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February 27, 2020

Seema Verma, MPH
Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
Attn: CMS-9916-P
P.O. Box 8010
Baltimore, MD 21244

RE: Patient Protection and Affordable Care Act; HHS Notice of Benefit and Payment Parameters for 2021; Notice Requirement for Non-Federal Governmental Plans (CMS-9916-P)

Dear Administrator Verma:

On behalf of the American Speech-Language-Hearing Association, I write to offer comments on the proposed rule: Patient Protection and Affordable Care Act; HHS Notice of Benefit and Payment Parameters for 2021; Notice Requirement for Non-Federal Governmental Plans.

The American Speech-Language-Hearing Association (ASHA) is the national professional, scientific, and credentialing association for 211,000 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 committed to ensuring that Americans have access to affordable, high quality, and patient-centered health insurance coverage that meets their individual needs. Meaningful coverage of the essential health benefits of rehabilitative and habilitative services and devices is a top priority for ASHA. This letter includes ASHA's comments on the following topics discussed in the 2021 Payment Notice proposed rule:

- annual reporting of state-required benefits;
- promoting value-based insurance design; and
- automatic re-enrollment process.

Annual Reporting of State-Required Benefits

In the 2017 Payment Notice, the Centers for Medicare & Medicaid Services (CMS) affirmed a transitional policy specifying that § 156.110(f) allows states to determine services included in the habilitative services and devices category without triggering defrayal if the state's base-benchmark plan does not include coverage for that category. CMS interprets this to mean that, when a state has an opportunity to reselect its essential health benefit (EHB) benchmark plan, a state may update its habilitative services category as part of EHB-benchmark plan reselection without those updates subject to defrayal. As such, once a state has defined its habilitative services category under § 156.110(f), changes to state-required benefits related to habilitative services may trigger defrayal in accordance with § 155.170 if they are in addition to meeting EHB requirements and/or outside of an EHB-benchmark plan selection process. ASHA supports CMS's interpretation of the statutory requirements.

In response to concerns that states may not be defraying the costs of their state-required benefits that exceed EHB required levels, CMS proposes an annual reporting requirement to the Department of Health and Human Services (HHS) beginning in 2021. Under this proposal, states will be required to identify benefits mandated by state law, as well as which of those benefits are in addition to or outside of meeting the federal EHB mandates. ASHA understands that one purpose of this proposal is to provide additional information to HHS for increased oversight regarding whether states appropriately determine: 1) which state-required benefits require defrayal; 2) whether states implement the definition of EHB correctly; and 3) whether qualified health plan (QHP) issuers properly allocate the portion of premiums attributable to EHB for purposes of calculating premium tax credits.

While ASHA recognizes and supports CMS's intent to enforce existing policy, ASHA expresses concern that an additional reporting requirement for states creates an administrative burden since states already bear the responsibility for identifying which state-required benefits require defrayal. ASHA recommends that CMS enhance the specificity of the data requested from states to include the data elements referenced above and continue to allow states that collect, analyze, and track state-required benefits to submit this information to HHS in a form determined by the state. Such an approach aligns more fully with CMS's ongoing efforts to enhance state flexibility and reduce administrative burden.

Finally, ASHA appreciates CMS's longstanding policy related to improving coverage for habilitative services and devices during the EHB benchmark plan selection process. The American Occupational Therapy Association's 2019 Analysis of Rehabilitation and Habilitation Benefits in Qualified Health Plans found that the most basic information about the rehabilitation and habilitation benefits is often unclear or absent. In fact, only 50% of reviewed plans listed therapies under their habilitation benefit.¹ ASHA urges CMS to continue to monitor closely QHP habilitation coverage to ensure that plans cover all required services and devices determined to be medically necessary, and that QHPs implement the benefit category as intended by CMS.

Promoting Value-Based Insurance Design

CMS proposes a "value-based" model QHP that contains consumer cost sharing levels aimed at driving utilization of high value services while lowering utilization of low value services when medically appropriate. In the proposed rule, Table 11 lists high value services and drugs that an issuer may want to consider offering with lower or zero cost sharing. High value services include those that most people will benefit from and have a strong clinical evidence base demonstrating appropriate care. ASHA appreciates that CMS wants to give greater flexibility to QHPs to offer reduced or no cost sharing for certain chronic conditions. ASHA maintains that delivery system reform requires the involvement of the provider community (e.g., audiologists, speech-language pathologists), payers, and patients.

Following the Medicare Advantage Value-Based Insurance Design Model, QHPs could target the following conditions:

- diabetes;
- chronic obstructive pulmonary disease (COPD);
- congestive heart failure (CHF);
- past stroke history;
- hypertension;
- coronary artery disease (CAD); and

- mood disorders.

ASHA supports the inclusion of these conditions given their potential for high cost complications. In fact, audiologists and speech-language pathologists (SLPs) frequently provide care for patients with these diagnoses. Audiologists typically treat patients with stroke, hypertension, and CAD for balance/vestibular issues. Patients with diabetes often have hearing loss with tinnitus due to systemic causes or as a result of high doses of antibiotics that require ototoxicity monitoring. SLPs provide swallowing and communication treatment for stroke, CAD, CHF, and hypertension patients, as these conditions can impair communication for the patient. SLPs also provide swallowing treatment for dysphagia in patients with COPD and stroke.

Automatic Re-Enrollment Process

ASHA is disappointed with CMS's proposal to modify the automatic re-enrollment process. Currently, Exchange enrollees that remain eligible for a QHP from one year to the next are automatically re-enrolled in the same plan, unless they terminate that coverage or actively enroll in a different plan. Automatic re-enrollment has occurred since the initial year of enrollment. Under the new proposal, any enrollee who would be automatically re-enrolled in their QHP with an advance premium tax credit (APTC) that would cover the enrollee's entire premium would, instead, be automatically re-enrolled without APTC. CMS asserts this would ensure that any enrollee in this situation would need to return to the Exchange and obtain an updated eligibility determination prior to having APTC paid on his or her behalf for the upcoming year.

An internal CMS analysis found that ending automatic re-enrollment would result in 200,000 fewer individuals enrolled through the Exchanges in 2020 and 100,000 fewer each subsequent year. In addition, Congress included a provision in the most recent budget bill to direct the Secretary of HHS to establish an automatic re-enrollment process for plan year 2021 for the federally facilitated exchange.²

This proposal runs counter to broad stakeholder feedback, across several years of comments, which overwhelmingly supports automatic re-enrollment. In addition, this new process could be confusing for consumers and discourage consumers from re-enrolling in their coverage.

ASHA opposes CMS's proposed modification to re-enrollment that will negatively impact hundreds of thousands of Americans. ASHA urges CMS to abandon this policy.

ASHA appreciates the opportunity to provide comments on this 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,



Theresa H. Rodgers, MA, CCC-SLP
2020 ASHA President

¹ American Occupational Therapy Association (2019). *Analysis of Rehabilitation and Habilitation Benefits in Qualified Health Plans*. Retrieved from <https://www.aota.org/~media/Corporate/Files/Advocacy/Health-Care-Reform/Essential-Benefits/2019-Analysis-Rehabilitation-Habilitation-Benefits-Qualified-Health-Plans.pdf>.

² Keith, K. (2020). The 2021 Proposed Payment Notice, Part 2: Exchange Provisions, *Health Affairs Blog*, doi: 10.1377/hblog20200201.566219.