Report of the Tennessee Advisory Commission on Intergovernmental Relations

Speech Therapy for Stuttering and Insurance Coverage in Tennessee

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Report of the Tennessee Advisory Commission on Intergovernmental Relations

Speech Therapy for Stuttering and Insurance Coverage in Tennessee

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State of Tennessee

Tennessee Advisory Commission on Intergovernmental Relations
226 Anne Dallas Dudley Boulevard, Suite 508
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June 18, 2026

The Honorable Randy McNally
Lieutenant Governor and Speaker of the Senate

The Honorable Cameron Sexton
Speaker of the House of Representatives

Members of the General Assembly
State Capitol
Nashville, TN 37243

Ladies and Gentlemen:

Transmitted herewith is the commission's report in response to Public Chapter 416, Acts of 2025, which directed the commission to study the feasibility and effects of implementing insurance coverage for speech therapy services. The bill, as originally introduced, would have required insurance plans—the State Group Insurance Program, Affordable Care Act (ACA) plans, TennCare, and CoverKids—to cover speech therapy services for stuttering for both habilitative and rehabilitative care without age or visit caps, or utilization review. Because of concerns about eliminating utilization review and altering minimum coverage standards for ACA plans, the commission does not recommend the bill as originally filed. Compared to other states and Tennessee programs like the State Group Insurance Program, TennCare, and CoverKids, Tennessee's ACA visit limits are relatively low, and strict caps can prevent individuals from receiving consistent, clinically recommended therapy. Instead, the report recommends increasing the minimum number of covered visits under ACA plans—by way of updating Tennessee's Essential Health Benefits benchmark plan—to improve access.

The commission approved the report on June 18, 2026, and it is hereby submitted for your consideration.

Respectfully yours,

Senator Ken Yager
Chairman

Cliff Lippard
Executive Director

The Tennessee Advisory Commission on Intergovernmental Relations

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MEMORANDUM

TO: Commission Members

FROM: Cliff Lippard
Executive Director

DATE: 18 June 2026

SUBJECT: Public Chapter 416, Acts of 2025 (Speech Therapy Services)—Final Report for Approval

The attached commission report is submitted for your approval. It was prepared in response to Public Chapter 416, Acts of 2025, which directed the commission to study the feasibility and effects of implementing the changes to insurance coverage for speech therapy services that were included in the bill as originally filed. The original bill, Senate Bill 231 by Senator Akbari and House Bill 296 by Representative Love, would have required some insurance plans—the State Group Insurance Program, Affordable Care Act (ACA) plans, TennCare, and CoverKids—to cover speech therapy services for stuttering for both habilitative and rehabilitative care without age or visit caps, or utilization review requirements.

Insurance provisions such as utilization review and visit limits can interrupt care, potentially limiting progress. Eliminating these restrictions, as proposed in the bill, could reduce claim denials, lower out-of-pocket costs, and improve access to needed therapy. But the original bill still raises some concerns. Utilization review is commonly used across healthcare administrative tools to control costs but also to ensure policyholders receive consistent, medically appropriate care. Removing these reviews could potentially lead to higher costs, increased risk of overutilization, reduced oversight and accountability, and greater variation in care that may ultimately affect premiums and public spending. Additionally, changes to coverage requirements for ACA plans may trigger state defrayal obligations, increasing state costs. For these reasons, the report does not recommend the bill as originally filed.

The recommendation of the report as presented at the January 2026 commission meeting remains unchanged:

Visit limits are one of the primary reasons why insurance claims for speech therapy are denied and because public programs in Tennessee—the State Group Insurance Program, TennCare, and CoverKids—already provide coverage for medically necessary therapies with either no visit limits or higher visit limits, increasing the minimum number of therapy visits required under ACA plans would help ensure more equitable access to care. To achieve this without triggering state defrayal costs or disrupting standard insurance practices such as utilization review, **the final report recommends that the Tennessee Department of Commerce and Insurance update Tennessee's Essential Health Benefits (EHB) benchmark plan for ACA plans to increase the minimum annual number of speech therapy visits each plan is required to cover.** But selecting a new EHB plan would adopt all coverage requirements of the selected plan, and therefore it would be beneficial for the state to consider how broader changes to the essential health benefits—not just speech therapy—may affect cost and coverage.

Contents

Summary and Recommendation: Removing Barriers to Stuttering Therapy by Increasing the Minimum Number of Visits Covered Under Affordable Care Act Plans

Michael Kidd-Gilchrist, a former National Basketball Association player turned advocate, grew up feeling insecure about his stutter. Like many people who stutter, he faced challenges expressing himself fluently, which created barriers for him in the classroom and made it more difficult to build social connections with his peers. Although he received some stuttering therapy as a child, significant progress was not made until his early adult years. His story is all too common for the 1% of the population affected by stuttering long term in the US—including an estimated 72,000 Tennesseans—as well as the approximately 5% of children who experience a period of stuttering lasting at least six months. Despite the essential role of communication, many people who stutter continue to face similar challenges expressing themselves fluently. Without effective stuttering treatment, stuttering may lead to frustration, social withdrawal, anxiety, and lost opportunities, even when the underlying condition is mild.

For many people who stutter, the cost of therapy remains a barrier to care.

For many people who stutter, the cost of therapy remains a barrier to care. While some individuals may have access to public programs or public or private insurance that help cover the cost of speech therapy, these benefits can be limited in scope, impose age or visit caps, or require proof of medical necessity (see table 1). As a result, stakeholders say these limitations create a barrier for people seeking speech therapy services, and even with available resources, navigating the speech therapy services landscape remains challenging. Recognizing these challenges, Senate Bill 231 by Senator Akbari and House Bill 296 by Representative Love, as originally filed in the 114th General Assembly, would have required Affordable Care Act (ACA) plans, TennCare, CoverKids, and the Tennessee State Group Health Insurance Program—which includes plans for eligible Tennessee state and higher education employees, dependents and retirees, as well as plans for local education and local government agencies that opt in—to cover speech therapy services for both habilitative and rehabilitative needs without age or visit caps or utilization review requirements (see appendix A). The bill was amended and enacted as Public Chapter 416, Acts of 2025, which directed the Tennessee Advisory Commission on Intergovernmental Relations to study the feasibility and effects of implementing insurance coverage for speech therapy services according to Senate Bill 231 and House Bill 296 as originally filed (see appendix B).

Table 1. Current Coverage for Stuttering Therapy in Insurance Programs That Would Have Been Affected by Senate Bill 231 and House Bill 296 as Originally Filed

Insurance Program	Is Stuttering Therapy Covered?	Is Utilization Review Applied to Stuttering Therapy?	Are There Annual Visit Limits for Stuttering Therapy?
TennCare	Yes	Yes - for example, much like care for other conditions, stuttering therapy must be deemed medically necessary to be covered	No
CoverKids	Yes	Yes - for example, much like care for other conditions, stuttering therapy must be deemed medically necessary to be covered	Yes - limited to 52 visits per therapy type per calendar year
Tennessee State Group Insurance Program*	Yes	Yes - for example, much like care for other conditions, stuttering therapy must be deemed medically necessary to be covered	No
Affordable Care Act (ACA) Marketplace Plans	Yes	Yes - for example, much like care for other conditions, stuttering therapy must be deemed medically necessary to be covered	Yes - limits can vary by plan, but plans must cover at least 20 visits per year

* Includes plans for eligible Tennessee state and higher education employees, dependents, and retirees, as well as plans for local education and local government agencies that opt in.

Source: Tennessee Department of Finance and Administration Chapter 1200-13-14; TennCare 2025; State of Tennessee 2025a; State of Tennessee 2025b; State of Tennessee 2025c; Centers for Medicare & Medicaid Services 2025b; and Tennessee EHB Benchmark Plan (2025-2027).

The original bill raises policy concerns because it would have eliminated utilization review and made legislative changes to ACA plans.

The original version of Senate Bill 231 and House Bill 296 would have likely made it less costly for individuals to access stuttering therapy services. By eliminating utilization reviews and visit limits, the bill would have reduced the likelihood that insurance claims would be denied. This could

reduce direct out-of-pocket costs for individuals receiving therapy and, as a result, lead to individuals seeking and receiving more needed therapy.

Despite the original bill's potential benefits to individuals seeking therapy for stuttering, the policy changes proposed in it raise some concerns. There is no comparable therapy service or similar condition that is exempt from utilization review. Insurance companies use utilization reviews like prior authorization and medical necessity not only as administrative tools to control costs but also to ensure policyholders receive consistent, medically appropriate care. Removing these reviews could potentially lead to higher costs, increased risk of overutilization, reduced oversight and accountability, and greater variation in care that may ultimately affect premiums and public spending—though the Fiscal Review Committee estimated that the bill would lead to individuals' premiums increasing by less than 1%.

Insurance companies use utilization reviews like prior authorization and medical necessity as administrative tools to control costs and to ensure policyholders receive consistent, medically appropriate care.

Moreover, because the bill would have made legislative changes to the minimum coverage required for ACA plans in Tennessee, it would have resulted in additional costs to the state. Of the $3 million increase in annual state costs estimated by Fiscal Review from passing the original bill, approximately $1.8 million would have resulted from the changes made to ACA plans (see table 2). Under the Affordable Care Act, each state selects an Essential Health Benefits (EHB) benchmark plan that defines the minimum coverages required for ACA plans in that state. If a state wants to change its benchmark to alter requirements for ACA plans, there is an existing administrative process through which it can select a new EHB plan. But if a state, instead, makes legislative changes to the coverage requirements for ACA plans and those changes increase the cost of ACA plans, then the incremental cost increases must be covered by the state—a process referred to as "defrayal." As originally filed, the bill would have likely resulted in defrayal for the state.

Because of the concerns involved in eliminating utilization reviews and making legislative changes to minimum coverage standards for ACA plans, the commission does not recommend the bill as originally filed.

Table 2. Projected Cost of Enacting Senate Bill 231 and House Bill 296 as Originally Filed in the 114th General Assembly

Coverage Type	Annual Increase to State	Annual Increase to Federal	Annual Increase to Local Gov't
TennCare	$ 822,674	$ 1,483,220	$ -
CHIP (CoverKids)	21,219	63,741	-
Tennessee State Group Insurance Program	454,637	49,714	307,822
Affordable Care Act Marketplace Plans	1,774,313	-	-
Total	$ 3,072,843	$ 1,596,675	$ 307,822

* Includes plans for state and higher education employees and their dependents, as well as plans for local education and local government agencies that opt in.

Source: Senate Bill 231 and House Bill 296 Fiscal Note.

Tennessee's current EHB requires insurers' ACA plans to cover a minimum of 20 visits per year for speech services, which for practical purposes, appears to have become the maximum covered under some plans.

Selecting a new state EHB plan to increase the minimum number of covered speech therapy visits in ACA plans could improve access to care in Tennessee.

Increasing the minimum number of speech therapy visits that must be covered annually in Tennessee's ACA plans by selecting a new EHB is an alternative to implementing the bill as originally filed. Tennessee's current EHB requires insurers' ACA plans to cover a minimum of 20 visits per year for speech therapy services annually. While insurers may choose to cover a higher visit limit, commission staff are aware of only one insurer in Tennessee whose ACA plans cover more than the minimum visits required by Tennessee's EHB plan. As a result, it appears that the minimum visit limit for stuttering therapy in the state's EHB is, for practical purposes, the maximum covered under some ACA plans in the state.

Increasing visit limits in Tennessee's ACA plans would likely help increase the ability of those covered by these plans to access stuttering therapy, in part because these limits are among the primary reasons why claims are denied by insurers. For example, representatives for one large insurer told commission staff that denials for speech therapy services are not typically triggered by medical necessity review but by exceeding visit limits—and some service providers reported they may stop attempting to bill insurance once caps are reached.

Compared to other states' ACA benchmark plans, Tennessee remains at the lower end of the visit-limit spectrum. For habilitative services, developing or improving skills, 16 states require ACA plans to cover unlimited

visits, 1 state requires a minimum of 120 visits, 22 states have minimums between 25 and 60 visits, 8 states require a minimum of 20 visits, 2 states do not require plans to cover any visits, and 1 state only covers a limited number of annual hours if related to Autism Spectrum Disorder. As for rehabilitative services, restoring lost skills, 13 states require ACA plans to cover unlimited visits, 1 state requires a minimum of 120 visits, 1 state requires a minimum of 90 visits, 23 states have minimums between 25 and 60 visits, 11 states require a minimum of 20 visits, and 1 state does not require plans to cover any visits (see appendix C). Similarly, the State Group Insurance Program and TennCare do not impose visit limits for medically necessary therapies, while CoverKids provides up to 52 visits per year when medically necessary.

Stakeholders say that strict visit limits can reduce the amount of treatment individuals receive, potentially preventing them from following their recommended treatment plans. Progress in fluency often requires ongoing, tailored sessions that extend beyond a set number of visits, so limiting therapy to 20 visits per year may prevent individuals from receiving the consistent and comprehensive care they need to manage their stuttering. Stakeholders—including clinicians and advocates—emphasize that stuttering is a chronic, variable condition and that treatment needs differ widely over time, a position reflected in clinical guidance from the American Speech-Language-Hearing Association, which recommends individualized treatment duration rather than strict visit caps. Having no visit limits, or a higher minimum standard, would allow speech therapy treatment to be driven by clinical need, supporting consistent improvement and preventing interruptions that can delay or reverse progress.

Stakeholders emphasize that stuttering is a chronic, variable condition with treatment needs varying over time. The American Speech-Language-Hearing Association recommends individualized treatment rather than strict visit caps.

The state can avoid most of the defrayal costs that would result from legislatively changing the coverage requirements for its ACA plans if it instead makes these changes through the administrative process of selecting a new EHB plan. By updating the EHB benchmark rather than enacting a state mandate, any added costs are absorbed into premiums avoiding direct state defrayal obligations. To select a new EHB benchmark plan, the Tennessee Department of Commerce and Insurance (TDCI) must notify the US Department of Health and Human Services of its selection of a new EHB by the first Wednesday in May, two years before the plan's effective date. Selecting a new EHB plan would adopt all coverage requirements of the selected plan, and therefore it would be beneficial for the state to consider how broader changes to the essential health benefits—not just speech therapy—may affect cost and coverage.

Because the State Group Insurance Program, TennCare, and CoverKids already provide coverage for medically necessary therapies with no or higher visit limits and because visit limits are one of the primary reasons why insurance claims for speech therapy are denied, increasing the minimum number of visits that must be covered by ACA plans would

help ensure equitable access to care. Updating the EHB benchmark plan would avoid defrayal costs to the state that would have resulted under the original version of Senate Bill 231 and House Bill 296 and would not disrupt standard coverage practices like utilization reviews. **The commission recommends that the Tennessee Department of Commerce and Insurance update Tennessee's Essential Health Benefits (EHB) benchmark plan for ACA plans to increase the minimum annual number of speech therapy visits each plan is required to cover.**

Analysis: Speech Therapy for Stuttering and Insurance Coverage in Tennessee

Michael Kidd-Gilchrist, a former National Basketball Association player, has spoken openly about how his stutter made him feel insecure during his school years and how it persisted through his professional basketball career. Like many people who stutter, he faced challenges expressing himself fluently, which created barriers for him in the classroom and made it more difficult to build social connections with his peers. Although he received some stuttering therapy as a child, significant progress was not made until his early adult years. His experience reflects what many people who stutter face, highlighting the broader emotional and social effects of the disorder.[1] But research shows that early and ongoing therapy improves speech and confidence, helping individuals fully participate in school, work, and community life.[2]

Approximately 1% of the US population—around 3 million people, including an estimated 72,000 Tennesseans—stutters long term.

Stuttering is a speech disorder characterized by involuntary disruptions in fluency, such as repetitions, prolongations, or blocks, and may be accompanied by physical behaviors like eye blinking or visible struggle. It most often begins in early childhood as language skills develop, though it can also arise following neurological injury.[3] Approximately 1% of the US population—around 3 million people, including an estimated 72,000 Tennesseans[4]—stutters long term. An analysis of recent studies found that an estimated 8% to 10% of people will experience stuttering at some point in their lifetime.[5] Approximately 5% of children experience a period of stuttering lasting at least six months.[6]

Effective therapies exist to help individuals manage their stuttering, but the cost of these services remains a barrier for many people who stutter. People who stutter may be able to access insurance or state programs that help cover speech therapy, reducing or eliminating the need to pay entirely out of pocket, but public and private insurance benefits may be limited by age restrictions, visit caps, or utilization reviews, which can include but are not limited to medical necessity reviews or prior authorization, making

[1] The Stuttering Foundation 2016.
[2] Lawrence and Barclay 1998.
[3] National Institute on Deafness and Other Communication Disorders 2017.
[4] TACIR staff calculations based on national average of 1% of the US population.
[5] Guitar 2025.
[6] The Stuttering Foundation "FAQ."

access to consistent therapy difficult to obtain and sustain.[7] In response to these challenges, Senate Bill 231 by Senator Akbari and House Bill 296 by Representative Love, as originally filed in the 114th General Assembly, would have required Affordable Care Act (ACA) plans, TennCare—which is Tennessee's Medicaid program—CoverKids, and the Tennessee State Group Health Insurance Program to cover stuttering therapy services for both habilitative and rehabilitative needs without age or visit limits or utilization review requirements (see appendix A). Habilitative speech therapy is generally used to help people keep, learn, or improve skills for daily living, whereas rehabilitative speech therapy would help a person restore or improve skills for daily living that have been lost or impaired. The bill was amended and enacted as Public Chapter 416, Acts of 2025 (see appendix B), which directed the Tennessee Advisory Commission on Intergovernmental Relations to study the feasibility and effects of implementing the broader insurance coverage framework outlined in the bills as originally filed.

Symptoms of fluency impairment often vary and can be caused by a variety of reasons, none of which are related to a person's intelligence or cognitive ability.

Stuttering involves involuntary disruptions to the flow of speech, varying in its underlying causes, severity, and duration.

People who stutter know what they want to say but have trouble producing fluent speech. Physical signs of stuttering can manifest in several different ways, including involuntary speech interruptions, rapid eye blinks, lip tremors, or visible struggle behaviors.[8] Symptoms of fluency impairment often vary and can worsen during activities like group speaking or phone conversations[9] but may lessen during singing or speaking in unison.[10] These disruptions can significantly reduce the speaker's ability to participate in the activities of everyday life.[11]

Stuttering can be caused by a variety of reasons, none of which are related to a person's intelligence or cognitive ability. Factors like genetics, brain differences, family dynamics, and environment can contribute

[7] Interview with Brooke Edwards, director, The Stuttering Association for the Young, June 26, 2025; interview with Naomi Eichorn, assistant professor, Julie Marshall, clinical associate professor, and Katherine Mendez, clinical assistant professor, School of Communication Sciences and Disorders, University of Memphis, May 7, 2025; Erdemir et al. 2022; interview with Robin M. Jones, associate professor and vice chair for faculty development, Vanderbilt Bill Wilkerson Center, May 5, 2025; interview with Jennifer Henderson, vice president of legislative affairs, and Jessica Lenden-Holt, president elect, Tennessee Association of Audiologists and Speech-Language Pathologists, May 5, 2025; interview with Jack Henderson, speech-language pathologist and co-leader of Nashville Chapter, National Stuttering Association, May 1, 2025; and TACIR staff survey of speech-language pathologists on insurance coverage and access to stuttering therapy 2025.

[8] Hendrickson 2023; Guitar 2025; Zebrowski, Anderson, and Conture 2022; Smith and Weber 2017; and Mayo Clinic 2024.

[9] Mayo Clinic 2024.

[10] National Institute on Deafness and Other Communication Disorders 2010.

[11] Smith and Weber 2017; Guitar 2025; and Zebrowski, Anderson, and Conture 2022.

to the development of stuttering.[12] The most common form of speech impediment is developmental stuttering, which occurs as children develop language skills. Other types of stuttering include neurogenic stuttering, which occurs after a brain injury or stroke, and some individuals may experience psychogenic stuttering, which is rare but arises from emotional or psychological factors, often manifesting in response to stress or trauma.[13] There are several common misconceptions about stuttering. For example, stuttering cannot be attributed to learning a second language or differences in intelligence.[14] While bilingual children may show temporary disfluencies while developing two languages, this is a normal part of language growth—learning multiple languages does not cause stuttering.[15]

Stuttering typically begins between ages two and five as children develop language skills.[16] Approximately 75% of children who stutter will eventually stop, while the remaining 25% will continue to stutter into adulthood.[17] While there is no cure for stuttering, recovery most often occurs by age seven or eight; stuttering that continues beyond these ages is likely to persist.[18]

Stuttering can profoundly shape the way a person communicates, influencing not just speech but their confidence, interactions, and daily experiences.

Stuttering can have wide ranging effects on communication, social and psychological well-being, and educational and professional outcomes.

Stuttering can profoundly shape the way a person communicates, influencing not just speech but their confidence, interactions, and daily experiences. And because fluent communication is central to how we express ourselves and navigate the world, stuttering can create challenges that extend into nearly every part of life. Adolescents who stutter report lower self-perceived communication competence, increased apprehension, higher rates of teasing and bullying, and a tendency to conceal their stuttering.[19] Some individuals who stutter have experienced associated physical tension or struggle behaviors during verbal communication.[20] Listeners can become distracted by the disruptions in speech flow caused

[12] Guitar 2025; Zebrowski, Anderson, and Conture 2022; Smith and Weber 2017; and Mayo Clinic 2024.
[13] National Institute on Deafness and Other Communication Disorders 2010; and National Institute on Deafness and Other Communication Disorders 2017.
[14] NIH Medline Plus 2019; and Shenker "Stuttering and the Bilingual Child."
[15] Shenker "Stuttering and the Bilingual Child."
[16] National Institute on Deafness and Other Communication Disorders 2010; and Mayo Clinic 2024.
[17] Erdemir et al. 2022; and American Institute for Stuttering 2020.
[18] Erdemir et al. 2022; and interview with Robin M. Jones, associate professor and vice chair for faculty development, Vanderbilt University School of Medicine, May 5, 2025.
[19] Erickson and Block 2013.
[20] Canadian Stuttering Association 2022; and American Speech-Language-Hearing Association "Characteristics of Typical Disfluency and Stuttering."

by stuttering, which can shift their attention away from the speaker's message and toward the stutter itself.[21]

The challenges of stuttering can often influence social and psychological health, affecting relationships, confidence, and quality of life.[22] People who stutter describe anxiety over anticipating a stuttering moment, feeling stuck or loss of control, fear of negative evaluation, and reduced participation in school, work, or social settings.[23] Stuttering can lead to social withdrawal and isolation, affecting self-esteem. Increased dysfunctional thoughts and beliefs about stuttering and decreased perceived social support were correlated with poorer mental well-being.[24] Many people who stutter may experience anxiety, feeling misunderstood, and fear of speaking in public,[25] with parent-reported stuttering in adolescence being associated with increased psychological distress scores in adulthood.[26]

Many people who stutter may experience anxiety, feeling misunderstood, and fear of speaking in public.

Educational settings introduce unique challenges for students who stutter, influencing participation, classroom engagement, and learning experiences. Students may avoid participating in class or giving presentations all together.[27] School-aged children with fluency disorders showed lower academic performance, more peer problems, and lower self-esteem compared with peers without fluency disorders.[28] Adolescents who stuttered at age 16 performed less well on cognitive tests, were more likely to have experienced bullying, and had worse educational achievement and employment outcomes compared to their non-stuttering counterparts.[29] A significant negative relationship was found between the severity of stuttering and the highest level of education attained.[30]

As people who stutter move into adulthood, the effects of stuttering can also carry into their workplace, influencing career opportunities, job performance, and professional confidence. People who stutter may often face discrimination during the hiring process or are overlooked for promotions.[31] People who stutter may earn less or be underemployed,[32] with their career growth severely limited because of stigma or fear of speaking.[33] Stuttering has also been associated with significant occupational

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[21] American Speech-Language-Hearing Association "Stuttering, Cluttering, and Fluency Disorders"; and Werle, Byrd, and Coalson 2023.
[22] American Institute for Stuttering 2020; Guitar 2025; and Zebrowski, Anderson, and Conture 2022.
[23] Jackson et al. 2015.
[24] Turkili, Turkili, and Aydin 2022.
[25] Mayo Clinic 2024; and National Stuttering Association and Sam Genusso "Stuttering and Mental Health: You are Not Alone."
[26] McAllister, Collier and Shepstone 2013.
[27] Stuttering Society "For Students | Stuttering and the Academic Challenges."
[28] Akelah et al. 2025.
[29] McAllister, Collier, and Shepstone 2012; and O'Brian et al. 2011.
[30] O'Brian et al. 2011.
[31] Weiner and Tetnowski 2016; and SHRM 2022.
[32] Gerlach et al. 2018; and Pease 2024.
[33] Gerlach et al. 2018.

disadvantages in the US, including reduced earnings and higher rates of underemployment. People who stutter earned, on average, over $7,000 less annually than their non-stuttering counterparts, with females who stutter being 23% more likely to be underemployed compared to females who do not stutter.[34]

Speech-Language Pathologists Diagnose Stuttering by Reviewing the Individual's Case History, Speech and Language Assessments, and Considering the Emotional and Social Effects of Stuttering.

Diagnosing an individual with stuttering involves a comprehensive evaluation performed by a licensed health care provider who may refer patients to a speech-language pathologist (SLP) for specialized care. Evaluations performed by an SLP assess the underlying communication disorder and its effects on daily life across multiple settings.[1] The SLP assesses the person's speech and language skills, observing disfluency patterns or involuntary speech interruptions like repetitions, prolongations, blocks or stoppage in the flow of speech, speech motor tension, and any secondary behaviors like eye-blinking or lip tremors.[2] For children, SLPs would also assess parental reactions, type of stuttering behaviors, physical manifestations, and accompanying speech or language delays,[3] as well as distinguishing normal developmental disfluency—common in young children learning to talk—from persistent stuttering that may require early intervention.[4]

[1] Tennessee Department of Education 2018; American Institute for Stuttering 2020; and Guitar 2025; and Zebrowski, Anderson, and Conture 2022.
[2] Mayo Clinic 2024.
[3] American Institute for Stuttering 2020; and interview with Naomi Eichorn, assistant professor, Julie Marshall, clinical associate professor, and Katherine Mendez, clinical assistant professor, School of Communication Sciences and Disorders, University of Memphis, May 7, 2025.
[4] The Stuttering Foundation "Differential Diagnosis."

Therapy for stuttering provides individuals with strategies and support to improve speech fluency, confidence, and overall communication effectiveness.

Stuttering therapy has been found to improve overall speech fluency and increase confidence in daily communication, including participation and comfort in social, academic, and workplace settings.[35] These services allow for people who stutter to learn effective communication strategies like pacing of speech, controlled breathing, and self-monitoring techniques, while also building emotional resilience and reducing anxiety or avoidance related to speaking situations.[36] Beyond speech outcomes, stuttering therapy enhances quality of life by promoting clearer, more confident, and more enjoyable communication rather than focusing solely on complete fluency.[37] Through therapy sessions, individuals develop self-

[34] Ibid.
[35] Craig, Blumgart, Tran 2009; and Boyle 2015.
[36] American Speech-Language-Hearing Association "Stuttering, Cluttering, and Fluency."
[37] Ibid.

advocacy skills that enable them to communicate their needs effectively in school, work, and community environments.[38] Conversely, one speech-language pathologist (SLP) reported that not receiving therapy can result in worsening fluency, regression or loss of previously acquired skills, reduction in self-confidence, and academic struggles.[39]

Evidence demonstrates functional improvement in individuals based on the number of SLP sessions received. According to data from the American Speech-Language-Hearing Association (ASHA), individuals who received fewer than six sessions had a 15% functional improvement in producing fluent speech, being better understood, and speaking in a way that is less distracting to the listener in typical and high-stress situations. In contrast, individuals who received upwards of 13 to 18 sessions showed a 27% functional improvement.[40] While even a small number of sessions can result in meaningful gains, these findings suggest that increasing the number of sessions may further improve outcomes.

Evidence shows that while fewer than six speech-language pathology sessions yield about 15% functional improvement, increasing to 13–18 sessions is associated with greater gains of around 27%, suggesting more sessions lead to better outcomes.

Stuttering treatment varies by age and individual needs, focusing on evidence-based, personalized approaches that prioritize communication and self-acceptance over fluency.

While there are evidence-based strategies that can help reduce the effect of stuttering, not every approach works for every individual. Excessive or misapplied treatment "could lead to frustration that could, in turn, demotivate the client to continue with therapy."[41] SLPs can help people understand the causes of their stuttering, set realistic treatment goals, and improve communication skills in everyday life.[42] Some SLPs say speech therapy shouldn't promise complete fluency but focus instead on effective communication and self-acceptance.[43] The duration of therapy can vary widely depending on individual needs, goals, age, and the severity of the stuttering.[44] There is no one-size-fits-all therapy method; individualized, holistic approaches to therapy are best for those who stutter.[45]

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[38] American Speech-Language-Hearing Association "Stuttering, Cluttering, and Fluency."
[39] TACIR staff survey of speech-language pathologists on insurance coverage and access to stuttering therapy 2025.
[40] Email from Tracy Schooling, senior director, American Speech-Language-Hearing Association, September 16, 2025.
[41] Baxter et al. 2016. Similar sentiments are expressed in interview with Jennifer Henderson, vice president of legislative affairs, and Jessica Lenden-Holt, president elect, Tennessee Association of Audiologists and Speech-Language Pathologists, May 5, 2025.
[42] Yaruss 1998.
[43] Byrd, Coalson, and Conture 2024; and interview with Naomi Eichorn, assistant professor, Julie Marshall, clinical associate professor, and Katherine Mendez, clinical assistant professor, School of Communication Sciences and Disorders, University of Memphis, May 7, 2025.
[44] Guitar 2025; and Zebrowski, Anderson, and Conture 2022.
[45] Interview with Brooke Edwards, director, The Stuttering Association for the Young, June 26, 2025.

Common examples of therapy vary by age and include but are not limited to the following: For preschool-aged children, treatment may involve parent-led activities and professional therapy in which parents or caregivers are coached by speech-language pathologists to use specific techniques during everyday routines like modeling slower speech, reducing time pressure, or creating a calm speaking environment.[46] A typical session lasts around 30 minutes, with weekly hour-long parent sessions over four to six weeks for preschoolers.[47] For school-aged children therapy includes fluency shaping, where the SLP teaches techniques to reduce stuttering, like slowing their rate of word production.[48] Stuttering modification techniques help children manage and reduce their stress when they do stutter. Children may also benefit from emotional support and desensitization.[49] Peer interaction is important as many participants have never met another child who stutters.[50] For adolescents and adults, therapy also focuses on managing stuttering through fluency shaping and stuttering modification techniques, while also addressing emotional factors like anxiety, self-acceptance, and confidence in real-world communication situations.[51] Intensive programs, like week-long group therapy retreats, are valuable for individuals facing more profound social-emotional challenges, but they can be costly.[52] Counseling and support groups can help individuals who stutter manage the emotional effects of stuttering.[53]

Early intervention is important, especially for children. Research shows that early identification and treatment of speech and language disorders significantly improve long-term communication, academic, and social outcomes and yield better outcomes and lower lifetime costs than delaying treatment until adulthood.[54] The earlier therapy begins, typically before age seven, the greater the likelihood of preventing persistent stuttering or other speech challenges.[55] When children are able to receive services as early and often as needed, it supports long-term language learning and social development by reducing physical tension and struggle behaviors commonly associated with stuttering, such as anxiety, avoidance of

Research shows that early identification and treatment of speech and language disorders significantly improve long-term communication, academic, and social outcomes and yield better outcomes and lower lifetime costs than delaying treatment until adulthood.

[46] Guitar 2025; and Zebrowski, Anderson, and Conture 2022.
[47] Interview with Brooke Edwards, director, The Stuttering Association for the Young, June 26, 2025.
[48] Laubenstein 2019.
[49] Guitar 2025; and Zebrowski, Anderson, and Conture 2022.
[50] Interview with Brooke Edwards, director, The Stuttering Association for the Young, June 26, 2025.
[51] Guitar 2025; and Zebrowski, Anderson, and Conture 2022.
[52] Interview with Naomi Eichorn, assistant professor, Julie Marshall, clinical associate professor, and Katherine Mendez, clinical assistant professor, School of Communication Sciences and Disorders, University of Memphis, May 7, 2025.
[53] National Institute on Deafness and Other Communication Disorders 2010.
[54] American Speech-Language-Hearing Association 2021; email from Tracy Schooling, senior director, American Speech-Language-Hearing Association, September 16, 2025; National Institute on Deafness and Other Communication Disorders 2010; Menzies et al. 2019; Guitar 2025; and Zebrowski, Anderson, and Conture 2022.
[55] Guitar 2025; Zebrowski, Anderson, and Conture 2022; Menzies et al. 2019; and Patterson Neubert 2014.

speaking, and peer socialization challenges that accompany persistent stuttering.[56]

The cost of stuttering therapy can be prohibitive.

SLPs surveyed for this study reported high out-of-pocket costs as one of the primary reasons why speech therapy services can be difficult to access.[57] The cost of stuttering therapy varies widely by service setting, provider type, session length, insurance coverage, type of therapy, age and diagnosis, need for specialized services, and whether sliding scale or discount options are available.[58]

Access to treatment can be costly with private clinic sessions ranging from $100-$250 per session; group therapy from $50-$100 per hour; and hospital services evaluation costs ranging from $75 to $500.

Private clinic sessions typically range from $100 to $250 per session, depending on duration and provider expertise. Group therapy may cost less, around $50 to $100 per hour, with more intensive weeklong group sessions costing thousands of dollars.[59] Hospital-based services may involve higher evaluation costs ranging from $75 to $500.[60] Because of these costs, it can be difficult for people who stutter to pay for services out of pocket.

Health insurance plans can cover stuttering therapy services, but plans may also include provisions that can limit access to care.

Health insurance plans may cover stuttering therapy services, but coverage is typically governed by utilization management (UM) processes that determine the use, scope, and duration of covered services. UM mechanisms are intended to ensure that care is delivered in a clinically appropriate manner while maintaining consistency, accountability, and cost predictability within health plans.[61]

At a structural level, UM includes both case-by-case clinical review processes referred to as utilization reviews (UR) and predetermined coverage rules applied automatically, which are referred to as benefit design rules.[62] UR is a core mechanism used by insurers to assess whether medical care,

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[56] Patterson Neubert 2014.
[57] TACIR staff survey of speech-language pathologists on insurance coverage and access to stuttering therapy 2025.
[58] Cost How Much "How Much Does Speech Therapy Cost?"; and Kids First 2025.
[59] Cost How Much "How Much Does Speech Therapy Cost?"; Kids First 2025; and interview with Naomi Eichorn, assistant professor, Julie Marshall, clinical associate professor, and Katherine Mendez, clinical assistant professor, School of Communication Sciences and Disorders, University of Memphis, May 7, 2025.
[60] Cost How Much "How Much Does Speech Therapy Cost?"
[61] Tennessee Department of Finance and Administration Chapter 1200-13-14; TennCare 2025; State of Tennessee 2025a; State of Tennessee 2025b; State of Tennessee 2025c; Centers for Medicare & Medicaid Services 2025b; Tennessee EHB Benchmark Plan (2025-2027); and MD Clarity "Utilization Management."
[62] MD Clarity "Utilization Management"; and Institute of Medicine, Committee on Utilization Management by Third Parties 1989.

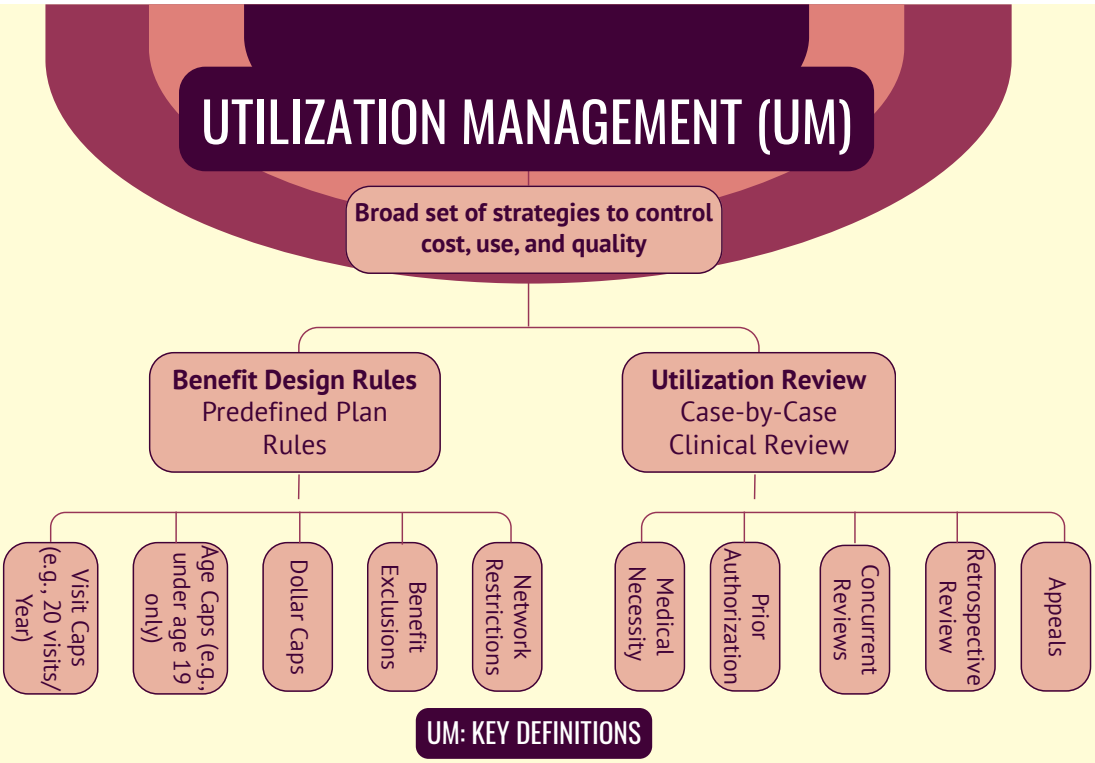
including speech therapy services, meets coverage criteria.[63] This process may occur before services begin (prior authorization), during treatment (concurrent review), or after services are provided (retrospective review).[64] Tennessee law requires utilization reviews to be reasonable, timely, and clinically based, with clear notice of denials and access to internal and external appeals.[65] Coverage determinations are generally expected to align with accepted clinical standards, rely on evidence-based tools—such as the Stuttering Severity Instrument—and follow professional guidelines, including those established by the American Speech-Language-Hearing Association.[66] See figure 1.

In contrast, benefit design rules, such as visit limits, age limits, dollar caps, benefit exclusions, and network restrictions, are applied automatically based on plan rules and do not involve individualized clinical judgment.[67] As a fixed coverage rule, visit limits are one component of benefit design rules within broader utilization management mechanisms, defining the maximum number of therapy sessions covered over a given period, serving as a non-clinical tool insurers may use to manage utilization alongside processes like utilization review. Because visit limits are predefined and not based on individual patient need, they can restrict care, often interrupting necessary treatment.[68] See figure 1.

Visit limits and other insurance benefit design rules are preset restrictions that cap therapy sessions and can interrupt necessary care by not accounting for individual patient needs.

[63] American Speech-Language-Hearing Association "Module Three: Documentation of SLP Services in Different Settings"; and ACMA 2022.
[64] American Speech-Language-Hearing Association "Private Health Plans"; ACMA 2022; Giardino and Wadhwa 2023; Institute of Medicine, Committee on Utilization Management by Third Parties 1989; and MD Clarity "Utilization Review."
[65] Tennessee Code Annotated, Sections 56-6-701 through 56-6-706.
[66] Clinical Tools Library 2025; American Specialty Health "Clinical Practice Guideline 166: Speech-Language Pathology"; and American Speech-Language-Hearing Association 2015.
[67] Institute of Medicine, Committee on Utilization Management by Third Parties 1989.
[68] Zarefsky 2025; and ACMA 2022.

Figure 1. Utilization Management: Key Tools and Definitions



UM: KEY DEFINITIONS

Utilization management (UM) is the umbrella concept—it includes all the methods insurers use to control how, when, and for whom services are covered. UM encompasses both benefit design limits, such as visit or age caps, and clinical utilization review processes, such as medical necessity determinations and prior authorization.
Benefit design rules are a subset of UM. They are predefined coverage rules that apply automatically and do not involve case-by-case clinical review.
Utilization review (UR) is a subset of UM. It refers to clinical, case-by-case reviews used to determine medical necessity and compliance with coverage requirements, such as timing, setting, or appropriateness of care.
Dollar caps may apply either to an individual's covered treatment or to a health plan overall, depending on plan design, and function as a dollar amount a plan will pay for a covered service or benefit, per year or over a lifetime.
Benefit exclusions are coverage design features that specify services or conditions that are not covered under the health plan.
Network restrictions are plan rules that limit coverage to providers or facilities within a designated network.
Medical necessity is a determination, based on clinical criteria and patient-specific information, that a service is appropriate, effective, and covered under the health plan.
Prior authorization is a utilization review process that requires approval before a service is provided to confirm it meets medical necessity and coverage requirements.
Concurrent review are reviews conducted while treatment is ongoing to determine whether additional services remain covered.
Retrospective review are reviews conducted after services have been provided, often to determine payment or compliance with coverage criteria.
Note: *The tools shown are examples of utilization management approaches. Whether and how they apply (e.g., age limits or prior authorization) depends on the plan, benefit design, and specific clinical circumstances.*

Source: MD Clarity "Utilization Management"; Institute of Medicine, Committee on Utilization Management by Third Parties 1989; American Speech-Language-Hearing Association "Module Three: Documentation of SLP Services in Different Settings"; ACMA 2022; American Speech-Language-Hearing Association "Private Health Plans"; Giardino and Wadhwa 2023; and MD Clarity "Utilization Review."

Within federal and state guidelines, insurance providers retain discretion to design their utilization management processes, including utilization review requirements, visit limits, and other documentation requirements.[69] External review mechanisms exist to support fair and consistent evaluation.[70] The Tennessee Department of Commerce and Insurance (TDCI) oversees health insurers compliance with state insurance laws, assists consumers through complaint mediation, and enforces insurance regulations, with review and assistance available when consumers believe they have been treated unfairly.[71] The denial or approval of insurance claims for services must be based on whether services match clinical need and are appropriate in scope and duration, like approving an evidence-based number of therapy sessions or reassessing at regular intervals rather than abruptly discontinuing care.[72] Similar cases must be treated the same regardless of nonclinical factors like age, gender, or socioeconomic status.[73]

Tennessee Department of Commerce and Insurance's Role in Regulating Insurance Providers

The Tennessee Department of Commerce and Insurance (TDCI) is responsible for regulating insurance companies and brokers operating within the state. TDCI oversees traditional insurance policies sold in Tennessee to ensure compliance with state insurance laws, financial stability, and fair treatment of consumers. TDCI does not oversee self-insured health insurance plans.[1] These are plans where employers assume the financial risk of providing healthcare benefits to employees and pay employee claims directly instead of purchasing coverage from an insurance company. These plans are not regulated at the state level and, instead, fall under federal oversight through the Employee Retirement Income Security Act (ERISA), which establishes standards for employee benefit plans, including self-insured health plans.[2]

[1] Tennessee Department of Commerce and Insurance 2020.
[2] 29 U.S.C. Section 1001 et seq.

[69] 42 CFR Parts 422, 431, 435, 438, 440, and 457; and Tennessee Department of Commerce and Insurance 2020; interview with Meghan Ryan, director, Health Care Policy, Private Health Plans, American Speech-Language-Hearing Association, September 15, 2025; American Speech-Language-Hearing Association 2015; and interview with Zachary Crandall, director of policy analysis, Scott McAnally, director of insurance, and Candace D. Payne, manager of the life, accident, and health section, Tennessee Department of Commerce and Insurance, June 23, 2025.
[70] Tennessee Code Annotated, Sections 56-6-701 through 56-6-706; American Specialty Health "Clinical Practice Guideline 166: Speech-Language Pathology"; and interview with Zachary Crandall, director of policy analysis, Scott McAnally, director of insurance, and Candace D. Payne, manager of the life, accident, and health section, Tennessee Department of Commerce and Insurance, June 23, 2025.
[71] Tennessee Department of Commerce and Insurance 2020; and interview with Zachary Crandall, director of policy analysis, Scott McAnally, director of insurance, and Candace D. Payne, manager of the life, accident, and health section, Tennessee Department of Commerce and Insurance, June 23, 2025.
[72] Tennessee Code Annotated Sections 56-6-701 through 56-6-706; and American Specialty Health "Clinical Practice Guideline 166: Speech-Language Pathology."
[73] Tennessee Code Annotated Sections 56-6-701 through 56-6-706; and American Specialty Health "Clinical Practice Guideline 166: Speech-Language Pathology."

According to SLPs and advocates for people who stutter, utilization management processes can create challenges in getting insurance claims approved.[74] Insurance policies commonly prioritize physical restoration over developmental or functional improvement,[75] with developmental stuttering typically not deemed medically necessary, making reimbursements for developmental stuttering therapy unlikely.[76] As a result, insurance often denies coverage for habilitative therapy sessions for developmental stuttering that does not meet the insurance companies' medical necessity standards, with some SLPs indicating that this is often the case for adults with developmental stuttering.[77] Insurers may require measurable reductions in stuttering frequency or severity, use of speech strategies, or observable functional gains—metrics that may not fully reflect therapeutic progress, especially for long-term conditions.[78] It can be complicated to document measurable progress from stuttering treatment, and one small insurer said that this lack of documentation is one cause of claim denial.[79]

National survey data show that prior authorization requirements impose substantial administrative burdens on providers, including treatment delays, increased staff time dedicated to paperwork, and higher rates of burnout.

Even when claims are approved, utilization reviews can result in administrative burdens for providers. National survey data show that prior authorization requirements impose substantial administrative burdens on providers, including treatment delays, increased staff time dedicated to paperwork, and higher rates of burnout.[80]

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[74] Interview with Jennifer Henderson, vice president of legislative affairs, and Jessica Lenden-Holt, president elect, Tennessee Association of Audiologists and Speech-Language Pathologists, May 5, 2025; and interview with Brooke Edwards, director, The Stuttering Association for the Young, June 26, 2025.

[75] National Stuttering Association "Navigating Insurance for Speech and Language Services"; National Stuttering Association 2006; and interview with Jack Henderson, speech-language pathologist and co-leader of Nashville Chapter, National Stuttering Association, May 1, 2025.

[76] Interview with Jennifer Henderson, vice president of legislative affairs, and Jessica Lenden-Holt, president elect, Tennessee Association of Audiologists and Speech-Language Pathologists, May 5, 2025; interview with Jack Henderson, speech-language pathologist and co-leader of Nashville Chapter, National Stuttering Association, May 1, 2025; interview with Brooke Edwards, director, The Stuttering Association for the Young, June 26, 2025; and interview with Naomi Eichorn, assistant professor, Julie Marshall, clinical associate professor, and Katherine Mendez, clinical assistant professor, School of Communication Sciences and Disorders, University of Memphis, May 7, 2025.

[77] The Stuttering Foundation 2002; interview with Meghan Ryan, director, Health Care Policy, Private Health Plans, American Speech-Language-Hearing Association, September 15, 2025; American Speech-Language-Hearing Association 2015; interview with Jack Henderson, speech-language pathologist and co-leader of Nashville Chapter, National Stuttering Association, May 1, 2025; and TACIR staff survey of speech-language pathologists on insurance coverage and access to stuttering therapy 2025.

[78] American Speech-Language-Hearing Association 2015; and interview with Ben Moran, vice president, product performance, Maris Mellon, manager, regulatory operations, Timothy Schurwan, contract associate and negotiator, and Daniel Martinez, regulatory operations and risk management, Ambetter, September 5, 2025.

[79] American Speech-Language-Hearing Association "Overview of Documentation for Medicare Outpatient Therapy Services"; and interview with Ben Moran, vice president, product performance, Maris Mellon, manager, regulatory operations, Timothy Schurwan, contract associate and negotiator, and Daniel Martinez, regulatory operations and risk management, Ambetter, September 5, 2025.

[80] American Medical Association 2024; and McCormick 2025.

The limits on stuttering therapy coverage included in some insurance plans may result in patients paying for care out of pocket. Many SLPs in private practice face complexities with insurance billing, including delayed payments, claim denials, and limited coverage for certain services, which can create financial strain and administrative burdens, sometimes leading clinicians to limit insurance participation or focus on private-pay clients.[81] In cases where patients pay out of pocket, such as when their provider is out-of-network or when an initial claim is denied, the patient may seek reimbursement or file an appeal with their insurance provider.[82] In these instances, the patient can request a superbill—a detailed invoice that includes the necessary codes and details—from their SLP to support their claim submission or appeals process. The codes and details in a superbill can be helpful in requesting reimbursement from their insurance provider but may not always result in the patient successfully receiving reimbursement.[83]

Insurance limits on stuttering therapy often shift costs to patients and offer no guarantee of reimbursement, while creating administrative strain for providers.

Senate Bill 231 and House Bill 296 as originally filed would have ensured access to stuttering therapy with no limitations for some insurance plans in Tennessee.

In response to concerns with the existing framework of utilization management voiced by various stakeholders, including SLPs and advocates for people who stutter, Senate Bill 231 and House Bill 296, as originally introduced by Senator Akbari and Representative Love (see appendix A), would have

- required some health insurance providers to cover speech therapy services for stuttering for both habilitative and rehabilitative care,
- prohibited some insurers from denying claims for stuttering therapy based on utilization review, and
- prohibited some insurers from setting age or visit limits for stuttering therapy.

The bill would have applied to the following insurance plans in Tennessee: the State Group Insurance Program, ACA Marketplace Plans, TennCare, and CoverKids (see table 1 (reposted)).

- The State Group Insurance Program: The State Group Insurance Program is a self-insured plan provided by the State of Tennessee for state and higher education employees, retirees, and dependents, as well as local education agencies and local governments that choose to participate in the state's plan.[84] As

[81] Aboena 2021.
[82] HealthCare.gov "How to Appeal an Insurance Company Decision."
[83] Interview with Robert Reichhardt, board certified specialist-stuttering, cluttering, and fluency disorders, Pathways for Stuttering, September 9, 2025.
[84] Partners for Health "Eligibility."

As originally filed, Senate Bill 231 and House Bill 296 would have expanded access to stuttering therapy in Tennessee by requiring coverage without visit or age limits and restricting insurers from denying claims based on utilization review.

of May 2025, there are over 300,000 people including retirees covered under the State Group Insurance Program, with 133 local education agencies and 360 local government agencies opting into the program.[85] Only 2.6% of members with a procedure code for evaluation of speech fluency or treatment of speech, language, voice, communication, or auditory processing disorder had a primary diagnosis of childhood- or adult-onset fluency disorder in fiscal year 2024-25.[86]

- Affordable Care Act Plans: ACA plans are health insurance plans sold through the Health Insurance Marketplace that meet the federal standards for comprehensive coverage and consumer protection.[87] Under the ACA, each state selects an Essential Health Benefits (EHB) benchmark plan that defines the minimum level of coverage required for ACA plans (see appendix D).[88] Tennessee's benchmark plan is currently based on a Blue Cross Blue Shield plan.[89] ACA plans are available to US citizens and lawfully[90] present residents who don't have access to affordable employer-sponsored insurance, Medicaid, or Medicare and who buy coverage through the federal Health Insurance Marketplace or their state's Marketplace if their state has one; Tennessee does not have its own Marketplace.[91]
- TennCare: TennCare is Tennessee's Medicaid program and provides health coverage to individuals who meet eligibility requirements. Despite the steady growth in speech therapy utilization (see appendix E), TennCare's overall spending on speech therapy services has remained relatively stable at

[85] Interview with Meagan Jones, director of policy research and legislative analysis, Tennessee Department of Finance and Administration, Division of Benefits Administration, May 6, 2025.
[86] Email from Meagan Jones, director of policy research and legislative analysis, Tennessee Department of Finance and Administration, Division of Benefits Administration, September 19, 2025.
[87] Public Law 111–148—March 23, 2010 124 Statute 119; and HealthCare.gov "Get Ready to Apply for Health Coverage."
[88] Federal law requires EHB plans to cover 10 categories of care for ACA plans, including ambulatory patient services, emergency services, hospitalization, maternity and newborn care, mental health and substance use disorder services, prescription drugs, habilitative and rehabilitative services, laboratory services, preventive and wellness services, and pediatric services. Speech therapy services for stuttering fall under habilitative and rehabilitative services. In Tennessee, there are six major insurance providers that offer ACA compliant plans, and all counties have at least two insurer options.
[89] Interview with Zachary Crandall, director of policy analysis, Scott McAnally, director of insurance, and Candace D. Payne, manager of the life, accident, and health section, Tennessee Department of Commerce and Insurance, June 23, 2025.
[90] For ACA eligibility, a lawfully present individual includes non-US citizens with federally recognized immigration statuses—such as lawful permanent residents (green card holders), refugees, asylees, individuals granted withholding of removal or protection under the Convention Against Torture, parolees (for at least one year), people with Temporary Protected Status, Cuban/Haitian entrants, victims of trafficking or crime with T or U visas, individuals with pending asylum or adjustment applications, and certain valid nonimmigrant visa holders—who may enroll in marketplace coverage.
[91] Public Law 111–148—March 23, 2010 124 Statute 119.

$37 million to $42 million annually from 2022 through 2024. Within that total, stuttering-related services accounted for only approximately $378,816 in 2023, representing about 1% of total speech therapy expenditures.[92]

- CoverKids: CoverKids is Tennessee's Children's Health Insurance Program (CHIP) and provides free health coverage for uninsured children under 19 and pregnant women who do not qualify for TennCare.[93] Enrollees must be Tennessee residents with household incomes at or below 250% of the federal poverty level.[94] Although the number of CoverKids enrollees receiving speech therapy services increased steadily in recent years, spending on stuttering-related services remained minimal (see appendix E). In 2023, CoverKids spent approximately $15,796 on stuttering-related speech therapy services.[95]

To varying degrees, each of these plans includes limitations on stuttering therapy services that would have been prohibited by Senate Bill 231 and House Bill 296. For example, all four of these plans subject speech therapy services to utilization reviews, though the components of these reviews vary. All four plans require reviews for medical necessity (see table 1). But only the State Group Insurance Program and ACA plans require prior authorization.[96] Regarding visit limits, the State Group Insurance Program, TennCare, and some ACA plans have no visit limits for speech therapy services. Under the state's EHB, ACA plans are required to cover a minimum of 20 visits for speech therapy services annually, though they can provide more (see table 1 (reposted)).[97] Moreover, none of the four plans specifically excludes habilitative or developmental stuttering therapy, and none of the plans has age limits specific to speech therapy services.[98]

The State Group Insurance Program and TennCare have no visit limits for speech therapy services; CoverKids covers up to 50 visits, and ACA plans are required to cover a minimum of 20 visits annually.

[92] Senate Bill 231 and House Bill 296 Fiscal Note; and interview with Cooper Lloyd, chief medical officer, Vaughn Frigon, associate medical director, and Drew Staniewski, deputy director, TennCare, May 27, 2025.
[93] The Children's Health Insurance Program (CHIP) is a joint federal-state program that provides free or low-cost health coverage for children and pregnant women in households with incomes too high for TennCare (Medicaid) but too low to afford private insurance.
[94] TennCare "CoverKids| Eligibility"; and US Department of Health and Human Services 2025. For a family of four, the federal poverty level in dollars per year is $32,150, making 250% of the federal poverty level $88,412.
[95] Senate Bill 231 and House Bill 296 Fiscal Note.
[96] Tennessee Department of Finance and Administration Chapter 1200-13-14; TennCare 2025; State of Tennessee 2025a; State of Tennessee 2025b; State of Tennessee 2025c; Centers for Medicare & Medicaid Services 2025b; and Tennessee EHB Benchmark Plan (2025-2027).
[97] Interview with Zachary Crandall, director of policy analysis, Scott McAnally, director of insurance, and Candace D. Payne, manager of the life, accident, and health section, Tennessee Department of Commerce and Insurance, June 23, 2025; Tennessee Department of Finance and Administration Chapter 1200-13-14; TennCare 2025; State of Tennessee 2025a; State of Tennessee 2025b; State of Tennessee 2025c; Centers for Medicare & Medicaid Services 2025b; and Tennessee EHB Benchmark Plan (2025-2027).
[98] Tennessee Department of Finance and Administration Chapter 1200-13-14; TennCare 2025; State of Tennessee 2025a; State of Tennessee 2025b; State of Tennessee 2025c; Centers for Medicare & Medicaid Services 2025b; and Tennessee EHB Benchmark Plan (2025-2027).

Table 1 (reposted). Current Coverage for Stuttering Therapy in Insurance Programs That Would Have Been Affected by Senate Bill 231 and House Bill 296 as Originally Filed

Insurance Program	Is Stuttering Therapy Covered?	Is Utilization Review Applied to Stuttering Therapy?	Are There Annual Visit Limits for Stuttering Therapy?
TennCare	Yes	Yes - for example, much like care for other conditions, stuttering therapy must be deemed medically necessary to be covered	No
CoverKids	Yes	Yes - for example, much like care for other conditions, stuttering therapy must be deemed medically necessary to be covered	Yes - limited to 52 visits per therapy type per calendar year
Tennessee State Group Insurance Program*	Yes	Yes - for example, much like care for other conditions, stuttering therapy must be deemed medically necessary to be covered	No
Affordable Care Act (ACA) Marketplace Plans	Yes	Yes - for example, much like care for other conditions, stuttering therapy must be deemed medically necessary to be covered	Yes - limits can vary by plan, but plans must cover at least 20 visits per year

* Includes plans for eligible Tennessee state and higher education employees, dependents, and retirees, as well as plans for local education and local government agencies that opt in.

Source: Tennessee Department of Finance and Administration Chapter 1200-13-14; TennCare 2025; State of Tennessee 2025a; State of Tennessee 2025b; State of Tennessee 2025c; Centers for Medicare & Medicaid Services 2025b; and Tennessee EHB Benchmark Plan (2025-2027).

The primary effect of the bill, therefore, would have been to remove utilization management mechanisms; specifically, it would have (1) eliminated utilization review for stuttering therapy for each of these plans and (2) removed visit limits for stuttering therapy for the ACA plans that currently have limits and for CoverKids. In doing so, it would have likely made it less costly for individuals to access stuttering therapy services. By eliminating utilization reviews and visit limits, the bill would have reduced the likelihood that insurance claims would be denied. This could reduce direct out-of-pocket costs for individuals receiving therapy and,

as a result, lead to individuals seeking and receiving more therapy than they otherwise would—coverage expansions for similar conditions, such as autism, resulted in an increase in individuals with unmet needs seeking services.[99] Clinicians say that if the bill passed it would allow them to recommend session frequency and duration based on clinical judgment rather than visit limits or restrictive insurance definitions.[100] Even though insurance premiums would increase too, the Fiscal Review Committee estimated that individuals' premiums would increase by less than 1% (see table 2 and appendix F).[101]

Removing utilization management entirely, as proposed in Senate Bill 231 and House Bill 296, raises broader policy and implementation considerations.

Removing all utilization management requirements, as proposed in Senate Bill 231 and House Bill 296, could raise concerns about cost control, increased demand for services, and maintaining targeted care for those with the greatest clinical need.

Despite the potential for improving access to care, removing all utilization management requirements—including utilization reviews and defined benefit limits like visit limits— as proposed in Senate Bill 231 and House Bill 296 raises several policy concerns. For example, one major insurance provider stated that if visit limits were removed, some form of utilization management would remain necessary to ensure that services are targeted to children with significant clinical need.[102] Insurance providers may worry that removing utilization management could affect insurance participation and plan affordability; for example, within utilization management, TennCare said that limiting utilization review may lead to more people seeking services, though it indicated it would also be able to meet demand if these limitations were removed.[103] The State of Tennessee's Benefits Administration noted that the bill would remove cost-control mechanisms rather than expand covered services[104] and, in doing so, increase plan costs.[105]

Removing utilization review entirely for one category of services represents a significant departure from standard insurance practice. Utilization review is not unique to speech therapy; it is applied broadly across nearly all outpatient therapies to ensure care is medically appropriate and

[99] Candon et al. 2019.
[100] TACIR staff survey of speech-language pathologists on insurance coverage and access to stuttering therapy 2025.
[101] Senate Bill 231 and House Bill 296 Fiscal Note.
[102] Interview with Cooper Lloyd, chief medical officer, Vaughn Frigon, associate medical director, and Drew Staniewski, deputy director, TennCare, May 27, 2025; and interview with Lindsey Smith, state government relations, Keeling Baird, state government relations, Andrea Willis, chief medical officer, Michael Eiselstein, vice president of product strategy, and Russell Marty, state government relations, Blue Cross Blue Shield of Tennessee, May 19, 2025.
[103] Interview with Cooper Lloyd, chief medical officer, Vaughn Frigon, associate medical director, and Drew Staniewski, deputy director, TennCare, May 27, 2025.
[104] Interview with Meagan Jones, director of policy research and legislative analysis, and Andrea Dowdy, director of clinical services, Division of Benefits Administration, Tennessee Department of Finance and Administration, May 6, 2025.
[105] Senate Bill 231 and House Bill 296 Fiscal Note.

evidence-based for each patient.[106] Ultimately, there is no comparable therapy service or similar condition that is exempt from utilization review in the plans that would have been affected by the bill. Insurance companies use utilization reviews, like prior authorization and medical necessity, not only as administrative tools to control costs but also to ensure policyholders receive consistent, medically appropriate care.[107] Removing these reviews could potentially lead to higher costs, increased risk of overutilization, reduced oversight and accountability, and greater variation in care that may ultimately affect premiums and public spending.[108]

Moreover, limiting coverage changes solely to stuttering could raise compliance concerns under federal disability and nondiscrimination laws, potentially requiring broader application to all speech therapy services and increasing implementation costs beyond current estimates. If the bill were enacted, to avoid potential legal challenges or unequal treatment, insurers and state programs may need to extend the same coverage provisions to all speech therapy services, not just those related to stuttering.[109]

There is no comparable therapy service or similar condition that is exempt from utilization review in the plans that would have been affected by Senate Bill 231 and House Bill 296.

Access to speech therapy in Tennessee can be improved by using an existing administrative process to raise visit limits, a key driver of claim denials.

Adjusting benefit design rules, specifically annual visit limits, may provide a more targeted alternative to eliminating utilization management altogether. Of the four plans that would have been affected by Senate Bill 231 and House Bill 296, CoverKids limits speech therapy services to 52 visits annually, and some ACA plans also have visit limits.[110] Under the state's EHB, ACA plans are required to cover a minimum of 20 visits annually.[111] While insurers may choose to cover a higher visit limit,

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[106] Flarey 2025.

[107] American Specialty Health "Clinical Practice Guideline 166: Speech-Language Pathology"; interview with Meagan Jones, director of policy research and legislative analysis, and Andrea Dowdy, director of clinical services, Division of Benefits Administration, Tennessee Department of Finance and Administration, May 6, 2025; interview with Cooper Lloyd, chief medical officer, Vaughn Frigon, associate medical director, and Drew Staniewski, deputy director, TennCare, May 27, 2025; interview with Lindsey Smith, state government relations, Keeling Baird, state government relations, Andrea Willis, chief medical officer, Michael Eiselstein, vice president of product strategy, and Russell Marty, state government relations, Blue Cross Blue Shield of Tennessee, May 19, 2025; and interview with Zachary Crandall, director of policy analysis, Scott McAnally, director of insurance, and Candace D. Payne, manager of the life, accident, and health section, Tennessee Department of Commerce and Insurance, June 23, 2025.

[108] Interview with Representative Harold Love, 58th District of Tennessee, and Senator Raumesh Akbari, 29th District of Tennessee, April 25, 2025; and interview with Cooper Lloyd, chief medical officer, Vaughn Frigon, associate medical director, and Drew Staniewski, deputy director, TennCare, May 27, 2025.

[109] 42 U.S.C. Section 12182; and US Department of Justice Civil Rights Division 1993.

[110] Tennessee Department of Finance and Administration Chapter 1200-13-14; TennCare 2025; State of Tennessee 2025a; State of Tennessee 2025b; State of Tennessee 2025c; Centers for Medicare & Medicaid Services 2025b; and Tennessee EHB Benchmark Plan (2025-2027).

[111] Centers for Medicare & Medicaid Services 2025b; Tennessee EHB Benchmark Plan (2025-2027); and Kaiser Health News 2016.

commission staff are aware of only one insurer in Tennessee whose ACA plans cover more than the minimum visits required by Tennessee's EHB plan.[112] As a result, it appears that the minimum visit limit for stuttering therapy in the state's EHB is, for practical purposes, the maximum covered under some ACA plans in the state.

These limits may be insufficient for conditions like developmental stuttering, which often require sustained, long-term intervention.[113] Stakeholders say that strict visit limits can reduce the amount of treatment individuals receive, potentially preventing them from following their recommended treatment plans.[114] Progress in fluency often requires ongoing, tailored sessions that extend beyond a set number of visits, so limiting therapy to 20 visits per year may prevent individuals from receiving the consistent and comprehensive care they need to manage their stuttering. Stakeholders—including clinicians and advocates—emphasize that stuttering is a chronic, variable condition, with treatment needs differing widely across individuals.[115] This is a position reflected in clinical guidance from the American Speech-Language-Hearing Association, which recommends individualized treatment duration rather than setting treatment plans based on the number of visits covered by a patient's insurance plan.[116]

Increasing visit limits in Tennessee's ACA plans in particular would likely help increase the ability of those covered by these plans to access stuttering therapy, in part because these limits are among the primary reasons why

Improving access to speech therapy in Tennessee could be achieved by increasing annual visit limits, because current limits may be too restrictive for conditions like stuttering that require individualized, long-term care.

[112] Interview with Ben Moran, vice president, product performance, Maris Mellon, manager, regulatory operations, Timothy Schurwan, contract associate and negotiator, and Daniel Martinez, regulatory operations and risk management, Ambetter, September 5, 2025.
[113] The Stuttering Foundation 2020; interview with Brooke Edwards, director, The Stuttering Association for the Young, June 26, 2025; and interview with Jennifer Henderson, vice president of legislative affairs, and Jessica Lenden-Holt, president elect, Tennessee Association of Audiologists and Speech-Language Pathologists, May 5, 2025.
[114] Interview with Brooke Edwards, director, The Stuttering Association for the Young, June 26, 2025; interview with Naomi Eichorn, assistant professor, Julie Marshall, clinical associate professor, and Katherine Mendez, clinical assistant professor, School of Communication Sciences and Disorders, University of Memphis, May 7, 2025; Erdemir et al. 2022; interview with Robin M. Jones, associate professor and vice chair for faculty Development, Vanderbilt Bill Wilkerson Center, May 5, 2025; interview with Jennifer Henderson, vice president of legislative affairs, and Jessica Lenden-Holt, president elect, Tennessee Association of Audiologists and Speech-Language Pathologists, May 5, 2025; interview with Jack Henderson, speech-language pathologist and co-leader of Nashville Chapter, National Stuttering Association, May 1, 2025; and TACIR staff survey of speech-language pathologists on insurance coverage and access to stuttering therapy 2025.
[115] Interview with Brooke Edwards, director, The Stuttering Association for the Young, June 26, 2025; interview with Naomi Eichorn, assistant professor, Julie Marshall, clinical associate professor, and Katherine Mendez, clinical assistant professor, School of Communication Sciences and Disorders, University of Memphis, May 7, 2025; Erdemir et al. 2022; interview with Robin M. Jones, associate professor and vice chair for faculty Development, Vanderbilt Bill Wilkerson Center, May 5, 2025; interview with Jennifer Henderson, vice president of legislative affairs, and Jessica Lenden-Holt, president elect, Tennessee Association of Audiologists and Speech-Language Pathologists, May 5, 2025; interview with Jack Henderson, speech-language pathologist and co-leader of Nashville Chapter, National Stuttering Association, May 1, 2025; and TACIR staff survey of speech-language pathologists on insurance coverage and access to stuttering therapy 2025.
[116] American Specialty Health "Clinical Practice Guideline 166: Speech-Language Pathology."

claims are denied by insurers. For example, representatives for one large insurer told commission staff that denials for speech therapy services are not typically triggered by medical necessity review but by exceeding visit limits.[117] And some service providers may stop attempting to bill insurance once caps are reached.[118] Similarly, TDCI staff said that all of the appeals it has received related to speech therapy claims were related to limitations on the number of speech therapy sessions allowed, not medical necessity review or other aspects of utilization review.[119] Individuals with ACA plans can file complaints with TDCI related to their claims; overall, TDCI receives approximately 3,500 to 4,000 formal complaints annually. In the past five years, six complaints were filed specifically related to speech therapy, and all of these complaints were related to the limitations that carriers placed on the number of sessions allowed.[120] From 2022 through 2024, TennCare has had no appeals or grievances related to speech therapy services.[121]

Legislative changes to increase minimum visit requirements for ACA plans under Senate Bill 231 and House Bill 296 would have triggered state defrayal obligations, resulting in significant additional costs to the state.

The number of individuals who seek more than 20 visits a year may not be overwhelming. One small insurer that offers ACA plans with no visit limit reported that 10 out of 141 members who received speech therapy services exceeded the 20-visit mark within a calendar year in 2024 and, similarly, one of 68 members as of May of 2025.[122]

Making legislative changes to the minimum visit requirements for ACA plans would have led to additional costs to the state.

Because the Senate Bill 231 and House Bill 296 would have made legislative changes to the minimum coverage required for ACA plans in Tennessee, it would have resulted in additional costs to the state. Under the ACA, if a state makes legislative changes to the coverage requirements for ACA plans and those changes increase the cost of ACA plans, then the incremental cost increases must be covered by the state—a process referred to as "defrayal."[123] The state can defray costs by paying insurers or reimbursing enrollees. This prevents states from raising premiums by adding mandates without covering the extra expense themselves. Of the approximately $3.1 million increase in combined annual state costs

[117] Interview with Lindsey Smith, state government relations, Keeling Baird, state government relations, Andrea Willis, chief medical officer, Michael Eiselstein, vice president of product strategy, and Russell Marty, state government relations, Blue Cross Blue Shield of Tennessee, May 19, 2025.
[118] Ibid.
[119] Interview with Zachary Crandall, director of policy analysis, Scott McAnally, director of insurance, and Candace D. Payne, manager of the life, accident, and health section, Tennessee Department of Commerce and Insurance, June 23, 2025.
[120] Email from Vickie Trice, director, Consumer Insurance Services Division, Tennessee Department of Commerce and Insurance, July 24, 2025.
[121] Interview with Cooper Lloyd, chief medical officer, and Vaughn Frigon, associate medical director, Drew Staniewski, deputy director, TennCare, May 27, 2025.
[122] Email from Ben Moran, vice president product performance, Ambetter, September 24, 2025.
[123] 45 Code of Federal Regulations 155.170; and Pogue et al. 2024.

resulting from the bill, $1.8 million would have resulted from the changes made to ACA plans (see table 2 (reposted)).

Table 2 (reposted). Projected Cost of Enacting Senate Bill 231 and House Bill 296 as Originally Filed in the 114th General Assembly

Coverage Type	Annual Increase to State	Annual Increase to Federal	Annual Increase to Local Gov't
TennCare	$ 822,674	$ 1,483,220	$ -
CHIP (CoverKids)	21,219	63,741	-
Tennessee State Group Insurance Program	454,637	49,714	307,822
Affordable Care Act Marketplace Plans	1,774,313	-	-
Total	$ 3,072,843	$ 1,596,675	$ 307,822

* Includes plans for state and higher education employees and their dependents, as well as plans for local education and local government agencies that opt in.

Source: Senate Bill 231 and House Bill 296 Fiscal Note.

Selecting a new EHB benchmark plan could offset defrayal costs.

If Tennessee pursues an EHB update administratively, the state may avoid some of the defrayal costs that could arise under the original version of Senate Bill 231 and House Bill 296. By updating the EHB benchmark rather than enacting a state mandate, any added costs are absorbed into premiums avoiding direct state defrayal obligations. There is an existing administrative process in which states can select new EHB plans.[124] If TDCI determines it beneficial to update the state's EHB benchmark plan, it must notify the US Department of Health and Human Services of its selection of a new plan by the first Wednesday in May, two years before the plan's effective date.[125] Selecting a new EHB plan would adopt all coverage requirements of the selected plan, and therefore it would be beneficial for the state to consider how broader changes to the essential health benefits—not just speech therapy—may affect cost and coverage.[126]

By updating the EHB benchmark rather than enacting a state mandate, any added costs are absorbed into premiums, avoiding direct state defrayal obligations.

[124] Interview with Zachary Crandall, director of policy analysis, Scott McAnally, director of insurance, and Candace D. Payne, manager of the life, accident, and health section, Tennessee Department of Commerce and Insurance, June 23, 2025.
[125] Centers for Medicare & Medicaid Services 2025a; and 45 Code of Federal Regulations section 156.111.
[126] 45 Code of Federal Regulations section 156.111; and interview with Zachary Crandall, director of policy analysis, Scott McAnally, director of insurance, and Candace D. Payne, manager of the life, accident, and health section, Tennessee Department of Commerce and Insurance, June 23, 2025.

Tennessee's current EHB is set for plan year 2025 through 2027. If no changes are made, the existing EHB will remain in effect.[127]

Aligning Tennessee's EHB benchmark plan closer to the provisions for speech therapy services in the State Group Insurance Program, TennCare, and CoverKids would promote consistency across programs and ensure equitable access to therapy services for all insured Tennesseans. The State Group Insurance Program, TennCare, and CoverKids already provide coverage for medically necessary therapies with no or higher visit limits than the 20-visit minimum set for ACA. Adopting a new EHB plan with more generous benefits for speech therapy services would also adopt similar benefits for all other habilitative and rehabilitative services covered such as physical and occupational therapy.[128]

Tennessee's EHB minimum standard is below the national average for both habilitative and rehabilitative speech therapy services.

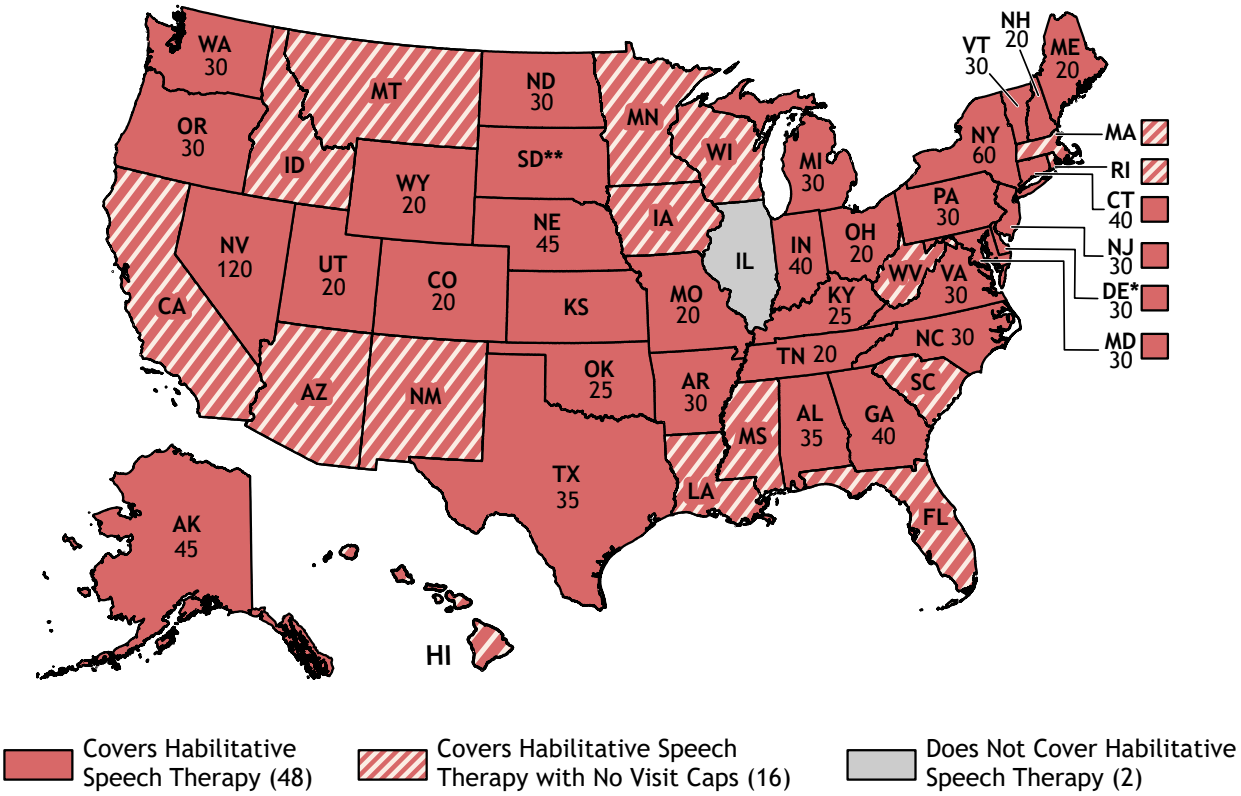
Compared to other states' EHB benchmark plans, Tennessee remains at the lower end of the visit limit spectrum.

Tennessee's minimum 20 visit limit for both habilitative and rehabilitative speech therapy services in ACA plans remains at the lower end of the spectrum compared to other states. For habilitative services, developing or improving skills, 16 states require ACA plans to cover unlimited visits, 1 state requires a minimum of 120 visits, 22 states have minimums between 25 and 60 visits, 8 states require a minimum of 20 visits, 2 states do not require plans to cover any visits, and 1 state only covers a limited number of annual hours if related to Autism Spectrum Disorder. As for rehabilitative services, restoring lost skills, 13 states require ACA plans to cover unlimited visits, 1 state requires a minimum of 120 visits, 1 state requires a minimum of 90 visits, 23 states have minimums between 25 and 60 visits, 11 states require a minimum of 20 visits, and 1 state does not require plans to cover any visits. Tennessee's 20-visit minimum standard is therefore below the national average for both categories. See maps 1 and 2 and appendix C for a list of states and their minimum visit limit standard for speech therapy services for ACA plans.

[127] Centers for Medicare & Medicaid Services 2025a.

[128] Those changes would occur automatically because occupational and physical therapy are included under both habilitative and rehabilitative services within the Essential Health Benefits framework, meaning that any change to limits on the overarching category would apply across those services, see also Appendix D. Centers for Medicare & Medicaid Services 2025a.

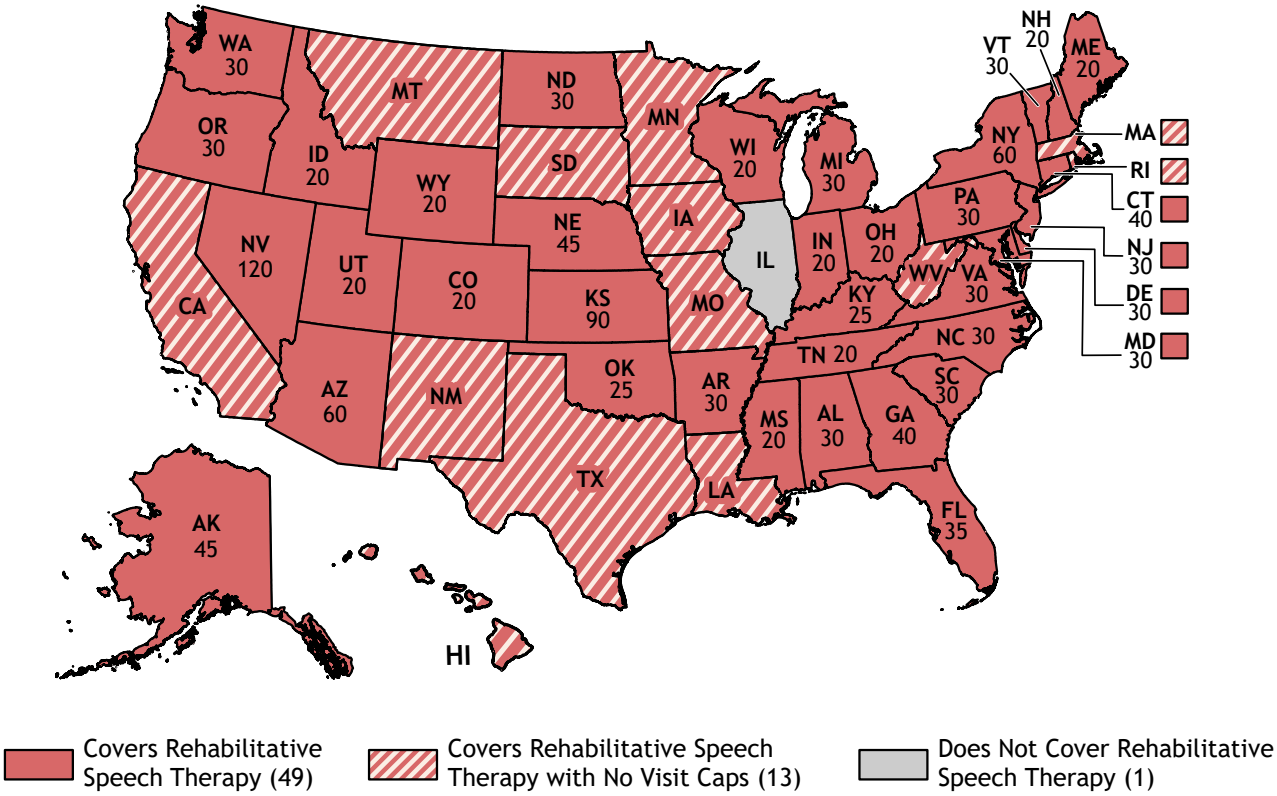
Map 1. States' Essential Health Benefits for Habilitative Speech Therapy Services: Minimum Number of Visits That Must be Covered by ACA Plans



*Delaware's Essential Health Benefits plan covers habilitative speech therapy, but speech therapy is not covered for attention disorders, behavior problems, conceptual handicaps, learning disabilities, or developmental delays.
**For South Dakota's Essential Health Benefits Plan, speech therapy for Autism Spectrum Disorder is covered, with Applied Behavioral Analysis therapy subject to minimum annual hour limits of 1,300 hours for ages 0 through 6, 900 hours for ages 7 through 13, and 450 hours for ages 14 through 18.

Source: Centers for Medicare & Medicaid Services 2025a.

Map 2. States' Essential Health Benefits for Rehabilitative Speech Therapy Services: Minimum Number of Visits That Must be Covered by ACA Plans



Source: Centers for Medicare & Medicaid Services 2025a.

Several states have enacted legislation expanding access to speech therapy for individuals who stutter, though the structure and implementation of these laws vary. In many cases, coverage expansions retain age limits or utilization management controls (see table 3). Within the past year and a half, Delaware,[129] Nevada,[130] and Pennsylvania[131] have enacted laws expanding children's access to speech therapy. Delaware's coverage expansion law applies to children up to age 18, Nevada's applies to persons less than 26 years of age, while Pennsylvania's requirements apply to children ages two to six. Delaware and Pennsylvania's laws apply to ACA plans, while Nevada's law applies to Medicaid plans and ACA plans. In all three states, the mandates include both habilitative and rehabilitative treatment for stuttering (see table 3).

[129] 84 Delaware Law Chapter 520 (2024).
[130] Nevada Chapter 462 (2025).
[131] Pennsylvania Act 2024-104 (2024).

Table 3. Legislation in Other States

State	Habilitative Services Covered	Rehabilitative Services Covered	Applies to Medicaid/ TennCare	Applies to ACA Plans	Applies to State Employee Health Insurance Plan	Annual Visit Limits	Age-Based Coverage Limits	Use of Utilization Management Prohibited	Void if ACA Defrayment Required
Tennessee	Y	Y	Y	Y	Y	N	N	Y	N
Enacted Legislation									
Delaware	Y	Y	N	Y	N	N	Y (0-18 y/o)	N	N
Kentucky	Y	Y	Y	Y	Y	N	N	Y	Y
Nevada	Y	Y	Y	Y	N	N	Y (0-26 y/o)	Y	N
Pennsylvania	Y	Y	N	Y	N	Not Specified	Y (2-6 y/o)	N	N
Pending Legislation									
Illinois	Y	Y	Y	Y	Y	Not Specified	Y (0-18 y/o)	N	N
Massachusetts	Y	Y	Y	Y	Y	N	N	Y	N
Failed Legislation									
New Jersey	Y	Y	Y	Y	Y	Not Specified	N	Y	N
New York	Y	Y	N	Y	N	N	N	N	N
Virginia	Y	Y	N	Y	N	N	N	N	Y
West Virginia	Y	Y	N	Y	N	N	Y (0-18 y/o)	Y	N

Source: Tennessee Senate Bill 231 and House Bill 296 (2025); 84 Delaware Law Chapter 520 (2024); Illinois SB 0040 (2025); Kentucky Chapter 69 (2024); Massachusetts HB 1218 (2025); Nevada Chapter 462 (2025); New Jersey Senate No. 3558 (2024); New York SB 3654 (2025); Pennsylvania Act 2024-104 (2024); Virginia HB 1633 (2024); and West Virginia HB 3090 (2025).

Kentucky has also enacted similar, though broader, legislation. Kentucky's law expands access to speech therapy for stuttering for both adults and children and applies to Medicaid plans, ACA plans, and the state government employee insurance plan. The law covers both habilitative and rehabilitative speech therapy services and allows for teletherapy.

Approaches to managing potential state costs differ. Kentucky's legislation Public Chapter 69, Acts of 2024, includes a defrayal provision stating that the coverage requirement will not take effect if it triggers a state obligation to defray costs for benefits exceeding Kentucky's current EHB benchmark. As a result, Kentucky has reported no current fiscal effect, and implementation of the law is on hold pending federal approval of the new EHB. Kentucky submitted an EHB benchmark amendment to the Centers for Medicare & Medicaid Services in May 2025 and is awaiting guidance before coverage can take effect, potentially in January 2027.[132] By contrast, Pennsylvania, Delaware, and Nevada enacted coverage expansions without explicit defrayal clauses.

Individuals may be able to access stuttering therapy at low or no cost through alternative programs, for example, school-based services or university clinics.

Conversely, similar bills in Virginia[133] and West Virginia[134] did not pass. During consideration of these measures, insurers raised concerns that new coverage mandates could potentially increase insurance costs for consumers.[135]

Individuals seeking stuttering therapy services may qualify for other public programs, financial assistance, or grants.

Individuals may also be able to receive stuttering therapy at no out-of-pocket cost or reduced cost from other programs. Examples include services for school-aged and preschool-aged children, as well as services provided at university clinics, among other options.[136]

Children may qualify for speech therapy services under the federal Individuals with Disabilities Education Act (IDEA). IDEA helps ensure that children with disabilities, including speech and language impairments, receive free and appropriate public education and early intervention services.[137] Under IDEA Part B, the Tennessee Department of Education supports students ages 3 through 21 through special education programs, including speech-language therapy and related supports in public

[132] Interview with Shaun T. Orme, executive advisor, Angela Raley, director of the health, managed care, and life division, and Beth Taylor, counsel, Kentucky Department of Insurance, July 10, 2025.
[133] Virginia HB 1633 (2024).
[134] West Virginia HB 3090 (2025).
[135] Povich 2024.
[136] Tennessee Department of Education 2022; and Austin Peay State University "APSU Speech-Language & Swallowing Community Clinic."
[137] Individuals with Disabilities Education Act, Chapter 33, Sections 1400 through 1482.

schools.[138] Students are eligible for services if it is determined that their impairment is present and adversely affects their educational performance and is included in their Individualized Education Program (IEP).[139] School districts are responsible for evaluating students, allocating resources, and ensuring qualified staff are available to deliver speech therapy in accordance with the student's IEP. Referrals for speech therapy services can be initiated by teachers, parents, or others, with eligibility determined based on the presence of the speech impairment and its adverse effects on academic performance. Parents can initiate evaluations and have legal recourse if they disagree with an IEP or feel their child's needs are unmet. Services are provided at no cost to families.[140] Senate Bill 231 and House Bill 296 would not have affected services schools are required to provide pursuant to IDEA. The number of children receiving services for speech or language impairments has decreased slightly in recent years (see appendix E).

Under IDEA Part C, the Tennessee Early Intervention System (TEIS) provides services for infants and toddlers from birth to age three who have or are at risk for developmental delays, with an extended option allowing services to continue until kindergarten entry.[141] TEIS is overseen by the Tennessee Department of Disability and Aging and is funded through a combination of federal and state funds. Services are provided at no cost to families, and TEIS functions as the payer of last resort and pays the service providers directly. Under the program, nine district offices coordinate services through contracted agencies that provide speech, occupational, and physical therapy, as well as developmental and behavioral supports. Families work with service coordinators to develop Individualized Family Support Plans. Referrals may come from doctors, hospitals, or families themselves, and appeals are allowed under IDEA. Approximately 40% of children enrolled in TEIS currently receive speech therapy services, an increase from 25% to 30% four years ago.[142] Services are typically delivered weekly in a child's typical environment, such as homes and

Eligible individuals can receive no-cost speech therapy through school-based IEP services and early intervention programs like TEIS, which provide coordinated, federally supported care for children with developmental needs.

[138] Individuals with Disabilities Education Act, Chapter 33, Sections 1411 through 1419.
[139] An IEP is an agreement stipulating services to be provided to a student with a disability consistent with the federal Individuals with Disabilities Education Act (IDEA). Services for homeschooled or private school students are offered through an Individualized Services Plan. See interview with Jamie Seek, speech-language and related services coordinator, Amy M. Owen former education senior policy director, Lexi Harless, former policy and research analyst, and Robin Yeh, former policy analyst, Tennessee Department of Education, May 2, 2025.
[140] Interview with Jamie Seek, speech-language and related services coordinator, Amy M. Owen former education senior policy director, Lexi Harless, former policy and research analyst, and Robin Yeh, former policy analyst, Tennessee Department of Education, May 2, 2025.
[141] Individuals with Disabilities Education Act, Chapter 33, Sections 1431 through 1444; Tennessee Department of Disability and Aging "Tennessee Early Intervention System (TEIS)"; and interview with Carly Carlton, program director, and Amanda Sheaffer, senior director of strategy and operations, Tennessee Early Intervention System, Tennessee Department of Disability and Aging, September 11, 2025.
[142] Interview with Carly Carlton, program director, and Amanda Sheaffer, senior director of strategy and operations, Tennessee Early Intervention System, Tennessee Department of Disability and Aging, September 11, 2025.

childcare settings, with teletherapy available for speech therapy. In 2024, TEIS served over 22,000 children statewide, with 14,000 to 15,000 children receiving services at any given time (see appendix E). The program strives for flexibility and family centered care but faces provider shortages particularly in rural areas.[143]

Other entities may offer free or discounted services. For instance, Austin Peay State University's Speech-Language & Swallowing Community Clinic offers free speech, swallowing, and cognitive therapy services for children and adults. The clinic accepts patients and operates during academic terms with limited appointment availability and provides services at no cost.[144] Additionally, nonprofits like the Stuttering Association for the Young (SAY) and grants from the United Healthcare Children's Foundation and the First Hand Foundation can help families cover costs, often awarding funds directly to therapists to ensure children receive the speech therapy they need.[145]

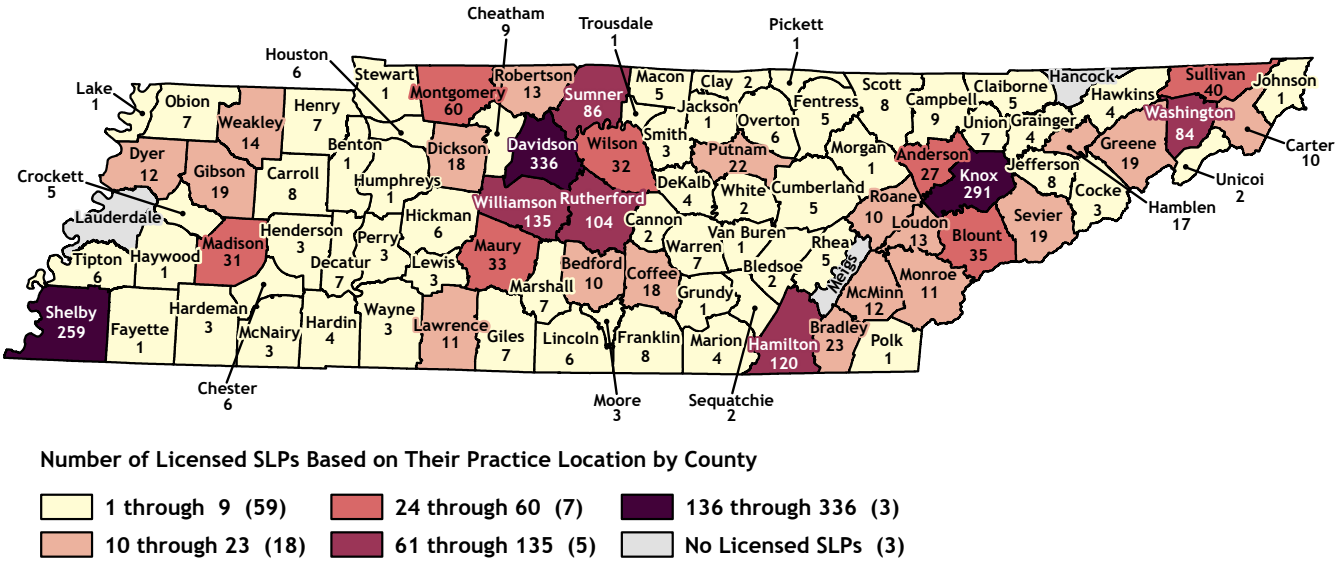
Access to stuttering therapy in Tennessee remains limited in rural areas because of shortages of licensed SLPs and a concentration of providers in urban regions.

There are other challenges to accessing stuttering therapy services.

Access to stuttering therapy may remain constrained in rural areas because of a limited number of speech-language pathologists (SLPs) with fluency-specific training. As of October 2025, there are 2,192 active licensed SLPs in Tennessee.[146] While this reflects a sizable statewide workforce, shortages persist, particularly in rural areas (see map 3).[147] Providers are disproportionately concentrated in urban regions, where most speech therapy visits occur, contributing to longer wait times and reduced access in rural communities.[148] TennCare data indicate that among TennCare and CoverKids providers, urban-based providers account for the majority of speech therapy visits, although some clinicians offer services through teletherapy in addition to in-person care. See figure 2.

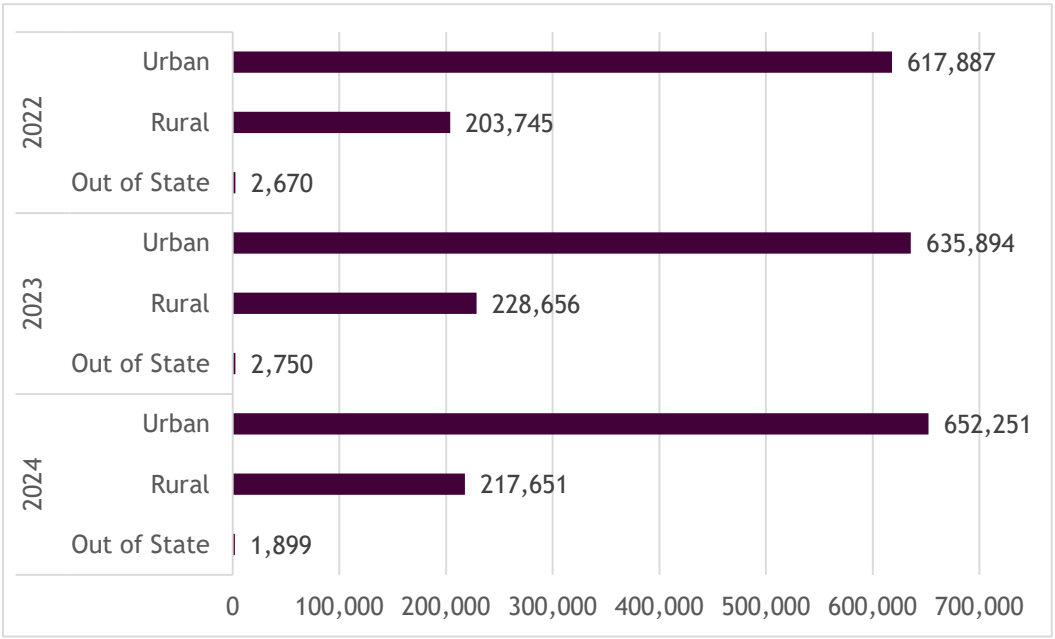
[143] Ibid.
[144] Austin Peay State University "APSU Speech-Language & Swallowing Community Clinic."
[145] Interview with Brooke Edwards, director, The Stuttering Association for the Young, June 26, 2025; United Healthcare Children's Foundation "Apply for a Grant"; email from Amy Steffen, customer service team, United Healthcare Children's Foundation, September 9, 2025; and email from Meghan Brown, director of programs, First Hand Foundation, September 23, 2025.
[146] TACIR staff analysis of data from Tennessee Department of Health 2025 Health Professional Licensing Reports.
[147] Interview with Jamie Seek, speech-language and related services coordinator, Amy M. Owen former education senior policy director, Lexi Harless, former policy and research analyst, and Robin Yeh, former policy analyst, Tennessee Department of Education, May 2, 2025.
[148] Interview with Carly Carlton, program director, and Amanda Sheaffer, senior director of strategy and operations, Tennessee Early Intervention System, Tennessee Department of Disability and Aging, September 11, 2025.

Map 3. Licensed Speech-Language Pathologists in Tennessee by Practice Location



Note: Speech-language pathologists may hold multiple licenses, and practice location data was not available for all.
Source: Tennessee Department of Health 2025.

Figure 2. Speech Therapy Visits by Provider Location for TennCare and CoverKids Enrollees, 2022 through 2024



Source: Data provided in email from Cooper Lloyd, chief medical officer, TennCare, May 28, 2025.

Teletherapy has the potential to improve reach in these areas and may help mitigate geographic disparities, particularly where in-person providers are scarce. Research indicates that teletherapy for stuttering is feasible and can produce outcomes comparable to in-person therapy, supporting its use as an access-expanding strategy when coverage policies allow.[149] Although teletherapy has expanded service options, it may not fully address access barriers for all people who stutter.[150] Limited broadband availability, licensing constraints, insurance coverage variability, and language or cultural considerations continue to restrict use.[151]

More broadly, there are few SLPs that hold advanced certification for stuttering in Tennessee.[152] Many graduate programs for speech-language pathology don't offer courses on stuttering.[153] Most graduate programs require only a single course in fluency and stuttering disorders, and as a result, many clinicians enter the field without the necessary skills to provide effective therapy for stuttering.[154] Limited training may result in inappropriate treatment or frequent referrals.[155] Not all SLPs may feel confident or trained to provide treatment specifically for stuttering.[156] Only seven licensed SLPs in Tennessee specialize in stuttering, some of whom reside out of state.[157]

While teletherapy can help expand access to stuttering treatment in underserved areas, its effect is limited by barriers like broadband access, insurance variability, and a shortage of specialized, highly trained SLPs in Tennessee.

Advanced training or certifications are costly, so SLPs may charge more because of their expertise.[158] Becoming a board certified SLP requires completing a graduate degree, hundreds of hours of supervised clinical practice, passing a national exam, and maintaining ongoing continuing education to retain certification through the American Board of Stuttering, Cluttering, and Fluency Disorders, making it a time-intensive and highly regulated process.[159] Some specialists therefore do not accept insurance and rely on private pay, particularly when services such as parent-only sessions or group therapy may not be reimbursable.[160]

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[149] Scott et al. 2025; and Ryu 2012.
[150] Telehealth.HHS.gov 2025; and Rameau et al. 2023.
[151] Rameua et al. 2023.
[152] American Board of Stuttering, Cluttering, and Fluency Disorders "Finding a Specialist."
[153] Interview with Jack Henderson, speech-language pathologist and co-leader of Nashville Chapter, National Stuttering Association, May 1, 2025.
[154] Interview with Jennifer Henderson, vice president of legislative affairs, and Jessica Lenden-Holt, president elect, Tennessee Association of Audiologists and Speech-Language Pathologists, May 5, 2025.
[155] Interview with Brooke Edwards, director, The Stuttering Association for the Young, June 26, 2025.
[156] Interview with Jack Henderson, speech-language pathologist and co-leader of Nashville Chapter, National Stuttering Association, May 1, 2025.
[157] American Board of Stuttering, Cluttering, and Fluency Disorders "Finding a Specialist."
[158] Bennett 2025.
[159] American Board of Stuttering, Cluttering, and Fluency Disorders "BCS-SCF Candidates"; Bennett 2025; and interview with Robert Reichhardt, board certified specialist-stuttering, cluttering, and fluency disorders, Pathways for Stuttering, September 9, 2025.
[160] Interview with Brooke Edwards, director, The Stuttering Association for the Young, June 26, 2025; and interview with Robert Reichhardt, board certified specialist-stuttering, cluttering, and fluency disorders, Pathways for Stuttering, September 9, 2025.

Reimbursement rates for some insurance programs may also be a challenge. TennCare reimbursement rates tend to be lower than for other programs. According to the Tennessee Association of Audiologists and Speech-Language Pathologists, low TennCare reimbursement rates and the absence of rate increases for more than a decade have further strained providers, contributing to staff attrition and service reductions.[161] But according to TennCare, there is no evidence of access issues or provider shortages reported, with 88% to 100% of providers accepting new patients and a provider network of 700 to 1,500 speech therapists.[162]

Caseloads can also create challenges particularly in schools. School-based SLPs report caseloads that are higher than national averages. ASHA data indicate that Tennessee's average school-based SLP caseload is 63 students, slightly above the national average of 54, and the state provides no official guidance on minimum or maximum caseloads.[163] Reported caseloads range from fewer than 25 students to more than 80, with administrative responsibilities further limiting direct therapy time.[164]

High caseloads among school-based SLPs in Tennessee—often exceeding national averages—can limit access to timely, high-quality care and contribute to burnout, with workload-based models offering a more comprehensive approach.

High caseloads can limit timely access and affect quality of care. In particular, SLPs with high caseloads may prioritize students with more overt academic needs.[165] In school settings, SLPs often report challenges with large caseloads, high administrative demands, including paperwork and IEP responsibilities, and relatively low pay, making it difficult to sustain a long-term career.[166] Overloaded SLPs may experience burnout and reduced job satisfaction. One study confirmed that caseload size, licensure and continuing education costs, and low professional awareness are the top contributors to burnout.[167]

While caseload caps are one strategy to address workload concerns, they do not fully capture the scope of SLP responsibilities.[168] The Tennessee Department of Education recommends a workload-based model that accounts for evaluations, IEP meetings, collaboration, supervision, and case management. Strict caseload limits may delay services for students with IEPs until additional staff are hired, in which case school systems may hire SLPs on a contractual basis to cover the services needed. But

[161] Information provided by email from Jennifer Henderson, vice president of legislative affairs, Tennessee Association of Audiologists and Speech-Language Pathologists, May 6, 2025.
[162] Interview with Cooper Lloyd, chief medical officer, and Vaughn Frigon, associate medical director, and Drew Staniewski, deputy director, TennCare, May 27, 2025.
[163] American Speech-Language-Hearing Association 2024.
[164] TACIR staff survey of speech-language pathologists on insurance coverage and access to stuttering therapy 2025.
[165] Interview with Naomi Eichorn, assistant professor, Julie Marshall, clinical associate professor, and Katherine Mendez, clinical assistant professor, School of Communication Sciences and Disorders, University of Memphis, May 7, 2025; and Erdemir et al. 2022
[166] American Speech-Language-Hearing Association 2025; and TACIR staff survey of speech-language pathologists on insurance coverage and access to stuttering therapy 2025.
[167] Spencer et al. 2025.
[168] Email from Lexi Harless, former policy and research analyst, Tennessee Department of Education, September 23, 2025; and Tennessee Department of Education 2022.

reliance on contracted providers can create fiscal strain and raise concerns about consistency and compliance.[169]

[169] Email from Lexi Harless, former policy and research analyst, Tennessee Department of Education, September 23, 2025.

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Appendix A: Senate Bill 231 and House Bill 296

HOUSE BILL 296
By Love

SENATE BILL 231

By Akbari

AN ACT to amend Tennessee Code Annotated, Title 8; Title 56; Title 63; Title 68 and Title 71, relative to speech therapy.

BE IT ENACTED BY THE GENERAL ASSEMBLY OF THE STATE OF TENNESSEE:

SECTION 1. Tennessee Code Annotated, Title 56, Chapter 7, Part 23, is amended by adding the following as a new section:

(a) As used in this section:

(1) "Habilitative services" means healthcare services that help an individual keep, learn, or improve skills and functioning for daily living;

(2) "Habilitative speech therapy" means speech therapy that helps a person keep, learn, or improve skills and functioning for daily living;

(3) "Health benefit plan":

(A) Means a hospital or medical expense policy; health, hospital, or medical service corporation contract; policy or agreement entered into by a health insurer; or health maintenance organization contract offered by an employer;

(B) Includes a state insurance plan set out in title 8, chapter 27; a policy or contract for health insurance coverage provided under the TennCare medical assistance program or a successor program provided for in title 71, chapter 5; and a policy or contract for health insurance coverage provided under the CoverKids program or a successor program provided for in title 71, chapter 3; and

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(C) Does not include policies or certificates covering only accident, credit, dental, disability income, long-term care, hospital indemnity, medicare supplement, as defined in § 1882(g)(1) of the Social Security Act (42 U.S.C. § 1395ss(g)(1)), specified disease, or vision care; other limited benefit health insurance; coverage issued as a supplement to liability insurance; workers' compensation insurance; automobile medical payment insurance; or insurance that is statutorily required to be contained in any liability insurance policy or equivalent self insurance;

(4) "Rehabilitative services" means healthcare services that help a person restore or improve skills and functioning for daily living that have been lost or impaired;

(5) "Rehabilitative speech therapy" means speech therapy that helps a person restore or improve skills and functioning for daily living that have been lost or impaired; and

(6) "Speech therapy" means the therapeutic care provided to an individual for treatment administered by a licensed speech language pathologist.

(b) A health benefit plan that amends, renews, or delivers a policy of coverage on or after July 1, 2025, and that provides coverage for:

(1) Habilitative services, must provide coverage for habilitative speech therapy as a treatment for stuttering, regardless of whether the stuttering is classified as developmental;

(2) Rehabilitative services, must provide coverage for rehabilitative speech therapy as a treatment for stuttering; or

(3) Both habilitative services and rehabilitative services, must provide the coverage required under subdivisions (b)(1) and (2).

(c) The coverage required under subsection (b):

(1) Must not be subject to any maximum annual benefit limit, including any limits on the number of visits an insured may make to a speech-language pathologist;

(2) Must not be limited based on the type of disease, injury, disorder, or other medical condition that resulted in the stuttering;

(3) Must not be subject to utilization review or utilization management requirements, including prior authorization or a determination that the speech therapy services are medically necessary; and

(4) Must include coverage for speech therapy provided in person and via telehealth.

SECTION 2. This act takes effect upon becoming a law, the public welfare requiring it.

Appendix B: Public Chapter 416, Acts of 2025

State of Tennessee

PUBLIC CHAPTER NO. 416

SENATE BILL NO. 231

By Akbari, Campbell, Yarbro

Substituted for: House Bill No. 296

By Love, Behn, Freeman, Terry, Helton-Haynes, Clemmons, Keisling, Eldridge, Hale

AN ACT to amend Tennessee Code Annotated, Title 8; Title 56; Title 63; Title 68 and Title 71, relative to speech therapy.

BE IT ENACTED BY THE GENERAL ASSEMBLY OF THE STATE OF TENNESSEE:

SECTION 1. The Tennessee advisory commission on intergovernmental relations (TACIR) shall conduct a study on the feasibility of implementing and potential effects of enacting the insurance coverage requirements proposed in Senate Bill 231 of the 114th General Assembly, as originally filed with the chief clerk of the senate on January 21, 2025. TACIR shall publish a report of its findings and recommendations and deliver a copy of the report to the chief clerk of the senate, the chief clerk of the house of representatives, and the legislative librarian no later than July 31, 2026.

SECTION 2. This act takes effect upon becoming a law, the public welfare requiring it.

SENATE BILL NO. 231

PASSED: April 21, 2025

RANDY McNALLY
SPEAKER OF THE SENATE

CAMERON SEXTON, *SPEAKER*
HOUSE OF REPRESENTATIVES

APPROVED this 9th **day of** May **2025**

BILL LEE, *GOVERNOR*

Appendix C: Number of Minimum Visits Required Under State's Essential Health Benefits Benchmark for ACA Plans

State	Minimum Visits for Habilitative	Minimum Visits for Rehabilitative	EHB Plan
Alabama	35	30	2017-2026 EHB Benchmark Plan Information (ZIP)
Alaska	45	45	2026 EHB Benchmark Plan Information (ZIP)
Arizona	no limit	60	2017-2026 EHB Benchmark Plan Information (ZIP)
Arkansas	30	30	2017-2026 EHB Benchmark Plan Information (ZIP)
California	no limit	no limit	2017-2026 EHB Benchmark Plan Information (ZIP)
Colorado	20	20	2027 EHB Benchmark Plan Information (ZIP)
Connecticut	40	40	2017-2026 EHB Benchmark Plan Information (ZIP)
Delaware	30	30	2017-2026 EHB Benchmark Plan Information (ZIP)
Florida	no limit	35	2017-2026 EHB Benchmark Plan Information (ZIP)
Georgia	40	40	2017-2026 EHB Benchmark Plan Information (ZIP)
Hawaii	no limit	no limit	2017-2026 EHB Benchmark Plan Information (ZIP)
Idaho	no limit	20	2017-2026 EHB Benchmark Plan Information (ZIP)
Illinois	0	0	2020-2026 EHB Benchmark Plan Information (ZIP)
Indiana	40	20	2017-2026 EHB Benchmark Plan Information (ZIP)
Iowa	no limit	no limit	2017-2026 EHB Benchmark Plan Information (ZIP)
Kansas	0	90	2017-2026 EHB Benchmark Plan Information (ZIP)
Kentucky	25	25	2017-2026 EHB Benchmark Plan Information (ZIP)
Louisiana	no limit	no limit	2017-2026 EHB Benchmark Plan Information (ZIP)

State	Minimum Visits for Habilitative	Minimum Visits for Rehabilitative	EHB Plan
Maine	20	20	2017-2026 EHB Benchmark Plan Information (ZIP)
Maryland	30	30	2017-2026 EHB Benchmark Plan Information (ZIP)
Massachusetts	no limit	no limit	2017-2026 EHB Benchmark Plan Information (ZIP)
Michigan	30	30	2022-2026 EHB Benchmark Plan Information (ZIP)
Minnesota	no limit	no limit	2017-2026 EHB Benchmark Plan Information (ZIP)
Mississippi	no limit	20	2017-2026 EHB Benchmark Plan Information (ZIP)
Missouri	20	no limit	2017-2026 EHB Benchmark Plan Information (ZIP)
Montana	no limit	no limit	2017-2026 EHB Benchmark Plan Information (ZIP)
Nebraska	45	45	2017-2026 EHB Benchmark Plan Information (ZIP)
Nevada	120	120	2017-2026 EHB Benchmark Plan Information (ZIP)
New Hampshire	20	20	2017-2026 EHB Benchmark Plan Information (ZIP)
New Jersey	30	30	2017-2026 EHB Benchmark Plan Information (ZIP)
New Mexico	no limit	no limit	2022-2026 EHB Benchmark Plan (ZIP)
New York	60	60	2017-2026 EHB Benchmark Plan Information (ZIP)
North Carolina	30	30	2017-2026 EHB Benchmark Plan Information (ZIP)
North Dakota	30	30	2025-2026 EHB Benchmark Plan Information (ZIP)
Ohio	20	20	2017-2026 EHB Benchmark Plan Information (ZIP)
Oklahoma	25	25	2017-2026 EHB Benchmark Plan Information (ZIP)
Oregon	30	30	2022-2026 EHB Benchmark Plan Information (ZIP)

State	Minimum Visits for Habilitative	Minimum Visits for Rehabilitative	EHB Plan
Pennsylvania	30	30	2017-2026 EHB Benchmark Plan Information (ZIP)
Rhode Island	no limit	no limit	2017-2026 EHB Benchmark Plan Information (ZIP)
South Carolina	no limit	30	2017-2026 EHB Benchmark Plan Information (ZIP)
South Dakota	does not include habilitative unless associated with Autism Spectrum Disorder	no limit	2021-2026 EHB-Benchmark Plan Information (ZIP)
Tennessee	20	20	2017-2026 EHB Benchmark Plan Information (ZIP)
Texas	35	no limit	2017-2026 EHB Benchmark Plan Information (ZIP)
Utah	20	20	2017-2026 EHB Benchmark Plan Information (ZIP)
Vermont	30	30	2025-2026 EHB Benchmark Plan Information (ZIP)
Virginia	30	30	2025-2026 EHB Benchmark Plan Information (ZIP)
Washington	30	30	2026 EHB Benchmark Plan Information (ZIP)
West Virginia	no limit	no limit	2017-2026 EHB Benchmark Plan Information (ZIP)
Wisconsin	no limit	20	2017-2026 EHB Benchmark Plan Information (ZIP)
Wyoming	20	20	2017-2026 EHB Benchmark Plan Information (ZIP)

Source: Centers for Medicare & Medicaid Services 2025a

Appendix D: State of Tennessee Essential Health Benefits Benchmark Plan (2025-2027)

TENNESSEE EHB BENCHMARK PLAN (2025-2027)

SUMMARY INFORMATION

Plan Type	Small Group Market
Issuer Name	BlueCross BlueShield of Tennessee
Product Name	Small Group Shop HDHP
Plan Name	SG Gold 13S
Supplemented Categories (Supplementary Plan Type)	None

BENEFITS AND LIMITS

A Benefit	B EHB	C Is the Benefit Covered?	D Quantitative Limit on Service?	E Limit Quantity	F Limit Unit	G Exclusions	H Explanations
Primary Care Visit to Treat an Injury or Illness	Yes	Covered	No				
Specialist Visit	Yes	Covered	No				
Other Practitioner Office Visit (Nurse, Physician Assistant)	Yes	Covered	No				
Outpatient Facility Fee (e.g., Ambulatory Surgery Center)	Yes	Covered	No				
Outpatient Surgery Physician/Surgical Services	Yes	Covered	No				
Hospice Services	Yes	Covered	No			Inpatient hospice services, unless approved by Case Management.	Prior Authorization required for Inpatient Hospice.
Routine Dental Services (Adult)	No	Not Covered	No				
Infertility Treatment	No	Not Covered	No			Services or supplies that are designed to create a pregnancy, enhance fertility or improve conception quality, including but not limited to: artificial insemination, in vitro fertilization.	Services or supplies for the evaluation of infertility.
Long-Term/Custodial Nursing Home Care	No	Not Covered	No				
Private-Duty Nursing	No	Not Covered	No				
Routine Eye Exam (Adult)	No	Not Covered	No				
Urgent Care Centers or Facilities	Yes	Covered	No				
Home Health Care Services	Yes	Covered	Yes	60	Visit(s) per Year		
Emergency Room Services	Yes	Covered	No				
Emergency Transportation/Ambulance	Yes	Covered	No				
Inpatient Hospital Services (e.g., Hospital Stay)	Yes	Covered	No			Exclusions: Inpatient stays primarily for therapy (such as physical or occupational therapy). Private room when not Authorized by the Plan and room and board charges are in excess of semi-private room. Services that could be provided in a less intensive setting.	
Inpatient Physician and Surgical Services	Yes	Covered	No				
Bariatric Surgery	No	Not Covered	No				
Cosmetic Surgery	No	Not Covered	No				
Skilled Nursing Facility	Yes	Covered	Yes	60	Day(s) per Year	Exclusions: Custodial, domiciliary or private duty nursing services. Skilled Nursing services not received in a Medicare certified skilled nursing facility.	Skilled Nursing and Rehabilitation Facility limited to 60 days/year combined.
Prenatal and Postnatal Care	Yes	Covered	No				
Delivery and All Inpatient Services for Maternity Care	Yes	Covered	No				
Mental/Behavioral Health Outpatient Services	Yes	Covered	No				
Mental/Behavioral Health Inpatient Services	Yes	Covered	No				
Substance Abuse Disorder Outpatient Services	Yes	Covered	No				
Substance Abuse Disorder Inpatient Services	Yes	Covered	No				
Generic Drugs	Yes	Covered	No				
Preferred Brand Drugs	Yes	Covered	No				
Non-Preferred Brand Drugs	Yes	Covered	No				
Specialty Drugs	Yes	Covered	No				

A Benefit	B EHB	C Is the Benefit Covered?	D Quantitative Limit on Service?	E Limit Quantity	F Limit Unit	G Exclusions	H Explanations
Outpatient Rehabilitation Services	Yes	Covered	Yes	20	Visit(s) per Year		Therapy limited to 20 visits per type per year. The limit on the number of visits for therapy applies to all visits for that therapy, whether received in a Practitioner's office, outpatient facility or home health setting.
Habilitation Services	Yes	Covered	Yes	20	Visit(s) per Year		Therapy limited to 20 visits per type per year. The limit on the number of visits for therapy applies to all visits for that therapy, whether received in a Practitioner's office, outpatient facility or home health setting.
Chiropractic Care	Yes	Covered	Yes	20	Visit(s) per Year		Therapy limited to 20 visits per type per year. The limit on the number of visits for therapy applies to all visits for therapy, whether received in a Practitioner's office, outpatient facility or home health setting.
Durable Medical Equipment	Yes	Covered	No				Durable medical equipment over $500 requires prior authorization.
Hearing Aids	Yes	Covered	Yes	1	Item(s) per 3 Years		
Imaging (CT/PET Scans, MRIs)	Yes	Covered	No			Exclusion: Diagnostic Services not ordered by a Practitioner.	
Preventive Care/Screening/Immunization	Yes	Covered	No				
Routine Foot Care	No	Not Covered	No			Exclusions: Routine foot care for the treatment of: (1) flat feet; (2) corns; (3) bunions; (4) calluses; (5) toenails; (6) fallen arches; and (7) weak feet or chronic foot strain.	
Acupuncture	No	Not Covered	No				
Weight Loss Programs	No	Not Covered	No				
Routine Eye Exam for Children	Yes	Covered	Yes	1	Exam(s) per Benefit Period		
Eye Glasses for Children	Yes	Covered	Yes	1	Item(s) per Benefit Period		
Dental Check-Up for Children	Yes	Covered	Yes	1	Exam(s) per 6 Months		
Rehabilitative Speech Therapy	Yes	Covered	Yes	20	Visit(s) per Year		Therapy limited to 20 visits per type per year. Physical, speech or occupational therapy provided in the home does not require Prior Authorization.
Rehabilitative Occupational and Rehabilitative Physical Therapy	Yes	Covered	Yes	20	Visit(s) per Year		Therapy limited to 20 visits per type per year. Physical, speech or occupational therapy provided in the home does not require Prior Authorization.
Well Baby Visits and Care	Yes	Covered	No				
Laboratory Outpatient and Professional Services	Yes	Covered	No			Exclusion: Diagnostic Services not ordered by a Practitioner.	
X-rays and Diagnostic Imaging	Yes	Covered	No			Exclusion: Diagnostic Services not ordered by a Practitioner.	
Basic Dental Care - Child	Yes	Covered	No				
Orthodontia - Child	Yes	Covered	No				
Major Dental Care - Child	Yes	Covered	No				
Basic Dental Care - Adult	No	Not Covered	No				
Orthodontia - Adult	No	Not Covered	No				
Major Dental Care – Adult	No	Not Covered	No				
Abortion for Which Public Funding is Prohibited	No	Not Covered	No			Induced abortion unless: (1) the health care Practitioner certifies in writing that the pregnancy would endanger the life of the mother, or; (2) the pregnancy is a result of rape or incest.	Covers Medically Necessary and Appropriate termination of a pregnancy.

A Benefit	B EHB	C Is the Benefit Covered?	D Quantitative Limit on Service?	E Limit Quantity	F Limit Unit	G Exclusions	H Explanations
Transplant	Yes	Covered	No				Transplant services or supplies that have not received Prior Authorization will not be Covered.
Accidental Dental	Yes	Covered	No				
Dialysis	Yes	Covered	No				
Allergy Testing	Yes	Covered	No				
Chemotherapy	Yes	Covered	No				
Radiation	Yes	Covered	No				
Diabetes Education	Yes	Covered	No				
Prosthetic Devices	Yes	Covered	No				
Infusion Therapy	Yes	Covered	No				
Treatment for Temporomandibular Joint Disorders	Yes	Covered	No				
Nutritional Counseling	Yes	Covered	No				For Diabetes Treatment only.
Reconstructive Surgery	Yes	Covered	No				Covered Services: Surgery to correct significant defects from congenital causes, (except where specifically excluded), accidents or disfigurement from a disease state. Reconstructive breast Surgery as a result of a mastectomy or partial mastectomy (other than lumpectomy).

PRESCRIPTION DRUG EHB-BENCHMARK PLAN BENEFITS BY CATEGORY AND CLASS

CATEGORY	CLASS	SUBMISSION COUNT
Analgesics	Nonsteroidal Anti-inflammatory Drugs	19
Analgesics	Opioid Analgesics, Long acting	9
Analgesics	Opioid Analgesics, Short-acting	21
Anesthetics	Local Anesthetics	1
Anti-Addiction/ Substance Abuse Treatment Agents	Alcohol Deterrents/Anti-craving	2
Anti-Addiction/ Substance Abuse Treatment Agents	Opioid Dependence	4
Anti-Addiction/ Substance Abuse Treatment Agents	Opioid Reversal Agents	0
Anti-Addiction/ Substance Abuse Treatment Agents	Smoking Cessation Agents	1
Antibacterials	Aminoglycosides	3
Antibacterials	Antibacterials, Other	14
Antibacterials	Beta-lactam, Cephalosporins	8
Antibacterials	Beta-lactam, Penicillins	5
Antibacterials	Carbapenems	0
Antibacterials	Macrolides	4
Antibacterials	Quinolones	4
Antibacterials	Sulfonamides	2
Antibacterials	Tetracyclines	4
Anticonvulsants	Anticonvulsants, Other	5
Anticonvulsants	Calcium Channel Modifying Agents	3
Anticonvulsants	Gamma-aminobutyric Acid (GABA) Modulating Agents	9
Anticonvulsants	Sodium Channel Agents	6
Antidementia Agents	Antidementia Agents, Other	1
Antidementia Agents	Cholinesterase Inhibitors	3
Antidementia Agents	N-methyl-D-aspartate (NMDA) Receptor Antagonist	1
Antidepressants	Antidepressants, Other	7
Antidepressants	Monoamine Oxidase Inhibitors	3
Antidepressants	SSRIs/SNRIs (Selective Serotonin Reuptake Inhibitors/ Serotonin and Norepinephrine Reuptake Inhibitors)	13
Antidepressants	Tricyclics	11
Antiemetics	Antiemetics, Other	8
Antiemetics	Emetogenic Therapy Adjuncts	5
Antifungals	No USP Class	12
Antigout Agents	No USP Class	6

CATEGORY	CLASS	SUBMISSION COUNT
Antimigraine Agents	Calcitonin Gene-Related Peptide (CGRP) Receptor Antagonists	0
Antimigraine Agents	Ergot Alkaloids	3
Antimigraine Agents	Prophylactic	4
Antimigraine Agents	Serotonin (5-HT) Receptor Agonist	6
Antimyasthenic Agents	Parasympathomimetics	1
Antimycobacterials	Antimycobacterials, Other	2
Antimycobacterials	Antituberculars	8
Antineoplastics	Alkylating Agents	3
Antineoplastics	Antiandrogens	5
Antineoplastics	Antiangiogenic Agents	3
Antineoplastics	Antiestrogens/Modifiers	4
Antineoplastics	Antimetabolites	4
Antineoplastics	Antineoplastics, Other	5
Antineoplastics	Aromatase Inhibitors, 3rd Generation	3
Antineoplastics	Enzyme Inhibitors	2
Antineoplastics	Molecular Target Inhibitors	16
Antineoplastics	Monoclonal Antibody/Antibody-Drug Conjugates	0
Antineoplastics	Retinoids	2
Antineoplastics	Treatment Adjuncts	4
Antiparasitics	Anthelmintics	4
Antiparasitics	Antiprotozoals	13
Antiparkinson Agents	Anticholinergics	2
Antiparkinson Agents	Antiparkinson Agents, Other	4
Antiparkinson Agents	Dopamine Agonists	5
Antiparkinson Agents	Dopamine Precursors and/or L-Amino Acid Decarboxylase Inhibitors	3
Antiparkinson Agents	Monoamine Oxidase B (MAO-B) Inhibitors	2
Antipsychotics	1st Generation/Typical	10
Antipsychotics	2nd Generation/Atypical	10
Antipsychotics	Treatment-Resistant	1
Antispasticity Agents	No USP Class	3
Antivirals	Anti-cytomegalovirus (CMV) Agents	1
Antivirals	Anti-hepatitis B (HBV) Agents	4
Antivirals	Anti-hepatitis C (HCV) Agents	1
Antivirals	Antiherpetic Agents	3

CATEGORY	CLASS	SUBMISSION COUNT
Antivirals	Anti-HIV Agents, Integrase Inhibitors (INSTI)	2
Antivirals	Anti-HIV Agents, Non-nucleoside Reverse Transcriptase Inhibitors (NNRTI)	6
Antivirals	Anti-HIV Agents, Nucleoside and Nucleotide Reverse Transcriptase Inhibitors (NRTI)	13
Antivirals	Anti-HIV Agents, Other	3
Antivirals	Anti-HIV Agents, Protease Inhibitors (PI)	7
Antivirals	Anti-influenza Agents	4
Antivirals	Antiviral, Coronavirus Agents	0
Anxiolytics	Anxiolytics, Other	4
Anxiolytics	Benzodiazepines	8
Anxiolytics	SSRIs/SNRIs (Selective Serotonin Reuptake Inhibitors/ Serotonin and Norepinephrine Reuptake Inhibitors)	5
Bipolar Agents	Bipolar Agents, Other	8
Bipolar Agents	Mood Stabilizers	4
Blood Glucose Regulators	Antidiabetic Agents	16
Blood Glucose Regulators	Glycemic Agents	1
Blood Glucose Regulators	Insulins	10
Blood Products and Modifiers	Anticoagulants	7
Blood Products and Modifiers	Blood Products and Modifiers, Other	6
Blood Products and Modifiers	Hemostasis Agents	2
Blood Products and Modifiers	Platelet Modifying Agents	7
Cardiovascular Agents	Alpha-adrenergic Agonists	4
Cardiovascular Agents	Alpha-adrenergic Blocking Agents	4
Cardiovascular Agents	Angiotensin II Receptor Antagonists	8
Cardiovascular Agents	Angiotensin-converting Enzyme (ACE) Inhibitors	10
Cardiovascular Agents	Antiarrhythmics	14
Cardiovascular Agents	Beta-adrenergic Blocking Agents	12
Cardiovascular Agents	Calcium Channel Blocking Agents, Dihydropyridines	7
Cardiovascular Agents	Calcium Channel Blocking Agents, Nondihydropyridines	2
Cardiovascular Agents	Cardiovascular Agents, Other	5
Cardiovascular Agents	Diuretics, Loop	4
Cardiovascular Agents	Diuretics, Potassium-sparing	2
Cardiovascular Agents	Diuretics, Thiazide	5
Cardiovascular Agents	Dyslipidemics, Fibric Acid Derivatives	2

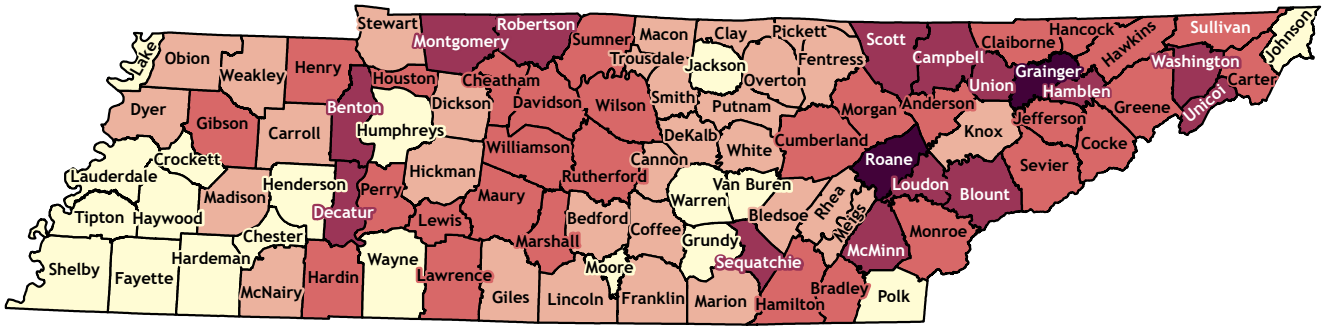
CATEGORY	CLASS	SUBMISSION COUNT
Cardiovascular Agents	Dyslipidemics, HMG CoA Reductase Inhibitors	7
Cardiovascular Agents	Dyslipidemics, Other	5
Cardiovascular Agents	Mineralocorticoid Receptor Antagonists	2
Cardiovascular Agents	Sodium-Glucose Co-Transporter 2 Inhibitors (SGLT2i)	0
Cardiovascular Agents	Vasodilators, Direct-acting Arterial	2
Cardiovascular Agents	Vasodilators, Direct-acting Arterial/Venous	3
Central Nervous System Agents	Attention Deficit Hyperactivity Disorder Agents, Amphetamines	4
Central Nervous System Agents	Attention Deficit Hyperactivity Disorder Agents, Non-amphetamines	4
Central Nervous System Agents	Central Nervous System, Other	10
Central Nervous System Agents	Fibromyalgia Agents	3
Central Nervous System Agents	Multiple Sclerosis Agents	6
Dental and Oral Agents	No USP Class	7
Dermatological Agents	Acne and Rosacea Agents	11
Dermatological Agents	Dermatitis and Pruritus Agents	22
Dermatological Agents	Dermatological Agents, Other	12
Dermatological Agents	Pediculicides/Scabicides	5
Dermatological Agents	Topical Anti-infectives	16
Electrolytes/ Minerals/ Metals/ Vitamins	Electrolyte/Mineral Replacement	4
Electrolytes/ Minerals/ Metals/ Vitamins	Electrolyte/Mineral/Metal Modifiers	4
Electrolytes/ Minerals/ Metals/ Vitamins	Phosphate Binders	3
Electrolytes/ Minerals/ Metals/ Vitamins	Potassium Binders	1
Electrolytes/ Minerals/ Metals/ Vitamins	Vitamins	1
Gastrointestinal Agents	Anti-Constipation Agents	5
Gastrointestinal Agents	Anti-Diarrheal Agents	4
Gastrointestinal Agents	Antispasmodics, Gastrointestinal	3
Gastrointestinal Agents	Gastrointestinal Agents, Other	10
Gastrointestinal Agents	Histamine2 (H2) Receptor Antagonists	3
Gastrointestinal Agents	Protectants	2
Gastrointestinal Agents	Proton Pump Inhibitors	5
Genetic or Enzyme or Protein Disorder: Replacement, Modifiers, Treatment	No USP Class	5
Genitourinary Agents	Antispasmodics, Urinary	6
Genitourinary Agents	Benign Prostatic Hypertrophy Agents	8
Genitourinary Agents	Genitourinary Agents, Other	5

CATEGORY	CLASS	SUBMISSION COUNT
Hormonal Agents, Stimulant/ Replacement/ Modifying (Adrenal)	No USP Class	8
Hormonal Agents, Stimulant/ Replacement/ Modifying (Pituitary)	No USP Class	1
Hormonal Agents, Stimulant/ Replacement/ Modifying (Prostaglandins)	No USP Class	1
Hormonal Agents, Stimulant/ Replacement/ Modifying (Sex Hormones/ Modifiers)	Anabolic Steroids	1
Hormonal Agents, Stimulant/ Replacement/ Modifying (Sex Hormones/ Modifiers)	Androgens	3
Hormonal Agents, Stimulant/ Replacement/ Modifying (Sex Hormones/ Modifiers)	Estrogens	14
Hormonal Agents, Stimulant/ Replacement/ Modifying (Sex Hormones/ Modifiers)	Progestins	16
Hormonal Agents, Stimulant/ Replacement/ Modifying (Sex Hormones/ Modifiers)	Selective Estrogen Receptor Modifying Agents	3
Hormonal Agents, Stimulant/ Replacement/ Modifying (Thyroid)	No USP Class	2
Hormonal Agents, Suppressant (Adrenal or Pituitary)	No USP Class	6
Hormonal Agents, Suppressant (Thyroid)	Antithyroid Agents	2
Immunological Agents	Angioedema Agents	2
Immunological Agents	Immunoglobulins	0
Immunological Agents	Immunological Agents, Other	7
Immunological Agents	Immunostimulants	2
Immunological Agents	Immunosuppressants	13
Inflammatory Bowel Disease Agents	Aminosalicylates	4
Inflammatory Bowel Disease Agents	Glucocorticoids	6
Metabolic Bone Disease Agents	No USP Class	11
Ophthalmic Agents	Ophthalmic Agents, Other	4
Ophthalmic Agents	Ophthalmic Anti-allergy Agents	6
Ophthalmic Agents	Ophthalmic Anti-Infectives	15
Ophthalmic Agents	Ophthalmic Anti-inflammatories	10
Ophthalmic Agents	Ophthalmic Beta-Adrenergic Blocking Agents	4
Ophthalmic Agents	Ophthalmic Intraocular Pressure Lowering Agents, Other	8
Ophthalmic Agents	Ophthalmic Prostaglandin and Prostamide Analogs	4
Otic Agents	No USP Class	9
Respiratory Tract/ Pulmonary Agents	Antihistamines	10
Respiratory Tract/ Pulmonary Agents	Anti-inflammatories, Inhaled Corticosteroids	8
Respiratory Tract/ Pulmonary Agents	Antileukotrienes	3

CATEGORY	CLASS	SUBMISSION COUNT
Respiratory Tract/ Pulmonary Agents	Bronchodilators, Anticholinergic	4
Respiratory Tract/ Pulmonary Agents	Bronchodilators, Sympathomimetic	11
Respiratory Tract/ Pulmonary Agents	Cystic Fibrosis Agents	3
Respiratory Tract/ Pulmonary Agents	Mast Cell Stabilizers	1
Respiratory Tract/ Pulmonary Agents	Phosphodiesterase Inhibitors, Airways Disease	2
Respiratory Tract/ Pulmonary Agents	Pulmonary Antihypertensives	5
Respiratory Tract/ Pulmonary Agents	Pulmonary Fibrosis Agents	0
Respiratory Tract/ Pulmonary Agents	Respiratory Tract Agents, Other	5
Skeletal Muscle Relaxants	No USP Class	9
Sleep Disorder Agents	Sleep Promoting Agents	9
Sleep Disorder Agents	Wakefulness Promoting Agents	1

Appendix E: Figures and Maps of Utilization of Speech Therapy Services for TennCare and CoverKids, Tennessee Early Intervention System, and Tennessee Department of Education

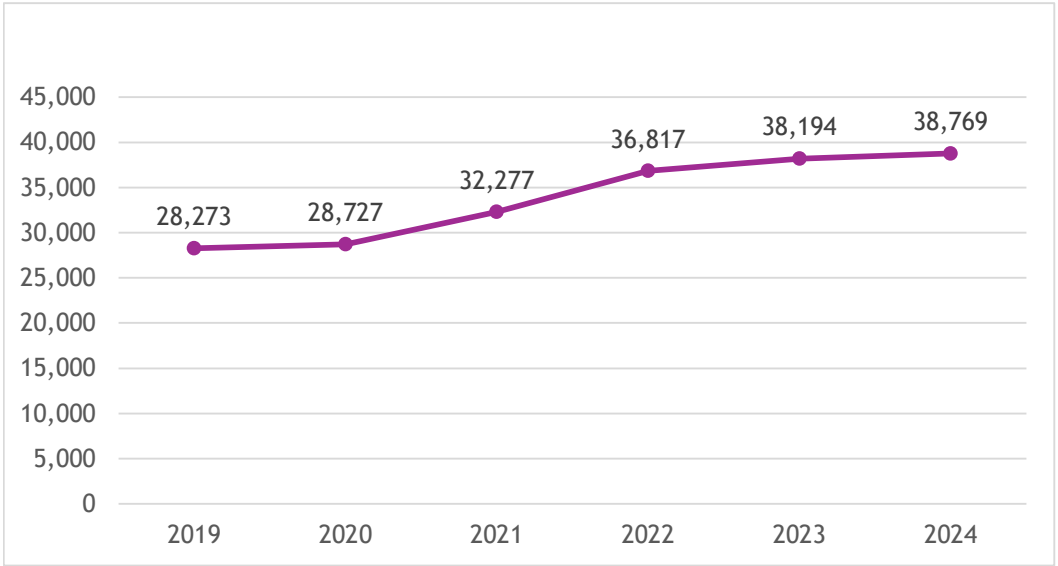
Percentage of TennCare and CoverKids Enrollees Receiving Speech Therapy Services by County, 2024



Note: Data is for all speech therapy services; data was not available for stuttering services only.

Source: Data provided in email from Cooper Lloyd, chief medical officer, TennCare, June 4, 2025.

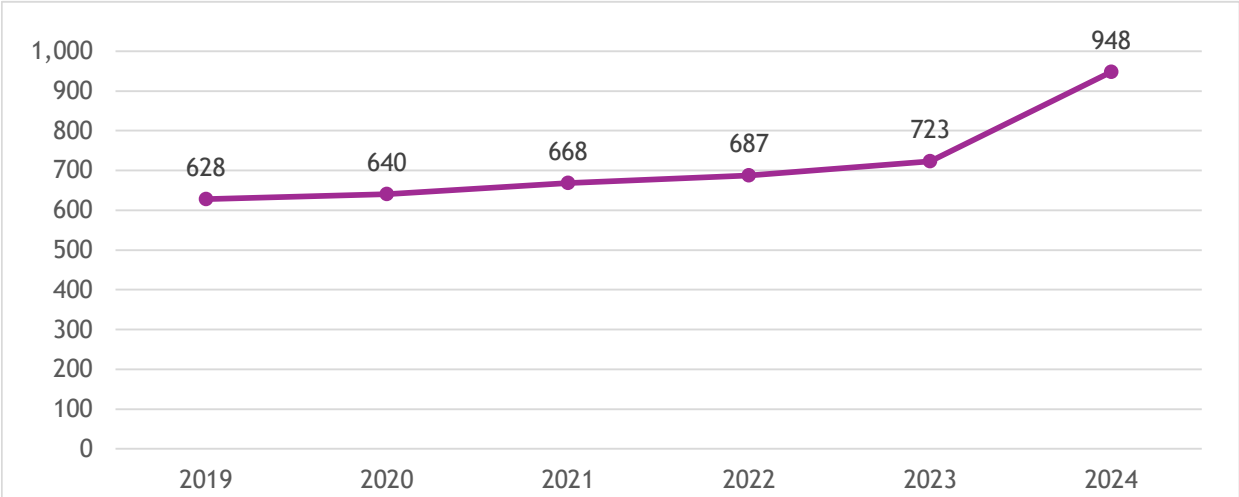
TennCare Enrollees Utilizing Speech Therapy Services, 2019 through 2024



Note: Data is for all speech therapy services; data was not available for stuttering services only.

Source: Data provided in email from Cooper Lloyd, chief medical officer, TennCare, August 19, 2025.

CoverKids Enrollees Utilizing Speech Therapy Services, 2019 through 2024



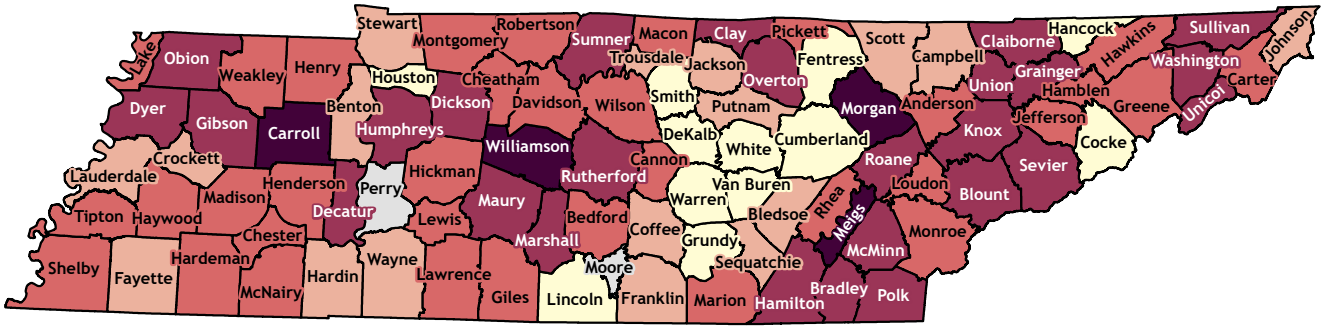
Source: Data provided in email from Cooper Lloyd, chief medical officer, TennCare, August 19, 2025.

TennCare and CoverKids Enrollees Utilizing Speech Therapy Services by Age, 2024

Age Group	Number of Enrollees
<21	38,419
>=21	750

Source: Data provided in email from Cooper Lloyd, chief medical officer, TennCare, May 28, 2025.

Percentage of Tennessee Early Intervention System (TEIS) Enrollees Receiving Speech Therapy Services by County, 2024

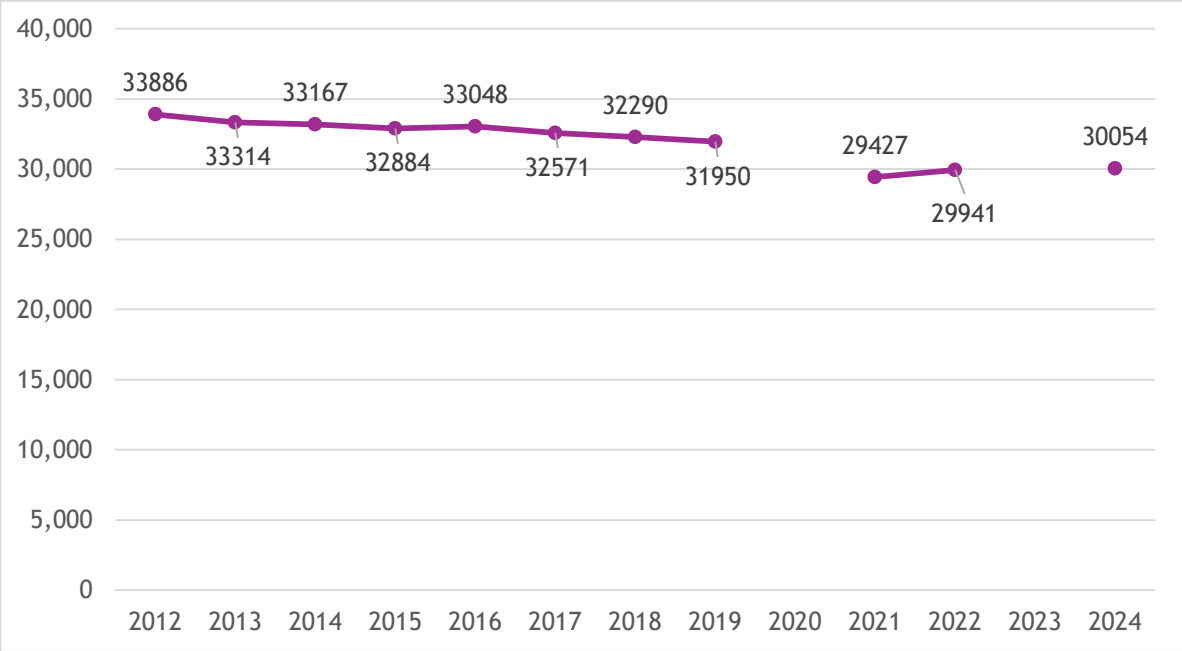


Percent of Total TEIS Enrollees Receiving Speech Therapy Services by County

- 4.5% to 15.0% (12)
- 15.1% to 30.0% (17)
- 30.1% to 45.0% (34)
- 45.1% to 60.0% (26)
- 60.1% to 75.0% (4)
- No Enrollees Receiving Speech Therapy (2)

Source: Data provided in email from Amanda Sheaffer, senior director of strategy and operations, Tennessee Early Intervention System, Tennessee Department of Disability and Aging October 8, 2025.

Number of Children Ages 3 through 21 with Disability Receiving Special Education Services for Speech and Language Impairments in Tennessee, 2012 through 2024



Note: Tennessee Department of Education data was not available for the years 2020 or 2023.

Source: Tennessee Department of Education Annual Statistical Reports for the years 2012 through 2024.

Appendix F: Senate Bill 231 and House Bill 296 Fiscal Note

SB 231 - HB 296
FISCAL NOTE

Fiscal Review Committee
Tennessee General Assembly

March 6, 2025

Fiscal Analyst: Chris Higgins | Email: chris.higgins@capitol.tn.gov | Phone: 615-741-2564

SUMMARY OF BILL: Requires a health benefit plan that provides coverage for habilitative services to provide coverage for habilitative speech therapy as a treatment for stuttering, regardless of whether the stuttering is classified as developmental. Requires a health benefit plan that covers rehabilitative services to provide coverage for rehabilitative speech therapy as a treatment for stuttering.

Establishes that habilitative and rehabilitative services must not be subject to any maximum annual benefit limit; not be limited based on the type of disease, injury, disorder, or other medical condition that resulted in the stuttering; not be subject to utilization review or utilization management requirements, including prior authorization or a determination that the speech therapy services are medically necessary; and must include coverage for speech therapy provided in person and via telehealth.

FISCAL IMPACT:

STATE GOVERNMENT	
EXPENDITURES	**General Fund**
FY25-26 & Subsequent Years	$3,072,800

FEDERAL GOVERNMENT	
EXPENDITURES	
FY25-26 & Subsequent Years	$1,596,700

LOCAL GOVERNMENT	
EXPENDITURES	**Mandatory**
FY25-26 & Subsequent Years	$307,800
Article II, Section 24 of the Tennessee Constitution provides that: no law of general application shall impose increased expenditure requirements on cities or counties unless the General Assembly shall provide that the state share in the cost.	

OTHER FISCAL IMPACT
Potential Impact on Health Insurance Premiums (required by Tenn. Code Ann. § 3-2-111): Such legislation will result in an increase in the cost of health insurance premiums for procedures and treatments being provided by plans that do not currently offer these benefits at the proposed mandated levels. It is estimated that the increase to each individual's total premium will be less than one percent.

SB 231 - HB 296

Assumptions:

Division of TennCare

- The proposed legislation will expand speech therapy coverage for stuttering under the TennCare program and the CoverKids program.
- According to the National Institute on Deafness and Other Communication Disorders, approximately five percent of all children will stutter for some period in their life and about one percent continue to stutter as adults.
- Based on information provided by the Division of TennCare (Division), it is estimated that there are potentially 43,025 TennCare enrollees (37,234 children + 5,791 adults) and 1,531 CoverKids enrollees (1,439 children + 92 adults) who have a stuttering disorder.
- According to the Department of Education's *2024 Annual Statistical Report*, there are 30,054 students with a speech/language impaired disability receiving special education services.
- Due to the elimination of medical necessity determinations and the coverage requirements of the proposed legislation, it is estimated that 15 percent of eligible children and 5 percent of eligible adults will receive speech therapy services for stuttering.
- The Division's average reimbursement for speech therapy for stuttering in 2023 was $457 per member.
- The total cost to the TennCare program for speech therapy services for stuttering is estimated to be $2,684,710 {[(37,234 x 15%) + (5,791 x 5%)] x $457]}.
- The total cost to the CoverKids program for speech therapy services for stuttering is estimated to be $100,756 {[(1,439 x 15%) + (92 x 5%)] x $457]}.
- In 2023, managed care organizations reimbursed a total of approximately $378,816 for speech therapy for stuttering under the TennCare program, and $15,796 for speech therapy for stuttering under the CoverKids program.
- These amounts will not be included in new expenditures from the proposed legislation; therefore, the net impact to the TennCare program is estimated to be $2,305,894 ($2,684,710 - $378,816), and the net impact to the CoverKids program is estimated to be $84,960 ($100,756 - $15,796) in FY25-26 and subsequent years.
- TennCare expenditures receiving matching funds at a rate of 64.323 percent federal to 35.677 percent state. CoverKids expenditures receive matching funds at a rate of 75.025 percent federal to 24.975 percent state.
- The total estimated increase in expenditures to the Division is as follows:

	Expenditures	State Share	Federal Share
TennCare Program	$2,305,894	$822,674	$1,483,220
CoverKids Program	$84,960	$21,219	$63,741
	Total:	$843,893	$1,546,961

Division of Benefits Administration

- The proposed legislation will also expand coverage for the health plans under the State Group Insurance Program (SGIP).
- Based on information provided by the Division of Benefits Administration, increasing speech therapy coverage and eliminating the use of medical management tools will result in

an increase in expenditures to the SGIP of approximately $898,421 in FY25-26 and subsequent years.

- It is estimated that 48 percent of members are on the State Employee Plan, 43 percent are on the Local Education Plan and 9 percent are on the Local Government Plan.
- The state contributes 80 percent of member premiums resulting in a recurring increase in state expenditures of $344,994 ($898,421 x 48% x 80%)
- Some state plan members' insurance premiums are funded through federal dollars. It is estimated 14.41 percent of the state share of the state plan is funded with federal dollars, resulting in an increase in federal expenditures of $49,714 ($344,994 x 14.41%).
- The state contributes 45 percent of instructional member premiums (75 percent of Local Education Plan members) and 30 percent of support staff member premiums (25 percent of Local Education Plan members) resulting in state expenditures of $159,357 [($898,421 x 43% x 75% x 45%) + ($898,421 x 43% x 25% x 30%)].
- The mandatory increase in expenditures for the local government share of the Local Education Plan is estimated to be $226,964 [($898,421 x 43%) - $159,357)].
- The state does not contribute to the Local Government Plan. It is estimated the Local Government Plan would be responsible for a mandatory increase in local expenditures estimated to be $80,858 ($898,421 x 9%).
- The total increase in state expenditures from the SGIP is estimated to be $454,637 ($344,994 - $49,714 + $159,357).
- The total increase in federal expenditures is estimated to be $49,714.
- The total mandatory increase in local expenditures is estimated to be $307,822 ($226,964 + $80,858).

Commercial Insurance

- According to the Department of Commerce and Insurance (DCI), the proposed legislation will be considered an additional coverage mandate to the essential health benefits (EHB) of the qualified health plans (QHPs) offered on and off the Marketplace Exchange.
- The state will be required to defray the cost of benefits to commercial insurers because they exceed those provided under Tennessee's EHB benchmark plan.
- As of January 2025, the Centers for Medicare and Medicaid Services (CMS) showed a total population of 624,867 covered lives on QHPs in Tennessee.
- According to estimates from multiple QHP providers, the increase in costs per member per month as a result from the proposed draft legislation will be approximately $0.23. This would result in an increase in state expenditures of $1,774,313 [($0.23 x 642,867) x 12 months] annually in order for DCI to defray the costs of this increase.

Total Impacts

- The total increase in state expenditures will be $3,072,843 ($843,893 + $454,637 + $1,774,313) in FY25-26 and subsequent years.
- The total increase in federal expenditures will be $1,596,675 ($1,546,961 + $49,714) in FY25-26 and subsequent years.
- The total increase in mandatory local expenditures will be $307,822 in FY25-26 and subsequent years.

- Potential Impact on Health Insurance Premiums (required by Tenn. Code Ann. § 3-2-111): Such legislation will result in an increase in the cost of health insurance premiums for procedures and treatments being provided by plans that do not currently offer these benefits at the proposed mandated levels. It is estimated that the increase to each individual's total premium will be less than one percent.

IMPACT TO COMMERCE:

BUSINESS IMPACT		
FISCAL YEAR	**REVENUE**	**EXPENSES**
FY25-26 & Subsequent Years	$4,977,300	<$4,977,300

Assumptions:

- Speech therapy providers will experience an increase in business revenue of approximately $4,977,340 ($3,072,843 + $1,596,675 + $307,822) in FY25-26 and subsequent years for providing treatment for stuttering.
- For business to remain solvent, any increase in expenditures for providing services is expected to be less than the amount of revenue collected.
- It is unknown if increased speech therapy utilization will result in providers hiring additional speech therapists in the state.

CERTIFICATION:

The information contained herein is true and correct to the best of my knowledge.

Bojan Savic, Executive Director