OFFICE of the INSURANCE COMMISSIONER
WASHINGTON STATE

Mandated Health Benefits Report

2022 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 2022 plan year.

Background and methodology

Under the Affordable Care Act (ACA), when a state legislature enacts a benefit mandate that exceeds its 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 (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. Under the rule, the first report from the state would have been submitted to CMS by the Insurance Commissioner by July 1, 2021. 85 Fed. Reg. 29164 (May 14, 2020). The PY 2022 Notice of Benefit and Payment Parameters rule delayed the date for submission of the first report to July 1, 2022.

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 legislation passed in 2021 to determine whether a new health benefit mandate was established based on if the legislation covers 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 2021 legislation

Telemedicine payment parity and audio-only coverage (Chap. 157, Laws of 2021)

In 2021, the Washington State Legislature passed Engrossed Substitute House Bill (ESHB) 1196[4]. The law addresses coverage of telemedicine services, including audio-only telemedicine services. ESHB 1196 requires coverage of audio-only telemedicine services under specified conditions and amends the statutory language related to telemedicine payment parity. Beginning January 1, 2021, health carriers must reimburse providers for services provided through telemedicine at the same rate as if they were provided in-person.

Because ESSB 1196 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]

National 988 system (Chap. 302, Laws of 2021)

In 2021, the Washington State Legislature enacted Engrossed Second Substitute House Bill (E2SHB) 1477. In anticipation of implementing the new 988 phone number and system in 2022 for people experiencing a behavioral health crisis, the law enhances Washington State's behavioral health crisis response and suicide prevention system.

Section 106 of E2SHB 1477[6] provides that health plans issued or renewed on or after January 1, 2023 must make next-day appointments available to enrollees experiencing urgent, symptomatic behavioral health conditions. The appointment may be with a licensed provider other than a behavioral health professional if that provider is acting within their scope of practice and may be provided through telemedicine, consistent with RCW 48.43.735.

Because E2SHB 1477 only alters the terms and conditions (i.e., timely access to appointments, benefit delivery method) for an existing benefit, it does not constitute a new benefit and does not exceed the existing EHB.

Opioid overdose reversal medication (Chap. 273, Laws of 2021)

In 2021, the Washington State Legislature enacted Second Substitute Senate Bill (2SSB 5195). Beginning January 1, 2022, the law sets standards for hospitals and behavioral health agencies to prescribe opioid

[4] Chap. 157, Laws of 2021, 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] Codified at RCW 48.43.790

overdose reversal medication to individuals with symptoms of an opioid use disorder, overdose, or other adverse event related to opioid use. Sections 3 and 4 of the law[7] require a hospital or behavioral health agency to bill an individual's health plan if they have private health insurance.

Because 2SSB 5195 only alters the terms and conditions (i.e., direction to submit a claim for covered prescription drugs, reimbursement to providers) for an existing benefit, it does not constitute a new benefit and does not exceed the existing EHB.

Reimbursement for personal protective equipment (Chap. 94, Laws of 2021)

In 2021, the Washington State Legislature enacted Substitute Senate Bill (SSB) 5169[8]. The law is applicable only during the duration of the COVID-19 federal public health emergency. During this period, health plans must reimburse providers for personal protective equipment expenses as a separate expense for each individual encounter with a patient. Enrollee cost-sharing does not apply to this additional provider payment.

Because SSB 5169 only alters the terms and conditions (reimbursement to providers and applicability of consumer cost-sharing) for an existing benefit (services included in the EHB), it does not constitute a new benefit and does not exceed the existing EHB.

Access to gender-affirming health care (Chap. 280, Laws of 2021)

In 2021, the Washington State Legislature enacted Second Substitute Senate Bill (2SSB) 5313, which the insurance commissioner noted clarified state law. 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 it is a benefit excluded by the terms of a health plan. RCW 48.43.0128 as originally enacted prohibits discrimination by carriers based on race, color, national origin, disability, age, sex, gender identity, or sexual orientation.

The insurance commissioner's interpretation is grounded in required compliance with federal law. 2SSB 5313 aligns with the federal Mental Health Parity and Addiction Equity Act (MHPAEA) and §1557 of the ACA. The MHPAEA requires parity in coverage of mental health and substance-use disorder services as compared to medical/surgical services. The MHPAEA prohibits categorical exclusions of services to treat mental health or substance-use disorder conditions that are covered for treatment of medical or surgical conditions. Gender dysphoria is a diagnosis, or mental health condition, listed in the Diagnostic and Statistical Manual of Mental Disorders (DSM).

Section 1557 of the ACA prohibits discrimination of health care services based upon sex. On May 21, 2021, the U.S. Department of Health and Human Services announced that the Office of Civil Rights will

[7] Codified at RCW 70.41.485 and RCW 71.24.594
[8] Codified at RCW 48.43.785

enforce section 1557 prohibitions on health care discrimination based on sex to include sexual orientation and gender identity[9].

2SSB 5313 applies to health plans issued on or after January 1, 2022.[10] It provides that a health carrier cannot limit coverage for gender-affirming care that is prescribed due to the patient's gender expression or identity, is medically necessary and is prescribed in accordance with accepted standards of care. Additionally, carriers cannot apply categorical exclusions to gender-affirming treatment nor issue an adverse benefit determination limiting access to gender-affirming services, unless a health care provider with experience prescribing or delivering gender-affirming treatment has reviewed the appropriateness of the adverse benefit determination.

Based on the reasons above, 2SSB 5313 is necessary to comply with the MHPAEA and ACA. Therefore, cost defrayal is not required.

Student health plans (Chap. 53, Laws of 2021)

In 2021, the Washington State Legislature enacted House Bill (HB) 1009. The law applies to student health plans issued or renewed on or after January 1, 2022 and makes them subject to the same abortion requirements as other health plans under RCW 48.43.073.

The ACA's cost defrayal requirement applies only to qualified health plans, which do not include student health plans. Therefore, HB 1009 does not require cost defrayal.

[9] HHS Announces Prohibition on Sex Discrimination Includes Discrimination on the Basis of Sexual Orientation and Gender Identity (May 10, 2021), accessed on November 2, 2021 at https://www.hhs.gov/about/news/2021/05/10/hhs-announces-prohibition-sex-discrimination-includes-discrimination-basis-sexual-orientation-gender-identity.html

[10] Codified at RCW 48.43.0128

Conclusion

Since the laws enacted by Washington State's Legislature in 2021 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.