ASHA
American
Speech-Language-Hearing
Association

February 2, 2026

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

The Honorable Jason Smith
Chair
Committee on Ways and Means
1139 Longworth House Office Building
Washington, DC 20515

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

The Honorable Richard Neal
Ranking Member
Committee on Ways and Means
1139 Longworth House Office Building
Washington, DC 20515

Dear Chairman Guthrie, Chairman Smith, Ranking Member Pallone, and Ranking Member Neal:

The American Speech-Language-Hearing Association (ASHA) supports efforts by the Committees on Energy and Commerce and Ways and Means to assess how commercial insurance policies affect clinical practice, financial sustainability of health care professions, and access to care for patients.

ASHA is the national professional, scientific, and credentialing association for more than 241,000 members, certificate holders, and affiliates who are audiologists; speech-language pathologists (SLPs); speech, language, and hearing scientists; audiology and speech-language pathology assistants; and students. Audiologists specialize in preventing and assessing hearing and balance disorders as well as providing audiologic treatment, including hearing aids. SLPs identify, assess, and treat speech, language, swallowing, and cognitive communication disorders. ASHA members practice in hospitals, skilled nursing facilities, inpatient rehabilitation facilities, outpatient clinics, schools, home health, and private practices. They experience firsthand how insurer policies directly shape patient access, outcomes, and affordability.

Prior Authorization Is a Barrier to Timely, Medically Necessary Care

Prior authorization is intended to ensure appropriate care. However, its excessive and inappropriate use by health plans, particularly Medicare Advantage (MA) plans, has become a barrier to timely treatment. Prior authorization unnecessarily delays treatments, disrupts continuity of care, undermines clinicians' professional judgment, and worsens patient outcomes.

In addition to the potential for patient harm, prior authorization requirements often increase administrative burden for patients and their clinicians as they must fax or use inefficient online portals to send documentation and appeal inappropriate denials. Simple and inadvertent errors in the submission process cause denials despite the medical necessity of the care.

ASHA has heard from insurers and clinicians that the vast majority—in some cases more than 90%—of prior authorization requests are ultimately partially or fully approved, undermining the utility of such practices. Such high approval rates also raise doubts about the appropriateness of the administrative costs related to prior authorization review processes. Programs to eliminate prior authorization requirements for clinicians who consistently are approved for meeting coverage standards, often referred to as "gold carding," are frequently mismanaged. For such gold card programs to function as intended, criteria must be objective, transparent, and consistently applied. Further, gold card programs are rarely made available to nonphysician providers, preventing audiologists and SLPs from qualifying despite high levels of prior authorization approvals.

Federal oversight bodies have documented these problems. Analyses by the U.S. Department of Health and Human Services Office of Inspector General and investigations by the Senate Permanent Subcommittee on Investigations Majority Staff in the 118th Congress have shown that MA plans routinely delay or deny services that meet Medicare coverage criteria, including in post-acute care settings where audiologists and SLPs practice.[1,2]

These practices are particularly harmful for older adults, as well as individuals recovering from strokes, neurological injuries, or serious illnesses. Delays or denials of critical audiology and speech-language pathology rehabilitation services may lead to poorer patient health outcomes and higher long-term costs. The use of prior authorization by MA plans to deny claims for services that would have been approved under traditional Medicare creates an inequitable system in which coverage for a medically necessary service is dependent on whether the Medicare beneficiary has chosen an MA plan or traditional Medicare.

It is certainly not the intention of the Part C program to set up disparate coverage systems that inherently place these enrollees at a disadvantage in accessing the Medicare benefit compared to their Medicare Part B counterparts. ASHA has worked with payers to try to improve MA prior authorization processes with limited success, in part due to a lack of federal requirements governing the use of prior authorization.[3]

ASHA urges the Committees to maintain oversight of prior authorization practices and to advance legislative solutions—such as Representative Mike Kelly's Improving Seniors' Timely Access to Care Act (H.R. 3514)—that improve transparency, expedite review processes, and bolster oversight.

Delayed and Inadequate Provider Payments Undermine Network Stability

ASHA members report persistent challenges related to delayed reimbursement and payment rates that fall below the cost of providing care. Unlike traditional Medicare, MA plans are not required to reimburse providers at consistent rates comparable to those paid under fee-for-service Medicare, even though MA benchmarks are derived from traditional Medicare spending. This imbalance has contributed to providers exiting MA networks, which threatens access to care—especially in rural and underserved communities.

Delayed payment for "clean," in-network claims compounds these challenges, forcing providers to absorb administrative costs and cash flow disruptions that small and independent practices cannot sustain. When providers are forced out of networks, patients

face fewer choices, longer wait times, and increased travel burdens, all of which raise costs and limit access to care.

ASHA encourages the Committees to examine insurer payment practices and advance bipartisan legislation—including Representative Lloyd Doggett's Prompt and Fair Pay Act (H.R. 4559), which would require MA plans to reimburse at least what would be paid under traditional Medicare—and implement enforceable standards for timely payment of clean claims.

Lack of Coverage for Medically Necessary Hearing Devices

ASHA is concerned about private insurers' widespread denial of coverage for medically necessary, osseointegrated hearing devices—including bone-anchored hearing aids and related services. These devices are not optional or cosmetic; they are essential for children and adults whose hearing needs cannot be met by conventional hearing aids. When coverage is denied, patients and families face significant out-of-pocket costs or forgo treatment entirely, resulting in long-term educational, social, and health consequences.

Failure to cover these devices and associated services, such as programming and aural rehabilitation, shifts costs to families and increases long-term public expenditures tied to untreated hearing loss. Ensuring appropriate coverage for osseointegrated devices aligns with broadly shared principles of affordability, prevention, and value-based care.

We urge the Committees to advance Ally's Act (H.R. 4606)—bipartisan legislation sponsored by Representatives Joe Neguse and Brian Fitzpatrick—that would compel private insurers to cover these hearing devices that are often wrongly denied.

Implementing Protections Against Provider Discrimination

Section 108 of the No Suprises Act, enacted as part of the Consolidated Appropriations Act of 2021 (P.L. 116-260), requires implementation of the provider nondiscrimination protections in Section 2706(a) of the Public Health Service Act. These protections require that "a group health plan and a health insurance issuer offering group or individual health insurance coverage shall not discriminate with respect to participation under the plan or coverage against any health care provider who is acting within the scope of that provider's license or certification under applicable State law."[4]

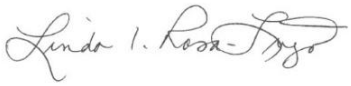
This policy is designed to prevent insurers from arbitrarily excluding certain provider types from their coverage networks. It also fosters more efficient utilization of the health care provider workforce. When patients are unable to access services that fall within nonphysician providers' state-licensed scopes of practice, it unnecessarily limits access to services those providers are licensed and qualified to provide.

To date, the U.S. Department of Health and Human Services, the U.S. Department of Labor, and the U.S. Department of the Treasury have not issued regulations implementing these provider nondiscrimination protections—regulations that by law were required to be enacted within one year of the No Surprises Act being passed. ASHA members continue to experience discrimination from health insurance companies. Audiologists and SLPs increasingly report coverage challenges and stagnant or declining reimbursement rates.

It is unacceptable that the administration has failed to promulgate rulemaking nearly four years past the statutory deadline provided under the No Surprises Act. We urge the Committees to require the Department of Health and Human Services, Department of Labor, and Department of the Treasury to issue regulations—as required by Congress—to protect health care providers from discrimination by health insurance companies and ensure access to the care they provide.

We appreciate the Committees' attention to these important issues. If you have additional questions, please contact Josh Krantz, director of federal affairs for health care, at jkrantz@asha.org.

Sincerely,



Linda I. Rosa-Lugo, EdD, CCC-SLP
2026 ASHA President

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[1] U.S. Department of Health and Human Services Office of Inspector General. (2022, April 27). *Some Medicare Advantage Organization Denials of Prior Authorization Requests Raise Concerns About Beneficiary Access to Medically Necessary Care*. https://oig.hhs.gov/reports/all/2022/some-medicare-advantage-organization-denials-of-prior-authorization-requests-raise-concerns-about-beneficiary-access-to-medically-necessary-care/

[2] U.S. Senate Permanent Subcommittee on Investigations. (2024, October 17). *Refusal of Recovery: How Medicare Advantage Insurers Have Denied Patients Access to Post-Acute Care*. https://www.hsgac.senate.gov/wp-content/uploads/2024.10.17-PSI-Majority-Staff-Report-on-Medicare-Advantage.pdf

[3] American Speech-Language-Hearing Association. (2025, March 22). *UnitedHealthcare Announces Broad Prior Authorization Requirements for Therapy and Chiropractic Services Under Its Medicare Advantage Plans*. https://www.asha.org/news/2024/unitedhealthcare-announces-broad-prior-authorization-requirements-for-therapy-and-chiropractic-services-under-its-medicare-advantage-plans/

[4] The Patient Protection and Affordable Care Act, H.R. 3590, Sec. 1201 amending the Public Health Services Act, Sec. 2706.