OFFICE of the INSURANCE COMMISSIONER
WASHINGTON STATE

Mandated health benefits report

2023 plan year

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Summary

Washington state will not need to defray costs that are incurred by state health insurance benefit requirements for the 2023 plan year.

Background and methodology

Under the Affordable Care Act (ACA), when a state legislature enacts a benefit mandate that exceeds a state's selected set of Essential Health Benefits (EHB) and is 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. 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 Centers for Medicare and Medicaid Services (CMS) has interpreted cost-sharing, provider type, benefit delivery method, and method of reimbursement as not constituting a new benefit mandate.[2]

[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.

[2] 78 F.R. 12834, at 12838 (February 25, 2013), accessed on Oct. 20, 2022, 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. 20, 2022, 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).

For the purposes of this report, we analyzed 2022 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.

Review of 2022 legislation

Allowing providers to bill separately for immediate postpartum contraception (Chap. 122, Laws of 2022)

In 2022, the Washington state Legislature enacted House Bill (HB) 1651.[3]

The ACA requires non-grandfathered health plans in the individual and small group markets to cover maternity and newborn care, and preventive services, which includes contraceptive care, as categories of EHB[4]. The state-designated EHB benchmark plan requires non-grandfathered individual or small group plans to include provider contraceptive services and supplies and coverage of prescription drug services. This includes all FDA-approved contraceptive methods and prescription-based sterilization procedures.[5]

HB 1651 applies to health plans issued or renewed on or after Jan. 1, 2023. For births taking place in a hospital or birthing center, a health plan must allow a provider to bill separately for devices, implants, or services associated with immediate postpartum contraception. It may not consider such devices, implants, or services to be part of any payments for general obstetric procedures.

Because HB 1651 relates to the method of reimbursement and only alters the terms and conditions for an existing benefit (contraception is included in Washington's EHB package), it does not constitute a new benefit and does not exceed the existing EHB package in Washington.

Exempting biomarking testing from prior authorization for patients with late-stage cancer (Chap. 123, Laws of 2022)

In 2022, the Washington state Legislature enacted Engrossed Substitute House Bill (ESHB) 1689[6]. This law applies to health plans issued or renewed on or after Jan. 1, 2023. Health plans must exempt an enrollee from prior authorization requirements for coverage of biomarker testing for either: Stage 3 or 4 cancer; or recurrent, relapsed, refractory or metastatic cancer.

ESHB 1689 requires that the biomarker testing be:

- Recommended in the latest version of nationally recognized guidelines or biomarker compendia.
- Approved by the U.S. Food and Drug Administration or a validated clinical lab test performed in a clinical lab certified under the Clinical Laboratory Improvement Amendments or in an alternative lab program approved by the Centers for Medicare and Medicaid Services.

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[3] Codified at RCW 41.05.430 and 48.43.0725
[4] 42 U.S.C. §18022(b)(1)(D) (§1302(b)(1)(D))
[5] WAC 284-43-5642
[6] Codified at RCW 48.43.810

- A covered service.
- Prescribed by an in-network provider.

Section 5 of ESHB 1689 states that nothing in the section may be construed to mandate coverage of a health care service.

Because ESHB 1689 does not mandate coverage of biomarker testing, it does not constitute a new benefit and does not exceed the existing EHB package in Washington.

Concerning facility fees for audio-only telemedicine (Chap. 126, Laws of 2022)

In 2022, the Washington state Legislature enacted Substitute House Bill (SHB) 1708.[7]

Under Washington state law, if the services are covered as EHB, insurance carriers must reimburse providers for health care services provided through telemedicine or transfer of a consumer's health information to another provider for purposes of diagnosis or treatment (store-and-forward technology). . A health carrier must reimburse a provider for a health care service provided to a covered person through telemedicine or store-and-forward technology if certain criteria are met, including for a service recognized as an EHB.[8]

SHB 1708 prohibits a hospital that is an originating site or distant site for audio-only telemedicine from charging a facility fee.

Because SHB 1708 relates to a benefit delivery method (i.e., telemedicine) and method of reimbursement (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 and does not exceed the existing EHB package in Washington.

Concerning the definition of established relationship for purposes of audio-only telemedicine (Chap. 213, Laws of 2022)

In 2022, the Washington state Legislature enacted Engrossed Substitute House Bill (ESHB) 1821.[9]

Under the ACA, if the services are covered as EHB, insurance carriers must reimburse providers for health care services provided through telemedicine or store-and-forward technology. Mental health and substance use disorder services, which includes behavioral health treatment, are a category of EHB.[10] Under Washington law, a health carrier must reimburse a provider for a health care service

[7] Codified at RCW 70.41.530
[8] RCW 48.43.735
[9] Codified at RCW 41.05.700, 48.43.735, 71.24.335, and 74.09.325
[10] 42 U.S.C. §18022(b)(1)(E) (§1302(b)(1)(E))

provided to a covered person through telemedicine or store-and-forward technology if certain criteria are met, including for a service recognized as an EHB.[11]

ESHB 1821 applies to health coverage offered by the Health Care Authority (the Public Employees Benefits Board and School Employees Benefits Board), a health carrier regulated by the Office of the Insurance Commissioner, Medicaid managed care plans, and behavioral health administrative services organizations. Starting Jan. 1, 2023, for audio-only telemedicine, the standards for what constitutes an "established relationship" are modified by ESHB 1821.

ESHB 1821 revises the definition of "established relationship" to provide as follows:

- The provider offering audio-only telemedicine has access to sufficient health records to ensure safe, effective and appropriate care services.
- For behavioral health treatment, the covered person has had within the past three years, an in-person appointment or a real-time interactive appointment using both audio and video technology with:
  - The same provider;
  - A provider in the same medical group or clinic; or
  - A provider the person has been referred to when the provider making the referral has cared for the person in the timeframes above and has shared relevant information with the other provider.
- For all other health care services, the covered person has had, within the past two years, at least one in-person appointment or, until Jan. 1, 2024, at least one real-time interactive appointment using both audio and video technology, with:
  - The same provider;
  - A provider in the same medical group or clinic; or
  - A provider the person has been referred to when the provider making the referral has cared for the person in the timeframes above and has shared relevant information with the other provider.

Because ESHB 1821 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 and does not exceed the existing EHB package in Washington.

Preserving a pregnant individual's ability to access abortion care (Chap. 65, Laws of 2022)

In 2022, the Washington state Legislature enacted Engrossed House Bill 1851.[12]

[11] RCW 48.43.735

[12] Codified at RCW 9.02.100, 9.02.110, 9.02.130, 9.02.140, 9.02.160, 9.02.170, and 9.02.120

Under Washington law, coverage of a voluntary abortion or termination of a pregnancy may be included in a health plan's EHB package. If a health plan provides maternity care or services, it must provide substantially equivalent coverage to permit the abortion of a pregnancy.[13]

In Engrossed House Bill 1851, statutes related to reproductive decisions change references of "woman" to "pregnant individual." The type of provider that may perform or assist in the termination of a pregnancy is expanded to include a physician assistant, advanced registered nurse practitioner, or other health care provider acting within provider's scope of practice. The state is prohibited from penalizing, prosecuting, or otherwise taking adverse action against an individual based on the individual's actual, potential, perceived, or alleged pregnancy outcomes. This also includes an individual who aids or assists a pregnant individual to exercise the pregnant individual's right to reproductive freedom with the individual's voluntary consent. Because Engrossed House Bill 1851 relates to the types of providers who can deliver a covered service, it does not constitute a new benefit and does not exceed the existing EHB package in Washington.

Concerning insulin affordability (Chap. 10, Laws of 2022)

In 2022, the Washington state Legislature enacted Substitute Senate bill (SSB) 5546.[14]

The ACA requires non-grandfathered health plans in the individual and small group markets to cover EHBs in the category of prescription drugs.[15] The state-designated EHB benchmark plan requires insulin coverage.[16]

SSB 5546 applies to health plans issued or renewed on or after Jan. 1, 2023, and expires Jan. 1, 2024. 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 5546 addresses cost sharing for a prescription drug benefit (insulin) covered under the EHB, it does not constitute a new benefit and does not exceed the existing EHB package in Washington.

Requiring cost sharing for prescription drugs to be counted against an enrollee's obligation (Chap. 228, Laws of 2022)

In 2022, the Washington state Legislature enacted Substitute Senate bill (SSB) 5610.[17]

[13] RCW 48.43.073; WAC 284-43-5642
[14] Codified at RCW 41.05.017 and 48.43.780
[15] 42 U.S.C. §18022(b)(1)(F) (§1302(b)(1)(F))
[16] WAC 284-43-5642
[17] Codified at RCW 41.05.017 and 48.43.435

The ACA requires non-grandfathered health plans in the individual and small group markets to cover prescription drugs as a category of EHB.[18] The state designated EHB benchmark plan requires prescription drug coverage.[19]

Under SSB 5610, starting Jan. 1, 2023, when calculating an enrollee's contribution to any type of cost-sharing, a health carrier offering a non-grandfathered plan or health care benefit manager must include any cost-sharing amounts paid by the enrollee directly or on behalf of the enrollee by another person for a covered prescription drug. Cost-sharing includes copayments, coinsurance, deductibles, out-of-pocket maximum or other similar obligations. This requirement is applicable to drugs that do not have a generic equivalent, drugs that do not have a therapeutic equivalent preferred under the health plan's formulary, or drugs for which the enrollee obtained access via prior authorization, step therapy, or an exception process.

Because SSB 5610 only alters the terms and conditions (addresses treatment of third-party payment toward enrollee cost-sharing) for an existing benefit (prescription drugs), it does not constitute a new benefit and does not exceed the existing EHB package in Washington.

Requiring coverage for donor human milk (Chap. 236, Laws of 2022)

In 2022, the Washington state Legislature enacted Engrossed Second Substitute Senate Bill (E2SSB) 5702.[20]

The law applies to large group health plans issued or renewed on or after Jan. 1, 2023, and the state Medicaid program. Health plans must provide coverage for medically necessary donor human milk for inpatient use when a licensed health care provider or international board-certified lactation consultant prescribes and orders it under these circumstances:

- An infant who is medically or physically unable to receive maternal human milk or participate in chest feeding; or
- A parent who is medically or physically unable to produce maternal human milk in sufficient quantities or caloric density or participate in chest feeding; and
- The infant meets at least one qualifying criterion described in section (1)(a) through (o) of RCW 48.43.815.

The donor human milk must be obtained from a milk bank that meets standards established by the Washington state Department of Health.

Upon authorization from the Legislature to modify the state's EHB benchmark plan under 45 C.F.R. Sec. 156.111, the insurance commissioner must include coverage for donor human milk in the updated plan.

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[18] 42 U.S.C. §18022(b)(1)(F) (§1302(b)(1)(F))
[19] WAC 284-43-5642
[20] Codified at RCW 48.43.815, 48,43,715, 41.05.017, 74.09.825, and 43.70.645

E2SSB 5702 requires coverage of donor human milk, but the mandate applies only to the large group market. The ACA cost pay requirements apply to EHB, which apply only in the individual and small group markets. OIC has not received authorization from the Legislature to modify the state's EHB benchmark plan.

Conclusion

Since the laws enacted by the Washington state Legislature in 2022 did not establish any new benefit mandates, the Insurance Commissioner concludes there is no obligation for the state to pay costs for QHPs associated with those laws.