NAME	ENTITY	COMMENT
Judith L. Page, PhD, CCC-SLP 2015 ASHA President	**American Speech-Language Hearing Association**	In regard to rehabilitative and habilitative Essential Health Benefit (EHB), says that United States Department of Health and Human Services (HHS) has recently adopted a new definition of habilitative: Habilitation services and devices—Cover health care services and devices that help a person keep, learn, or improve skills and functioning for daily living (habilitative services). Examples include therapy for a child who is not walking or talking at the expected age. These services may include physical and occupational therapy, speech-language pathology and other services for people with disabilities in a variety of inpatient and/or outpatient settings. She asks the Office of the Insurance Commissioner (OIC) to adopt the new HHS definition of habilitative. Asks OIC to offer separate visit limits for each type of therapy, such as speech, physical, and occupational therapies. Asks the OIC to not allow medical necessity requirements, visit limitations or other exclusions to prevent access to rehabilitation and habilitation, or to stop these services too soon. Asks the OIC to require coverage for "augmentation and alternative communication" devices such as speech-generating devisions, and to require coverage for both cochlear and non-cochlear hearing aids. Says that WA can get around this being a "mandate" (i.e., requiring the Legislature to defray the cost) because: "HHS explained in the final rule that state benefit mandates enacted to define habilitative services are part of the essential health benefit—states do not defray the cost. (See page 226 of the NBPP: https://s3.amazonaws.com/public-inspection.federalregister.gov/2015-03751.pdf). This clarification allows states to address coverage gaps in their state. State mandates would not only enhance benefits, but would also improve access to habilitation services— Qualified Health Plans (QHP) would need to cover these enhanced services according to the revised benchmark plan."
Mark Del Beccaro, MD, Senior Vice President and Chief Medical Officer	**Seattle Children's**	Asks the OIC to revise the rule to either create a separate section containing EHBs that apply to children or add language to 284-43-878 that states that EHBs also have to be available to children.
Beth Berendt	**Principal Consultant, Berendt and Associates, LLC**	Asks OIC to clarify the preventive care requirements regarding prenatal care, says she'll send additional background information regarding this issue.

NAME	ENTITY	COMMENT
Waltraut Lehmann	**Premera**	Not in favor of the draft incorporating a lot of the federal guidance (from the HHS FAQs). Says that HHS issues this guidance in a piecemeal manner, including this in the rule pins things down in the rule, will have to constantly update the rule as HHS changes existing guidance or issues new guidance. Asks OIC to remove the sections that refer to the federal guidance, or to just refer to that federal guidance in those specific sections instead of including the rephrased guidance in the rule.
Daneen Grooms	**American Speech-Language Hearing Association**	Asks OIC to add non-cochlear hearing aids as required coverage. Specifically, says that the OIC could classify this as a "device" under the rehabilitative benefit. Said she'll send additional background info.
Beth Berendt	**Principal Consultant, Berendt and Associates, LLC**	Says that the reference to hearing aids in the rule is confusing, asks OIC to clarify so that it's easier to understand. In section (9)(a)(iv)(A) [page 36], Beth asks the OIC to clarify the language to make it more clear that this covers any child who's on an applicable health plan, not just a child who's on the policy as a dependent. (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 Affordable Care Act (ACA) definition). In section (6)(e)(iv) [page 26] regarding medication synchronization, says this issue doesn't seem relevant enough to be included as part of the EHBs. Asks OIC to remove it.
Meg Jones	**UnitedHealthcare**	Cautions OIC to avoid putting in any unnecessary provisions regarding prior authorization and payment processes. HHS recently issued a new definition of habilitative services. Asks OIC to replace definition that's currently in the draft with the new definition. With how the OIC wrote the draft, the old rule would no longer be effective as of the date that the new rule goes into effect (September 2015), which could be problematic. Suggests solutions for how the OIC could have the old rule remain in effect until 12/31/16 and then have new rule go into effect 1/1/17.

NAME	ENTITY	COMMENT
Ellen Silverman	**DOH**	Deductibles and Out-of-Pocket limits: Suggest that the potential for $8,600 per year for families of children with special health care needs be re-considered and the amounts reduced. And since this does not account for premiums, this will likely place an undue burden on families. Additionally, the co-pay of $200 on emergency room visits seems high if the emergency is a legitimate emergency. Urgent Care: This 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. Specialty Drugs: Access to specialty formulas and supplements for children with inborn errors of metabolism. Insure that children have coverage for insulin pens; for some children, coverage for insulin pumps. Insure that children can obtain at no additional cost, additional epinephrine auto injectors for use in school and other settings. Durable Medical Equipment: Access to appropriate glucose monitoring equipment and supplies. The information on-line does not address non-durable equipment such as orthotics and prosthetics. This information needs to be more transparent. Rehabilitation & Habilitative services: The benefits as outlined are insufficient for children with special health care needs. Are there requirements for the plan to allow for requesting additional visits? One example to consider are children with spasticity who are receiving botulinum toxin injections require additional therapies for bracing, strength building, etc. the limits as described are insufficient to meet the medical needs of these children. We are extremely concerned about the limits on age 6 for neurodevelopmental services; these need to extend through age 20 to be comparable with Early and Periodic Screening, Diagnostic, and Treatment (EPSDT). Additionally, schools and early intervention cannot be relied on for provision of these medically necessary services. Hospice: It is not clear if the plan covers “Concurrent Care” for children in hospice.

NAME	ENTITY	COMMENT
Ellen Silverman (continued)	**DOH (continued)**	Tobacco Cessation: It is not clear if children (teens) are eligible for tobacco cessation counseling or medications. Hearing services: Recommend that comprehensive hearing services be covered. Hearing exams should be considered a preventive benefit and part of a comprehensive well child visit. If a child needs a hearing aid, these should be covered as well. It is not clear from the information online, if cochlear or Bone-anchored hearing aid (BAHA) implants and supplies are covered. Preventive Benefits: 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.
Bat-Sheva Stein	**DOH**	• 2015 Issue- Many insurance plans in 2015 did not include lactation support or breast feeding supplies in their certificate of coverage for 2015. Possible solution- will outline lactation support and breastfeeding supplies in their certificate of coverage for 2016. • 2015 issue- The majority of plans do not list lactation consultants in their provider types. Those that do list the term "lactation support" have OBGYN and other maternity care providers listed, but when women call them they deny having the ability to help women with lactation support. Some women are getting reimbursed back from insurance companies at an out of network rate when they have an International Board Certified Lactation Consultant (IBCLC) come to their home to help them with lactation issues. Examples of insurance responses: 1. Bridgespan Health- lists OBGYN, MD, ARNP- I called the first 6 and they do not provide lactation services or support. 2. Community health plan of WA- does not list any lactation providers. When called, said they did not offer lactation support. 3. Lifewise- lists 4 lactation clinics in 3 counties in Washington. When called, said they only offer lactation services with those 4 in network providers. 4. Regence Blue shield- lists every OBGYN, MD, or ARNP on their roster under lactation support. Called 10 of them listed in Thurston County and not one of them could offer assistance with lactation.

NAME	ENTITY	COMMENT
Bat-Sheva Stein (continued)	**DOH (continued)**	5. Moda Health- don't have lactation or breastfeeding providers listed. When called and emailed customer service they said they would look into it. When called a week later- still have not found a solution to the problem. 6. Time insurance company- no lactation or breastfeeding options under provider search. When called, stated that I needed to get lactation services from the birthing hospital. Possible solution- Have insurance companies define lactation consultants and recruit them into their network. The highest level of lactation consultants are the IBCLC. An IBCLC is a health care professional who specializes in the clinical management of breastfeeding. An IBCLC is certified by the International Board of Lactation Consultant Examiners, Inc. under the direction of the US National Commission for Certifying Agencies. An IBCLC works in a wide variety of health care settings, including hospitals, pediatric offices, public health clinics, and private practice. The only state that has passed legislation to license lactation consultants is Rhode Island in 2014. They require lactation consultants to be board certified as an IBCLC and meet the following requirements: (a) Be at least eighteen (18) years of age; (b) Successfully complete an academic and practical program in lactation that is accredited by the International Board of Lactation Consultant Examiners; (c) Pass the examination for board certification as an International Board Certified Lactation Consultant offered by the International Board of Lactation Consultant Examiners, or any successor organization; and (d) Currently be board certified as an International Board Certified Lactation Consultant For more information about their Rhode Island qualifications for licensure: http://sos.ri.gov/documents/archives/regdocs/released/pdf/DOH/8067.pdf
Cynthia Harris	**DOH**	Essential Community Providers (ECP): It is my understanding that they are going to drop the option for Qualified Health Plans (QHPs) to contract with only 30% of ECPs 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? Take Chelan and Douglas Counties. There is not a clinic in Douglas County but often people from Douglas County go to Wenatchee in Chelan County for services.

NAME	ENTITY	COMMENT
Maria Nardella	**DOH**	In selecting a benchmark plan, suggest looking at WA Medicaid Fee-for-Service (FFS) benefits as a model; FFS includes a comprehensive array of services with plans to increase Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) visits and developmental screenings to comport with Bright Futures recommendations, Medicaid FFS includes: o Applied Behavior Analysis coverage; o Neurodevelopmental therapies beyond age six o Unlimited Occupational Therapy, Physical Therapy, and Speech Therapy coverage, o Registered Dietitian services o Access to eye glasses and hearing aids for clients 20 years of age and younger, o Additional Medicaid waiver programs delivered through the Department of Social and Health Services which include a variety of supports for both the pediatric and adult populations such as Medicaid personal care, respite services, behavioral support. Selected plans must have clear and transparent processes for prior authorization and a reasonable time to make and communicate decisions. There needs to be an expedited exception request for exigent circumstances where an enrollee is suffering from a health condition that may seriously jeopardize his/her life, health, or ability to regain maximum function or when an enrollee is undergoing a current course of treatment using a non-formulary drug or other special treatments. Therapy and habilitation benefits are easy to access with minimal or no Prior Authorization for children with special health care needs beyond age six. Prior Authorization requirement for clients with chronic conditions that are well documented and likely to last a lifetime need to be minimal and not place undue burden on providers or result in interruption in treatment, nor need to be repeated frequently when the condition is lifelong. Benefits are easily identifiable through a website or call center with minimal call wait times. Benefits are transparent and published across the different health insurance plans (this may be out of scope but we wanted to capture the importance of this consumer choice feature). Selected plans have access to interpreters at their call centers and that their written materials are in different languages that reflect the plan's membership.

NAME	ENTITY	COMMENT
Maria Nardella (continued)	**DOH (continued)**	Identify opportunities and mandate that plans have a consumer advisory committee. Limitations on cost-sharing and deductibles. Access to in-state care coordination. Easily understood explanation of benefits (EOB). More flexible open enrollment options for: a. children transitioning off of parents insurance b. pregnancy c. transitioning from a family planning only program Recommend that plans be NCQA certified and that, where appropriate, plans incorporate the Standards for Systems of Care for Children and Youth with Special Health Care Needs available online at: http://lpfch-cshcn.org/publications/research-reports/developing-structure-and-process-standards-for-systems-of-care-serving-children-and-youth-with-special-health-care-needs/ The selected plan needs to provide access to a broader range of pediatric services that includes the full range of services that children need for healthy development. The guidance for coverage is outlined in the American Academy of Pediatrics' Scope of Health Care Benefits for Children. Plan needs to comport with all of the Bright Futures Recommendations. Children require comprehensive benefits to meet their needs. Under many 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/caregivers pay out-of-pocket or accessing limited foundational support dollars at WA's neurodevelopmental therapy centers. This places a burden on the consumer as well as strains the systems that rely on fund raising to fill the gap for clients who are uninsured or underinsured. In addition, many plans limit comprehensive therapies to age six, which ultimately, results in insufficient treatment leading to lower quality of life and higher costs in the long run. Network adequacy. Plans need to ensure that they work with providers to ensure that they are taking on new clients. Care Coordination: Work with inpatient facilities, most notably facilities with NICUs on care coordination and discharge planning; this is critical for ensuring that clients have a provider before being discharged from the NICU facility.

NAME	ENTITY	COMMENT
Maria Nardella (continued)	**DOH (continued)**	Plans need to identify unique programs like Asthma Home Visiting, Nurse Family Partnership, Parents as Teachers, etc. and provide these services where possible. Consider contracting with alternative providers such as school-based health centers or local health department services (immunizations, First Steps). More flexible open enrollment options for: a. children transitioning off of parents insurance, b. pregnancy c. transitioning from a family planning only program
Joelle Pyatt, Tobacco Cessation Consultant	**DOH**	Tobacco Cessation falls under the Essential Health Benefit (EHB) - Prevention and Wellness Services. A health plan is consider in compliance with the federal Department of Labor (DOL) guidelines (#5) when a plan covers the following: tobacco use counseling and interventions without cost-sharing: 1. Screening for tobacco use; 2. For those who use tobacco products, at least two tobacco cessation attempts per year. For this purpose, covering a cessation attempt includes coverage for: Four tobacco cessation counseling sessions of at least 10 minutes each (including telephone counseling, group counseling and individual counseling) without prior authorization; and 3. All Food and Drug Administration (FDA)-approved tobacco cessation medications (including both prescription and over-the-counter medications) for a 90-day treatment regimen when prescribed by a health care provider without prior authorization. The Benchmark EHB plan needs to be upgraded to meet DOL federal guidelines for tobacco cessation. The current Regence Gold + Benchmark Plan has many gaps and most insurance companies in WA are out of federal compliance. The bench mark plan should list all provider types able to provide smoking cessation counseling such as, but not limited to: Physicians, Physician's Assistant, Advanced Registered Nurse Practitioner, Behavioral Health Counselor, Psychologist, Dentist, Dental Hygienist, train smoking cessation counselors, and telephone based services.

NAME	ENTITY	COMMENT
Joelle Pyatt, Tobacco Cessation Consultant (continued)	**DOH (continued)**	This work is called out in Results Washington 1.2.Ae: Decrease % of adults that smoke from 17% to 15% by 2017. The WA state tobacco quitline is funded for 3000 calls for the underinsured with no free gum or patch to callers. Private Insurance is supposed to help people in WA, but we are finding many gaps in the current system. Educating insurers on EHB for smoking cessation as listed in the U.S. Preventive Services Task Force guidelines, called out under the Affordable Care Act remain a priority for the Tobacco Prevention and Control Program.
Elizabeth Crutsinger-Perry	**DOH**	Can the quarterly screenings for high risk individuals prescribed Truvada for Pre Exposure Prophylaxis (PrEP) be included in the EHP Preventive services? • PrEP is a single-dose daily pill of Human Immunodeficiency Virus (HIV) medication for HIV-negative persons. When used before possible exposure, PrEP helps at-risk persons avoid infection. Truvada is currently the only drug approved by the FDA for PrEP and this has been the case since 2012. • CDC Clinical Practice Guidelines released in 2014 recommend • Documented HIV negative test result prior to PrEP prescription; • Normal renal function • Documented hepatitis B virus infection and vaccination status Once prescribed PrEP: • Follow up visits at least every 3 months; • HIV test • Medication Adherence counseling • Behavioral risk reduction support • STI tests (6 months) • Renal function assessment • These quarterly screenings are very costly and represent barriers to individuals being able to afford to maintain adherence to this revolutionary prevention for HIV infection. • If the screenings were included as preventive services and no cost to the patient, the barrier would be removed and the likelihood that HIV transmission will occur is almost eliminated. • Estimate of lifetime HIV treatment costs is $367,134. Estimated medical savings from infections averted by US prevention programs is $129.9 billion with 361,878 HIV infections averted.

NAME	ENTITY	COMMENT
Elizabeth Crutsinger-Perry (Continued)	**DOH (Continued)**	• DOH does not know how many individuals are currently prescribed PrEP in Washington State. However, we expect the numbers to remain low in comparison to other disease issues so making this addition to preventive services to avert HIV infection will remain focused on a small patient population at high risk of HIV. • These quarterly screenings are very costly and represent barriers to individuals being able to afford to maintain adherence to this revolutionary prevention for HIV infection. • If the screenings were included as preventive services and no cost to the patient, the barrier would be removed and the likelihood that HIV transmission will occur is almost eliminated. • Estimate of lifetime HIV treatment costs is $367,134. Estimated medical savings from infections averted by US prevention programs is $129.9 billion with 361,878 HIV infections averted. • DOH does not know how many individuals are currently prescribed PrEP in Washington State. However, we expect the numbers to remain low in comparison to other disease issues so making this addition to preventive services to avert HIV infection will remain focused on a small patient population at high risk of HIV. Can multi-site testing for gonorrhea (GC) be included in screenings for gay and bisexual men? Currently GC is under diagnosed in this population and statewide because providers conduct only a urethral test. Esophageal and anal screening would produce a more accurate result and avoid missed infections that present later with more advanced disease. Individuals at high risk for these infections are also considered high risk for HIV and syphilis and should be referred to PrEP to reduce likelihood of HIV infection.
Bat-Sheva Stein	**DOH**	• Certificate of coverage should have breast pumps and lactation consultation listed (those fall under preventive services). • Insurance companies should define lactation consultants and allow them into their provider roster for “in network” care. • Ideally, insurance companies will follow national breast pump specifications so there are minimum specifications for breast pumps.

NAME	ENTITY	COMMENT
Waltraut Lehmann	**Premera**	As mentioned at the meeting, we would particularly caution against the inclusion of an abundance of detail from federal guidance, and especially sub-regulatory guidance, on elements of EHB's. The Companies are finding that federal guidance is constantly evolving and changing, with minute details added and explained, in some cases prospectively, in other cases as a retroactive clarification. We have seen such guidance issued on a weekly basis. Updating Washington regulations accordingly with such frequency is not practical, and in fact is impossible; nor do we believe it would be useful. To the extent that issuers must comply with federal EHB guidance, the incorporation would largely be redundant. Frequent revisions to state rules to duplicate what is already in effect -- when further federal guidance is issued, and existing guidance is modified or elaborated upon -- is unnecessary and will inevitably create conflicts and confusion. We therefore urge caution in any effort to incorporate too much federal detail into the amendments to the EHB rules. Gender reassignment services: We suggest greater clarity for the provision in draft section 284-43-878(3)(c)(ii), as follows [this is the suggested language]: The base-benchmark plan excludes coverage for sexual reassignment treatment, surgery, or counseling services. Health plans must cover such services required by and in a manner consistent with 42 U.S.C. 18116 section 1557, RCW 48.30.300 and 49.60.040. Mental health parity: Your 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. Preventive services: As stated above, we are particularly concerned about, and do not support, the incorporation of unnecessary federal guidance details into these rules. The area of preventive services is the one where federal guidance has been changing frequently, with weekly updates issued, where state rules cannot possibly keep up. As a result, a particular problem will ensue if state regulations exceed what is, in fact, considered preventive in nature and not subject to cost-shares. We do not believe that issuers should, or would want to, be precluded from defining benefits more generously than is required under applicable law.

NAME	ENTITY	COMMENT
Waltraut Lehmann (continued)	**Premera (continued)**	However, we urge the Office of the Insurance Commissioner (OIC) not to create a conflict in requirements will jeopardize the status of qualified high-deductible health plans, or invalidate the status of such plans retroactively (a situation for which there would be no remedy). We believe, as explained above, the solution is great restraint in inserting federal guidance details into these rules. Synchronization: We question the appropriateness of incorporating medication synchronization details into draft section 284-43-878(6Xe)(iv); as discussed at the meeting, this provision addresses a very specific claims processing element for prescription drugs and does not belong within the EHB rule. We suggest that the language be deleted from this rule draft. The requirement for synchronization being imposed under new legislation, we believe that rule language is unnecessary; if the OIC believes otherwise, then such a provision could be considered for inclusion elsewhere in this Subchapter.
Zach Snyder	**Cambia/Regence**	With regard to preventive care, the Affordable Care Act (ACA) requires carriers to cover preventive services rated 'A' or 'B' by the United States Preventive Services Task Force (USPSTF). In addition to the USPSTF recommendations, various federal agencies promulgate rules and issue sub-regulatory guidance that requires carriers to cover other services or interprets existing federal law. Here, the exposure draft appears to incorporate current federal rules or sub-regulatory guidance into our state insurance code. For an example of this apparent incorporation in the draft, please see the contraceptive care section. If OIC takes this approach, our insurance code may become out of sync with federal rules when federal rules change. To prevent that situation the draft should simply point to federal rules where applicable.
Lisa Humes-Schulz	**Planned Parenthood**	We are pleased with the additional detail and specificity around contraceptive coverage outlined in WAC 284-43-878, Essential health benefit categories. Specifically, 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 impost cost-sharing for contraceptives as part of women's preventive health care coverage. The exposure draft generally reflects the most recent CMS guidance on implementation of the contraceptive coverage mandate. We urge the Insurance Commissioner to strengthen the promise of the ACA's contraceptive coverage through this rule by incorporating the following changes: 1. Although this rule brings much-needed clarity and specificity to requirements for contraceptive coverage, Section 6(a)(iii) is still missing several components of comprehensive contraceptive care. In addition to an office or insertion visit, 2013 CMS guidelines clearly state that the removal of FDA-approved contraceptive devices without cost-sharing is part of the contraceptive coverage requirement.

NAME	ENTITY	COMMENT
Lisa Humes-Schulz (continued)	**Planned Parenthood (continued)**	2. Follow-up services related to side effect management or counseling for continued adherence as detailed in HRSA current guidelines must also be included in coverage. This section should ensure that device removal and medically necessary follow-up visits are guaranteed with no cost-sharing. The 2015 CMS guidance clearly specifies that contraceptive coverage without cost-sharing must include clinical services needed for the provision of an individual's chosen method. As currently written, the rule could be misconstrued to mean patient education and counseling are the only services necessary to provide contraceptives. We suggest the following edits to Section 6(a)(iii)(A) for clarity and accuracy: This includes the full range of food and drug administration approved contraceptive methods, including but not limited to barrier methods, hormonal methods, and implanted devices, as well as clinical services, including patient education and counseling, necessary for the provision of the contraceptive method as prescribed by a health care provider; 3. We suggest the following minor edits to Section 6(a)(iii)(C) to reflect the most recent guidance: Within each category of contraceptive method, plans may use reasonable medical management techniques. A plan generally may impose cost-sharing on some items and services to encourage use of other specific items and services within the chosen contraceptive method; 4. The OIC should further clarify insurance plans' obligation to develop a waiver process to ensure that a woman has access to the contraceptive method that her provider determines is medically necessary, even when a plan utilizes medical management techniques. We suggest the following edits to Section 6(a)(iii)(D) to strengthen plans' requirements and more accurately reflect the most recent federal guidance: If a plan uses reasonable medical management techniques within a specified contraceptive method of contraception, the plan must accommodate any individual for whom a particular drug (generic or brand name) would be medically inappropriate, as determined by the individual's health care provider. Plans must have a waiver process that is easily-accessible, transparent, and sufficiently expedient that is not unduly burdensome on individuals, providers, or other individuals acting as the patient's authorized representative. If an individual's provider recommends a particular service or FDA-approved item based on the determination of medical necessity with respect to that individual, the plan or issuer must waive the otherwise applicable cost-sharing for the brand or non-preferred brand version and cover that service or item without cost-sharing. The plan must defer to the determination of the provider.
Sarah Kwiatkowski	**Northwest Health Law Advocates**	WAC 284-43-877 Plan design. We support Office of the Insurance Commissioner's (OIC's) approach to retain in rule the prohibition on plans substituting benefits for the benefits identified in the base benchmark plan (BBP) until after plan year 2017. We appreciate that OIC has maintained the requirement in this rule with respect to substitution of benefits. It is critical that as we continue to monitor the implementation of the Affordable Care Act,

NAME	ENTITY	COMMENT
Sarah Kwiatkowski (continued)	**Northwest Health Law Advocates (continued)**	specifically the Essential Health Benefit (EHB) requirements therein, that every effort to ensure transparency and ease of comparison between plans is promoted by the rules. Consumers need predictability and a standardized set of benefits helps to achieve that goal. Moreover, this provision lessens the risk of plan designs that discriminate or contribute to adverse selection, ensuring a level playing field in the newly reshaped insurance market. We 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. WAC 284-43-878 Essential health benefit categories (1): Ambulatory Services. Subsection (a)(vii): Section 1001 of the Patient Protection and Affordable Care Act (ACA), which amends Section 2713 of the Public Health Services Act,2 requires all non-grandfathered group health plans and health insurance issuers offering group or individual coverage to provide coverage of and not impose cost sharing for certain preventive services for women. The list of women's preventive services which must be covered in plan years starting after Aug. 1, 2012, includes "all Food and Drug Administration approved contraceptive methods, sterilization procedures, and patient education and counseling for all women with reproductive capacity." (http://www.hrsa.gov/womensguidelines/) These methods are listed in the Food and Drug Administration's "Birth Control Guide." (http://www.fda.gov/downloads/ForConsumers/ByAudience/ForWomen/FreePublications/UCM356451.pdf) On Feb. 20, 2013, the Departments of Labor and Health and Human Services and the Treasury released a set of "Frequently Asked Questions" which affirmed that the ACA's women's preventive services requirement requires plans to provide coverage of IUDs. (http://www.dol.gov/ebsa/faqs/faq-aca12.html, see Questions 14 and 17) CMS recently clarified that all FDA approved devices must be covered as different methods. (http://www.cms.gov/CCIIO/Resources/Fact-Sheets-and-FAQs/Downloads/aca_implementation_faqs26.pdf) Counseling, education, insertion, and extraction with respect to FDA-approved contraceptive devices are also covered without cost-sharing under these rules. It is critical that access to the full preventive services under this benefit be available to women without barriers and without cost-sharing. This section should clearly state 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. Clarification within this rule about the purpose of classification would advance this objective.

NAME	ENTITY	COMMENT
Sarah Kwiatkowski (continued)	**Northwest Health Law Advocates (continued)**	Subsection (b)(vii): It is unclear why the rules continue to permit issuers to exclude coverage of hearing care and aids. Exclusion of these services and devices constitutes disability discrimination. ACA §1302 states that the EHB shall not be designed "in ways that discriminate against individuals because of their…disability." Under the Americans 2 42 U.S.C. Ch. 6A § 201 with Disabilities Act ("ADA"), the chief federal law governing access for individuals with disabilities, a hearing impairment may constitute a disability if it substantially limits a major life activity.3 Section 1557 of the ACA explicitly applies the ADA—including its definition of disability— to the health care context, encompassing entities created under Title I of the ACA (such as the Health Benefits Exchange) and entities receiving federal funding (such as premium tax credits). As such, it would seem that the ACA's nondiscrimination laws would prohibit 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. We recommend that the rule be amended to make clear that the BPP should permit coverage of hearing care and devices in the ambulatory service category to the extent that such services are medically necessary. (3) Hospitalization (b) (ii): We applaud the OIC for clearly stating throughout these rules that health plans may not discriminate against transgender members by restricting provision of health services under any benefit category to treat gender dysphoria and for making clear that gender reassignment surgery must be covered as a treatment. However, we are concerned that by not listing in this rule treatment for gender dysphoria as an exception to the rule that health plans may – but are not required to – cover breast reconstruction for members as part of treatment for gender dysphoria it will be designated as "cosmetic" by health plans and coverage for this medically necessary service will be denied. Medically necessary treatments for transgender people are distinct from cosmetic treatments sought by non-transgender people to improve appearance. By excluding these treatments for gender dysphoria in the list of exceptions in this rule, OIC posits that they are considered "cosmetic" disregarding the medical purpose of the treatments at issue and inappropriately focusing instead on the results of the treatment in isolation from the underlying diagnosis and overall therapeutic goals of treating gender dysphoria. By its very nature, gender dysphoria arises when a crisis develops between psychological sex and an individual's primary and secondary sex characteristics; treatment of this condition necessitates an evaluation and treatment of those characteristics to address the gender dysphoria. As such, treatments should be considered "reconstructive surgery" when those surgeries are performed to correct or repair abnormal structures of the body caused by congenital defects or disease. Gender dysphoria fits the classification of a disease according to the ICD-11 and DSM-V and the presence of secondary sex characteristics not in alignment with the gender identity of a person with gender dysphoria are the effects of this disease.

NAME	ENTITY	COMMENT
Sarah Kwiatkowski (continued)	**Northwest Health Law Advocates (continued)**	As such, reconstructive surgeries and other procedures, including breast reconstruction, that ameliorate these effects should be covered as treatment for gender dysphoria. To ensure that this treatment is available to transgender enrollees, we recommend that the language in this section be amended as follows: (b) A health benefit plan may, but is not required to, include the following services as part of the EHB-benchmark package. These services are specifically excluded by the base-benchmark plan, and should not be included in establishing actuarial value: *** (ii) Cosmetic or reconstructive services and supplies except in the treatment of a congenital anomaly, to restore a physical bodily function lost as a result of injury or illness, related to breast reconstruction following a medically necessary mastectomy, or for the treatment of Gender Dysphoria; (5) Mental Health and Substance Use Disorder Services, Including behavioral health treatment. We support the OIC's efforts to promote robust coverage in this category, recognizing that the traditional insurance market has offered sparse mental health and substance use disorder services when permitted the opportunity to do so. In particular, we appreciate the addition of subsection (5) (f), which explains the complementary role and continued applicability of both federal and state mental health parity laws. However, we note that subsection (5) (a) does not specifically reference screening/assessment of mental health or substance use disorder conditions as covered services. By way of comparison, WAC 284-43-877(1) describes EHB-benchmark ambulatory services as those recognized or accepted for "diagnostic or therapeutic purposes" (emphasis added). In order to meet parity requirements, we recommend specifically noting that diagnostic services are also covered under the mental health & substance use disorder category. (6) Prescription drug services (a) (iii): This section brings greater clarity and specificity to the requirement that plans must cover all FDA-approved contraceptive methods and sterilization procedures; however it falls short of fully explaining the services that should be available without cost-sharing. o First, the rule continues to lack a guarantee of coverage for the removal of FDA-approved contraceptive devices. Denial of such removal procedures can cost several hundred dollars. Follow-up services related to side effect management or counseling for continued adherence as detailed in current HRSA guidelines must also be included in coverage. This rule should clearly state that the removal of FDA-approved contraceptive devices and medically necessary follow-up visits are available are covered without cost-sharing.

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Sarah Kwiatkowski (Continued)	**Northwest Health Law Advocates (Continued)**	o Second, federal guidance released in May 2015 (http://www.cms.gov/CCIIO/Resources/Fact-Sheets-and-FAQs/Downloads/aca_implementation_faqs26.pdf) clearly states that services under this benefit category include clinical services needed for the provision of an individual's contraceptive method. The draft rule could be misconstrued to mean that patient education and counseling are the only services necessary to provide contraceptives. We suggest the following edits to Section 6(a)(iii)(A) for clarity and accuracy: (A) This includes the full range of food and drug administration approved contraceptive methods, including but not limited to barrier methods, hormonal methods, and implanted devices, as well as clinical services necessary for the provision of the contraceptive method as prescribed by a health care provider. Clinical services include but are not limited to patient education and counseling; (a)(iii)(D): We appreciate OIC's attempt to reduce barriers for women who must have access without cost-sharing to certain contraceptive methods as prescribed by their providers. However, 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 (generic or brand name) would be medically inappropriate as determined by her health care provider. The rule should clearly state that the determination of "medically inappropriate" is made by the woman's provider, not the health plan. Furthermore, the guidance requires health plans to have a mechanism for "waiving" the cost-sharing for a brand or non-preferred version (see http://www.cms.gov/CCIIO/Resources/Fact-Sheets-and-FAQs/Downloads/aca_implementation_faqs26.pdf). 5 This mechanism is described in the May 2015 FAQ as a health plan's "exceptions process" and it must comply with certain requirements described on page 4 of the guidance. To be both consistent with the federal guidance and clear to consumers, we recommend the following edits: (D) If a plan uses reasonable medical management techniques for a specified method of contraception, the plan must also have an exceptions process to accommodate an individual for whom a particular drug, service or item (generic or name brand) would be medically necessary as determined by the individual's health provider. Plans must have an exceptions process that is easily accessible, transparent, and sufficiently expedient. The exceptions process must not be unduly burdensome on individuals, providers, or other individuals acting as the patient's authorized representative. If an individual's provider recommends a particular service or FDA-approved item based on a determination of medical necessity with respect to that individual, the plan or issuer must cover that service or item without cost sharing. For purposes of this exceptions process, medical necessity shall include but not be limited to considerations such as severity of side effects, differences in permanence and reversibility of contraceptives, and ability to adhere to the appropriate use of the item or service.

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Sarah Kwiatkowski (continued)	**Northwest Health Law Advocates (continued)**	(7): Rehabilitative/Habilitative Services: We are concerned that in practice plans are not complying with the language in subsection (d)(ii) of this rule permitting plans to include reference-based limitations on habilitative services "only 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." We reviewed several QHP filings from 2014 (BridgeSpan, SERFF Tracking number RGWA-128954067; Premera Blue Cross, SERFF Tracking number PBCC-128966373; and Community Health Plan of Washington, SERFF Tracking number CHPW-129178321) as well as the BBP filing (Regence Direct Gold +) to determine the visit limitations that the plans applied to habilitative benefits. None of the plan filings we reviewed 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 plans seem to be reading the language out of the rule that requires adjustment of limitations based on a person's unique needs. OIC should either 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. (9) Preventive and wellness services, including chronic disease management (a)(ii)(C): As drafted, this section appears to limit genetic counseling and testing for the breast cancer susceptibility gene (BRCA) to women who have not been diagnosed with BCRA-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. (See FAQs About Affordable Care Act Implementation Part XII," February 20, 2013, available at: http://www.dol.gov/ebsa/faqs/faq-aca12.html). The drafting of this provision seems to be based on recently released HHS guidance on preventive services, including BRCA screening, counseling, and testing. (https://www.cms.gov/CCIIO/Resources/Fact-Sheets-and-FAQs/Downloads/aca_implementation_faqs26.pdf) The 2015 FAQs clarified that BRCA screening, testing, and after testing, counseling, must be available without cost-sharing to individuals who have not been diagnosed with BRCA-related cancer but who previously had breast cancer, ovarian cancer, or other cancer. However, this clarification did not supersede or end the requirement that health plans must also cover BRCA screening, testing and counseling to individuals with a family history of breast, ovarian, tubal, or peritoneal cancer as recommended in by USPSTF and in the HRSA guidelines. To ensure that all individuals who should be entitled to this service without cost-sharing receive it, the section should be edited as follows:

NAME	ENTITY	COMMENT
Sarah Kwiatkowski (continued)	**Northwest Health Law Advocates (continued)**	(C) A plan must cover without cost-sharing recommended preventive screening, genetic counseling and, if indicated after counseling, testing for the breast cancer susceptibility gene ("BRCA testing") for individuals with a family history associated with an increased risk for deleterious mutations in the BRCA1 and BRCA2 genes and for individuals who have not been diagnosed with BRCA-related cancer but who previously had breast cancer, ovarian cancer, or other cancer; (a)(iv)(A): This section requires that services, tests, screening and supplies recommended by HRSA's women's preventive and wellness guidelines be provided to "dependent children" when such children are covered under a given plan. Section 1302 of the Affordable Care Act states that any qualified health plan (QHP) offered on the Exchange at any metal level of coverage must also be offered as a corresponding child-only plan at the same metal level of coverage. We recommend deleting the "dependent" qualifier as it could cause significant gaps in coverage for children enrolled in child-only QHPs. (a)(iv)(B): Recent federal guidance clarifies a health plan's requirements with respect to providing preventive benefits, including breastfeeding support and lactation consultation (http://www.cms.gov/CCIIO/Resources/Fact-Sheets-and-FAQs/Downloads/aca_implementation_faqs26.pdf). Based on this guidance, two issues in the exposure draft should be clarified. First, the federal FAQs clarify that coverage can be for rental or purchase of breastfeeding equipment. Second, the exposure draft states that this coverage is available "during the postpartum period." The term "post-partum period" is not defined. The rules should conform to the language in the federal FAQs, which states that the coverage extends for the "duration of breastfeeding." We recommend the following edits: (B) A plan must provide coverage of breastfeeding services and supplies in conjunction with each birth. These services include comprehensive lactation support and counseling by a trained provider, as well as coverage for the cost of renting or purchasing breastfeeding equipment. The plan must make these services available both during pregnancy and for the duration of breastfeeding; In addition, we support OIC's clear statement in these draft rules that if a plan does not have a network to provide preventive services, the enrollee must be able to access benefits out of network without cost-sharing. 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.

NAME	ENTITY	COMMENT
Sarah Kwiatkowski (continued)	**Northwest Health Law Advocates (continued)**	OIC must consistently address when the BBP does not comply with EHB requirements and state and federal law. Throughout the draft rule, OIC is inconsistent in the form and manner in which it addresses when the BBP does not comply with the EHB requirements and state and federal law. These inconsistencies include differences in its language and order of phrasing which often do not make it clear when Regence Direct Gold+ coverage does not comply with the EHB requirements and do not clearly indicate precisely what is required of a health plan when the selected BBP does not align with the EHB legal requirements. Clear and consistent drafting of these sections is critical to ensure that health plans provide benefits in compliance with the EHB requirements and state and federal law. We recommend identifying and implementing a uniform way of addressing when the BBP deviates from EHB requirements so that health plans and consumers alike can clearly identify which services must be included in an EHB category despite limitations in the selected BBP. There are at least six instances in which coverage provided in the selected BBP, Regence Direct Gold+, that conflict with state and federal law. These instances include: WAC 284-43-878 (3)(c)(i); (3)(c)(ii); (5)(c)(i); (6)(c)(i); (6)(c)(ii); (10)(b)(i). We recommend stating first what health plans must cover and then state how the BBP does not align with EHB requirements and state or federal law. Using WAC 284-43-878 (5)(c)(i) as an example, we propose the following suggested structure: (c) 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 state EHB-benchmark plan requirements for these services with required supplementation are: (i) Health plans must cover mental health services and substance use disorder treatment delivered in a home health setting on parity with medical surgical benefits, consistent with state and federal law. The base-benchmark plan must be supplemented because it 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.
Steven Postal	**HAB Coalition**	Asks the Office of the Insurance Commissioner (OIC) to adopt the definition of habilitative that CMS issued on 2/27/15 and to use this as a floor for what plans must cover. Don't impose habilitative coverage limits that are less favorable than rehabilitative coverage limits. Don't impose combined limits on habilitative and rehabilitative services. "If you impose limits, the federal regulations require separate limits for rehabilitative and habilitative after 1/1/17."

NAME	ENTITY	COMMENT
Steven Postal (continued)	**HAB Coalition (continued)**	For habilitative and rehabilitative, provide coverage for devices including prosthetics, orthotics, hearing aids, etc. For plan years beginning on or after January 1, **2016**, for pediatric services that are required under §156.110(a)(10), provide coverage for enrollees until at least the end of the month in which the enrollee turns 19 years of age. [This refers to the requirement to cover pediatric services, including oral and vision]. Don't discriminate based on an individual's age, expected length of life, present or predicted disability, degree of medical dependency, quality of life, or other health conditions. These nondiscrimination protections are included in the ACA statute atSection 1302 and form the basis for plan benefit design that is equitable and meets the needs of diverse populations. We would also like to mention that HHS clarified in the most recent regulation that state benefit mandates enacted to define habilitative services are part of the essential health benefit—states do not defray the cost. This clarification allows states to address coverage gaps in their state. State mandates would not only enhance benefits, but would also improve access to habilitation services — Qualified Health Plans would need to cover these enhanced services according to the revised benchmark plan.
Bat-Steva Stein	**Department of Health (DOH)**	We noticed this morning that NO Intrauterine Devices or the option for them is included in the model plan (names of those: Mirena, Paraguard, Liletta, or Skyla). Also, there is no mention of the ability to get an implant (name: Nextplannon). We feel that this is a very important issue to address and hope that it can be addressed before the plan is approved. (In a later e-mail, though, she says she found this benefit listed in the Regence plan).
Joella Pyatt	**DOH**	The following is a link to the HHS/Department of Labor guidance for the USPSTF on Tobacco Cessation Interventions: http://www.dol.gov/ebsa/faqs/faq-aca19.html see #5. Q5: The USPSTF recommends that clinicians ask all adults about tobacco use and provide tobacco cessation interventions for those who use tobacco products. What are plans and issuers expected to provide as preventive coverage for tobacco cessation interventions? 1. As stated earlier, plans may use reasonable medical management techniques to determine the frequency, method, treatment, or setting for a recommended preventive service, to the extent not specified in the recommendation or guideline regarding that preventive service. Evidence-based clinical practice guidelines can provide useful guidance for plans and issuers.(13) The Departments will consider a group health plan or health insurance issuer to be in compliance with the requirement to cover tobacco use counseling and interventions, if, for example, the plan or issuer covers without cost-sharing:

NAME	ENTITY	COMMENT
Joella Pyatt	**DOH**	Screening for tobacco use; and, 2. For those who use tobacco products, at least two tobacco cessation attempts per year. For this purpose, covering a cessation attempt includes coverage for: o Four tobacco cessation counseling sessions of at least 10 minutes each (including telephone counseling, group counseling and individual counseling*) without prior authorization; and o All Food and Drug Administration (FDA)-approved tobacco cessation medications (including both prescription and over-the-counter medications) for a 90-day treatment regimen when prescribed by a health care provider without prior authorization. This guidance is based on the Public Health Service-sponsored Clinical Practice Guideline, Treating Tobacco Use and Dependence: 2008 Update, available at: http://www.ahrq.gov/professionals/clinicians-providers/guidelines-recommendations/tobacco/index.html#Clinic. *It has been interpreted as all three types of counselling are needed. It is important all plans have a quitline or wellness plan. Physicians are used to referring patients for this service. Rural residents cannot take four days off work to drive several hours for in office counseling with their provider. Many offices are not trained to do this type of counseling nor have the time in their primary practice schedule. The Regence benchmark plan should include telephone counseling, group counseling and individual counseling as a covered benefit. The Chemical Dependency Centers and Mental Health facilities are all going smoke free. Patients undergoing chemical dependency and mental health services need cessations services to be covered by the skilled counselors that treat them. If needed we can send evidence that smoking cessation works for dual treatment. Under general exclusions: (page 26): Remove the instructional programs including those to learn how to stop smoking. This is called group counseling and is a best practice. (page 24) States “We do not cover counselling in the absence of illness”? I would hope smoking cessation is exempt from this exemption. We want to prevent patients from the illness by helping them to quit.
Laurie Lippold	**American Academy of Pediatrics**	We noticed this morning that NO Intrauterine Devices or the option for them is included in the model plan (names of those: Mirena, Paraguard, Liletta, or Skyla). Also, there is no mention of the ability to get an implant (name: Nextplannon). We feel that this is a very important issue to address and hope that it can be addressed before the plan is approved. (In a later e-mail, though, she says she found this benefit listed in the Regence plan).