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December 30, 2020

Seema Verma, MPH  
Administrator  
Centers for Medicare & Medicaid Services  
Department of Health and Human Services  
Attention: CMS-9914-P  
P.O. Box 8016  
Baltimore, MD 21244-8016

RE: Patient Protection and Affordable Care Act; HHS Notice of Benefit and Payment Parameters for 2022 and Pharmacy Benefit Manager Standards; Updates To State Innovation Waiver (Section 1332 Waiver) Implementing Regulations

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 2022 and Pharmacy Benefit Manager Standards; Updates to State Innovation Waiver (Section 1332 Waiver) Implementing Regulations.

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 appreciates the Centers for Medicare & Medicaid Services (CMS) clarifying that an individual's loss of COBRA triggers a special enrollment period for Affordable Care Act (ACA) coverage. However, ASHA objects to several policies included in the 2022 Notice of Benefits and Payment Parameters (Payment Notice) proposed rule that will unnecessarily erode consumer protections and weaken access to affordable and comprehensive health insurance for every American. This letter includes ASHA's comments on the following topics discussed in the 2022 Payment Notice proposed rule:

- Consumer Assistance Tools and Programs of an Exchange (§ 155.205);
- 31 CFR Part 33 and 45 CFR Part 155 – State Innovation Waivers;
- Essential Health Benefits; and
- Premium Adjustment Percentage.

### **Consumer Assistance Tools and Programs of an Exchange (§ 155.205)**

Qualified health plans (QHPs) are required to translate website content into any non-English language that is spoken by a limited English proficient (LEP) population that makes up 10% or more of the total population of the relevant state. Currently, QHPs are required to translate website content no later than the first day of the individual market open enrollment period. In this proposed rule, CMS proposes to allow QHPs in the Federally-Facilitated Exchange Enhanced Direct Enrollment (FFE EDE) program additional time to come into

compliance with the website content translation requirements. Specifically, a QHP would have 12 months from the date it begins operating its FFE EDE website to comply with website content translation requirements. However, QHPs that are subject to requirements such as Summaries of Benefits and Coverage or provider directories, would not be afforded additional time for translation into applicable languages. ASHA does not support this policy to delay translating website content for LEP individuals as it might result in LEP individuals not enrolling in coverage and therefore not receiving the coverage they require for meaningful access. Moreover, translating website content for LEP individuals that make up 10% of a state's population omits speakers of low-incidence languages and excludes them from understanding and enrolling in Marketplace coverage.

### **31 CFR Part 33 and 45 CFR Part 155 – State Innovation Waivers**

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ASHA is concerned that CMS seeks to codify the 2018 Section 1332 State Relief and Empowerment Waiver Concepts Guidance (“Guidance document”).<sup>1</sup> The Departments of Health and Human Services, Treasury, and Labor (“the Departments”) assert that this proposal would give states greater certainty regarding how the Departments will apply section 1332’s statutory guardrails when determining whether a state’s waiver proposal can receive approval and remain in compliance.

In the 2018 Guidance document, CMS states that it will evaluate **comprehensiveness** by comparing access to coverage under the waiver to the state’s essential health benefit (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 who would have access to such coverage absent the waiver.

ASHA acknowledges that the 2018 Guidance document does not explicitly permit state 1332 waivers to eliminate protections for individuals with pre-existing conditions. It does, however, present a considerable expansion of state authority under Section 1332 in that “[a] section 1332 state plan should foster health coverage through competitive private coverage, including Association Health Plans (AHP) and short-term limited-duration insurance (STLDI) plans, over public programs.”

ASHA does not support the approval of waivers for other coverage types (e.g., AHPs, STLDI) that are deemed affordable as long as comprehensive coverage, at greater expense than STLDI, remains available. ASHA urges CMS to reject state waiver requests unless they provide affordable and comprehensive coverage to those who need it, including individuals with pre-existing conditions. Availability of coverage and actual coverage are not synonymous.

The non-ACA compliant coverage options encouraged within the 2018 Guidance document may accommodate relatively healthy individuals but not consumers with chronic conditions and disabilities. More 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 an individual’s control. For example, healthy consumers may become ill or injured (e.g., traumatic brain injury) after they opt for STLDI and then require rehabilitative therapy to help regain skills and functioning from their unexpected circumstance. However, if the STLDI plan chosen does not provide rehabilitation services, the consumer faces unexpected out-of-pocket costs for

medically necessary health care services that may not only threaten access to care but also impact their recovery, quality of life, financial stability, and their ability to return to a reasonable level of independence. ASHA urges CMS to abandon efforts to codify the harmful and short-sighted 2018 Guidance document related to section 1332 state waivers.

### **Essential Health Benefits**

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ASHA reiterates its strong objections to the finalized EHB benchmark plan selection and benefit substitution policies and urges CMS to withdraw this policy. These policies may erode important consumer protections and reduce access to comprehensive coverage. Consumers with speech, language, and/or hearing needs are particularly vulnerable and might be negatively impacted based on the approach selected by their state. For example, an individual with Parkinson's disease who has difficulty with speech and swallowing requires speech-language pathology services to treat those deficits. Another example is a 3-year-old child with severe congenital hearing loss who requires the fitting of hearing aids, and treatment to develop auditory and speech-language skills provided by an audiologist and speech-language pathologist. Depending on the EHB benchmark plan, selected by the state in these scenarios, the rehabilitative and habilitative services and devices' benefit might be weakened significantly or even substantively eliminated, thereby limiting or preventing access to medically necessary services. 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. Comprehensive coverage of rehabilitative and habilitative services reduces long-term disability and dependency costs to society while improving quality of life and functional independence.

A recent study of "silver" marketplace plans found that **rehabilitative and habilitative services and devices represent only 1% of an average premium cost (or \$84 annually) but provide return to function, productivity, and health. Financing rehabilitative and habilitative services and devices separately would cost \$2,530 per user on average.**<sup>2</sup>

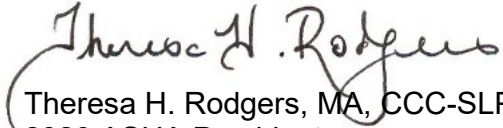
### **Premium Adjustment Percentage**

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ASHA reiterates its opposition to CMS's policy in the 2020 Payment Notice final rule to change the methodology for calculating the annual premium adjustment percentage that resulted in net premium increases of \$181 million per year for enrollees in Exchange-based health insurance. This policy negatively impacts individuals' ability to afford Exchange-based health insurance. The premium adjustment percentage is critically important because it is used for a variety of calculations including advance premium tax credits (APTCs) and annual cost sharing limits. APTCs allow enrollees to take a tax credit in advance to lower their monthly health insurance premium, whereas annual cost sharing limits dictate the maximum amount an enrollee pays out-of-pocket for covered services in a plan year. As a result, CMS anticipated 100,000 fewer individuals would enroll in Exchange-based health insurance in 2020. This anticipated decline further exacerbates the increase in the uninsured rate for adults.<sup>3</sup> Such a proposal is particularly irresponsible during the current public health emergency that has resulted in many Americans not having the ability to afford health insurance coverage when they need it the most. ASHA urges CMS to withdraw 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](mailto:dsekoni@asha.org).

Sincerely,



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

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<sup>1</sup> Centers for Medicare & Medicaid Services. (2018). *Section 1332 State Relief and Empowerment Waiver Concepts Discussion Paper*. <https://www.cms.gov/CCIIO/Programs-and-Initiatives/State-Innovation-Waivers/Downloads/Waiver-Concepts-Guidance.PDF>.

<sup>2</sup> Blumberg L., & Holahan, J. (2017). *The implications of cutting essential health benefits* [Health Policy in Brief: An RWJF Collection]. <https://www.rwjf.org/en/library/research/2017/07/the-implications-of-cutting-essential-health-benefits.html>.

<sup>3</sup> Gallup National Health and Well-Being Index. (2019). *U.S. Uninsured Rate Rises to Four-Year High*. <https://news.gallup.com/poll/246134/uninsured-rate-rises-four-year-high.aspx>.