



AMERICAN
SPEECH-LANGUAGE-
HEARING
ASSOCIATION

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December 21, 2018

Seema Verma, MPH
Administrator
Centers for Medicare & Medicaid Services
U.S. Department of Health and Human Services
Attention: CMS-9936-NC
P.O. Box 8013
Baltimore, MD 21244-8013

RE: State Relief and Empowerment Waivers (CMS-9936-NC)

Dear Administrator Verma:

On behalf of the American Speech-Language-Hearing Association, I write to offer comments on the State Relief and Empowerment Waivers guidance related to section 1332 of the Patient Protection and Affordable Care Act (PPACA).

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 strongly urges the Centers for Medicare and Medicaid Services (CMS) to approach state waiver requests under section 1332 of the PPACA in a manner consistent with the congressional intention of the section and to revise or rescind this guidance. ASHA supports CMS' goal of adopting innovative strategies to reduce health care costs through this guidance. However, the harmful effect on consumers' access to medically necessary rehabilitative and habilitative services and devices, especially those with pre-existing conditions, is of significant concern. Essential health benefits (EHB) and pre-existing conditions requirements protect consumers with specific health needs who require audiology and/or speech-language pathology services. In some cases, the health plan beneficiary has a pre-existing condition that triggers the need for rehabilitative care.

ASHA appreciates the opportunity to provide comments on the following topics:

- comprehensiveness and affordability statutory guardrail;
- number of state residents covered (coverage) statutory guardrail; and
- value of rehabilitative and habilitative services and devices.

Comprehensiveness and Affordability Statutory Guardrail

Under the guidance, CMS will evaluate *comprehensiveness* by comparing access to coverage under the waiver to the state's EHB benchmark. CMS will consider the *affordability* requirement to be met in a state waiver that provides consumers access to coverage options that are at least as affordable and comprehensive as the coverage options provided without the waiver to at least a comparable number of people as would have had access to such coverage absent the waiver.

ASHA acknowledges that the guidance does not explicitly permit state 1332 waivers that eliminate protections for individuals with pre-existing conditions. It does, however, present a considerable

expansion of state authority under Section 1332 in “[t]hese waivers could potentially be used to allow states to build on additional opportunities for more flexible and affordable coverage that the Administration opened through expanded options for Association Health Plans (AHP) and short-term, limited-duration insurance (STLDI).”

Maintaining access to comprehensive and affordable coverage must continue to be the primary measure of accountability for state 1332 waiver requests. “Comprehensive” and “affordable” should not be viewed as separate inquiries; they are dual prongs of a single, essential statutory requirement. Satisfying one element to the detriment of the other fails to meet consumer needs. ASHA is concerned that the guidance contemplates approval of waivers with other coverage types (e.g., AHPs, STLDI) that are deemed affordable as long as comprehensive coverage, at greater expense than STLDI, remains available. ASHA strongly urges CMS not to approve state waiver requests unless they provide affordable comprehensive coverage to those who need it, including individuals with pre-existing conditions.

The non-PPACA compliant coverage options encouraged within the guidance may accommodate relatively healthy individuals but not consumers with chronic conditions and disabilities. Most importantly, they will not meet the needs of those who have an unexpected illness or injury. Insurance, at its core, provides for shared risk to address both expected and unexpected health care needs that may be outside of an individual’s control. For example, consumers who are healthy when they opt for STLDI may become ill or injured (e.g., traumatic brain injury) and need rehabilitative therapy to help regain skills and functioning from their unexpected circumstance. 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 but also impact their recovery, quality of life, and their ability to return to a reasonable level of independence. When denied adequate access to rehabilitation, individuals that could otherwise return to independence and the workplace may be forced to rely unnecessarily on public support.

Number of State Residents Covered (Coverage) Statutory Guardrail

Under the waiver, CMS will consider the comprehensiveness and affordability guardrails met if consumers will continue to have access to coverage that is as affordable and comprehensive as coverage that would have been available without the waiver. ASHA does not agree with CMS’ interpretation. The clear language of the statute states that waivers must be measured by the coverage that they actually *provide*, not by the coverage that they *make available*.¹ Moreover, ASHA is concerned that CMS may approve waivers resulting in temporary reductions in coverage so long as the reduction is interpreted or characterized as reasonable. However, the statute does not allow waivers to make temporary reductions in the number of individuals covered, which runs counter to the congressional intent and established law.

Value of Rehabilitative and Habilitative Services and Devices

There is significant value in having insurance coverage that includes rehabilitative and habilitative services and devices.^{2,3} Rehabilitation services and devices help individuals retain, improve, or regain skills and functions that may have been lost or diminished due to an injury, illness, or disability. Rehabilitation addresses the functional needs of individuals with neurological and medical conditions such as acquired brain injury or disease, stroke, and head and neck cancers. For example, an individual with Parkinson’s disease who has difficulty with speech and swallowing requires rehabilitative speech-language pathology services to treat the deficits.


Individuals who need habilitation 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 many types of 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. For example, a 3-year-old child with severe congenital hearing loss requires the fitting of hearing aids and related habilitative treatment from audiologists and speech-language pathologists to develop auditory and speech-language skills in order to improve functional performance to keep pace at school and later in the workplace.

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. This reduces long-term disability and dependency costs to society.

Criticisms of the EHB requirement include concerns regarding increased premiums; however, evidence suggests that other factors, such as community rating, may have more of an effect on premiums. In fact, coverage of audiology and speech-language pathology services do not significantly increase premiums. Milliman provides an estimate of the total cost of 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 per member per month (PMPM) claim costs of approximately \$1.48 according to 2014 data.⁴ These estimates are based on current and commonly available levels of coverage, eligibility, and benefit design.

Thank you for the opportunity to provide comments on this guidance document. We urge CMS to ensure that any flexibility it affords to states does not make it harder for individuals with chronic conditions, disabilities, illnesses, or injuries to purchase the meaningful and affordable coverage needed to meet their health care needs. If you or your staff have any questions, please contact Daneen G. Sekoni, MHSA, ASHA's director for health care policy, health care reform, at dsekoni@asha.org.

Sincerely,



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

¹ <https://www.law.cornell.edu/uscode/text/42/18053>.

² National Outcomes Measurement System (NOMS) [Internet]. Rockville (MD): American Speech-Language-Hearing Association. Available from <https://www.asha.org/noms/>

³ Yoshinaga-Itano, C. (2003). From Screening to Early Identification and Intervention: Discovering Predictors to Successful Outcomes for Children with Significant Hearing Loss. *The Journal of Deaf Studies and Deaf Education*. 8(1), 11–30. Retrieved from <https://doi.org/10.1093/deafed/8.1.11>.

⁴ Milliman is an actuarial consulting firm with offices worldwide.