To : Chair Virginia Lyons and Members of the Senate Health & Welfare Committee

From: Jessa Barnard, Vermont Medical Society, jbarnard@vtmd.org

Date: February 20, 2023

RE: S. 37 Follow-up Comments and Mark-up Suggestions

VMS is responding to the questions we heard the Committee raise last Friday when discussing S. 37 regarding clinical guidelines for transgender care and insurance coverage. We have received input on these responses from Dr. Erica Gibson. We are also including feedback on Section 2 regarding malpractice coverage. Please let us know if we can assist further in the mark-up process.

What are the generally accepted clinical guidelines on transgender care?

Medical and mental health care providers follow a variety of established guidelines from a variety of different professional organizations and also routinely review emerging evidence-based research to guide care for any diagnosis; specific resources and types of research will vary, based on the provider's specialty and area of practice, the age of the patient, and other factors. The Endocrine Society is considered the international lead on medical guidelines for care for transgender care, and can be found at: https://www.endocrine.org/clinical-practice-guidelines/gender-dysphoria-gender-incongruence. WPATH, referenced in the bill, provides a more global overview of the general approach to care; it addresses more psychosocial and mental health aspects to care; it works in sync with the Endocrine Society guidelines (https://www.wpath.org/publications/soc). For the pediatric population, American Academy of Pediatric Guidelines refer to Endocrine Society and WPATH (and others), specific to children and adolescents: https://publications.aap.org/pediatrics/article/142/4/e20182162/37381/Ensuring-Comprehensive-Care-and-Support-for?autologincheck=redirected

Mental health professionals may follow other guidelines, such as those from the American Psychological Association: https://www.apa.org/practice/guidelines/transgender.pdf

These guidelines address *clinical practice* and therefore we do not support their inclusion in a section regarding *insurance coverage*. **VMS recommends that Section (3)(b)(1)(C) should be removed**. Standards of care are not referenced in other statutes creating insurance coverage mandates and we do not believe that DFR has expertise in identifying clinical guidelines.

What is "medically necessary and clinically appropriate" care as referenced in Section 3 of S. 37?

This term is used in the context of insurance coverage to determine which subset of all possible clinical services may be covered by a given payer or insurance plan. It is VMS' understanding that insurers may include factors such as specific diagnoses codes, following specific clinical guidelines or prior authorizations to determine which services they deem to be "medically necessary and clinically appropriate." **Because of this, VMS recommends that sections (3)(b)(1)(C) (referencing standards of care) and (3)(b)(2)(A) (referencing prior authorization) should be removed from this section.**

How could the bill clarify what underwriting methods may be used for malpractice coverage?

VMS has reviewed the testimony of the American Property Casualty Insurance Association and understands that they want to clarify that underwriting factors other than those listed in proposed sections § 4724 (F)(i)(I) through (IV) can be used to set malpractice premiums. VMS has concern with how (ii) is currently drafted to explain what factors can be considered for underwriting.

As currently drafted, (ii) would allow underwriting:

- "based on the health care provider's claims loss experience" – however this is not qualified and so could include claims loss experience directly related to protections in (III) (judgments) – exactly the scenario that the section is intended to protect against
- "based on underwriting or rate-setting criteria related to practices that do not meet the applicable professional standards of care" - stakeholders worked with the House Judiciary committee to remove references to "standards of care" in the bill's definitions as this term is not defined in Vermont law and means different things in different contexts such as malpractice and professional discipline – VMS does not believe it is appropriate to use the term in this context.

VMS instead suggests that this section could simply explain something to the effect of: *"(ii) For purposes of this subdivision (F), it shall not be unfairly discriminatory nor an arbitrary underwriting action against a health care provider if the risk classifications, premium charges, or other underwriting considerations <u>are based on factors other than those listed in (F)(i)(I)-(IV)."</u>*

After hearing further Committee discussion, VMS also suggests that Section ((F)(i)(I) should be expanded to: "abusive litigation against a provider concerning legally protected health care activity resulted in <u>a claim, settlement, or</u> a judgement against the provider…" Not all abusive litigation may end in a final judgement, but the filing of a claim or settlement of a claim is often used by malpractice carriers for the purposes of underwriting or rate-setting.

Thank you for considering our feedback in the mark-up process and please reach out to me at jbarnard@vtmd.org with any questions.