OFFICE of the INSURANCE COMMISSIONER
WASHINGTON STATE

Mandated health benefits report

2024 plan year

Dec. 15, 2023

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Summary

Washington state will not need to defray costs incurred by state health insurance benefit requirements for the 2024 health plan year.

Background and methodology

Under the Affordable Care Act (ACA), when a state legislature passes a benefit mandate that exceeds a state's selected set of Essential Health Benefits (EHB) and it's not adopting it to comply with federal requirements,[1] the state must defray the cost of Qualified Health Plans (QHPs) covering the benefit, per 42 USC §18116, §1311(d)(3)(B); and 45 CFR 155.170. This provision is known as the "cost defrayal" provision. Each state must identify any state benefit requirements adopted under the ACA that exceed the EHB package in the state.

To comply with the federal requirements (42 USC §18116, §1311(d)(3)(B) and 45 CFR 155.170), Washington state's Legislature assigned the responsibility for annually identifying state-mandated health benefits to the insurance commissioner (RCW 48.43.715).

The specific charge for this report is as follows:

> RCW 48.43.715(4): Beginning December 15, 2012, and every year thereafter, the commissioner shall submit to the legislature a list of state-mandated health benefits, the enforcement of which will result in federally imposed costs to the state related to the plans sold through the exchange because the benefits are not included in the essential health benefits designated under federal law. The list must include the anticipated costs to the state of each state-mandated health benefit on the list and any statutory changes needed if funds are not appropriated to pay the state costs for the listed mandate. The commissioner may enforce a mandate on the list for the entire market only if funds are appropriated in an omnibus appropriations act specifically to pay the state portion of the identified costs.

RCW 48.47.010(7) defines a mandated health benefit as "coverage or offering required by law to be provided by a health carrier to: (a) cover a specific health care service or services; (b) cover treatment of a specific condition or conditions; or (c) contract, pay or reimburse specific categories of health care providers for specific services;..." This definition is broader than the federal concept of "additional required benefits" for purposes of the federal government's analysis of state benefit requirements. The

[1] Examples of federal requirements that the essential health benefits must be modified to comply with include: requirements to provide benefits and services in each of the 10 categories of EHB; requirements to cover preventive services; requirements to comply with the Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008 (MHPAEA) (Pub. L. 110- 343, enacted October 3, 2008); and the removal of discriminatory age limits from existing benefits.

Centers for Medicare and Medicaid Services (CMS) interpreted cost-sharing, provider type, benefit delivery method and method of reimbursement as not constituting a new benefit mandate.[2]

For the purposes of this report, we analyzed 2023 legislation to determine whether a new health benefit mandate was established based on either a requirement to cover specific health care services or treatment of specific conditions. If we identified such requirements, we then determined whether the benefit was included in an EHB category. This report assesses whether those laws established a new benefit mandate for which the state must defray costs.

[2] 78 F.R. 12834, at 12838 (February 25, 2013), accessed on Oct. 31, 2023, at https://www.gpo.gov/fdsys/pkg/FR-2013-02-25/pdf/2013-04084.pdf; and 77 Fed. Reg. 70644, at 70647 (November 26, 2012), accessed on Oct. 31, 2023, at https://www.govinfo.gov/content/pkg/FR-2012-11-26/pdf/2012-28362.pdf; HHS Notice of Benefit and Payment Parameters for 2019; Final Rule, 83 Fed. Reg. 16930 (April 17, 2018).

Review of 2023 legislation

Requiring coverage for hearing instruments (Chap. 245, Laws of 2023)

In 2023, the Washington state Legislature passed Engrossed Substitute House Bill (ESHB) 1222.[3] This law requires non-grandfathered large group health plans and health plans offered to public employees and their covered dependents issued or renewed on or after Jan. 1, 2024, to include coverage for hearing devices, including bone conduction hearing devices. Coverage of over-the-counter (OTC) hearing devices is not required. Plans must provide coverage for hearing devices at no less than $3,000 per ear with hearing loss every 36 months.

Coverage for minors under 18 years of age is only available after the minor has received medical clearance within the past six months from:

- An otolaryngologist for an initial evaluation of hearing loss.
- A licensed doctor who indicates there has not been a substantial change in clinical status since the initial evaluation by an otolaryngologist.

ESHB 1222 requires coverage of hearing devices, but the mandate applies only to the large group market. The ACA cost defrayal requirements apply only to qualified health plans sold on the individual and small group markets, which must offer EHBs. As directed in Substitute Senate Bill (SSB) 5338, OIC is currently reviewing potential updates to the state EHB benchmark plan. ESHB 1222 provides that if the EHB plan is updated, then the update must include hearing device coverage.

Relating to health carriers offering dental only coverage (Chap. 216, Law of 2023)

In 2023, the Washington state Legislature passed Substitute House Bill (SHB) 1683.[4]

Under the "Every Category of Provider" law, health insurers must permit every category of health care provider to offer health services or care included in the Essential Health Benefits Benchmark Plan. That is provided the services or care are within the providers' permitted scope of practice.[5] This law covers all medical providers who are licensed, registered or certified by the Department of Health. This law does not cover certain health plans, including limited health plans such as dental, vision, specific disease or accident-only plans.

SHB 1683 requires certain health insurers to permit licensed denturists to provide dental services or care included in their benefits package. These insurers include every health insurer offering dental-only

[3] Codified at 48.43.135
[4] Codified at 48.43.745
[5] RCW 48.43.045

coverage or dental-only coverage in addition to a health plan delivered, issued or renewed on or after Jan. 1, 2024. The provided dental services must be within the denturist's scope of practice and the providers must agree to abide by standards related to:

- Provision, utilization review and cost containment of dental services.
- Management and administrative procedures.
- The provision of cost-effective and clinically effective care.

Because SHB 1683 relates to dental-only coverage, it does not address qualified health plans as defined under the ACA. The EHB only addresses pediatric dental services. SHB 1683 does not exceed the existing EHB package in Washington state and does not trigger the cost defrayal requirement.

Concerning telemedicine (Chap. 8, Laws of 2023)

In 2023, the Washington state Legislature passed Senate Bill (SB) 5036.[6]

Under RCW 48.43.735, if services are covered as EHB, health insurers must reimburse providers for health care services provided through telemedicine or store-and-forward technology if they meet certain criteria. Additional requirements apply to coverage of audio-only telemedicine services, one of which relates to a provider having an established relationship with a patient.

SB 5036 applies to health coverage offered by the following:

- Health Care Authority (the Public Employees Benefits Board and School Employees Benefits Board)
- A health insurer regulated by the Office of the Insurance Commissioner
- Medicaid managed care plans
- Behavioral health administrative services organizations

SB 5036 revises the definition of "established relationship" with respect to previous appointments with a provider, or a provider within the same medical group, clinic or integrated delivery system. To be considered as having an established relationship, a patient must have had a previous appointment within the past two years. SB 5036 revised this requirement, allowing previous appointments to occur by audio-video technology until July 1, 2024, instead of Jan. 1, 2024, as previously enacted. After this date, the previous appointment must have occurred in person.

Because SB 5036 relates to a benefit delivery method (i.e., the circumstances under which audio-only telemedicine will be covered for a service already considered an EHB), it does not constitute a new benefit, does not exceed the existing EHB package in Washington, and does not trigger the cost defrayal requirement.

[6] Codified at RCW 41.05.700, 48.43.735, and 74.09.325

Establishing 23-hour crisis relief centers in Washington state (Chap. 433, Laws of 2023)

In 2023, the Washington state Legislature passed Second Substitute Senate Bill (2SSB) 5120.[7]

The ACA requires non-grandfathered health plans in the individual and small group markets to cover emergency services as a category of EHB.[8] The state-designated EHB benchmark plan requires those same types of plans to cover certain emergency medical services. These covered services include services necessary to screen and stabilize a covered person when care is obtained from a hospital emergency department or a behavioral health emergency services provider.[9]

"Behavioral health emergency services" are emergency services provided in specific settings including crisis stabilization units and triage facilities. 2SSB 5120 revises the definition of "behavioral health emergency services provider" to include 23-hour crisis relief centers and removes triage facilities.

Because 2SSB 5120 relates to provider type (i.e., the definition of "behavior health emergency services provider"), it does not constitute a new benefit, does not exceed the existing EHB package in Washington, and does not trigger the cost defrayal requirement.

Establishing behavioral health support specialists (Chap. 270, Laws of 2023)

In 2023, the Washington state Legislature passed Substitute Senate Bill (SSB) 5189.[10]

The ACA requires non-grandfathered health plans in the individual and small group markets to cover mental health and substance use disorder services, including behavioral health treatment as a category of EHB.[11] The state-designated EHB benchmark plan requires those same types of plans to cover behavioral health treatment. These treatments include treatment for Diagnostic and Statistical Manual of Mental Disorders (DSM) category diagnoses, inpatient, residential and outpatient treatment, and services provided by a licensed behavior health provider in a skilled nursing facility.[12]

Under SSB 5189, a behavioral health support specialist is defined as:

> *"... a person certified to deliver brief, evidence-based interventions with a scope of practice that includes behavioral health under the supervision of a Washington state credentialed provider who*

[7] Codified at RCW 71.05.020, 71.05.050, 71.05.150, 71.05.153, 71.05.590, 71.24.025, 71.34.020, 71.34.351, 71.05.755, 71.24.890, 71.24.916, 10.31.110, 10.77.086, 10.77.088, and 48.43.005.
[8] 42 U.S.C. §18022(b)(1)(B)
[9] WAC 284-43-5642 and RCW 48.43.093
[10] Codified at RCW 18.130.040, 18.227.005, 18.227.010, 18.227.020, 18.227.030, 18.227.040, 18.227.050, 18.227.060, 18.227.070, 18.227.080, 18.227.090, 18.227.100, and 48.43.767
[11] 42 U.S.C. §18022(b)(1)(B)
[12] WAC 284-43-5642 and RCW 48.43.093

has the ability to assess, diagnose, and treat identifiable mental and behavioral health conditions as part of their scope of practice."

SSB 5189 requires every insurer to provide access to behavioral health support specialist services in a manner sufficient to meet network access standards by July 1, 2025.

Because SSB 5189 relates to provider type (i.e., a new type of licensed behavioral health provider), it does not constitute a new benefit, does not exceed the existing EHB package in Washington state and does not trigger the cost defrayal requirement.

Prohibiting cost-sharing for abortion (Chap. 194, Laws of 2023)

In 2023, the Washington state Legislature passed Senate Bill (SB) 5242.[13]

Under the ACA, non-grandfathered health plans in the individual and small group markets must cover maternity and newborn care.[14] The state-designated EHB benchmark plan requires those same types of plans to cover maternity and newborn services, including the termination of a pregnancy.[15]

SB 5242 prohibits a health insurer from imposing cost sharing for abortion for health plans issued or renewed on or after Jan. 1, 2024, including health plans offered to public employees.

SB 5242 limits cost-sharing for abortion to health plans offered as a qualifying health plan for a health savings account.

Because SB 5242 addresses cost-sharing for abortion, it does not constitute a new benefit, does not exceed the existing EHB package in Washington state and does not trigger the cost defrayal requirement.

Concerning continuity of coverage for prescription drugs prescribed for the treatment of behavioral health conditions (Chap. 325, Laws of 2023)

In 2023, the Washington state Legislature passed Substitute Senate Bill (SSB) 5300.[16]

The ACA requires non-grandfathered health plans in the individual and small group markets to cover mental health and substance use disorder services, including behavioral health treatment and prescription drugs as categories of EHB.[17] The state-designated EHB benchmark plan requires those

[13] Codified at RCW 48.43.073 and 41.05.850.
[14] 42 U.S.C. §18022(b)(1)(D)
[15] WAC 284-43-5642 and RCW 48.43.073
[16] Codified at RCW 69.41.190 and 48.43.0961
[17] 42 U.S.C. §18022(b)(1)(E) and (F)

same types of plans to cover behavioral health treatment and prescription drug services including mental health prescription drugs.[18]

SSB 5300 applies to health plans that include prescription drug coverage issued or renewed on or after Jan. 1, 2025. A health insurer or its health care benefit manager cannot require substituting a nonpreferred drug with a preferred drug in a given therapeutic class, or increase an enrollee's cost-sharing obligation mid-plan year for the drug, if the following are all true:

- The prescription is for a refill of an antipsychotic, antidepressant, or antiepileptic drug, or any other drug prescribed to treat the enrollee's serious mental illness.
- The enrollee is medically stable on the drug.
- A participating provider continues to prescribe the drug.

Because SB 5300 addresses cost-sharing and benefit delivery method for a prescription drug benefit (drugs prescribed for serious mental illnesses), it does not constitute a new benefit, does not exceed the existing EHB package in Washington state and does not trigger the cost defrayal requirement.

Concerning cost-sharing for diagnostic and supplemental breast examinations (Chap. 366, Laws of 2023)

In 2023, the Washington state Legislature passed Substitute Senate Bill (SSB) 5396.[19]

The ACA requires non-grandfathered health plans in the individual and small group markets to cover preventive or wellness services as a category of EHB.[20] The state-designated EHB benchmark plan requires those same types of plans to cover preventive and wellness services including those with a rating of A or B in the current United States Preventive Services Task Force (USPSTF) recommendations.[21]

At a B grade, the USPSTF recommends screening mammography, with or without clinical breast exam, every one to two years for women aged 40 years and older.

SSB 5396 applies to health plans issued or renewed on or after Jan. 1, 2024. For health plans that include coverage of supplemental breast exams and diagnostic breast exams, health insurers cannot impose cost sharing for such exams.

SSB 5396 defines supplemental breast exam as a medically necessary and appropriate exam, including an exam using breast magnetic resonance imaging (MRI) or ultrasound. This exam is used to screen for breast cancer based on an individual's personal or family medical history, or additional factors that may increase the individual's risk of breast cancer.

[18] WAC 284-43-5642
[19] Codified at RCW 48.20.393, 48.21.225, 48.44.325, 48.46.275, and 48. 43.076.
[20] 42 U.S.C. §18022(b)(1)(I)
[21] WAC 284-43-5642

SSB 5396 defines diagnostic breast exam as a medically necessary and appropriate exam, including an exam using diagnostic mammography, digital breast tomosynthesis, breast MRI or ultrasound. This exam is used to evaluate an abnormality seen or suspected from a screening exam for breast cancer, or detected by another means of exam.

Because SSB 5396 addresses cost sharing for supplemental and diagnostic breast exams, it does not constitute a new benefit, does not exceed the existing EHB package in Washington state and does not trigger the cost of defrayal.

Creating the profession of certified peer specialists (Chap. 469, Laws of 2023)

In 2023, the Washington state Legislature passed Second Substitute Senate Bill (2SSB) 5555.[22]

The ACA requires non-grandfathered health plans in the individual and small group markets to cover mental health and substance use disorder services, including behavioral health treatment and rehabilitative and habilitative services, and devices as categories of EHB.[23] The state-designated EHB benchmark plan requires those same types of plans to cover behavioral health treatment and rehabilitative and habilitative services.[24]

Under 2SSB 5555, a certified peer specialist is someone in recovery from a mental health condition, substance use disorder, or both, or the parent or legal guardian of a youth who is receiving or has received behavioral health services. Certified peer specialist trainees work toward the supervised experience and written exam requirements to become a certified peer specialist. The practice of peer support services means the provision of interventions by a certified peer specialist through the use of shared experiences to assist a client in the acquisition and exercise of skills needed to support the client's recovery.

2SSB 5555 requires each insurer to provide access to services provided by certified peer specialists and certified peer specialist trainees in a manner sufficient to meet the network access standards by July 1, 2026.

Because 2SSB 5555 relates to provider type (i.e., a new type of licensed behavioral health service provider), it does not constitute a new benefit, does not exceed the existing EHB package in Washington, and does not trigger the cost defrayal requirement.

[22] Codified at RCW 18.130.040, 18.130.040, 18.130.175, 43.43.842, 43.70.250, 48.43.825, 71.24.920, 71.24.922, 71.24.924, 18.420.005, 18.420.010, 18.420.020, 18.420.030, 18.420.040, 18.420.050, 18.420.060, 18.420.070, 18.420.080, 18.420.090, and 18.420.800.
[23] 42 U.S.C. §18022(b)(1)(E) and (G)
[24] WAC 284-43-5642

Concerning insulin affordability (Chap. 16, Laws of 2023)

In 2023, the Washington state Legislature passed Substitute Senate Bill (SSB) 5729.[25]

The ACA requires non-grandfathered health plans in the individual and small group markets to cover EHBs in the category of prescription drugs.[26] The state-designated EHB benchmark plan requires insulin coverage.[27]

SSB 5729 applies to health plans issued or renewed on or after Jan. 1, 2023. A health plan that provides coverage for prescription insulin drugs for the treatment of diabetes must cap the total amount that an enrollee is required to pay for a covered insulin drug. This amount cannot exceed $35 per 30-day supply of the drug.

Because SSB 5729 addresses cost sharing for a prescription drug benefit (insulin) covered under the EHB, it does not constitute a new benefit, does not exceed the existing EHB package in Washington state and does not trigger the cost defrayal requirement.

[25] Codified at 48.43.780
[26] 42 U.S.C. §18022(b)(1)(F)
[27] WAC 284-43-5642

Conclusion

Since the laws passed by the Washington state Legislature in 2023 did not establish any new benefit mandates, the Insurance Commissioner concludes there is no obligation for the state to pay costs for QHPs complying with those laws.