OFFICE of the INSURANCE COMMISSIONER
WASHINGTON STATE

Mandated Health Benefits Report

2021 Plan Year

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Summary

Washington State will not need to defray costs incurred due to state health insurance benefit requirements for the 2021 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.[2]

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, codified in Revised Code of Washington (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 defray 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

[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] In its PY 2021 Notice of Benefit and Payment Parameters final rule, the Centers for Medicare and Medicaid Services (CMS) amended 45 CFR §156.111 to require states to annually notify HHS of any state-required benefits applicable to qualified health plans in the individual and/or small group market that are considered to be in addition to the EHB package. The first report from the state must be submitted to CMS by the Insurance Commissioner by July 1, 2021. 85 Fed. Reg. 29164 (May 14, 2020)

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.[3]

For the purposes of this report, we analyzed 2020 legislation to determine whether a new health benefit mandate was established based on either requirements 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.

[3] 78 F.R. 12834, at 12838 (February 25, 2013), accessed on October 29, 2020, 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 October 30, 2020, 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 2020 Legislation

Telemedicine payment parity (Chap. 92, Laws of 2020)

In 2020, the Washington State Legislature passed Engrossed Substitute Senate Bill (ESSB) 5385.[4] It requires that, beginning January 1, 2021, health carriers reimburse providers for health care services provided through telemedicine at the same rate as the when it is provided in-person. Hospitals, hospital systems, telemedicine companies, and groups of 11 or more providers may negotiate and agree to reimbursement rates that differ from in-person rates.

Because ESSB 5385 only alters the terms and conditions (method of reimbursement) for an existing benefit (services included in the EHB), it does not constitute a new benefit and does not exceed the existing EHB.[5]

Health carrier requirements for prior authorization standards (Chap. 193, Laws of 2020)

In 2020, the Washington State Legislature passed Second Engrossed Senate Bill (E2SB) 5887.[6]

Under the ACA, the EHB includes ambulatory patient services, rehabilitative services and habilitative services. E2SB 5887 addresses utilization management and utilization review for certain benefits. It provides that a health carrier or its contracted entity may not require utilization management or review of any kind, including but not limited to prior, concurrent, or post-service authorization for initial evaluation and management visits and up to six consecutive treatment visits for new episodes of care for the following therapies:

- Chiropractic
- Physical
- Occupational
- Eastern medicine
- Massage
- Speech
- Hearing

Visits for which prior authorization are prohibited are subject to quantitative treatment limits of the health plan.

[4] Chap. 92, Laws of 2020, codified at RCW 48.43.735.

[5] See FN 8, Proposed rule: Patient Protection and Affordable Care Act; Standards Related to Essential Health Benefits, Actuarial Value, and Accreditation, 77 Fed. Reg. 70644 at 70647, November 26, 2012, accessed at https://www.govinfo.gov/content/pkg/FR-2012-11-26/pdf/2012-28362.pdf.

[6] Chap. 193, Laws of 2020, codified at RCW 48.43.016

Because E2SB 5887 only alters the terms and conditions (e.g., use of prior authorization) of an existing benefit (ambulatory patient services, rehabilitative services and habilitative services), it does not constitute a new benefit and does not exceed the existing EHB.

Cost-sharing requirements for coverage of insulin (Chap. 245, Laws of 2020)

Engrossed Second Substitute Senate Bill (E2SSB) 6087[7] requires that health plans issued or renewed on or after January 1, 2021, cap enrollees' out-of-pocket expenses at $100 for a 30-day supply of insulin. Under the ACA, prescription drugs are an EHB category and the state-designated EHB benchmark plan requires insulin coverage.

Because E2SSB 6087 only alters the terms and conditions (cost-sharing) for an existing benefit (prescription drugs), it does not constitute a new benefit and does not exceed the existing EHB.

Prohibiting discrimination in health care coverage (Chap. 228, Laws of 2020)

In 2020, the Washington State Legislature passed Substitute House Bill (SHB) 2338.[8] Under the ACA, the EHB include mental health and substance use disorder services. SHB 2338 updates the state mental health parity law to be consistent with the requirements of the federal Mental Health Parity and Addiction Equity Act (MHPAEA) and §1557 of the ACA. MHPAEA requires parity in coverage of mental health and substance-use disorder services as compared to medical/surgical services. Section 1557 prohibits discrimination in receipt or coverage of health care services based upon sex.

Under SHB 2338, for coverage issued or renewed on or after January 1, 2021, several previous exemptions from the definition of "mental health services" are eliminated. As noted above, the ACA requires coverage of substance-use disorder treatment services as EHB. These benefits were excluded from the scope of the state mental health parity law prior to passage of SHB 2338. MHPAEA does not allow categorical exclusions of services to treat mental health or substance-use disorder conditions that are covered for treatment of medical/surgical conditions. These services include:

- Skilled nursing facility services.
- Home health services.
- Residential treatment services.
- Custodial care services.

In addition, Washington State's current EHB benchmark plan requires coverage of skilled nursing facility and home health services, as well as residential treatment, for mental health and substance-use disorders.

Under SHB 2338, mental health treatment is defined to include medically necessary outpatient and inpatient services provided to treat mental disorders covered by the diagnostic categories listed in the

[7] Chap. 245, Laws of 2020, codified at RCW 48.43.780. The law expires on January 1, 2023.

[8] Chap. 228, Laws of 2020, codified at RCW 48.20.580, 48.21.241, 48.44.341, 48.46.291, 48.43.0128.

most current version of the *Diagnostic and Statistical Manual of Mental Health and Substance Use Disorders* (DSM). Prior to passage of SHB 2338, a number of mental health disorder diagnostic codes related to gender were excluded from the definition of mental health services. Section 1557 of the ACA prohibits discrimination based upon sex.[9] SHB 2338 brings the state mental health parity statute into compliance with §1557.

Diagnostic codes for life transition problems were also excluded from the definition of mental health services prior to passage of SHB 2338. The Office of the Insurance Commissioner (OIC) conducted research to determine if these codes were used, and if so, whether removal of these diagnostic codes would trigger creation of a new mandated benefit. Our research indicates that providers did not bill under these code because they are diagnostic codes rather than billing codes, and are used as an adjunct to billing codes for mental health disorders, such as depression or anxiety. In addition, several carriers indicated that they covered those services as required under OIC's mental health parity rules. Washington Administrative Code (WAC) 284-43-7080 provides that if a service is prescribed for a mental health condition and is medically necessary, it may not be denied solely on the basis that it is a benefit excluded by the terms of a health plan.[10]

Based on the foregoing reasons, SHB 2338 does not constitute a new benefit and does not exceed the existing EHB.

Protecting patients from excess prescription medication charges (Chap. 116, Laws of 2020)

In 2020, the Washington State Legislature passed Substitute House Bill (SHB) 2464.[11] Under the ACA, the EHB include prescription drug coverage. Beginning January 1, 2021, the maximum amount a pharmacy benefit manager or issuer may require an enrollee to pay at the point of sale for a covered prescription medication is the lesser of the applicable cost-sharing for the medication or the amount the person would pay for the medication if they purchased it without using a health plan.

Because SHB 2642 only alters the terms and conditions (cost-sharing limitations) of an existing benefit (prescription drug coverage), it does not constitute a new benefit and does not exceed the existing EHB.

Removing health coverage barriers to accessing substance-use disorder treatment services (Chap. 345, Laws of 2020)

In 2020, the Washington State Legislature passed Engrossed Substitute House Bill (ESHB) 2642.[12] Under the ACA, the EHB must include mental health and substance use disorder treatment services. ESHB 2642 addresses carriers' use of prior authorization requirements for withdrawal management and inpatient or

[9] See *Bostock v. Clayton County, Georgia,* No. 17-1618, 590 U.S. __ (2020); *Asapansa-Johnson Walker and Gentili v. Azar,* No. 20-CV-2834 (E.D.N.Y. August 17, 2020); accessed at https://img.nyed.uscourts.gov/files/opinions/20cv2834mo08172020.pdf

[10] WAC 284-43-7080

[11] Chap. 116, Laws of 2020, codified at RCW 48.43.430.

[12] Chap. 345, Laws of 2020, codified at RCW 48.43.761.

residential substance use disorder treatment services. It limits the use of prior authorization for the first two (inpatient or residential substance-use disorder treatment) or three (withdrawal management services) days of care. Once the specified time period has passed, carriers can initiate utilization management review procedures if the provider continues to provide services or is in the process of arranging for a seamless transfer to an appropriate facility or a lower level of care.

Because ESHB 2642 only alters the terms and conditions (use of prior authorization) of an existing benefit (substance use disorder treatment services), it does not constitute a new benefit and does not exceed the existing EHB.

Conclusion

Since the laws enacted by Washington State's Legislature in 2020 did not establish any new benefit mandates, the commissioner concludes there is no obligation for the state to defray costs for QHPs associated with those laws.