President, Retail Customer Experience

XXX
Director, HR Corporate

XXX
Senior Vice President, Chief Communications Officer

XXX
Manager, Health and Welfare



**6. Letter to the
First Lady**

SEND THIS LETTER TO ALL EXCEPT THE INSURANCE COMPANY

April 8, 2XXX

Mrs. Laura Bush
White House
1600 Pennsylvania Avenue NW
Washington, DC 20500

Re: John Doe

Dear Mrs. Bush:

Enclosed for your review is a copy of my second appeal letter to our insurance carrier, *Insurance Company X*, dated April 3, 2XXX. This request is in regards to hearing aids that are medically necessary for my eight-month-old son John.

John's hearing condition is not an actual acquired "hearing loss", but a birth defect he was born with. Without hearing aids the only sounds my son can hear, at best, are muffled noises, he is not able to hear someone speaking to him and understand what they are saying. If my son were born with a different birth defect, *Insurance Company X* would have covered his medical needs.

I am writing this letter to make people like yourself aware of what I consider discrimination by *Insurance Company X* insurance. I would also like to know what more I can do in my son's case, and for all the other children out there who may need hearing aids, but are being denied them. I feel this discrimination is a great injustice and will continue pursuing every avenue possible. When an insurance company denies a child hearing aid/s the impact of their decision affects more than his/her parents that pay for their discrimination. The future impact on school districts, employers, and social systems will be affected financially. Not to mention John's personal development and self-esteem. Without hearing aids my son would have to be in speech therapy, special education classes, etc. throughout all of his school years. With hearing aids he has the chance to hear and learn, like you and I. Who pays for this special education? The insurance companies do not pay for this specialized education, our government pays, which means you and I pay. I cannot imagine the amount of monies that would need to be spent on specialized education and learning for my son, when a set of hearing aids costing approximately \$7,800 would eliminate that need.

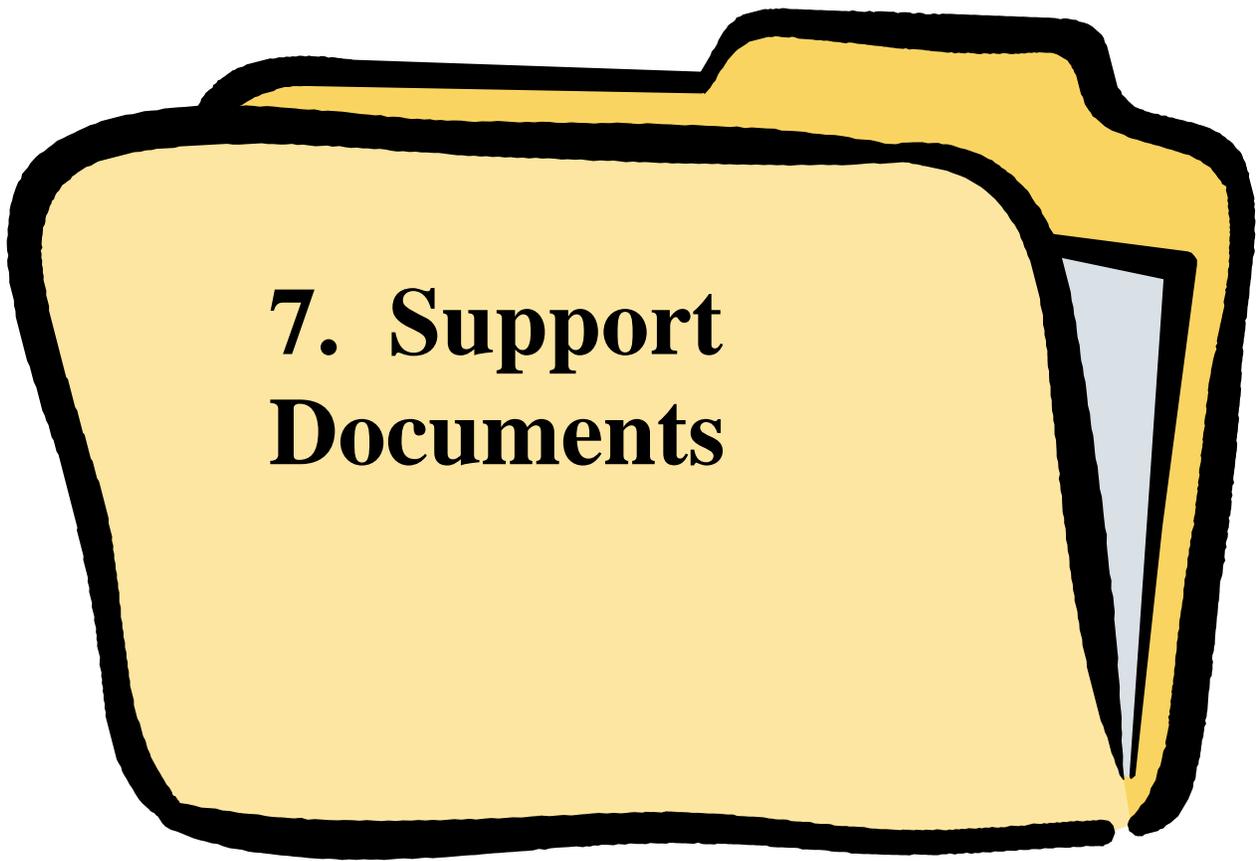
As stated earlier, please let me know if there is anything more I can do. I would like to pursue every avenue available to alleviate the discrimination we are currently experiencing with *Insurance Company X*. Thank you in advance for your time. I hope to hear from you or your office soon.

Yours truly

Jane Doe
John Doe's Mother

Enclosures

Cc: Minnesota Insurance Commissioner
Minnesota Department of Commerce
Minnesota Department of Health
Minnesota State Representative for the House
Minnesota State Representative for the Senate
Attorney General's Office



7. Support Documents

TESTIMONY FROM DR. ROBERT MARGOLIS, PROFESSOR OF AUDIOLOGY, DEPARTMENT OF
OTOLARYNGOLOGY, UNIVERSITY OF MINNESOTA

23 FEBRUARY 2003

(NOTE: This testimony was given *prior* to passing Minnesota Statute 62Q.675)

One of the most dramatic changes in public health in recent years is the establishment of universal newborn hearing screening in birthing hospitals throughout the US. Ten years ago only very sick babies were screened for hearing loss at birth. Today 32 states have legislative mandates that require all babies to be screened for hearing loss in the nursery. In Minnesota, over 90% of the 65,000 babies born each year are screened for hearing loss in the hospital, a tremendous accomplishment for a state without a legislative mandate. This has occurred because of broad support led by funding from the Lions 5M Hearing Foundation, the US Maternal and Child Health Bureau, the Centers for Disease Control and tireless efforts by professionals, parents, and state officials.

A change in health policy of this magnitude does not occur without a strong justification. The justification is that there is incontrovertible evidence that early identification of and intervention for congenital hearing loss prevents or reduces permanent, lifelong consequences of untreated hearing loss including developmental delays in speech and language, diminished school achievement, diminished employability and career opportunities, and limitations on social development and opportunities.

In addition to prevention of serious permanent consequences of untreated hearing loss, early intervention significantly decreases the cost of education and rehabilitation of hearing-impaired children. The cost of special education for hearing impaired children is three times the cost of regular education. The cost of education in a residential program like our State Academy for the Deaf in Faribault is eight times that of regular education. Early intervention moves children from more expensive educational program to less expensive programs.

Permanent congenital hearing loss is a chronic disease that when left untreated, results in serious permanent impairment.

Please consider the experience of learning at the time your baby is born that the child has permanent hearing loss. The good news is that a treatment is available. If the appropriate treatment is surgery, your health insurance will pay for it. If the treatment is medication, your health insurance will pay for it. But for the overwhelming majority of people with permanent hearing loss, the only appropriate treatment is hearing aids. But your health insurance won't pay for hearing aids unless you are lucky enough to be a state employee or you qualify for medical assistance or you are a member of a small minority who have hearing aid coverage in commercial health plans. If the treatment is one thing it is covered. If it is another, no matter how effective, it is not covered. This is not responsible or fair health policy.

The Joint Committee on Infant Hearing 2000 position statement, supported by the American Academy of Pediatrics, the American Academy of Audiology, and many other professional health agencies, recommends intervention for permanent congenital hearing loss by 6 month of

age. The current lack of access to appropriate treatment is the most significant obstacle to achieving this goal.

All health plans should pay for hearing aids when they are the appropriate treatment for significant childhood hearing loss. This makes sense medically; it makes good sense economically, and it makes sense morally.

***TESTIMONY FROM A PARENT WHO WAS SUCCESSFUL IN GETTING HEARING AIDS
ADDED TO THEIR BENEFIT SET
2003 LEGISLATIVE SESSION***

(NOTE: This testimony was given *prior* to passing Minnesota Statute 62Q.675)

My name is Amy Deneen. I am from Red Wing Minnesota. I come before you today as a voice for my soon to be eight year old son who has a bilateral moderate sensorineural hearing loss. He was born prior to Universal Newborn Hearing Screening and was not identified with the loss until he was 3 1/2 years old. We have been playing catch up and facing challenges ever since.

I don't think any parent is ever fully prepared for the news that their child has a disability. Not emotionally, psychologically, and certainly not financially. When we found out our son's hearing was irreversibly damaged, it was a shock. How did it happen? Why did it happen? When did it happen? And finally, what do we do about it? Without extensive medical tests there were no answers to the first three questions, but the forth was clear -- He needed hearing aids as soon as possible.

We soon learned the price of the aids and the fact that they were not covered by insurance. As many young families, we were paying off student loans, had a mortgage, and all of the other budgeted and non-budgeted household expenses; hearing loss and hearing aids were not part of the plan. Luckily, our church came to our rescue by holding a benefit for our family and raised the money for the hearing aids. It is very difficult thing to accept charity when you've been raised to pay your own way; but it was charity or no hearing aids and Matthew needed to hear.

3 1/2 years later we were told that he would soon need new hearing aids as his aids were beginning to fail. The typical child needs new hearing aids every 2-4 years. This time we were determined to get him what he needed without talk of benefits or charity. We also knew it was coming and had a plan in place. Filing an insurance claim was part of that plan.

Because of the insurance industry's generalized view of hearing aids, our health care professionals believed filing a claim was futile; therefore, if we wanted to file a claim we would have to do it for ourselves.

The first thing we were "informally" told is that the insurance industry views hearing aids as cosmetic and therefore would not cover them. If you were to ask my son why he wears his hearing aids I can guarantee that it would not be to improve his appearance. His answer would be simply, "They help me hear". We had a duty to our son to educate the misinformed so we compiled all of the necessary documentation and we filed the claim.

A few months later we received a denial of coverage letter from our insurance company stating the following: "Your plan of benefits provides coverage for services or supplies that (our insurance company) determines are necessary. To meet this requirement the service or supply must be accepted under recognized professional standard as appropriate for the diagnosis, care,

or treatment of the disease or injury involved. In addition, it should not be experimental or still under clinical investigation. Based on the information provided, this expense does not meet this requirement of your plan of benefits and is not covered. If there is additional information that should be brought to our attention, please contact us."

Upon receiving this letter, we proceeded to gather documentation to answer the questions they had and refute the reason for denial. Letters were written by the prescribing ENT and the clinical audiologist as to professional standard of care regarding our son's diagnosis; a report by the educational audiologist stating word recognition scores in quiet and in noise comparing the new to the old hearing aids; a progress note from a pediatric neurologist stating significant improvement in Matt's behavior, development, and speech as a result of the new hearing aids (you see many kids with hearing loss, especially late or unidentified hearing loss, often get misdiagnosed with other things such as ADHD and Autism); and finally a letter from us outlining the package.

Two months later we received another response from the insurance company with another stated reason for denial of payment. It said, "We have determined no benefits are payable because (my husband's employer's policy) specifically excludes hearing aids. It is (our insurance company's) standard to cover hearing aids due to hearing loss or impairment caused solely by an accidental bodily injury." Which is their same policy regarding speech therapy. So if our son had lost his hearing due to an accident, then they would cover his hearing aids, but since his loss is congenital he is excluded.

We had one last chance for appeal through my husband's employer. We provided them with the same package of documentation. About 1 month later we received the great news -- we would receive partial reimbursement for the hearing aids. Less than the cost of one hearing aid. Based upon the research and documentation we provided them, his employer decided to add hearing aid coverage to all of its plans for this year.

This process took over 6 months. Not all families have the time, energy, resources, or skills to complete an appeal, nor should they have to. The benefits are clear and common sense. The benefits far outweigh the costs. Hearing aids should be covered by insurance. Thank you for your time.

**TESTIMONY FROM A PARENT REQUESTING HEARING AID COVERAGE
2003 LEGISLATIVE SESSION**

(NOTE: This testimony was given *prior* to passing Minnesota Statute 62Q.675)

My name is Diane Wonchoba. I am the mother of Eric and Cameron. My 5-year old twin boys have a moderate to severe hearing loss due to a congenital malformation. Today, we are asking you to pass House File 287 which would provide a uniform interpretation of law 62A.042 when hearing aids are the only treatment option for a congenital malformation in the inner ear which causes a hearing loss. This debate should be about whether hearing aids are an accepted and effective treatment option for a congenital malformation in the inner ear. However, since it has become a debate about whether hearing aids are a fiscally viable option for insurance plans, I would like to share my experience with both effective treatment options and societal costs for our boys' birth defect.

Eric and Cameron have a malformation of the nerve that connects the ear to the brain. As a result, they have a hearing threshold of 55 to 65 decibels which is considered moderate to severe. When a child cannot hear things below 55 decibels, he's missing a lot of spoken information. Missing that information has compromised the boys' brain development and means of effectively communicating. Our boys were not part of the Universal Newborn Hearing Screening. They were 2 years and 4 months old when they were diagnosed with their hearing loss. Before treatment began, they were diagnosed with Autism and their IQ scores were a whole year behind the average for their age.

We were told about four types of treatment for hearing loss: surgery, cochlear implant, analog hearing aids, or digital hearing aids. The cause of our boys' hearing loss was not correctable by surgery. Cochlear Implants were out of the question since they had a significant amount of residual hearing. Surgery and Cochlear Implants would have been more expensive options and would have been covered by our insurance company. However, our only option was hearing aids.

There are two types of hearing aids, analog and digital.

The analog hearing aids cost us \$800 per aid. We initially chose this option because of cost. Analog hearing aids improved our boys' hearing by about 50% from a 60-decibel cutoff to a 40-decibel cutoff. This was certainly an improvement, but a hearing threshold of 40 decibels is still not ideal. There were still substantial educational and social gaps. In fact, after 2 years of therapy, a psychologist who specializes in children with a hearing loss determined that Cameron had ADD.

The truly effective option for our boys is digital hearing aids. Digital hearing aids cost us \$2000 per aid. They can be programmed to each frequency level to improve their hearing to the most ideal decibel levels. With digital hearing aids, my boys can now hear down to about 25 decibels – nearly a 90% improvement. Now, with the digital hearing aids, both boys are getting

the maximum benefit from their education. After years of therapy and wearing appropriate hearing aids, both boys are testing at normal IQ levels and no one believes they are Autistic nor have ADD.

I believe the educational and developmental benefits are obvious, so I'd like to take this time to look at the monetary benefits of providing children with digital hearing aids. There is a 1999 Johns Hopkins University study that *conservatively* estimated that intervening a hearing loss can save \$30,000 to \$200,000 in K-12 educational *expenses per child*. Research and parent testimony shows that when a child receives intervention within the first year of life, the special education services, and therefore the money spent for these services, is essentially eliminated.

For my boys, the taxpayer and insurance money was spent in three primary services: private speech therapy, public special education and social services.

First, our insurance company, like many, covers the cost of private speech therapy. Our insurance company spends \$2200 *per summer* per child for therapy. Understand, this is not just for speech therapy, but also to help their brain development, which was being seriously impeded.

Second, the boys received quality education from the school district. In the past 2 ½ years, they have had 26 different teachers, bus drivers, and paras working to improve their understanding. We need them all! However, our boys would not need them if early detection and intervention had occurred and hearing aids had been made available to them since birth.

Third, we received social services. Children with a hearing loss have a great deal of frustration because they don't know how to communicate. This often leads to a number of behavior problems. They had a dramatically low IQ scores, and the state intervened with a 7-member social services team, which provided us with respite care that cost \$600 per month and a behavioral specialist. This was all very costly, but the take-home message is that once the boys learned to communicate, the behavior issues were eliminated and after 2 ½ years of special education, they are now testing near normal IQ range for their age.

For my children, the best way to treat their hearing loss caused by a congenital malformation is clearly with digital hearing aids. I appreciate the concern that requiring hearing aid coverage is costly. Please refer to the refer to the Table titled Cost Comparison of Hearing Aids vs. Other Insurance Costs, Respite Care and Educational Costs. In my experience, not providing hearing aid coverage is more costly in terms of special education, insurance costs for private speech therapy, and social services – all of these costs are paid for by a small business as well as every other taxpayer and insurance policy holder. We have two choices, support Universal Newborn Hearing Screening by providing affordable hearing aids from birth, or delay intervention and be at the mercy of the educational system, social services, and private therapy. I am a mother, but I am also a taxpayer and pay insurance premiums for health insurance. When I see all the money that my provider continues to pay in speech therapy costs and that the state pays in special education costs and respite care costs that could be prevented with early intervention, I ask myself why? Even more importantly, hearing aids gives my boys the chance to reach their full potential to become responsible, contributing citizens – the chance to become an effective member in the workforce. When considering this clause, please note that Eric and

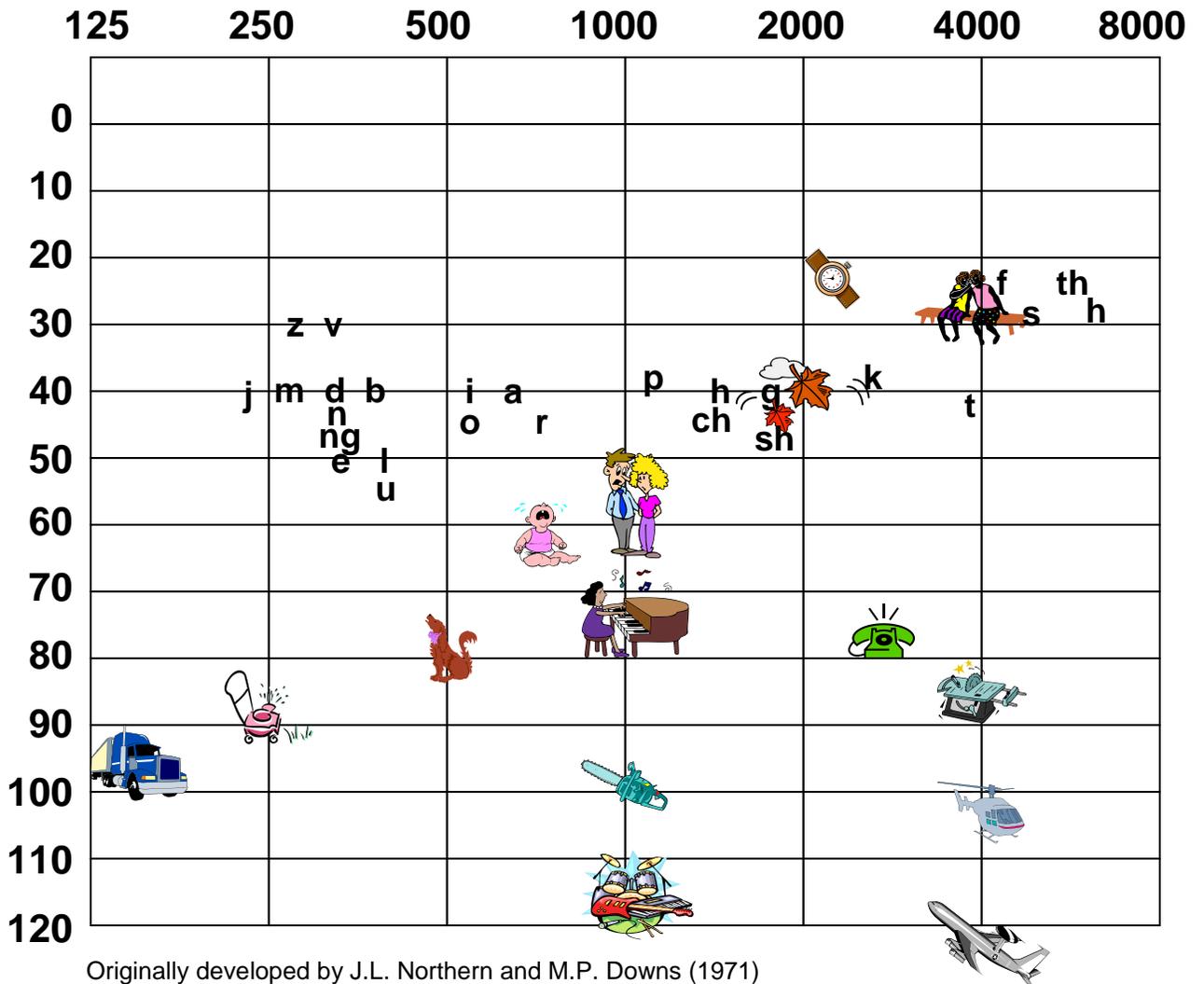
Cameron do not have a choice about their hearing impairment. The cost to intervene the disability will have a miniscule effect on insurance policy holders who do have choices about how they manage their health care. Law 62A.042 states insurance policies need to cover newborn babies for injury, illness, congenital malformation, and premature birth. By adding House File 287, we acknowledge that hearing aids is an accepted and effective treatment for a congenital malformation in the inner ear. Law 62A.042 does not state that it should only cover inexpensive malformations, however adding this clause would save insurance providers money in speech therapy costs and saves the state millions in special education costs. By adding this clause, we have a more educated workforce and that is good business!

AUDIOGRAM

This audiogram includes some environmental and speech sounds to help show what the child can and cannot hear.

Frequency in Hertz (pitch)

Hearing Level in Decibels (loudness)

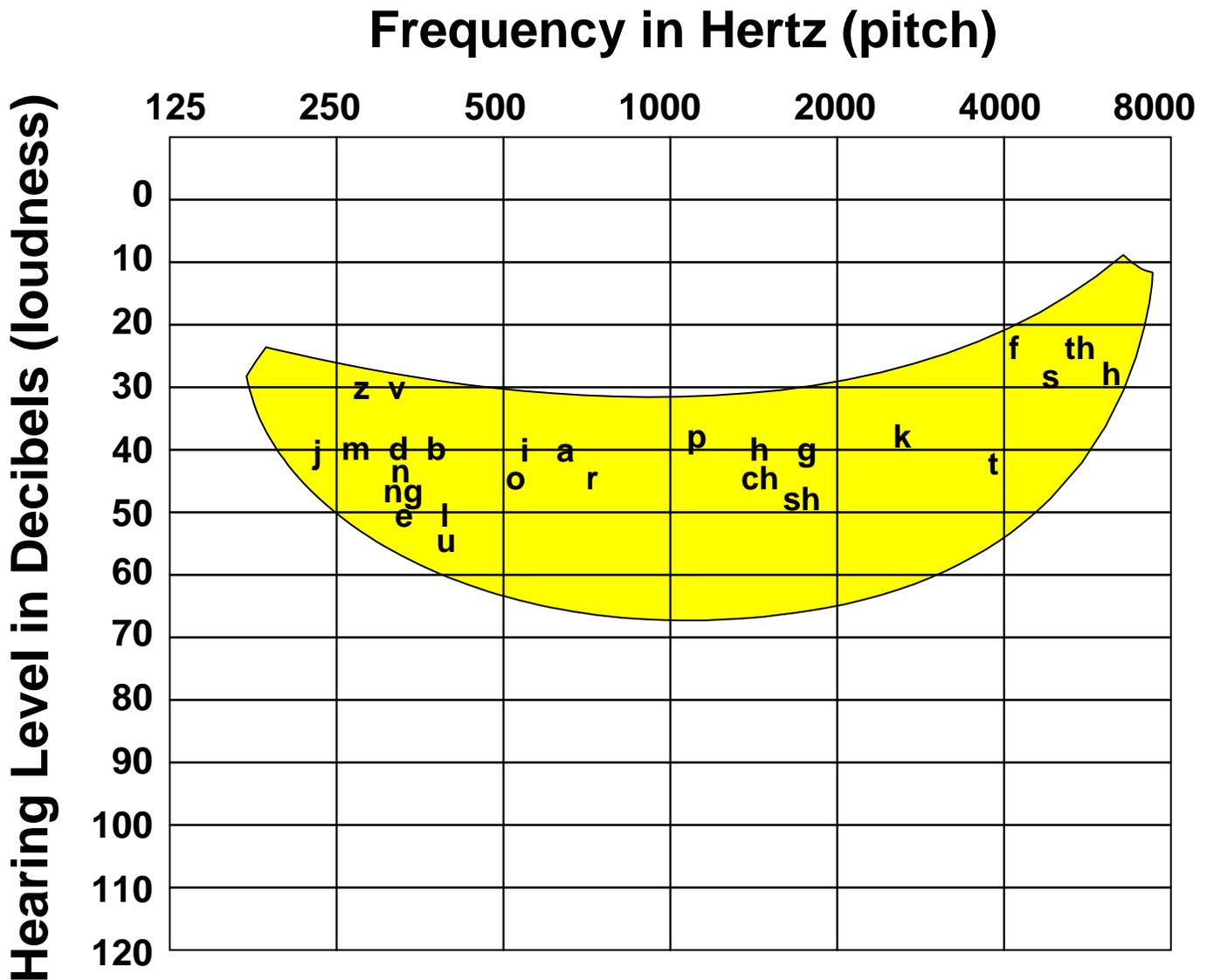


Originally developed by J.L. Northern and M.P. Downs (1971)
 Updated by Deaf and Hard of Hearing Services – Metro (2004)

AUDIOGRAM SHOWING THE SPEECH BANANA

This audiogram highlights the area where speech sounds are found. This area is referred to as the “speech banana” because it resembles the shape of a banana when a line is drawn around the speech sounds on the audiogram.

Many times a child’s unaided responses fall below the speech banana. However, in many situations the aided responses show that the child is able to hear many, if not all of the speech sounds. It is important to be aware of the speech banana because it gives even more information what my child can and cannot hear – without and with hearing aids.



Cost of Hearing Aids vs. Education, Speech, & Social Services

Developed in 2003 by the Minnesota Commission Serving Deaf and Hard of Hearing People

OPTION A Provide Hearing Aid Coverage		OPTION B No Hearing Aid Coverage	
Intervene at birth with digital hearing aids:		Delayed Intervention until average age of detection (2 ½ years old) which costs taxpayers and the insurance plan the following:	
At Birth	\$4,000	Private Therapy (age 3 – 18) at \$2,200 per summer	\$33,000
3 years old	\$4,000	Special Education (K-12)	\$30,000 to \$200,000
6 years old	\$4,000	Respite Care (age 2 to 5) at \$600 per month	\$18,000
9 years old	\$4,000	7 Member Social Services Team	Cost Unknown
12 years old	\$4,000		
15 years old	\$4,000		
18 years old	\$4,000		
Total:	\$28,000	Total:	\$81,000 to \$251,000

Factual Notes

- 95% of all hospitals within the State of Minnesota are using the Universal Newborn Hearing Screening, which detects a hearing problem.
- In 2002, there were under 200 kids born with some type of a hearing problem and only 35 of those children had a hearing loss that required amplification with hearing aids. All the rest were treatable by either medicine or surgery.
- The dollar savings to an insurance plan would be lessened if we take care of the issue up front before there to prevent problems for that child instead of after the fact.

Comparing the Cost of Hearing Aid Purchases vs. Speech Therapy Costs

Survey Conducted in 2003 by the Minnesota Commission Serving Deaf and Hard of Hearing People
and the Minnesota Alexander Graham Bell Association

MCDHH cited studies that showed the correlation between early childhood intervention and reduced costs in rehabilitative therapies during Senate hearings for SF155, the companion bill to HF287. MCDHH, Dr. Robert Margolis of the University of Minnesota Audiology Clinic and parents argued costs of insurance coverage would offset the costs in reduced need for speech therapy.

The insurance industry and the Minnesota Chamber of Commerce said they didn't believe the costs would be offset, but offered no proof. In response to concerns by the insurance industry and legislators that this would significantly increase the costs of insurance premiums, MCDHH and the Minnesota A.G. Bell Association conducted a survey of parents and asked if they had hearing aid coverage and speech therapy coverage. Thirty-seven parents out of 43 receive speech therapy services and only 3 have hearing aid coverage.

Studies from the American Speech and Hearing Association and John Hopkins University demonstrate significant reductions in rehabilitative therapies result when early intervention occurs.

Item	Cost	Cost/Week	Cost/Week @ 80% minus deductible	Cost/Month@80% minus deductible	Cost to the Insurance Company/3 Years	Savings to Insurance Company Every Three Years **
One Hearing Aid replaced every 3 years	\$2000	\$13.50	\$8.64	\$34.56	\$1600	\$6,934 to \$13,030 (28 to 52 weeks of speech therapy minus the cost of one hearing aid)
Two Hearing aids replaced every 3 years	\$4000	\$27	\$21.60	\$88	\$3,200	
Private Speech Therapy	\$127 flat rate/visit with a 28 week cap	68.38	54.7	\$237	\$8,534.4	
Private Speech Therapy	\$127 flat rate/visit	\$127	\$101.6	\$406.4 @ 1 time/week	\$14,630.4	

FOUR MONTHS OF SPEECH THERAPY ONCE A WEEK FOR A YEAR COSTS MORE THAN THE PURCHASE OF ONE HEARING AID EVERY THREE YEARS. EIGHT MONTHS OF SPEECH THERAPY COSTS ARE GREATER THAN THE COST OF THE PURCHASE OF TWO HEARING AIDS ONCE EVERY THREE YEARS.

SURVEY TAKEN MARCH 2003	HEARING AIDS	SPEECH THERAPY
PARENTS WITH COVERAGE	3	37
PARENTS WITHOUT COVERAGE	40	6

POSSIBLE EFFECTS OF HEARING LOSS

Note: Every child is different. The possible effects of a hearing loss depends on many factors. Some of those factors include degree of hearing loss, early identification and application, early intervention services, and parental involvement.

NORMAL HEARING (-10 to +15 dB HL)

Children have better hearing sensitivity than the accepted normal range for adults. A child with hearing sensitivity in the -10 to +15 dB range will detect the complete speech signal even at soft conversation levels. However, good hearing does not guarantee good ability to discriminate speech in the presence of background noise.

BORDERLINE (16 to 25 dB HL)

May have difficulty hearing faint or distance speech. At 15 dB, student can miss up to 10% of speech signal when teacher is at a distance greater than 3 feet and when the classroom is noisy, especially in the elementary grades when verbal instruction predominates. May be unaware of subtle conversational cues which could cause child to be viewed as inappropriate or awkward. May miss portions of fast-paced peer interactions.

MILD (26 to 40 dB HL)

At 30 dB, can miss 25-40% of speech signal. The degree of difficulty experienced in school will depend upon the noise level in classroom, distance from teacher and the configuration of the hearing loss. Without amplification the child with 35-40 dB loss may miss at least 50% of class discussions, especially when voices are faint or speaker is not in line of vision. Will miss consonants, especially when a high frequency hearing loss is present. Child begins to lose ability for selective hearing, and has increasing difficulty suppressing background noise which makes the learning environment stressful.

MODERATE (41 to 55 dB HL)

Understands conversational speech at a distance of 3-5 feet (face-to-face) only if structure and vocabulary are controlled. Without amplification the amount of speech signal missed can be 50% to 75% with 40 dB loss and 80% to 100% with 50 dB loss. Is likely to have delayed or defective syntax, limited vocabulary, imperfect speech production and an atonal voice quality. Often with this degree of hearing loss, communication is significantly affected, and socialization with peers with normal hearing becomes increasingly difficult.

MODERATE TO SEVERE (56 to 70 dB HL)

Without amplification, conversation must be very loud to be understood. A 55 dB loss can cause a child to miss up to 100% of speech information. Will have marked difficulty in school situations requiring verbal communication in both one-to-one and group situations. Delayed language, syntax, reduced speech intelligibility and atonal voice quality likely.

SEVERE (71 to 90 dB HL)

Without amplification may hear loud voices about one foot from ear. When amplified optimally, children with hearing ability of 90 dB or better should be able to identify environmental sounds and detect all the sounds of speech. If loss is of prelingual onset, oral language and speech may not develop spontaneously or will be severely delayed. If hearing loss is of recent onset, speech is likely to deteriorate with quality becoming atonal.

PROFOUND (91 dB HL or more)

Aware of vibrations more than tonal pattern. May rely on vision rather than hearing as primary avenue for communication and learning. Detection of speech sounds dependent upon loss configuration and use of amplification. Speech and language will not develop spontaneously and is likely to deteriorate rapidly if hearing loss is of recent onset.

UNILATERAL (One normal hearing ear and one ear with at least a permanent mild hearing loss)

May have difficulty hearing faint or distant speech. Usually has difficulty localizing sounds and voices. Unilateral listener will have greater difficulty understanding speech when environment is noisy and/or reverberant. Difficulty detecting or understanding soft speech from side of bad ear, especially in a group discussion. Child may be accused of selective hearing due to discrepancies in speech understanding in quiet versus noise.

Developed by Karen L. Anderson, Ed.S & Noel D. Matkin, Ph.D (1991)

Adapted from: Bernero, R.J. & Bothwell, H. (1966)



Effects of Hearing Loss

It is well recognized that hearing is critical to speech and language development, communication, and learning. Children with listening difficulties due to hearing loss or auditory processing problems continue to be an underidentified and underserved population.

The earlier hearing loss occurs in the child's life, the more serious the effects on the child's development. Similarly, the earlier the problem is identified and intervention begun, the less serious the ultimate impact.

There are four major ways in which hearing loss affects children--

1. It causes delay in the development of receptive and expressive communication skills (speech and language).
2. The language deficit causes learning problems that result in reduced academic achievement.
3. Communication difficulties often lead to social isolation and poor self-concept.
4. It may have an impact on vocational choices.

Communication Effects

Vocabulary

- Vocabulary develops more slowly in children who have hearing loss.
- Children with hearing loss learn concrete words like "cat," "jump," "five," and "red" more easily than abstract words like "before," "after," "equal to," and "jealous." They also have difficulty with function words like "the," "an," "are," and "a."
- The gap between the vocabulary of children with normal hearing and those with hearing loss widens with age. Children with hearing loss do not catch up without intervention.
- Children with hearing loss have difficulty understanding words with multiple meanings. For example, the word "bank" can mean the edge of a stream or a place where we put money.

Sentence Structure

- Children with hearing loss comprehend and produce shorter and simpler sentences than children with normal hearing.

- Children with hearing loss often have difficulty understanding and writing complex sentences such as those with relative clauses (*The teacher whom I have for math was sick today*) or passive voice (*The ball was thrown by Mary*).
- Children with hearing loss often cannot hear word endings such as "-s" or "-ed." This leads to misunderstandings and misuse of verb tense, pluralization, non-agreement of subject and verb, and possessives.

Speaking

- Children with hearing loss often cannot hear quiet speech sounds such as "s," "sh," "f," "t," and "k" and therefore do not include them in their speech. Thus, speech may be difficult to understand.
- Children with hearing loss may not hear their own voices when they speak. They may speak too loudly or not loud enough. They may have a speaking pitch that is too high. They may sound like they are mumbling because of poor stress, poor inflection, or poor rate of speaking.

Academic Achievement

- Children with hearing loss have difficulty with all areas of academic achievement, especially reading and mathematical concepts.
- Children with mild to moderate hearing losses, on the average, achieve 1-4 grade levels lower than their peers with normal hearing, unless appropriate management occurs.
- Children with severe to profound hearing loss usually achieve skills no higher than the 3rd or 4th grade level, unless appropriate educational intervention occurs early.
- The gap in academic achievement between children with normal hearing and those with hearing loss usually widens as they progress through school.
- The level of achievement is related to parental involvement and the quantity, quality, and timing of the support services children receive.

Social Functioning

- Children with severe to profound hearing losses often report feeling isolated, without friends, and unhappy in school, particularly when their socialization with other children with hearing loss is limited.
- These social problems appear to be more frequent in children with mild or moderate hearing losses than in those with severe to profound losses.

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From: American Speech-Language-Hearing Association|
www.asha.org/public/hearing/disorders/effects.htm

Facts & Figures About Hearing Loss in Children

The Prevalence and Incidence of Hearing Loss in Children

- * About 34 million people in the U.S. have some degree of reduced hearing sensitivity. Of this number, 80% have irreversible hearing loss and 6 million of the 34 million are profoundly deaf.
- * Over 1 million children in the U.S. have a hearing loss.
- * 5% of children 18 years and under have hearing loss.
- * 1 in 22 infants born in the U.S. has some kind of hearing problem.
- * 6 in every 1000 infants born in the U.S. has some degree of hearing loss.
- * 1 in every 1000 infants born in the U.S. has a severe or profound hearing loss.
- * 83 out of every 1000 children in the U.S. have what is termed an educationally significant hearing loss.
- * Among every 1000 school-age students in the U.S., 7 have bilateral and 16-19 have unilateral hearing losses that may significantly interfere with their education.
- * Among school age children, severe to profound hearing loss occurs in about 9 children of every 1000.
- * 10 in 1000 school age students have permanent sensorineural hearing loss.
- * Approximately 30% of children who are hard of hearing have a disability in addition to a hearing loss.

Did you know that...

- * Hearing loss is the most common congenital anomaly found in newborns...and yet not all newborns are routinely tested for it.
- * Approximately three per 1000 babies are born with a significant hearing loss, and many more children are born with milder forms of hearing loss.
- * 14.9% of US children aged six to nineteen have a measurable hearing loss in one or both ears.
- * Any degree of hearing loss can be educationally handicapping for children. Even children with mild to moderate hearing losses can miss up to 50% of classroom discussions. Unmanaged hearing loss in children can affect their speech and language development, academic capabilities and educational development, and self-image and social/emotional development.
- * The average age of identification of hearing loss in infants is two and a half to three years of age - well past the critical period for speech & language development.
- * Studies estimate that as much as 90% of what young children learn is attributable to the reception of incidental conversations around them.
- * 37% of children with only minimal hearing loss fail at least one grade.
- * All children can be evaluated for hearing loss. Even children who are only minutes old can have their hearing assessed using tests that are safe, painless and easy to administer.
- * Recent NIH studies have shown that children with hearing loss who are identified and receive early intervention prior to six months of age develop significantly better language ability than children identified after six months.
- * 93 percent of deaf children are born into hearing families; only 7 percent are born into deaf families.
- * American Sign Language (ASL) is the third most widely used language in the United States.

CONTACTING YOUR STATE LEGISLATOR

Some parents want to send a copy of their appeal letter to their local legislators. To find the addresses of your elected officials, follow the procedure below.

1. Go to <http://maps.commissions.leg.state.mn.us/website/districts/> .
2. Type in your home address.
3. Click on “Search”.
4. The legislator’s address should be easy to locate – if you don’t see it, sometimes by clicking on the “contact” button, it will display their address.

WEBSITES

For Supporting Documents:

Varying Degrees of Hearing Loss

Children's Hospital and Regional Medical Center, Seattle, Washington
www.newborn-hearing-screening.org/pdf/degree_hearingloss_chart.pdf

(A copy is also included in the "Support Documents" folder.)

Effects of Hearing Loss

American Speech-Language-Hearing Association (ASHA)

www.asha.org/public/hearing/disorders/effects.htm

(A copy is also included in the "Support Documents" folder.)

Facts & Figures about Hearing Loss in Children

Help Kids Hear

<http://84.40.22.54/facts/index.html>

(A copy is also included in the "Support Documents" folder.)

For More Information:

Alexander Graham Bell Organization

www.agbell.org

Minnesota Academy of Audiology

www.minnesotaaudiology.org

click on the "Patient Resources" link on the left side

American Academy of Otolaryngology – Head and Neck Surgery (AAO–HNS)

www.entnet.org/HealthInformation/childshearing.cfm

American Speech-Language-Hearing Association (ASHA)

www.asha.org/public/

Boystown

www.boystownhospital.org

click on the "Hearing Loss" tab

Early Hearing Detection & Intervention (EHDI) Program

www.cdc.gov/ncbddd/hearingloss

League for the Hard of Hearing

www.chchearing.org/

click on "About Hearing Loss."

IMPACT OF VARYING DEGREES OF HEARING LOSS

Degree of Hearing Loss	What it Means	<u>Without</u> Amplification and Early Intervention	<u>With</u> Amplification and Early Intervention
Mild	Sounds softer than 25 dB (decibels) to 40 dB are not detected.	<p>Soft sounds such as a faucet dripping, birds chirping, and some speech sounds may not be heard.</p> <p>Sounds that are moderately loud to a normal hearing person, such as speech, will be soft.</p> <p>A child will have trouble hearing faint or distant speech, and may have trouble hearing in a noisy environment.</p>	Most children can recognize and understand soft sounds of speech and the world around them.
Moderate	Sounds softer than 40 dB (decibels) to 65 dB are not detected.	<p>Most speech sounds, and louder sounds such as a clock ticking, or a vacuum cleaner may not be heard.</p> <p>Sounds that are loud to a normal hearing person will be soft. Speech can only be understood if it is loud.</p> <p>A child may have limitations in vocabulary, language comprehension and language usage.</p> <p>A child may have errors in his or her own speech.</p>	<p>Most children can recognize and understand soft sounds of speech and the world around them.</p> <p>Most children develop age-appropriate vocabulary, language comprehension and language usage.</p> <p>Most children learn to monitor their own speech production and to speak clearly.</p>
Severe	Sounds softer than 65 dB (decibels) to 90 dB are not detected.	<p>Most speech sounds will not be understood, and other loud sounds such as a phone ringing or a dog barking may be missed.</p> <p>Sounds that are very loud to a normal hearing person will be very soft.</p> <p>Speech will only be heard if it is shouted in the ear.</p> <p>Spoken language comprehension and speech will not develop spontaneously.</p> <p>A child with severe hearing loss will have mostly unintelligible speech.</p>	<p>The majority of children can detect and understand most sounds.</p> <p>Most children can learn to understand and use spoken conversation, even though they will not hear speech the way normal hearing people do.</p> <p>Most children will need special accommodations, especially in school, to compensate for the challenges that distance and background noise present.</p>
Profound or Severe-Profound	<p>Sounds softer than 90 dB (decibels) are not detected.</p> <p>A child with a profound or severe-profound hearing loss may be called Deaf.</p>	<p>Very loud sounds such as an airplane flying overhead or a lawnmower will not be detected.</p> <p>A child will rely on vision rather than hearing for primary communication.</p> <p>A child will have unintelligible speech.</p>	<p>Many children can detect moderately loud sounds and spoken conversation under ideal listening conditions (no background noise and facing the speaker).</p> <p>Many children still need visual communication to assist them in understanding spoken conversation.</p> <p>Most children will need special accommodations, especially in school, to compensate for the challenges that distance and background noise present.</p> <p>Many children can develop age-appropriate language comprehension and language usage.</p>