ASHA
American
Speech-Language-Hearing
Association

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July 27, 2021

The Honorable Patty Murray
Chair, Committee on
Health, Education, Labor, and Pensions
428 Dirksen Senate Office Building
Washington, DC 20510

The Honorable Frank Pallone
Chair, Committee on
Energy and Commerce
2125 Rayburn House Office Building
Washington, DC 20515

Chairwoman Murray and Chairman Pallone:

On behalf of the American Speech-Language-Hearing Association, I write to provide a response to the recent request for information on design considerations for legislation to develop a public health insurance option.

The American Speech-Language-Hearing Association (ASHA) is the national professional, scientific, and credentialing association for 218,000 members and affiliates who are audiologists; speech-language pathologists; speech, language, and hearing scientists; audiology and speech-language pathology support personnel; and students. Audiologists specialize in preventing and assessing hearing and balance disorders as well as providing audiologic treatment, including hearing aids. Speech-language pathologists (SLPs) identify, assess, and treat speech, language, swallowing, and cognitive-communication disorders.

Overview

Audiologists and SLPs are highly educated, trained, and certified health care professionals who are licensed in every state to provide evaluation and treatment services. In New Jersey and Washington state, there are over 11,300 ASHA members who work across health settings to help people learn, maintain, or improve skills and functional abilities that have not developed normally (habilitation), and to regain skills that have been impaired due to injury, illness, or condition(s) that have impacted normal functioning (rehabilitation).[1,2]

Principles for a Public Health Insurance Option

The Coronavirus Disease 2019 (COVID-19) pandemic has highlighted and exacerbated pervasive inequities and deficiencies in our health care system, especially for those who lack health coverage through their employers, private payers, or public programs such as Medicare or Medicaid. ASHA agrees that all Americans should have access to affordable and high-quality health care. The following comments outline principles for designing a public option that would expand quality coverage of hearing, balance, speech, language, swallowing, and cognitive care to more Americans, improve affordability for families, and lower health care costs.

Comprehensive Coverage of Essential Health Benefits

The Patient Protection and Affordable Care Act (ACA) mandated 10 specific benefit categories, or essential health benefits (EHBs), that ACA health plans must offer to consumers who purchase health insurance coverage in the individual or small group markets.[3] Under the law, marketplace health insurance plans must cover habilitative and rehabilitative services and devices to help people with injuries, disabilities, or chronic conditions gain or recover mental and physical skills.

Habilitative and rehabilitative benefits are particularly important for people with hearing loss, stroke, traumatic brain injury, and autism spectrum disorder. These conditions can affect an individual's ability to communicate with others and can impact their quality of life as well as impose avoidable costs on the health care system.

Audiology and speech-language pathology services are vital services for helping patients with speech, language, cognitive, swallowing, hearing, and balance disorders acquire, maintain, or regain skills to improve functional communication outcomes. Effective treatment leads to enhanced social, emotional, educational, and employment opportunities that increase the likelihood of independent living and may even halt or slow the progression of a disability—resulting in an improved quality of life and lower health care costs.

For example, children whose hearing loss is identified within the first few months of life and who receive early intervention have significantly better language, speech and social-emotional development.[4] Two-thirds of adults with diseases of the central nervous system (e.g., Parkinson's disease, multiple sclerosis) who were unintelligible at the outset of speech-language treatment progressed to a level of increased communicative independence.[5] Furthermore, 80% of stroke patients with receptive and expressive language disorders achieved one or more levels of progress on a standardized measurement scale with speech and language therapy.[6]

ASHA supports ensuring comprehensive coverage of EHBs—such as habilitation and rehabilitation service—as part of any public option legislation.

Ensuring Adequate Payment for Services

The ability of a public option to encourage the participation of a sufficient number of qualified providers, particularly for specialized health care services such as those furnished by audiologists and SLPs, will be determined in large part by the reimbursement rates for those services. Regardless of how provider payment rates are calculated or structured, it must be financially feasible for providers to participate and practical for them to offer an appropriate range of services to meet the clinical needs of each individual patient. The experiences of ASHA members under Medicare and Medicaid provide some insight in this area.

Under Medicare, payments under Part B for outpatient services paid under the Medicare Physician Fee Schedule must be budget neutral, requiring arbitrary cuts to reimbursement for some services—unrelated to the cost of providing care—to increase payments for others. The resulting payment volatility has threatened the financial stability of physician and nonphysician providers alike and prompted Congress to mitigate scheduled cuts for 2021. The financial instability and excessive reductions to reimbursement unrelated to the cost of providing care would have inhibited the ability of audiologists and SLPs to provide services that improve outcomes and lower costs had Congress not acted.

Other Medicare policies, such as the Patient-Driven Payment Model (PDPM) that revised the payment methodology for the skilled nursing facility prospective payment system, have had unintended consequences that resulted in reduced hours and layoffs for therapy providers.[7] The Centers for Medicare & Medicaid Services reported that average therapy minutes provided per patient, per day, dropped from 91 minutes to 62 minutes (a decrease of approximately 30%) under the new system in 2020.[8]

Under Medicaid, state Medicaid programs are required to ensure that provider payments are "consistent with efficiency, economy, and quality of care and are sufficient to enlist enough providers" to provide access to care and services comparable to those generally available.[9] However, some states have utilized flexibility provided by the Centers for Medicare & Medicaid Services during the previous Administration to establish payment rates and ranges below the current fee-for-service (FFS) Medicaid rate, which lowers provider reimbursements to unsustainable levels and imperils access to care. Florida is one example where the Medicaid Managed Care Organization (MCO) network may reimburse providers below the base FFS rate. Other states, like South Carolina, may honor the current FFS rate for existing providers in MCOs only, but require new providers to accept 80% of the FFS rate. Consequently, fewer providers are able to participate in the network, constraining access to care for program participants.

These examples illustrate the importance of establishing payment policies that prioritize access to high quality care while ensuring sufficient provider participation, so beneficiaries have access to the services they need. Providers such as audiologists and SLPs should be reimbursed appropriately under any public option as both are essential to the delivery of integrated, team-based care that is critical to the health and well-being of individuals who would obtain coverage through such a system.

ASHA offers the following information for questions 2 and 3:

- In response to question number 2 on the RFI, ASHA maintains that sufficient payment is one important way to ensure adequate access to providers for enrollees in a public option.
- Regarding question number 3, ASHA maintains that payment for services and devices must meet the needs of individuals and reflect the practical applications of providing such items and services to ensure a meaningful benefit. For example, hearing aids should be provided in conjunction with coverage for related services when medically necessary. Such services may include a comprehensive hearing evaluation, fitting, verification, patient training and education on functionality, safety and appropriate use, a minimum of one follow-up visit for calibration and adjustments, and routine maintenance visits on a specified schedule.

ASHA supports ensuring adequate provider payments to guarantee that individuals have access to necessary audiology and speech-language pathology services and devices.

Provider Nondiscrimination Protection

An adequate network of qualified health care professionals is necessary to ensure meaningful access to covered benefits and to meet individual needs and preferences, especially in rural and medically underserved areas. In addition to adequate reimbursement, one important way to ensure an adequate network of providers is to include protections to prohibit discrimination against qualified licensed health care professionals based solely on their license.

The ACA included a provider nondiscrimination provision to prohibit health plans from discriminating against such nonphysician health care professionals, although it was not implemented by the required deadline of January 1, 2014. This provision is a critical part of ensuring that patients have access to care, no matter where they live, by requiring insurers to treat providers fairly. The lack of current regulation to ensure that discrimination does not take place has resulted in providers (e.g., audiologists and SLPs who are acting within the scope of

their license and certification) being excluded from insurance networks or experiencing payment discrimination.

ASHA appreciates your leadership in requiring the U.S. Departments of Health and Human Services, Labor, and Treasury to promulgate regulations to implement this provision by January 1, 2022, as part of H.R. 133, the Consolidated Appropriations Act, 2021 (Public Law 116-260), and maintains that similar protections should be part of any public option to promote competition, consumer choice, and access to high quality health care.

ASHA supports inclusion of provider nondiscrimination provisions to ensure qualified and licensed health care professionals are protected against discriminatory practices based solely on their license.

Protections for People with Preexisting Conditions

According to the Center for American Progress, 135 million people under age 65, or about half of nonelderly people, have a preexisting condition that an insurer could use to discriminate against them if they ever sought coverage through the individual market in the absence of ACA protections.[10] Although ACA protections remain in place, ongoing court challenges and legislative efforts to eliminate those protections loom. Yet, 75% of Americans say it is "very important" to retain the ACA provision to prevent insurance companies from denying coverage based on a person's medical history and 72% say it is "very important" to prohibit insurance companies from charging sick people more.[11] The ability of individuals with preexisting conditions to obtain coverage of needed services is a fundamental feature on which the success of any public option depends on.

ASHA supports ensuring that individuals with preexisting conditions may obtain coverage in a manner equitable to those without such conditions.

Enrollee Nondiscrimination Protections

ASHA fully supports equal health care protections for all, regardless of age, race, ethnicity, national origin, sex, gender identity, sexual orientation, or disability. ASHA applauds the May 10, 2021, decision issued by the U.S. Department of Health and Human Services to interpret and enforce the ACA Section 1557 nondiscrimination provision to include sexual orientation and gender identify, contrary to efforts of the previous Administration to roll back these protections.

The fear of discrimination may lead individuals to forego needed care and treatment, adversely impacting their health and leading to higher costs as a result.[12] Benefit design should be carefully considered to ensure that people with disabilities and/or chronic conditions do not experience discrimination based on age, disability, and the type and/or severity of their disability, particularly relating to accessing habilitation and rehabilitation services.

For example, ASHA supports coverage protections for transgender individuals and access to gender affirmation services. ASHA members provide vital speech-language pathology services to individuals who want to ensure their voice reflects their gender identity.[13] However, health plans inconsistently cover voice treatment for transgender and gender diverse individuals, even when they identify it consistently as a key health service related to their transition.[14]

Age limits also are often applied on the coverage for hearing aids. Several EHB benchmark plans offer no coverage at all or limit coverage to children only. Failure to cover hearing aids

discriminates against a specific group of people with hearing loss. In addition, coverage of hearing aids for children only and not for adults potentially violates the ACA prohibition against discrimination in plan design based on age.

ASHA supports ensuring that all individuals have access to medically necessary care provided by audiologists and SLPs regardless of their age, race, ethnicity, national origin, sex, gender identity, sexual orientation, or disability.

Promoting Health Equity

The COVID-19 pandemic has highlighted disparities and inequities in our health care system that make it more challenging for historically underrepresented and underserved groups, including individuals with disabilities, to obtain care than others. Unfortunately, despite the ACA, Black, Hispanic, American Indian, and Alaska Native individuals are much more likely than non-Hispanic white people to be uninsured.[15] For example, in 2018, Hispanic people were more than 250% more likely to be uninsured than non-Hispanic white individuals.[16]

In response to question number 8 on the RFI, ASHA maintains that it is critical for these disparities and inequities to be addressed. This may be achieved by specifically incorporating members of such communities in the design process and ensuring robust coverage of identified services based on relevant quality measures to meet their needs.

ASHA supports engagement with members of historically underrepresented and underserved communities as part of the design and decision-making process to identify and address the needs of such communities.

Ensuring Patient/Consumer Affordability

It is important to note that meaningful access to comprehensive coverage requires financial affordability. Design consideration such as how the prices for items and services are determined, how the benefit package is structured, and whether and how much premium assistance to provide must account for the impact on premiums, deductibles, and copayments, and whether the resulting coverage not just lowers costs, but is within the financial means of participants.

ASHA supports enhancing affordability by promoting enrollment that helps reduce cost through shared risk as well as providing financial support for lower income Americans.

Conclusion

Thank you for the opportunity to provide comments to the request for information on design considerations for legislation to develop a public health insurance option. If you or your staff have any questions, please contact Jerry White, ASHA's director of federal and political affairs, at jwhite@asha.org.

Sincerely,

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2021 ASHA President

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