August 16, 2023

Rules Coordinator
Washington State Office of the Insurance Commissioner
P.O. Box 40258
Olympia, WA 98504
Submitted via e-mail to: rulescoordinator@oic.wa.gov

RE: Consolidated Health Care Rulemaking CR-101(R 2023-07)

To whom it may concern,

On behalf of Cambia Health Solutions family of insurance companies ("Cambia"), including Regence BlueShield, Regence BlueCross BlueShield of Oregon, Regence BlueShield of Idaho, Asuris Northwest Health, and BridgeSpan Health Company, thank you for the opportunity to provide feedback on the CR-101 for the consolidated health care rulemaking. Through our efforts to implement the various pieces of legislation this rulemaking will cover we have identified areas of the laws that would benefit from additional clarification. It is important all carriers issuing health plans in Washington interpret the requirements in a similar manner to ensure a level playing field in the industry and a consistent consumer experience. With that in mind, we would like to offer the following comments for your consideration as you draft rules.

ESHB 1222 – Requiring coverage for hearing instruments

Section 1 of the legislation requires large group health plans to cover hearing instruments and several associated services. The legislation does not address coverage requirements in terms of provider network status. We strongly recommend these rules clarify whether health plans must provide the coverage required in ESHB 1222 from both in-network and out-of-network health care providers. We believe the intent of the legislation was to provide minimum coverage for hearing instruments and services, regardless of network status.

ESHB 1222 also prohibits the health plans from applying a member's deductible unless the health plan is a qualified high-deductible health plan. However, the legislation is silent regarding other forms of member cost-sharing, such as co-pays and co-insurance. We believe the intent of the legislation was to allow normal health plan design for other forms of cost-sharing and recommend these rules clarify that allowance.

Section 3 of the legislation specifies hearing instruments must be covered at no less than $3,000 *per ear* with hearing loss every 36 months (emphasis added). In other states with similar mandates, health plans have required providers to bill for hearing instruments with either a LT (left side) or RT (right side) modifier to meet this requirement. We are concerned with relying on a coding requirement because we cannot ensure non-contracted providers will bill accordingly, and we are concerned with denying claims due to billing errors. Alternatively, we would like to provide coverage at no less than $3,000 per device up to two devices every 36 months. This will also allow a member to replace a single device if needed without running into a single ear restriction. We believe this approach aligns with the spirit and intent of the law while easing administrative burden on providers and providing more flexibility to members within their benefit.

Section 5 of ESHB 1222 specifies that coverage for a minor under 18 years old should only be available after the minor has received medical clearance within the preceding six months. We believe this section would benefit from rulemaking to clarify the legislative intent. This requirement adds administrative burden and potentially delays care if health plans are required to validate medical clearance before covering a hearing instrument for a minor. We recommend clarification surrounding the health plan's obligation to ensure a provider and member meets this requirement before providing access to the hearing instrument benefit.

SB 5242 – Prohibiting cost-sharing for abortion

The legislation does not address cost-sharing requirements in terms of provider network status. We strongly recommend these rules clarify whether health plans must apply the cost-sharing prohibition to services provided by both in-network and out-of-network health care providers.

SSB 5396 – Cost-sharing for diagnostic and supplemental breast examinations

The legislation does not address cost-sharing requirements in terms of provider network status. We strongly recommend these rules clarify whether health plans must apply the cost-sharing prohibition to services provided by both in-network and out-of-network health care providers.

Thank you for considering our comments. Please let me know if you would like to discuss any of our feedback further. I can be reached at Jane.Douthit@Regence.com or (206) 332-5212.

Sincerely,

Jane Douthit
Cambia Health Solutions
Sr. Public & Regulatory Affairs Specialist