AMERICAN
SPEECH-LANGUAGE-
HEARING
ASSOCIATION

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April 23, 2018

Ms. Seema Verma
Administrator, Centers for Medicare & Medicaid Services
Department of Health and Human Services
P.O. Box 8010
Baltimore, MD 21244-8010

RE: Short-Term, Limited-Duration Insurance [CMS-9924-P]

Dear Administrator Verma:

On behalf of the American Speech-Language-Hearing Association, I write to offer comments on the proposed rule, Short-Term, Limited-Duration Insurance.

The American Speech-Language-Hearing Association (ASHA) is the national professional, scientific, and credentialing association for 198,000 members and affiliates who are audiologists; speech-language pathologists; speech, language, and hearing scientists; audiology and speech-language pathology support personnel; and students.

ASHA is concerned that, if implemented, the Short-Term, Limited-Duration Insurance (STLDI) proposed rule will negatively impact the individual market.[1] Currently, federal law requires critical consumer protections such as enforcing essential health benefits (EHB), banning pre-existing condition exclusions, and eliminating ratings based on health status within the individual market. These requirements protect consumers with specific health needs who require audiology and/or speech-language pathology services. In addition, consumers who are healthy when they choose an STLDI may become unexpectedly ill or injured (e.g., traumatic brain injury) and need rehabilitative therapy to help regain skills and functioning. However, if the STLDI plan chosen does not provide rehabilitation, the consumer will face unexpected out-of-pocket costs for medically necessary health care services that could threaten access to care and recovery.

This letter includes ASHA's comments on the following provisions outlined in the proposed rule:

- Expansion of Short-Term, Limited-Duration Plans
- Essential Health Benefits
- Consumer Disclosure Requirements

**Expansion of Short-Term, Limited-Duration Plans**

Short-term plans are designed to fill *temporary* gaps in coverage. These policies should not exceed 3 months and renewability should be restricted.

The proposed rule would allow STLDI plans to enroll individuals for as long as 364-days. Allowing extensions of these policies expands the period of time in which people may be underinsured, leaving consumers with inadequate coverage and at financial risk if they fall ill. Moreover, consumers could be left with uncovered bills and/or find themselves "uninsurable." Because insurers can deny a new contract if the enrollee becomes sick or injured during the coverage term, consumers may believe they can extend or renew coverage until rejected by the issuer. If their short-term plan ends before Marketplace open enrollment, their loss of coverage would not qualify for a special enrollment

period, leaving the consumer to wait until the next annual open enrollment period to select a new plan. This will result in a coverage gap for many consumers.

Consumers seeking coverage for 3 months or longer can get covered through the Marketplaces. Allowing short-term plans longer than 3 months undermines the risk pools in the individual market by encouraging healthy people to use short-term plans as an alternative to Affordable Care Act (ACA) plans. This would increase premiums in the individual market, making comprehensive coverage with pre-existing condition protections less affordable for consumers, particularly those that are ineligible for premium tax credits.[2]

Therefore, ASHA urges the U.S. Department of Health and Human Services, the Department of the Treasury, and the Department of Labor (Departments) not to finalize proposed changes to the regulation in §54.9801-2 / §2590.701-2 / §144.103. Instead, ASHA urges the Departments to retain the existing definition limiting the duration of STLDI to "less than 3 months", and should also retain the language, "taking into account any extensions that may be elected by the policyholder with or without the issuer's consent."

In addition, allowing renewals would also undermine the risk pools in the ACA-compliant individual market. States are the primary regulators of insurance and should maintain authority to regulate the renewability of these plans as well as the application and reapplication process.

**Essential Health Benefits**

Currently, federal law requires coverage of 10 essential health benefits (EHB), including rehabilitative and habilitative services and devices in the individual market. As a result of the proposed rule, STLDI plans could substantially scale back benefits by dropping benefit categories entirely or dramatically limiting them. Consumers with specific health needs would be impacted based on the generosity of the benefits offered. For example, an individual with Parkinson's disease who has difficulty with speech and swallowing, and requires rehabilitative speech-language pathology services to treat their deficits could be denied coverage. Another example is a 3-year-old child with severe congenital hearing loss who requires the fitting of hearing aids and habilitative treatment to develop auditory and speech-language skills provided by both an audiologist and speech-language pathologist could be denied coverage to one or both of those medically necessary services.

Rehabilitative services and devices are essential in helping Americans retain, improve, or regain skills and functions that may have been lost or diminished due to an injury, illness, or disability. Rehabilitation is provided to individuals with neurological and medical conditions such as acquired brain injury or disease, stroke, and head and neck cancers. Americans who need habilitative services and devices rely on their health care coverage to: (a) acquire skills and functions that were never learned due to a disability; and (b) retain skills so they can live as independently as possible. Habilitation is typically appropriate for individuals with neurological and developmental conditions that—in the absence of such services—prevent them from acquiring certain skills and functions over the course of their lives, particularly in childhood. Often skills acquired through rehabilitative and habilitative services and devices lead to breakthroughs in functional ability that would not have been possible without access to timely and appropriate rehabilitation and habilitation benefits. Coverage and access reduce long-term disability and dependency costs to society.

Before comprehensive coverage of medically necessary services was mandated, few Americans understood what habilitation is or the benefits it brings to those who rely on these services and

devices. In fact, only three states adopted coverage requirements for habilitative services in the individual market. Since the enactment of the EHB, the value of rehabilitative and habilitative services has been widely acknowledged and access to these services has appropriately expanded.[3, 4]

One of the criticisms of the EHB requirement is that it significantly increases premiums; however, evidence suggests that other factors may have a greater impact on premiums. For example, Milliman provides an estimate of the total cost for providing selected hearing services, speech-language therapy, hearing supplies, devices, and related professional services in a commercial employer group population, noting a utilization rate of approximately one per thousand, with PMPM (per member per month) claim costs of approximately $1.48 for 2014. These estimates are based on current levels of coverage, eligibility, and benefit design.[5]

A recent analysis indicates that removing EHBs would not notably trim the cost of monthly premiums.[6] Instead, costs absorbed by consumers would increase considerably. The analysis also finds that rehabilitative and habilitative care represent only 2% of the premium. ASHA remains steadfast in its support for the continued coverage of rehabilitative and habilitative services and devices within the individual market.

**Consumer Disclosure Requirements**

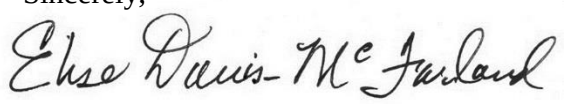
While ASHA has strong concerns about the implications of this rule, we do support efforts in the proposed rule to help consumers who purchase STLDI to understand the coverage they are purchasing. We believe notice is vital for consumers to understand the limits of STLDI and that STLDIs are not providing comprehensive coverage. We appreciate the specific language that clarifies that the STLDI plan does not comply with federal requirements and that enrollees might have to wait until an open enrollment period to get other, more comprehensive health insurance coverage.

ASHA recommends that the notice needs clarification and simplification to be understood by consumers and that the notice be available in multiple languages. As the preamble notes, allowing short-term plans to provide coverage for just under 1 year will make it more difficult for consumers to distinguish between short-term plans and ACA plans. The notice must make clear how short-term plans differ from ACA plans. ASHA recommends listing specific examples of ACA protections in the notice, including pre-existing conditions and EHBs. Also, the draft notice language does not clearly explain that loss of eligibility or coverage in a short-term plan will not trigger a special enrollment period. For example, if the Departments finalize this regulation, they should require short-term plans to create and disseminate summaries of benefits and coverage (SBCs) similar to existing requirements for individual health insurance plans. SBCs would help consumers understand the limitations of short-term coverage and make informed comparisons to ACA individual market plans.

In closing, expanding STLDI plans will undermine the individual market by pulling healthy individuals away and leaving an older, sicker risk pool within the Marketplace. Many individuals who rely on comprehensive coverage—including women, older adults, individuals with chronic conditions, and those with disabilities—would be left without affordable, comprehensive options. If healthier individuals are syphoned from the individual market, costs will increase and plan choices will decrease for the remaining individuals. In addition, middle-class consumers with incomes too high to qualify for subsidies, would face rising premiums and potentially fewer plan choices.

Thank you for the opportunity to provide comments on the Short-Term, Limited-Duration proposed rule. If you or your staff have any questions, please contact Daneen G. Sekoni, MHSA, ASHA's director of health care policy, health care reform, at dsekoni@asha.org.

Sincerely,



Elise Davis-McFarland, PhD, CCC-SLP
2018 ASHA President

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[1] Georgians for a Healthy Future. (218). *Non-ACA-Compliant Plans and the Risk of Market Segmentation.* Retrieved from http://healthyfuturega.org/wp-content/uploads/2018/03/Non-ACA-Compliant-Plans-and-the-Risk-of-Market-Segmentation.pdf.

[2] American Academy of Actuaries. (November 7, 2017). *Letter to Acosta, Hargan, and Mnuchin*. Retrieved from http://www.actuary.org/files/publications/Executive_Order_Academy_Comments_110717.pdf.

[3] Centers for Medicare & Medicaid Services. (n.d.) The Center for Consumer Information & Insurance Oversight. Retrieved from https://www.cms.gov/CCIIO/Resources/Forms-Reports-and-Other-Resources/.

[4] HealthCare.gov. (n.d.) Glossary of Health Coverage and Medical Terms. Retrieved from https://www.healthcare.gov/sbc-glossary/

[5] Milliman is an actuarial consulting firm with offices worldwide.

[6] Blumberg, Linda and Holahan J. (2017). Urban Institute and the Robert Wood Johnson Foundation. *The Implications of Cutting Essential Health Benefits: An Analysis of Nongroup Insurance Premiums under the ACA*. Retrieved from https://www.rwjf.org/en/library/research/2017/07/the-implications-of-cutting-essential-health-benefits.html?cid=xem_other_unpd_ini:qs7_dte:20170710.