Washington State Office of the Insurance Commissioner

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As required by

The Washington State Administrative Procedures Act
Chapter 34.05 RCW

Matter No. R 2015-2

Essential Health Benefit
designation and supplementation for 2017

CONCISE EXPLANATORY STATEMENT; RESPONSIVENESS SUMMARY; RULE DEVELOPMENT PROCESS AND IMPLEMENTATION PLAN

Relating to the amendment of

WAC 284-43-865, -877, -878, -879 and -880

and replacement with

WAC 284-43-8651, -8771, 8781, 8791 and -8801

September 29, 2015

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Section 1: Introduction

The Revised Code of Washington (RCW) 34.05.325 (6) requires the Office of Insurance Commissioner (OIC) to prepare a "concise explanatory statement" (CES) prior to filing a rule for permanent adoption. The CES:

1. Identifies the Commissioner's reason's for adopting the rule;

2. Describes the differences between the proposed rule and the final rule (other than editing changes) and the reasons for the difference; and

3. Summarizes and responds to all comments that the OIC received regarding the proposed rule during the official public comment period, indicating whether or not the comment resulted in a change to the final rule, or the OIC's reasoning in not incorporating the change requested by the comment;

4. Must be distributed to all persons who commented on the rule during the official public comment period and to any person who requests it.

Section 2: Reasons for Adopting the Rule

In early 2015, the U.S. Department of Health and Human Services published new rules that required each state to select a new base-benchmark plan and to update its Essential Health Benefits rule in conjunction with the new base-benchmark plan. The actions that the OIC took regarding this rule were in response to this requirement.

In addition, in the time since the OIC originally adopted this rule, the federal government has issued guidance and additional regulations regarding various health reform-related topics. Some state requirements have changed, too, as a result of bills, court decisions and other factors. The updated rule captures many of these changes and puts them all in one place.

To implement these changes, effective January 1, 2017, the OIC will repeal WAC 284-43-865, -877, -878, -879 and -880. At the same time, WAC 284-43-8651, -8771, 8781, 8791 and -8801 will go into effect. In the meantime, the OIC has amended WAC 284-43-865 through -880 to show that these rules will expire on December 31, 2016.

Background

Starting January 1, 2014, non-grandfathered individual and small group plans were required to cover Essential Health Benefits (EHBs) consistent with the definition under section 1302 of the Affordable Care Act and implementing regulations at 45 CFR sections 147, 155, and 156, the Patient Protection and Affordable Care Act; Standards Related to Essential Health Benefits, Actuarial Value, and Accreditation; Final Rule.

Under that definition, EHBs include items and services in ten statutory benefit categories, including but not limited to hospitalization, prescription drugs, and maternity and newborn care. These benefits are equal in scope of benefits to the state's selected benchmark plan, as supplemented.

RCW 48.43.715 directs the OIC to establish the essential health benefit benchmark plan by rule, to supplement the benchmark plan if required, and to ensure that the benefits are meaningful. The OIC originally completed this process in 2013.

In early 2015, the U.S. Department of Health and Human Services published new rules requiring each state to select a new base-benchmark plan and to update its Essential Health Benefits rule in conjunction with the new base-benchmark plan. This rule-making activity was the OIC's response to that requirement.

Section 3: Rule development process

On May 19, 2015, the OIC filed a Pre-proposal Notice of Inquiry (CR-101) proposing to designate a new base-benchmark plan for Essential Health Benefits, as well as to supplement the existing rules as necessary. The comment period on the CR-101 was open until July 7th.

On June 26, 2015, the OIC shared an exposure draft with interested stakeholders. The comment period on the exposure draft was open until July 7th.

The agency held a stakeholder meeting on June 30, 2015. During the meeting, OIC staff discussed the rule with stakeholders, answering their questions and giving an overview of various aspects of the rule.

On August 5, 2015, the Commissioner filed a CR-102. The agency held a hearing on September 9, 2015. The Commissioner filed a CR-103P to adopt the rule on September 29th, and the rule went into effect the same day.

Section 4: Differences between Proposed and Final Rule

- In 284-43-8781(5)(b)(ii), the agency deleted the reference to the DSM-IV, replacing it with a reference to the most recent version of the Diagnostic and Statistical Manual of Mental Disorders (DSM);

- In 284-43-8781(5)(b)(ii), the agency deleted the reference to gender identity disorder, replacing it with a reference to gender dysphoria;

- In 284-43-8781(5)(c), the agency deleted the words “a home health setting in;”

- In 284-43-8781(9)(d), the agency added “In accordance with Section 2713 of the Public Health Service Act (PHS Act) and its implementing regulations relating to coverage of preventive services, the base-benchmark plan does not impose cost-sharing requirements with respect to the preventive services listed in this section under paragraph 9(b) (i) to (iv) that are provided in-network.”

Section 5: Responsiveness Summary of Comments

The OIC received numerous comments and suggestions related to the rulemaking. The following information contains a description of the comments, the OIC’s assessment of the comments, and information about whether the OIC included or rejected the comments. When possible, the OIC has organized the comments and responses in relation to the applicable proposed text.

The OIC received comments from:

- American Academy of Pediatrics
- American Cancer Society Action Network
- American Speech-Language Hearing Association
- Berendt and Associates, LLC
- Cambia Health Solutions
- Coalition for Inclusive Healthcare

- Habilitation Benefits Coalition
- Northwest Health Law Advocates
- Planned Parenthood Votes Northwest and Hawaii
- Premera Blue Cross and LifeWise Health Plan of Washington
- Seattle Children's Hospital
- UnitedHealthcare
- Washington State Department of Health

Comments regarding the rule in general

Comment: *Please revise the rule to either create a separate section containing EHBs that apply to children or add language to WAC 284-43-878 that says that EHBs also have to be available to children.*

> **Response:** WAC 284-43-877 (8) of the existing rule already directly addresses this issue, so the OIC did not make changes in response to this comment.

Comment: *Some commenters pointed out that the stakeholder draft contained a reference to a new state law regarding medication synchronization. The commenters said that this issue doesn't seem relevant enough to be included as part of the EHBs, so they asked the OIC to remove it.*

> **Response:** In response to this request, the OIC has removed this reference.

Comment: *One commenter pointed out that based on the structure of the stakeholder draft, the old rule would no longer be effective as of the date that the new rule goes into effect in September 2015. This could lead to enforcement problems, the commenter observed, because there wouldn't be a rule in effect for the OIC to use for any necessary enforcement actions.*

Response: The OIC has restructured the rules so that the existing EHB rules will remain in effect until December 31, 2016, and the new EHB rules will go into effect on January 1, 2017.

Comment: *In regard to deductibles and out-of-pocket limits, one commenter asked the OIC to reconsider and reduce "the potential for $8,600 per year for families of children with special health care needs." This commenter also asked the OIC to address the issue of "$200 co-pays regarding emergency room visits for legitimate emergencies.***"**

Response: The OIC appreciates these suggestions. However, these issues are outside of the scope of the Essential Health Benefit rules. With the exception of preventive care coverage, the EHB rules do not address deductibles, out-of-pocket limits or co-pays. These requirements come from the federal government, so they are outside of the scope of the OIC's jurisdiction. As such, the OIC did not implement these suggestions.

Comment: *One commenter pointed out that urgent care may not be available in all areas of the state, so clients who live in frontier or rural communities may have to rely on emergency rooms for non-emergent issues.*

Response: This issue is outside of the scope of the EHB rules, which simply require that applicable health plans include coverage for emergency care. The EHB rules do not address network adequacy or network access issues, so the OIC did not make changes to the rule in response to this comment.

Comment: *One commenter asked the OIC to add the following benefits to the EHB rule: specialty formulas and supplements for children with inborn errors of metabolism, insulin pens for all children and insulin pumps for some children, and epinephrine auto injectors.*

Response: Section 284-43-878(6)(a)(v) of the existing EHB rule already requires plans to cover medical foods to treat inborn errors of metabolism, and 284-43-878(7)(f)(ii) already requires coverage for insulin pumps. The existing EHB rule does not require coverage for insulin pens or epi-injectors, but if the OIC required health plans to cover these benefits as part of the Essential Health Benefits, this would constitute a "mandate." Under the health reform law, if a state creates a new mandate, the state must fund that mandate. In our state, the legislature would need to provide this funding. To avoid having to ask the legislature to allocate funding to pay for new mandates, the OIC worked diligently to avoid creating any new mandates as part of this rulemaking process. For this reason, the OIC did not follow this suggestion to add these additional benefits to the rule.

Comment: *In regard to durable medical equipment, one commenter asked the OIC to require access to glucose monitoring equipment and supplies, and to require carriers to provide information online addressing non-durable equipment such as orthotics and prosthetics.*

Response: The existing EHB rule already required coverage for glucose equipment and supplies (WAC 284-43-878(7)(f)(ii)), plus orthotics and prosthetics (WAC 284-43-878(7)(b)(iv)), so the OIC did not make any changes to the rule in response to this comment.

Comment: *One commenter said: It is my understanding that they are going to drop the option for [Qualified Health Plans] to contract with only 30% of [Essential Community Providers] and improve that to one in each category by county. I still have a concern that if there is not an ECP in a particular county, will that mean that there is not a contract or will they contract with an ECP that covers that county?*

Response: This issue is beyond the scope of the EHB rule, because the EHB rule does not address network adequacy or network access issues. As such, the OIC did not make changes to the rule based on this comment.

Comment: *In regard to the selection of the base-benchmark plan, one commenter asked the OIC to look at the Washington Medicaid fee-for-service benefits as a model. The commenter also mentioned other issues, such as asking the OIC to require easy-to-understand explanations of benefits and to address limits on cost-sharing and deductibles, in addition to asking the OIC to add some additional benefits that weren't already included in the rule).*

Response: Federal and state law required the OIC to follow very specific criteria in selecting a base-benchmark plan. Under this criteria, the OIC identified the Regence Direct Gold + plan as the base-benchmark plan. The selection criteria didn't give the OIC the latitude to adopt the Washington Medicaid plan as a base-benchmark plan, or even to use that plan as a reference source for creating the EHB requirements.

Some of the other issues that the commenter referred to are outside of the scope of the EHB rules. For example, the federal government, not the OIC, sets forth the requirements regarding easy-to-understand Explanation of Benefits forms and limitations on cost-sharing and deductibles.

In regard to the additional benefits that this commenter asked the OIC to require, if the OIC required health plans to cover these benefits, this would constitute a "mandate." Under the health reform law, if a state creates a new mandate, the state must fund that mandate. In our state, the legislature – not the OIC – would need to provide this funding. To avoid asking the legislature to allocate funding to pay for a new mandate, the OIC tried to avoid creating any new mandates as part of this rulemaking process. For this reason, the OIC did not add the additional benefits that this commenter had requested to the rule.

Comment: *In regard to selecting the base-benchmark plan, one commenter asked the OIC to select a plan that provides access to a "broader range of pediatric services that*

includes the full range of services that children need for healthy development per the American Academy of Pediatrics' Scope of Health Care Benefits for Children and the Bright Futures recommendations."

Response: The Bright Futures requirement was already included in the original version of the EHB rule (WAC 284-43-848(9)(a)(iii), and the OIC did not change or remove it during this rulemaking process. The OIC did not take further action in response to this comment.

Comment: *One commenter stated that under many health plans, "therapy services are limited and children use their lifetime benefits within a relatively short period of time, causing children to either forgo therapies or have parents or caregivers pay out of pocket or access support dollars at WA's neurodevelopmental therapy centers. [..] In addition, many plans limit comprehensive therapies to age six […]."*

Response: In the new rule, the OIC addresses this issue in WAC 284-43-8781(10)(a)(i) and (b).

Comment: *In regard to network adequacy, one commenter said that plans need to ensure that they work with providers to ensure that they are taking on new clients.*

Response: The Essential Health Benefits rules do not address network adequacy or network access issues. These issues are in another part of WAC 284. Because these issues are outside of the scope of the EHB rule, the OIC did not make language changes in response to this comment.

Comment: *In regard to care coordination, one commenter asked the OIC to make sure that health plans work with inpatient facilities, especially neonatal ICUs.*

Response: The Essential Health Benefits rules do not address care coordination issues. Care coordination isn't a specific benefit; instead, it's a method of

providing benefits. In general, the EHB rules simply list the benefits that health plans must provide, not the method of delivery that plans must use to provide such benefits. As a result, the OIC has declined to make changes to the rule in response to this comment.

Comment: *One commenter said that plans need to identify unique programs like Asthma Home Visiting, Nurse Family Partnership and Parents as Teachers and provide these services where possible.*

Response: This issue is beyond the scope of the Essential Health Benefits rule. These issues aren't specific benefits; instead, they're methods of providing benefits. In general, the EHB rules simply list the benefits that health plans must provide, not the method of delivery that plans must use to provide such benefits.

Comment: *One commenter asked the OIC to consider contracting with alternative providers such as school-based health centers or local health department services in regard to services such as immunizations and First Steps.*

Response: This issue is beyond the scope of the Essential Health Benefits rule. This comment addresses network access, which is in a different section of WAC 284. Because this is outside of the scope of the EHB rule, the OIC declined to make changes to the EHB rule in response to this comment.

Comment: *One commenter said that plans need to provide more flexible open enrollment options for children transitioning off of parents' insurance, pregnancy, and transitioning from a family-planning-only program.*

Response: The issue that this commenter is referring to is called "special enrollment" and is a separate rule under WAC 284. The existing OIC special enrollment rules actually already address some of these issues. Because these

issues are outside of the scope of the EHB rule, the OIC did not make changes to the rule in response to this comment.

Comment: *One commenter addressed tobacco cessation, saying that the base-benchmark plan, as well as "most of the insurance companies in Washington" are not in compliance with the US Department of Labor guidelines for tobacco cessation. As an example, the commenter said that "it has been interpreted as all three types of [tobacco cessation] counselling are needed."*

Response: The OIC has performed extensive legal analysis regarding this issue. Under the OIC's legal analysis, the federal guidelines are a ceiling, not a floor. As a result, the OIC declined to make changes to the rule in response to these comments.

Comment: *One commenter asked the OIC to require coverage for quarterly screenings for high-risk individuals who are taking Truvada. The commenter explained that these screenings are expensive and serve as a barrier that prevent people from continuing to take this drug to prevent HIV infection.*

Response: If the OIC required health plans to cover this benefit under the EHB rule, this would constitute a "mandate." Under the health reform law, if a state creates a new mandate, the state must fund that mandate. In our state, the legislature – not the OIC – is the entity that would need to provide this funding. To avoid asking the legislature to allocate funding to pay for a new mandate, the OIC tried to avoid creating any new mandates as part of this rulemaking process. For this reason, the OIC did not add these benefits to the rule.

Comment: *One commenter asked the OIC to require coverage for multi-site testing for gonorrhea to be included in screenings for gay and bisexual men, explaining that this issue is under-diagnosed because providers only conduct a urethral test.*

Response: If the OIC required health plans to cover this benefit under the EHB rule, this would constitute a "mandate." Under the health reform law, if a state creates a new mandate, the state must fund that mandate. In our state, the legislature – not the OIC – is the entity that would need to provide this funding. To avoid asking the legislature to allocate funding to pay for a new mandate, the OIC tried to avoid creating any new mandates as part of this rulemaking process. For this reason, the OIC did not add this benefit to the rule.

Comment: *In regard to the stakeholder draft, one commenter thanked the OIC for maintaining the prohibition on plans substituting benefits for the benefits until after plan year 2017. The commenter was "similarly are pleased to see that there has been no proposed change to subsection (2) which makes clear that classification primarily affects actuarial value calculations, rather than determining coverage. This rule highlights the inevitable overlap in certain categories, such as pediatric behavioral health services and the behavioral health services in the mental health category. This provision serves to protect consumers in need of services."*

Response: The OIC appreciates this input. In this rulemaking process, the agency has extended the prohibition on plans substituting benefits to plans or policy years beginning on or after January 1, 2017.

Comment: *In regard to the stakeholder draft, one commenter asked the OIC to maintain consistency when addressing instances where the base-benchmark plan doesn't comply with EHB requirements and state and federal law. The commenter identified the specific subsections where the base-benchmark plan doesn't comply with EHB requirements or state or federal law and provided suggested language for the OIC to use.*

Response: The OIC appreciates this suggestion, and in response, has revised language throughout the draft to provide consistency regarding this issue.

Comment: *Please fix the spelling of the second word in Regence's name so that "BlueShield" is spelled as one word instead of two.*

Response: The OIC appreciates this input. The Code Reviser's Office was spelling it this way in order to conform to their internal editing requirements. The OIC is pleased to report that this issue is resolved as of the final (CR-103) draft.

Comment: *Several commenters asked why the CR-102 draft contains both the current EHB sections as well as the new sections.*

Response: The current version of the EHB rules applies to the 2016 health plans, which health plans already filed with the OIC's Rates and Forms Division long before the OIC finalized the EHB rule update. In case the OIC needs to pursue enforcement actions in regard to any of the 2016 health plans, the OIC needs to keep the existing rule in effect through the end of 2016. The new EHB rules will go into effect on January 1, 2017.

Comment: *Some commenters asked why the OIC didn't add new issues that it added to the version of the rule that goes into effect on 1/1/17 (such as requiring coverage for medically necessary services for transgender individuals) to the existing EHB rule that will remain in effect through 12/31/16.*

Response: Health plans are already required to comply with the new requirements, including but not limited to coverage for medically-necessary services for transgender individuals. In addition, health carriers had already filed the 2016 health plans with the OIC's Rates and Forms Division long before the agency reached the final stages of this rule, so making a change to the current rule language would not have changed current practice.

In addition, the name of the rule ("Essential Health Benefits Designation and Supplementation for 2017") indicates that the changes to the rule will affect the

2017 health plans, not prior plans, and the CR-101 form and CR-102 form issued for this rulemaking reflect this focus.

Comment: *In the CR-102 draft, in regard to WAC 284-43-877(1)(b), one commenter stated opposition to the OIC's approach to allow plans to substitute benefits for plan or policy years beginning on or after January 1, 2017. The commenter observed that the proposed change to WAC 284-43-877(1)(b) conflicts with WAC 284-43-8771(1)(a), which prohibits issuers from substituting benefits in plans that issuers offering plans on or after January 1, 2017.*

Response: Although WAC 284-43-877 does contain language that says that health plans can substitute benefits for policy years beginning on or after January 1, 2017, this rule expires on December 31, 2016. At that time, WAC 284-43-8771 will go into effect, and -8771 prohibits issuers from substituting benefits. As a result, health plans will not be able to substitute benefits.

Comment: *In regard to the CR-102 draft, some commenters expressed concern that WAC 284-43-878 didn't contain the language from 284-43-8781 that prohibited health insurers from excluding medically-necessary care for transgendered people.*

Response: Health plans are already required to comply with the new requirements, including coverage for medically-necessary services for transgender individuals. In addition, health carriers had already filed the 2016 health plans with the OIC's Rates and Forms Division long before the agency reached the final stages of this rule, so making a change to the current rule language would not have changed current practice.

In addition, the name of the rule ("Essential Health Benefits Designation and Supplementation for 2017") indicates that the changes to the rule will affect the 2017 health plans, not prior plans, and the CR-101 form and CR-102 form issued for this rulemaking reflect this focus.

Comments regarding OIC's incorporation of federal guidance in stakeholder draft

Comment: *In the stakeholder draft, the OIC included rephrased sections from some of the federal guidance that the U.S. Department of Health and Human Services (in conjunction with the U.S. Department of Labor and the U.S. Department of the Treasury) has issued in the form of FAQs. The OIC received several comments from health carrier representatives regarding this issue, all asking the OIC to remove the paraphrased language. The representatives said that HHS issues its FAQs in a piecemeal manner, often on a weekly basis. In addition, the representatives said, including this information in the rule will result in the OIC needing to constantly update the rule as HHS continues to change existing guidance or issue new guidance. The commenters asked the OIC to either remove the sections that referred to the federal guidance, or to just refer to that federal guidance in the applicable sections instead of including the rephrased guidance in the rule.*

> **Response:** Where possible and appropriate, the OIC removed the specific guidance from the rule, replacing it with references to HHS rulemaking and guidance in 284-43-8781(11), 284-43-8791(6), and 284-43-8801(4).

Comment: *In regard to the stakeholder draft, one commenter expressed gratitude regarding the additional detail and specificity around contraceptive coverage in WAC 284-43-878. The commenter said: "Section 6(a)(iii) is a clear attempt to ensure full compliance with the Patient Protection and Affordable Care Act's contraceptive coverage requirement for most insurance plans. Beginning August 1, 2012 non-grandfathered health plans must cover and not impose cost-sharing for contraceptives as part of women's preventive health care coverage."*

> **Response:** Although the OIC appreciates this comment, the agency has removed this guidance from the rule, replacing it with appropriate references to HHS rulemaking and guidance in 284-43-8781(11), 284-43-8791(6), and 284-43-

8801(4). In addition, the agency added language to clarify that services covered under preventive care won't incur cost-sharing if the service is provided in-network, or if the service isn't available in-network.

Comment: *As one commenter pointed out, the stakeholder draft contained language from the most recent CMS guidance on implementation of the contraceptive coverage mandate. The commenter asked the OIC to flesh out that language and provided proposed language for the OIC to use.*

Response: The OIC removed the federal guidance from the stakeholder draft and replaced it with broader language in 284-43-8781(11), 284-43-8791(6), and 284-43-8801(4). Because the OIC removed that language, the agency didn't follow this suggestion.

Comment: *One commenter said that the OIC should further clarify insurance plans' obligation to develop a waiver process to ensure that women have access to the contraceptive method that their provider determines is medically necessary, even when a plan utilizes medical management techniques. The commenter provided suggested language for the OIC to use.*

Response: The waiver requirement comes from the HHS FAQs, and in the CR-102 draft of the rule, the OIC removed the federal guidance from the stakeholder draft and replaced it with broad language in 284-43-8781(11), 284-43-8791(6), and 284-43-8801(4). Because the OIC removed the language, the agency did not implement this suggestion.

Comment: *One commenter said: "OIC should continue to reference federal guidance throughout the rules. We support OIC's reference to federal guidance and FAQs throughout the rules and advocate that OIC retain the references to such guidance within the rules for the following reasons. First, although health plans may already be aware of federal guidance and may have implemented it, consumers rely on reference*

to such guidance. Including references to the federal guidance throughout the rules alerts consumers to their rights and permits them the opportunity to hold health plans accountable for those rights. Second, including provisions based on federal guidance in state regulation further protects the consumer by elevating it from mere guidance to enforceable provisions when guidance is incorporated into the regulations consumers are better able to hold a health plan accountable for its policies."

Response: The OIC appreciates this comment. However, in the CR-102 draft, the OIC removed the federal guidance that had appeared in the stakeholder draft, replacing it with broad language in 284-43-8781(11), 284-43-8791(6), and 284-43-8801(4). Leaving the language would have created a future workload issue for the OIC because the agency would need to amend, add or delete language with all future federal guidance.

However, this is definitely an important issue, so the OIC is looking into a way to provide synopses of (or at least direct links to) key federal guidance on the consumer section of its website.

Comment: *In the stakeholder draft, the OIC paraphrased language from several HHS FAQs. The OIC did not include this language in the CR-102 draft, and several people commented on this difference, asking why the OIC removed the FAQ language from the CR-102 draft. Some people specifically asked why the agency removed particular sections, including but not limited to the language related to contraception and coverage for BRCA screening, asking whether the agency removed **only** those sections of the FAQs as opposed to **all** sections of the FAQs.*

Response: The OIC removed the FAQ language from various sections of the rule; not just in the sections referencing contraception or BRCA screening. However, these are definitely important issues, so the OIC is looking into a way to provide synopses of (or at least direct links to) key federal guidance on the consumer section of its website.

Comment: *In regard to the OIC removing the specific HHS guidance and replacing it with the broad language in 284-43-8781 (11), 284-43-8791 (6), and 284-43-8801 (4), one commenter said that the OIC hadn't defined "guidance," "clarifications," or "expectations" in this rule or elsewhere in the rules. The commenter said: "Failure to define these sections leaves too much space for health plans to interpret which guidance they must or must not "know and apply" which could be harmful for consumers and create barriers to accessing certain services and care. If OIC continues with its proposed approach, it must define these terms."*

> **Response:** The OIC appreciates this comment. However, the OIC already provided an example in the rules to illustrate the meaning of these terms ("Such clarifications may include, but are not limited to, Affordable Care Act implementation and frequently-asked questions jointly issued by the U.S. Department of Health and Human Services, the U.S. Department of Labor and the U.S. Department of the Treasury"). The agency declined to make further changes in response to this comment.

Comments regarding WAC 284-43-8781(1) - Ambulatory patient services

Comment: *One commenter said that it wasn't clear if the plan covers "concurrent care" for children in hospice.*

> **Response:** "Concurrent care" isn't necessarily within the scope of the Essential Health Benefit ("EHB"). Although it's a manner of delivering benefits, it's not a standalone benefit. However, hospice care is an EHB, so plans are required to cover it for people of any age. Because the EHB rules already require coverage for hospice care for children, and because concurrent care isn't necessarily within the scope of the EHB rule, the OIC did not take further action in response to this comment.

Comment: *Several commenters said that the EHBs exclude coverage of hearing care and aids, and said that excluding these services and devices constitutes disability discrimination. They cited ACA §1302, which says that the EHB can't be designed "in ways that discriminate against individuals because of their…disability." These commenters also cited the Americans with Disabilities Act, which says that a hearing impairment may constitute a disability if it substantially limits a major life activity. These commenters said that Section 1557 of the ACA explicitly applies the ADA to the health care context. As such, these commenters said, the ACA's nondiscrimination laws prohibits discrimination on the basis of hearing impairment when the impairment constitutes a disability, and would thereby prevent plan benefit designs that could lead to such discrimination, so plans should cover hearing care and devices in the ambulatory service category to the extent that such services are medically necessary.*

> **Response:** The EHB rule does require health plans to cover cochlear hearing aids, and adding non-cochlear hearing aids would still be considered a state mandate despite the applicability of the ADA to the ACA, and would therefore trigger the Washington state Department of Health's "sunset review" process, even if the state legislature didn't need to provide funding for the benefit. Very few states require health plans to provide this benefit as part of their EHB benefit package, and HHS does not require states to include this coverage as part of the Essential Health Benefits. As a result, the OIC did not add non-cochlear hearing aids as an Essential Health Benefit.

Comment: *One commenter said that the rule lacks a guarantee of coverage for the removal and insertion of FDA-approved contraceptive devices, such as IUDs, and that the rule should specifically state that plans must cover follow-ups for side effect management or for counseling for continued adherence. The commenter provided draft language for the OIC to use.*

> **Response:** There's actually a state regulation that predates the health reform law (WAC 284-43-822) that already requires coverage for IUD removal.

However, this commenter is specifically referring to clarification that HHS issued in its FAQs. In the CR-102 draft, the OIC deleted references to the FAQs, replacing them with more general references to HHS rulemaking and guidance in 284-43-8781(11), 284-43-8791(6), and 284-43-8801(4). Because the OIC deleted the specific (paraphrased) language that this commenter was referring to, the agency did not follow this suggestion to clarify that language.

Comment: *One commenter said: "We noticed this morning that NO Intrauterine Devices or the option for them is included in the model plan (Mirena, Paraguard, Liletta, or Skyla). Also, there is no mention of the ability to get an implant (Nextplannon). We feel that this is a very important issue to address and hope that it can be addressed before the plan is approved."*

Response: The ambulatory section of the EHB rule does require plans to cover such devices, and the base-benchmark plan does cover such devices. Although the ambulatory section requires coverage for such devices, it simply does not identify these devices by their brand names. In writing rules, agencies need to keep the language fairly general to avoid having to rewrite the rule later if, for example, a pharmaceutical company changes a brand name. Because of the importance of keeping rule language fairly general, the OIC did not add these brand names to the rule in response to this comment.

Comments regarding WAC 284-43-8781(3) – Hospitalization

Comment: *In regard the hospitalization requirement in the EHB rule, one commenter asked the OIC to specifically state in 284-43-878(5)(b)(ii) [the version of the rules that applies to the 2016 health plans] that plans must cover medically necessary breast reconstruction for consumers who are undergoing treatment for gender dysphoria. The commenter provided draft language and asked the OIC to incorporate that language into the rule.*

Response: Under the letter that the OIC sent to carriers in the summer of 2014, health plans are already required to comply with the new requirements, including coverage for medically-necessary services for transgender individuals. In addition, health carriers had already filed the 2016 health plans with the OIC's Rates and Forms Division long before the agency reached the final stages of this rule, so making a change to the current rule language would not have changed current practice.

Finally, the name of the rule ("Essential Health Benefits Designation and Supplementation for 2017") indicates that the changes to the rule will affect the 2017 health plans, not prior plans, and the CR-101 form and CR-102 form issued for this rulemaking reflect this focus. As a result, the agency declined to make changes to the rule in response to this comment.

Comment: *One commenter provided suggested language regarding coverage for sexual reassignment treatment, surgery, or counseling services.*

Response: The OIC amended this language in the rule.

Comments regarding WAC 284-43-8781(5) – Mental health and substance use disorder services, including behavioral health treatment

Comment: *One commenter said that the draft section 284-43-878(5)(c)(i) adds new language to require parity between mental health/substance use disorder home health services and medical home health services: "The language as drafted suggests the creation of a new parity subcategory of home health services, which goes well beyond federal requirements for parity within the larger category of outpatient services. We respectfully request that this subcategory language be deleted."*

Response: The agency has deleted this language in response to this comment.

Comment: *In regard to mental health and substance use disorder services, one commenter noted that subsection (5)(a) doesn't specifically reference screening/assessment of mental health or substance use disorder conditions as covered services. This commenter asked the OIC to mention that diagnostic services are also covered under the mental health & substance use disorder category.*

Response: The OIC has amended this language based on this comment.

Comment: *One commenter said that the base-benchmark plan establishes specific limitations on services classified to the mental health and substance abuse disorder services category that conflict with state or federal law as of January 1, 2017. The commenter asked the OIC to supplement the base-benchmark plan, saying that the plan does not provide coverage for mental health services and substance use disorder treatment in a home health setting at parity with medical home health services.*

Response: The OIC has amended the language in WAC 284-43-848(5)(c)(iii) to clarify health plans' responsibilities in regard to this benefit.

Comment: *One person pointed out that the Diagnostic and Statistical Manual is now in its fifth edition, yet the CR-102 version of the rule still referred to the DSM-IV. This commenter also pointed out that the DSM-V uses the phrase "gender dysphoria" instead of the phrase "gender identity disorder."*

Response: The OIC appreciates these reminders and has implemented these changes in the final (CR-103) draft of the rule.

Comment: *One commenter observed that WAC 284-43-8781(5)(b)(ii) requires plans to cover medically necessary treatment for gender identity disorder, but 284-43-878 does not. The commenter asked the OIC to add this requirement to 284-43-878, saying that there's no justification to use different approaches between the two sections applying in plan year 2016 and 2017. The commenter suggested proposed language.*

Response: Under the letter that the OIC sent to carriers in the summer of 2014, health plans are already required to comply with the new requirements, including coverage for medically-necessary services for transgender individuals. In addition, health carriers had already filed the 2016 health plans with the OIC's Rates and Forms Division long before the OIC reached the final stages of this EHB rule update. As a result, making a change to the current rule language would not have changed current practice.

Finally, the name of the rule ("Essential Health Benefits Designation and Supplementation for 2017") indicates that the changes to the rule will affect the 2017 health plans, not prior plans, and the CR-101 form and CR-102 form issued for this rulemaking reflect this focus.

Comment: *In regard to WAC 284-43-8781(5), one commenter said that proposed subsection 284-43-818(5)(c) still blends the concepts of home health care and mental health or substance abuse care provided in a home setting. The commenter said that the proposed requirement of parity between mental health/substance use disorder home health services and medical home health services goes beyond federal requirements for parity within the category of outpatient services, and suggests the creation of a new parity subcategory of home health services. The commenter asked the OIC to delete this language.*

Response: In response to this comment, the OIC changed this language.

Comments regarding WAC 284-43-8781(6) – Prescription drug services

Comment: *One commenter pointed to the guidance that HHS released in May 2015, which says that services under this benefit category include clinical services that are necessary as part of providing an individual's contraceptive method. The commenter said that the draft rule could be misconstrued to mean that patient education and*

counseling are the only services necessary to provide contraceptives. This commenter provided suggested language for the OIC to use.

> **Response:** This commenter is referring to language that the OIC added to the stakeholder draft of the rule that paraphrased some of the HHS FAQs. In the CR-102 draft, the OIC removed most of the language from the HHS FAQs, so the agency did not add follow this commenter's suggestion to add additional language regarding the May 2015 FAQs. The OIC is looking into a way to provide synopses of (or at least direct links to) key federal guidance on the consumer section of its website.

Comment: *One commenter said that the rule does not appropriately take into account recent federal guidance clarifying that a health plan must accommodate a woman for whom a particular method would be medically inappropriate as determined by her health care provider. This commenter asked the OIC to add language to the rule saying that the determination of "medically inappropriate" is made by the woman's provider, not the health plan.*

> **Response:** This language comes from the HHS FAQs. Although the OIC included language from several of the HHS FAQs in the stakeholder draft, the agency removed the language in the CR-102 draft, replacing it with general references to the guidance in 284-43-8781(11), 284-43-8791(6), and 284-43-8801(4). Because the agency removed the specific references to HHS FAQs, the OIC did not add this language to the rule. The OIC is looking into a way to provide synopses of (or at least direct links to) key federal guidance on the consumer section of its website.

Comment: *One commenter said that the HHS FAQ guidance requires health plans to have a mechanism for "waiving" the cost-sharing for a brand or non-preferred version, which the May 2015 FAQs describe as a health plan's "exceptions process." The commenter provided proposed language.*

Response: As the commenter mentioned, this language comes from the HHS FAQs. Although the OIC included language from several of the HHS FAQs in the stakeholder draft, the agency removed the language in the CR-102 draft, replacing it with general references to the guidance in 284-43-8781(11), 284-43-8791(6), and 284-43-8801(4). Because the agency removed the specific references to HHS FAQs, the OIC did not add this language to the rule to clarify this particular reference to the FAQs.

Comments regarding WAC 284-43-8781(7) – Rehabilitative and habilitative services

Comment: *Several commenters pointed out that HHS recently adopted a new definition of habilitative and asked the OIC to adopt the new definition.*

Response: The OIC appreciates this input and has adopted a new definition of habilitative that is substantially similar to the new federal definition.

Comment: *One commenter asked the OIC to require health plans to offer separate visit limits for each type of therapy, such as speech, physical, and occupational therapies.*

Response: The OIC has declined to follow this suggestion because this may constitute a new mandate. Under the health reform law, if a state creates a new mandate, the state must fund that mandate. In our state, the legislature – not the OIC – is the entity that would need to provide this funding. To avoid asking the legislature to allocate funding to pay for a new mandate, the OIC worked tried to avoid creating any new mandates as part of this rulemaking process. For this reason, the OIC did not make this change in the rule.

Comment: *One commenter asked the OIC to add language to prevent the use of medical necessity requirements, visit limitations or other exclusions to prevent*

consumers from accessing rehabilitation and habilitation, or to require consumers to stop those services too soon.

Response: Within certain limitations, health insurers are allowed to use reasonable medical necessity requirements and visit limitations. If the OIC required insurers to cover benefits without any medical necessity requirements or visit limitations, this may constitute a new mandate. Under the health reform law, if a state creates a new mandate, the state must fund that mandate. In our state, the legislature – not the OIC – is the entity that would need to provide this funding. To avoid asking the legislature to allocate funding to pay for a new mandate, the OIC tried to avoid creating new mandates as part of this rulemaking process. For this reason, the OIC did not add these benefits to the rule.

Comment: *One commenter asked the OIC to require health plans to cover "augmentation and alternative communication" devices such as speech-generating devices, and to require coverage for both cochlear and non-cochlear hearing aids. The commenter said that Washington can get around this being a "mandate" (i.e., the requirement that the Legislature provide funding to pay for it) because HHS explained in the final rule that state benefit mandates enacted to define habilitative services are part of the essential health benefit, so states do not need to defray the cost. Similarly, one commenter asked OIC to add non-cochlear hearing aids as required coverage, saying that the OIC could classify this as a "device" under the rehabilitative benefit.*

Response: The EHB rule does require health plans to cover cochlear hearing aids, and adding non-cochlear hearing aids would still be considered a state mandate despite the applicability of the ADA to the ACA.

Because it would be a mandate, even if the OIC added this to the EHB rule and even if the state legislature didn't need to provide funding, this benefit would need to undergo and pass the Department of Health's "sunrise review" process for evaluating new mandates before it could go into effect.

Very few states require health plans to provide this benefit as part of their EHB benefit package, and HHS does not require states to include this coverage as part of the Essential Health Benefits. For these reasons, the OIC did not add coverage of non-cochlear hearing aids as an Essential Health Benefit.

Comment: *In response to language in the stakeholder draft, one commenter said that the reference to hearing aids was confusing. This person asked the OIC to clarify the language so that it's easier to understand.*

Response: The OIC agreed that the language was confusing, so the agency updated the language in 284-43-878 (1)(b)(vii).

Comment: *In regard to rehabilitative and habilitative services, one commenter said that the required benefits under the EHB rules aren't sufficient for children with special health care needs. This person asked the agency to add requirements for the plan to allow consumers to request additional visits.*

Response: Consumers already have the option of obtaining additional visits by filing an appeal, including an appeal before an independent review organization ("IRO"). This option exists separately from the EHB rule – it's in another part of WAC 284 – so the OIC did not address this issue as part of this rulemaking.

Comment: *In regard to the stakeholder draft, one commenter expressed concern about the age of six limit for receiving neurodevelopmental services. The commenter asked the OIC to require plans to cover these services through the age of 20 to be comparable with Early and Periodic Screening, Diagnostic, and Treatment benefit under Medicaid.*

Response: The OIC addressed the age of six issue in WAC 284-43-8781(10)(a)(i) and (b). State and federal law required the OIC to use specific criteria in selecting the base-benchmark plan, so the OIC didn't have the option

of using Medicaid as a model for the base-benchmark plan. As a result, the OIC didn't make changes to the rule in response to this comment.

Comment: *In regard to rehabilitative and habilitative services, one commenter said that health plans aren't complying with the language in subsection (d)(ii). This section only allows health plans to include reference-based limitations on habilitative services if "the limitations take into account the unique needs of the individual and target measurable, and specific treatment goals appropriate for the person's age, and physical and mental condition." The commenter reviewed several QHP filings from 2014, as well as the base-benchmark plan, to identify the visit limitations that the plans applied to habilitative benefits. The commenter said: "None of the plan filings included the above-quoted language. All the plans subject habilitative benefits to the 25 combined visit limitation for occupational, speech, and physical therapy. These visit limitations in the approved filings contradict the rule language as none of them are subject to the limiting language requiring plans to consider an individual's circumstances and the special nature of habilitative services." The commenter asked the OIC to enforce the rule as written or redraft it to make clear that the habilitation benefit is not automatically subject to a combined 25 visit limitation.*

Response: The OIC declined to amend the language of the rule in response to this comment. However, this is a very important issue. If specific consumers are experiencing claim denials in regard to this issue, the OIC asks consumers to fill out an OIC complaint form at http://www.insurance.wa.gov/complaints-and-fraud/file-a-complaint/ so that the agency can address and resolve this issue.

Comment: *One commenter asked the OIC to add language to prevent health plans from imposing habilitative coverage limits that are less favorable than rehabilitative coverage limits.*

Response: The original version of the rule already addressed this issue in WAC 284-43-878(7)(d)(ii).

Comment: *One commenter asked the OIC to prevent plans from imposing combined limits on habilitative and rehabilitative services, saying that for plans that impose such limits, federal regulations require separate limits for rehabilitative and habilitative benefits after 1/1/17.*

> **Response:** The language of the federal rule says that issuers that previously excluded habilitative services, but subsequently added them, must impose separate limits on each service rather than retaining the rehabilitative services visit limit and having habilitative services count toward the same visit limit. This isn't applicable in Washington state, because this state's Essential Health Benefits rule has required coverage of habilitative benefits since its inception. As a result, the OIC did not make changes in response to this comment.

Comment: *In regard to habilitative and rehabilitative benefits, one commenter asked the OIC to require health plans to provide coverage for devices including prosthetics, orthotics, hearing aids, etc.*

> **Response:** The original version of this rule already required plans to cover prosthetics, orthotics and cochlear implants. However, adding a requirement for plans to cover hearing aids that are not cochlear implants would constitute a mandate, and as the OIC has mentioned in response to other commenters' questions, it was important for the agency to avoid creating additional mandates as part of this rulemaking process.

Comment: *One commenter said that HHS clarified that state benefit mandates enacted to define habilitative services are part of the essential health benefit, which means that states don't need to defray the cost. (Under the ACA, states would have to defray the cost of other mandates). The commenter said that this clarification allows states to address coverage gaps in their state.*

Response: The OIC needed to avoid additional mandates as part of this rulemaking process, even if the state legislature wouldn't need to provide funding to pay for it.

In Washington state, any new mandate must undergo an extensive "sunrise review" process through the Department of Health ("DOH"). As a result, even if the OIC added a new mandate to the EHB rule, there's no guarantee that the mandate would pass the DOH sunrise review process. The OIC tried to avoid creating new mandates as part of this rulemaking process, even if such new mandates did not require funding from the state legislature.

Comment: *In regard to rehabilitative services, one commenter asked for clarification regarding inpatient versus outpatient limits: "We are concerned that the language currently may result in confusion. The requirement not to classify certain services for chronic conditions as rehabilitative makes sense to us for outpatient settings in cases such as pulmonary rehabilitative care, or cardiac rehabilitative care."*

Response: The OIC has declined to make changes to this language in response to this comment.

Comments regarding WAC 284-43-8781(9) – Preventive and wellness services, including chronic disease management

Comment: *In regard to section 284-43-878(9)(a)(iv)(A), one commenter asked the OIC to clarify the language to make it clear that this requirement also applies to any child who's on an applicable health plan, not just a child who's on the policy as a dependent. The commenter said that the current language might not encompass a child who has a child-only policy, or a young person is over 18 and is not a "dependent" under the ACA definition.*

Response: In response to this request, the OIC has changed this language.

Comment: *One commenter said that it wasn't clear whether teens are eligible for tobacco cessation counseling or medications.*

> **Response:** In the original rule, WAC 284-43-877(8) says that the EHB services apply to people of all ages, so the OIC has declined to amend the rule in response to this comment.

Comment: *One commenter said: "While the plan covers well-child visits, it would be appropriate for the office to operate as a medical home and be reimbursed accordingly for shared care planning, care coordination, adolescent transition to adult medical care, etc."*

> **Response:** Shared care planning, care coordination, etc. are not specific benefits. Instead, they're methods of providing benefits. In general, the EHB rules simply list the benefits that health plans must provide, not the method of delivery that plans must use to provide such benefits. As a result, the OIC has declined to make changes to the rule in response to this comment.

Comment: *One commenter asked the OIC to add language to the rule that clearly states that services and supplies related to contraceptive coverage are included here solely for the purpose of calculating actuarial value and not for determination of how and when they may be covered or the cost-sharing to which these services, supplies, devices, and prescriptions may be subject.*

> **Response:** Although the OIC appreciates this comment, the agency declined to add this language to the rule.

Comment: *In response to the stakeholder draft, one commenter said that "the language in this section appears to limit genetic counseling and testing for the breast cancer susceptibility gene (BRCA) to women who have not been diagnosed with BRCA-related cancer but who previously had breast cancer, ovarian cancer, or other cancer.*

However, under the ACA, health plans must cover genetic counseling and testing for the BRCA genes for women with a family history associated with an increased risk for these genes as well." The commenter included proposed language.

Response: In the CR-102 draft of the rule, the OIC removed the language referring to the HHS FAQs, including the language that this commenter referenced above. The agency replaced it with language that referred generally to the HHS FAQs in WAC 284-43-8781(11), 284-43-8791(6), and 284-43-8801(4). Because the OIC removed the language, the OIC did not adopt this commenter's proposed language.

Comment: *One commenter asked the OIC to require plans to cover comprehensive hearing services as part of the Essential Health Benefits' preventive services requirement. This commenter said that, from the information that's available online, it's not clear whether plans must cover cochlear implants.*

Response: WAC 284-43-8781(b)(vii) requires health plans to cover cochlear implants and hearing screening tests that are required under the preventive services category. In addition, WAC 284-43-8781(7)(b)(i) also requires plans to cover cochlear implants.

Comment: *In regard to breastfeeding, one commenter asked the OIC to add the language from the federal FAQs that clarifies that coverage can be for rental or purchase of breastfeeding equipment, and change the language in the draft from "during the postpartum period," which is undefined, to the "duration of breastfeeding," which is the language that HHS uses. The commenter provided sample language.*

Response: The OIC has removed the specific guidance from the rule, replacing it with appropriate references to HHS rulemaking and guidance in 284-43-8781(11), 284-43-8791(6), and 284-43-8801(4). In addition, the agency added language to clarify that services covered under preventive care won't incur cost-

sharing if the service is provided in-network, or if the service isn't available in-network.

Comment: *One commenter pointed out that the EHB rule specifically mentions the Bright Futures preventive care schedule but the Regence plan doesn't specifically mention it.*

Response: To ensure that the Regence Direct Gold + plan covered the services that are included in the Bright Futures preventive care schedule, the OIC checked the policy as well as some additional Regence reference materials. After conducting this research, the agency found that although the plan doesn't specifically call those services "Bright Futures," the plan does cover these services.

Comment: *In regard to the stakeholder draft's language summarizing the HHS FAQs regarding contraceptive coverage, one commenter asked the OIC to add additional language to these sections.*

Response: The OIC has removed the specific guidance from the rule, replacing it with appropriate references to HHS rulemaking and guidance in 284-43-8781(11), 284-43-8791(6), and 284-43-8801(4). In addition, the agency added language to clarify that services covered under preventive care won't incur cost-sharing if the service is provided in-network, or if the service isn't available in-network.

Comment: *One commenter asked the OIC to include language within this rule detailing issuers' requirement to accommodate a woman for whom a particular method would be medically inappropriate as determined by her health care provider. This language comes from the HHS FAQs.*

Response: The OIC has removed the specific guidance from the rule, replacing it with appropriate references to HHS rulemaking and guidance in 284-43-8781(11), 284-43-8791(6), and 284-43-8801(4). The OIC is looking into a way to provide synopses of (or at least direct links to) key federal guidance on the consumer section of its website.

Comments regarding pediatric oral services [WAC 284-43-8791] and pediatric vision services [WAC 284-43-8801]

Comment: *One commenter asked the OIC to incorporate a recent federal requirement that says that for plan years beginning on or after January 1, 2016, for pediatric services that are required under §156.110(a)(10), pediatric dental and pediatric vision plans must provide coverage for enrollees until at least the end of the month in which enrollees turn 19 years of age.*

Response: In response to this comment, the OIC has added this language.

Section 6: Implementation plan

A. Implementation and enforcement of the rule.

The OIC intends to implement and enforce the rule by utilizing the Rates and Forms Division and Market Conduct Oversight Unit. Using existing resources, OIC staff will continue to work with issuers, providers, and interested parties in complying with the requirements of the Essential Health Benefit rules.

B. **How the agency intends to inform and educate affected persons about the rule**

After the agency files the permanent rule and adopts it with the Office of the Code Reviser:

- Policy staff will distribute copies of the final rule and the Concise Explanatory Statement (CES) to all interested parties through US mail, post to its standard rule making listserv and email to stakeholder participants.

- The Rules Coordinator will post the CR 103 documents on the Office of Insurance Commissioner's website

- OIC staff will address questions as follows:

Type of Inquiry	Division
Consumer assistance	**Consumer Protection Division**
Rule content	**Rates and Forms**
Authority for rules	**Policy and Legislative Affairs**
Enforcement of rule	**Legal Division**
Market Compliance	**Company Supervision**

C. How the agency intends to promote and assist voluntary compliance for this rule

The steps listed under implementation will inform and educate affected persons on the changes and help promote voluntary compliance.

D. How the agency intends to evaluate whether the rule achieves the purpose for which it was adopted

The OIC will work closely with issuers, providers, and other interested parties to evaluate the effectiveness of the rule as well as monitor consumer complaints and health plans for non-compliance.

Appendix A

CR-102 Hearing Summary

Summarizing Memorandum

To: **Mike Kreidler**
Insurance Commissioner

From: **Bianca Stoner**
Presiding Official, Hearing on Essential Health Benefit rule

Matter No. R 2015-02

Topic of Rule-making: Essential Health Benefits designation and supplementation for 2017

This memorandum summarizes the hearing on the above-named rule making, held on September 9th, 2015 at Training Room 120 in Tumwater, over which I presided in your place.

The hearing began at 1:00 p.m. Because testimony did not differ from the written comments that the OIC received, the applicable Commissioner's response for the written comment on the subject applies to the comments received at the hearing. The following stakeholders submitted testimony:

In attendance and testifying:

- Waltraut Lehmann on behalf of Premera Blue Cross and LifeWise Health Plan of Washington
- David Ward on behalf of the Coalition for Inclusive Healthcare

Contents of hearing presentations:

Premera Blue Cross and LifeWise Health Plan of Washington:

- In regard to WAC 284-43-8781(5)(c) in the CR-102 draft, the company feels that the language goes beyond federal requirements for parity and suggests the creation of a new parity subcategory of home health services
- In regard to WAC 284-43-8781(7)(g), the company requests clarification of inpatient versus outpatient limits

Coalition for Inclusive Healthcare:

- Concerned that the existing rules don't make it clear that state and federal anti-discrimination laws prohibit health insurance plans from excluding medically necessary care for transgender individuals
- Asks the OIC to also revise the existing rules (that apply to the 2016 plan year) instead of just revising the rules that apply starting with the 2017 plan year

The hearing was adjourned.

SIGNED this 9th day of September, 2015

Bianca Stoner, Presiding Official