



AMERICAN
SPEECH-LANGUAGE-
HEARING
ASSOCIATION

Submitted via e-mail to NMHealth.RateReview@state.nm.us

June 4, 2015

John G. Franchini
Superintendent of Insurance
Office of the Superintendent of Insurance
1120 Paseo De Peralta, 4th floor
Santa Fe, NM 87504

RE: 2017 Essential Health Benefit Benchmark Plan

Dear Superintendent Franchini:

The American Speech-Language-Hearing Association (ASHA) is the national professional, scientific, and credentialing association for 182,000 members and affiliates who are audiologists; speech-language pathologists; speech, language, and hearing scientists; audiology and speech-language pathology support personnel; and students. Nearly 1,500 of our members reside in New Mexico.

We understand that the New Mexico Office of the Superintendent of Insurance will select the 2017 Essential Health Benefit (EHB) Benchmark plan and would like to submit comments regarding the definition and coverage issues involving the benefit category of “rehabilitative and habilitative services and devices.”

Federal Definition of Habilitative Services

The Department of Health and Human Services (HHS) recently adopted a uniform definition for habilitation that states are required to use as the floor in determining coverage for habilitation services and devices for individual and small employer health insurance plans beginning in 2016.

Habilitation services and devices—Cover health care services and devices that help a person keep, learn, or improve skills and functioning for daily living (habilitative services). Examples include therapy for a child who is not walking or talking at the expected age. These services may include physical and occupational therapy, speech-language pathology and other services for people with disabilities in a variety of inpatient and/or outpatient settings.

ASHA has been working to ensure comprehensive coverage of audiology and speech-language pathology services for patients with chronic conditions and/or disabilities and fully supports the HHS uniform definition. Adopting a uniform definition minimizes the variability in benefits and lack of coverage for habilitative services versus rehabilitative services. Therefore, ASHA urges the state of New Mexico to adopt a habilitation services and devices benefit that complies with the newly adopted federal definition.

Separate Visit Limits Required in 2017

In the [2016 Notice of Benefit and Payment Parameters \(NBPP\) final rule](#) HHS required that, beginning in 2017, qualified health plans will not impose limits on coverage of habilitative services that are less favorable than any such limits imposed on coverage of rehabilitative services.

Furthermore, visit limits for habilitative services may not be combined with and must be separate and distinct from rehabilitative services benefit. ASHA supports this policy and further requests that the selected benchmark plan offer separate visit limits for each of the therapies (e.g. speech therapy, physical therapy, occupational therapy) as they provide distinct services focused on different functional goals. It is not uncommon for an enrollee to require up to 20 visits in a 6-week timeframe for speech therapy alone, depending on the diagnosis and treatment plan.

In addition, medical necessity definitions should not be used to prevent access to rehabilitation or habilitation altogether, or stop rehabilitation or habilitation prematurely through arbitrary visit limits or other limitations or exclusions. The complex nature of disabilities and chronic diseases often leads to a wide breadth of treatments from a range of providers. Services are often considered medically necessary as long as:

- separate and distinct goals are documented in the treatment plans of physicians, nurses, and therapists providing concurrent services;
- specific services are non-overlapping; and
- each discipline is providing some service that is unique to the expertise of that discipline and would not be reasonably expected to be provided by other disciplines.

Coverage of Habilitative Services and Devices

Habilitation services and devices are 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.¹ In addition, rehabilitative and habilitative devices typically prescribed by audiologists and speech-language pathologists include devices which aid in hearing and speech, including hearing aids, augmentative and alternative communication (AAC) devices, and other assistive technologies and supplies.

AAC devices are specialized devices, such as speech-generating devices, that assist individuals with severe speech or language problems to supplement existing speech or replace speech that is not functional.

Hearing aids and assistive listening devices are medical devices that amplify sound and/or counter the negative effects of environmental acoustics and background noise to assist individuals who have been diagnosed with a hearing loss by a physician and/or hearing health professional. Examples of these devices include, but are not limited to, hearing aids, cochlear implants, and osseointegrated/bone-anchored hearing aids.

State Mandates to Supplement Habilitative Services and Devices Benefit

ASHA is pleased that HHS explained in the final rule that state benefit mandates enacted to define habilitative services are part of the essential health benefit—states *do not* defray the cost. (See page 226 of the [NBPP](#)). This clarification allows states to address coverage gaps in their state. State mandates would not only enhance benefits, but would also improve access to habilitation services—

¹ ASHA Speech-Language Pathology Medical Review Guidelines: www.asha.org/uploadedFiles/SLP-Medical-Review-Guidelines.pdf.

Qualified Health Plans would need to cover these enhanced services according to the revised benchmark plan.

Currently, New Mexico [mandates coverage of habilitation services for autism spectrum disorders](#). ASHA believes that the newly adopted federal definition precludes limiting coverage for habilitative services to any particular condition and limiting access to services to any single treatment. It is inappropriate for a plan to cover speech-language pathology services for a child with autism but not cover such services for a child with impairments of speech resulting from cerebral palsy, cleft palate, hearing loss or another disabling condition.

In addition, ASHA requests that New Mexico change their [hearing aid mandate](#) to include coverage for adults. In the 2016 NBPP [proposed rule](#), HHS clarified that limiting hearing aids by age is a potentially discriminatory benefit design because hearing aids have been found to be clinically effective for all ages (see page 70723). Each proposed benchmark plan establishes age limits for hearing aid coverage.

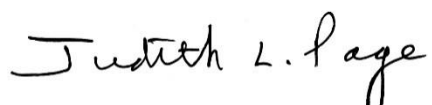
Some states, such as Maryland and Illinois, have passed legislation requiring health plans to provide habilitation services to children with congenital, genetic, or early acquired disorders under the age of 19. In these states, habilitation services are defined as occupational therapy, physical therapy, speech-language pathology services, and other services prescribed by the treating physician to enable a child to enhance function. (See, e.g., Md. INSURANCE Code Ann. §15-835(a)(3)). The state of Maryland found that its habilitation mandate (which covers individuals up to the age of 19) **costs 0.1% of the total premium cost** in the private insurance market, and expanding the mandate to individuals with congenital or genetic birth defects—regardless of age—would increase state plan expenditures by no more than 2%. If habilitation benefits were provided until age 25, responses from four insurance carriers in the state suggests that premiums would increase between 0% and 1.1%.

Recommendations

The 2017 Benchmark Plan should comply with the recently adopted federal definition for habilitation services and devices. Limitations, if any, should be applied separately to rehabilitation and habilitation and it is a violation of federal regulation to split an existing rehabilitation benefit in half and apply the same total visit limitation separately. Finally, any changes the state of New Mexico makes to ensure compliance with the federal definition of habilitation services and devices are not considered state mandates—New Mexico does not defray the cost. Rather, these changes are intended to ensure compliance with the federal regulation.

ASHA appreciates the opportunity to provide comments on this important topic. Please contact Eileen Crowe, ASHA's director of state association relations, at 301-296-5667 or ecrowe@asha.org, or Daneen Grooms, MHSA, ASHA's director of health reform analysis and advocacy, at 301-296-5651 or by e-mail at dgrooms@asha.org, if you require additional information or clarification.

Sincerely,



Judith L. Page, PhD, CCC-SLP
2015 ASHA President