

# State Benefit Requirements for the 2019 Plan Year

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Report to the Washington state Legislature  
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# Summary

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Washington state will not need to defray costs incurred due to state benefit requirements for the 2019 plan year.

## Background

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A state benefit requirement is a law requiring a health benefit plan to cover a specific type of health care service or treatment for its enrollees.<sup>i</sup>

State benefit requirements adopted prior to Dec. 31, 2011, are included in the state's Essential Health Benefits, the package of benefits that must be covered by individual and small group plans, including Qualified Health Plans offered through the Washington Health Benefit Exchange.<sup>ii</sup>

Federal law requires state exchanges to identify any state benefit requirements adopted after Dec. 31, 2011, which exceed the Essential Health Benefits package.<sup>iii</sup> For these benefits, the state must "defray" the cost associated with the benefit by making payments to Qualified Health Plan enrollees or issuers.<sup>iv</sup>

Starting in 2012, the Washington state Legislature directed the Insurance Commissioner to report the state's potential obligation to defray costs associated with coverage of state benefit requirements included in subsidized qualified health plans annually.<sup>v</sup> The commissioner must recommend statutory changes in relation to defraying such costs if applicable, and estimate the cost of the benefit.

## Report for the 2019 plan year

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The state is not required to defray costs associated with state benefit requirements for the 2019 plan year. There are no new state benefit requirements in effect at this time or any recommended statutory changes.

## OIC Review of ESHB 1523

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During the 2018 session, the Legislature passed ESHB 1523, addressing coverage of preventive health services.<sup>vi</sup> The legislation requires a health plan to, at a minimum, provide coverage for the same preventive services required by the Affordable Care Act and any federal rules or guidance in effect on December 31, 2016, implementing the Affordable Care Act's preventive services requirement. The health plan may not impose cost-sharing requirements for these preventive services. The insurance commissioner must enforce the requirement consistent with

federal rules, guidance, and case law in effect on December 31, 2016, applicable to the preventive services requirement in the Affordable Care Act.

ESHB 1523 makes Washington state law consistent with the Affordable Care Act provision requiring the inclusion of preventive health services in the essential health benefits and with section 2713 of the Public Health Services Act, which requires group-health plans to cover a range of preventive services without imposing cost-sharing on patients who receive these services. The OIC has concluded that because coverage of preventive services without cost sharing is already required under federal law, it is not a new state benefit mandate and the state is not required to defray these costs.

## **OIC Review of SSB 6219**

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In 2018, the Legislature passed SSB 6219<sup>vii</sup>, addressing coverage of contraceptive services and abortion. Health plans issued on or after January 1, 2019 must provide coverage for FDA-approved contraceptives, including FDA-approved over-the-counter contraceptive drugs, devices and products, voluntary sterilization procedures, and consultations, examinations, procedures and medical services necessary to the use of those services. Health plans cannot impose cost-sharing for use of these services. Health plans issued on or after January 1, 2019, that cover maternity care or services also must cover substantially equivalent coverage for abortion, subject to terms and conditions generally applicable to the health plan's coverage of maternity care or services, including applicable cost-sharing.

Under section 2713 of the Public Health Services Act, the Health Resource and Services Administration must publish women's preventive services guidelines. Those guidelines require coverage of the full range of female-controlled contraceptives identified by the FDA, including sterilization for women. The services must be covered without imposing cost-sharing.<sup>viii</sup>

The base benchmark plan for the essential health benefits in Washington is established in RCW 48.43.715 as the largest small group health plan in the state by enrollment. WAC 284-43-5602 designates the Regence Direct Gold+ small employer plan as the benchmark plan, per legislative direction. WAC 284-43-5642 established the requirements for essential health benefits. Subsection (1)(a) states that a health benefit plan must include provider contraceptive services and supplies, including but not limited to, vasectomy, tubal ligation and insertion or extraction of FDA-approved contraceptive devices. In addition, under subsection (4), termination of pregnancy is considered a maternity and newborn service under the essential health benefits.

The OIC has concluded that because contraceptive coverage and coverage for abortion is not a new state benefit mandate, the state is not required to defray these costs.

## OIC Review of SB 5912

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In 2018, the Legislature passed SB 5912.<sup>ix</sup> Under the Affordable Care Act, health benefit plans must provide, at a minimum, coverage with no cost-sharing for preventive or wellness services that have a rating of “A” or “B” in the current recommendations of the United States Preventive Services Task Force (USPSTF). The USPSTF recommends, at a “B” grade, screening mammography for women, with or without clinical breast examination, every one to two years for women age 40 years and older. SB 5912 addresses the inclusion of tomosynthesis as a means of providing mammograms. Because SB 5912 only alters the terms and conditions (i.e., the type of mammography used) of an existing benefit (coverage for mammography), it does not constitute a new benefit and does not exceed the existing essential health benefits.

## OIC Review of ESSB 6157

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In 2018, the Legislature passed ESSB 6157.<sup>x</sup> Under the Affordable Care Act, the essential health benefits include rehabilitative and habilitative services. ESSB 6157 addresses carriers’ use of prior authorization requirements for several types of rehabilitative services, including physical, occupational, speech and hearing therapies. It limits the use of prior authorization for initial evaluation and management visits and up to six consecutive treatment visits in a new episode of care for those services. Because ESSB 6157 only alters the terms and conditions (i.e., use of prior authorization) of an existing benefit (rehabilitative services), it does not constitute a new benefit and does not exceed the existing essential health benefits.

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<sup>i</sup> RCW 48.47.010(7). Note that while Washington law recognizes other types of coverage requirements, such as coverage of specific types of providers, federal law does not require the state to defray the cost of these requirements. See “Standards Related to Essential Health Benefits, Actuarial Value, and Accreditation, Final Rule” 78 FR 12834, at 12838 (Feb. 25, 2013)

<sup>ii</sup> See generally, WAC 284-43-5000 *et seq*

<sup>iii</sup> 45 CFR § 155.170

<sup>iv</sup> *Ibid*. Note that preliminary guidance indicates that this requirement may apply to Qualified Health Plans offered both inside and outside the Health Benefit Exchange, as Qualified Health Plan issuers are required to offer identical plans in each market.

<sup>v</sup> RCW 48.43.715(4)

<sup>vi</sup> Chapter 14, 2018 Laws, codified at RCW 48.43.047

<sup>vii</sup> Chapter 119, 2018 Laws, codified at RCW 48.43.072, .073

<sup>viii</sup> United States Health Resources and Services Administration, Updated HRSA-Supported Women’s Preventive Services Guidelines (2016), accessed at [Women’s Preventive Services Guidelines | Official web site of the U.S. Health Resources & Services Administration](#)

<sup>ix</sup> Chapter 115, 2018 Laws, codified at RCW 48.43.078

<sup>x</sup> Chapter 193, 2018 Laws, codified at RCW 48.43.016