November 5, 2021

Jane Beyer, Senior Health Advisor *submitted via electronic mail*
and
Rules Coordinator, Policy Division
Office of the Insurance Commissioner
P.O. Box 40258
Olympia WA 98504

Re: CR102, R2021-16 Implementing Sec. 106 of ESHB 1477, and gender affirming treatment network reporting standards

Dear Jane:

On behalf of PacificSource Health Plans, please accept our comments on the CR102 for rulemaking R2021-16. We hope that they are helpful to the Office of the Insurance Commissioner in crafting its rules implementing sec. 106 of ESHB 1477, and the gender affirming network reporting standards.

Regarding the proposed language establishing gender affirming treatment / services:

The OIC's reporting requirements and rules for network are tied to the provider and facility licensure. There is not a licensure based method to identify providers who offer gender affirming treatment. Because of that, providing a map or listing of providers offering these services will be difficult to create or confirm as accurate.

In evaluating implementation of the rule, PacificSource has identified some methods to try to identify gender affirming treatment / services providers for reporting, each of which has material drawbacks:

a) One method is reviewing claims for hormone therapy, facial conformation surgery, top / bottom surgeries, electrolysis associated with the surgery or anatomical site for top/bottom surgery, and depending on how coded, behavioral health therapy for co-morbidities of being transgender. This is very time consuming and adds cost to network administration that will not provide accurate information. or
b) Another is issuing a survey all provider types whose license has gender affirming treatment and services within scope, asking whether they provide such services. Survey responses are never 100%, and the information will be based on best effort, not actual accuracy in terms of assessing access.

We question whether this addition to the network reporting requirements supports effective oversight of access to services for transgender enrollees and ask the OIC to remove the requirement or in the alternative, requiring carriers to note in the provider directory if a provider has identified themselves as offering gender affirming treatment or services.

As noted above, the OIC's decision to require network access reporting based on specific types of services rather than provider licensure is a material departure from the current structure of its network access regulations. An agency decision that is the product of "illogical" or inconsistent reasoning that fails to consider "less restrictive, yet easily administered" regulatory alternatives may be determined to be arbitrary and capricious, which is not permitted under the

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Administrative Procedures Act. *Petroleum Commc'ns, Inc. v. FCC*, 22 F.3d 1164, 1172 (D.C. Cir. 1994); RCW 34.05.570.

The last part of the proposed requirement for gender affirming treatment asks carriers to establish processes to ensure that delay in access is not detrimental to the health of enrollees. This asks carriers to create a process to prove a negative using an undefined standard of what is 'detrimental'. The answer to whether something is detrimental can vary depending on whose perspective is applied and the standards applied. We ask OIC to consider removing this requirement or restating it so that carriers aren't required to prove a negative.

Regarding the next day appointment requirements:

ESHB 1477 (sec 106), codified as RCW 48.43.790, establishes the standard the rule repeats but does not clarify. That requirement – to make next-day appointments available to enrollees experiencing urgent, symptomatic behavioral health conditions to receive covered behavioral health service – does not specify how a carrier is to make an appointment available, or even what constitutes 'next-day' (business day or calendar day, within 24 hours? Within business hours?). What does 'available' mean for purposes of compliance? Is a carrier required to act affirmatively to make the appointment available, or is making telehealth services, their network providers and referrals to local crisis stabilization centers sufficient to comply? The rule does not answer these questions. Instead, the OIC proposes weekly reporting of the number of 'requests' received, and when members were seen. Nothing requires a carrier to set up a 'request' based system for making next day appointments available.

We are concerned that weekly reporting will have material negative effects:

- Members request appointments from providers, not their carrier. For carriers to provide weekly reports, behavioral health providers must provide reports of who they see that fits into the next day appointment definition, when they were contacted and when they were seen. This adds a material administrative burden on providers that may result in them leaving the network or limiting their practices, restricting access to services for enrollees. Many will not comply – resulting in a difficult decision for carriers: terminate the provider and further limit member access to behavioral health or be out of compliance with the insurance regulation. Neither outcome serves our enrollees, or our network providers.
- Carriers will each have different ways to approach compliance and obtain data. Providers will be confused and again, will limit participation in networks depending on the administrative complexity it introduces.
- Most behavioral health provider practices are not set up for next day appointment availability. The regulation appears to assume that carriers will require providers to have next day availability. Holding appointments open is expensive to a practice, and unless the carrier sets up a referral service for crisis appointments with select providers who we compensate for those open appointments, we cannot ask that of providers. In addition, that solution would create a tier in the network just for these behavioral health next day providers, which isn't currently allowed under the OIC network regulations.
- . Additionally, if providers block time for potential visits and no patients utilize that time, an available appointment has been taken away from patients. This reduces access, which is not the legislative goal.
- The aspirational design of the legislation does not align with workforce realities. Even if national telehealth service vendors are available to provide enhanced access for next day services, the continuity of care an enrollee with urgent symptomatic behavioral

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health needs will not be well served by defaulting to that as a solution even if it is compliant.

Rather than focusing on obtaining weekly reports that will disrupt network participation for behavioral health, and add cost to provider practices that will increase health care costs, we urge the OIC omit the reporting requirement at this time, and to convene carriers and providers in a workgroup to arrive at a solution on how to address RCW 48.43.790's requirements. The requirement doesn't apply until January 1, 2023. There is time to work on this collaboratively.

- How will the OIC use the report? A network report is typically used to monitor networks, but this report includes a requirement to make and justify not meeting the next day standard. There is not a safe harbor for best efforts, workforce refusal, or other mitigating circumstances.

  If the reporting requirement remains in the rule, we urge the OIC to remove the required reporting field mandating an explanation of why the next day appointment standard wasn't met, and instead to rely on market conduct review to identify non-compliance. Chapter 284 WAC is replete with examples of the Commissioner's right to request and receive information from carriers; a similar standard could be applied here that is less burdensome administratively and achieves the same result.

If the OIC is not amenable to removing the reporting requirement, PacificSource agrees with the Association of Washington Health Plan's request to limit reporting to quarterly intervals. We are concerned about the unintended consequences of any reporting requirement, however, and do urge the OIC to revisit its approach to ensuring compliance.

Sincerely
PacificSource Health Plans,

By: Meg L. Jones
Director, Government Relations

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