

Mandated health benefits report

2026 plan year
Dec. 15, 2025

Patty Kuderer, *Insurance Commissioner*
www.insurance.wa.gov

Table of contents

- Summary 3**
 - Background and methodology 3**
- Review of 2025 legislation 5**
 - Improving access to appropriate mental health and substance use disorder services (Chap. 227, Laws of 2025) 5**
 - Relating to coverage requirements for prosthetic limbs and custom orthotic braces (Chap. 96, Law of 2025)..... 6**
 - Relating to increasing access to prescription hormone therapy (Chap. 171, Laws of 2025)..... 7**
 - Relating to contraceptive coverage (Chap. 147, Laws of 2025) 8**
 - Relating to correcting obsolete or erroneous references in statutes administered by the insurance commissioner (Chap. 243, Laws of 2025) 8**
- Marketplace Integrity and Affordability Final Rule 10**
- Conclusion 12**

Summary

During the 2025 legislative session, the legislature did not enact any legislation that constitutes a new benefit mandate. However, due to the adoption of federal rules by the Department of Health and Human Services, Centers for Medicare and Medicaid Services (CMS) in June 2025 prohibiting the use of federal funds for a select subset of gender affirming care services and in the absence of a court order vacating the rules, Washington state may need to defray costs for the services referenced in the rules for the 2026 plan year. A lawsuit challenging the CMS rules is ongoing. The 2025 biennial budget appropriated \$1.1 million to the Office of the Insurance Commissioner for this purpose.

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.² 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 ACA,³ the Washington state Legislature assigned the responsibility for annually identifying state-mandated health benefits to the Insurance Commissioner.⁴

The specific charge for this report is as follows:⁵

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.

Our statute 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

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 42 USC §18116, §1311(d)(3)(B); and 45 CFR 155.170.

³ 42 USC §18116 and §18031(d)(3)(B), and 45 CFR 155.170.

⁴ RCW 48.43.715.

⁵ RCW 48.43.715(4).

care providers for specific services;..."⁶ 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.⁷

For the purposes of this report, the Office of the Insurance Commissioner (OIC) analyzed 2025 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 the OIC 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.

⁶ RCW 48.47.010(7).

⁷ 78 F.R. 12834, at 12838 (February 25, 2013), accessed on Nov. 24, 2025, 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 Nov. 24, 2025, 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 2025 legislation

Improving access to appropriate mental health and substance use disorder services (Chap. 227, Laws of 2025)

In 2025, the Washington state Legislature enacted Engrossed Second Substitute House Bill (E2SHB) 1432.⁸

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 essential health benefits (EHB).⁹ The state-designated EHB benchmark plan requires non-grandfathered individual or small group plans to cover mental health and substance use disorder services, as defined in the Diagnostic and Statistical Manual of Mental Disorders (DSM) through provision of inpatient, residential, and outpatient treatment, and services provided by a licensed behavior health provider in a skilled nursing facility.¹⁰ The state-designated EHB benchmark plan also covers prescription drugs, medications, and supplies.

E2SHB 1432 recodifies and expands Washington state's Mental Health Parity Act. It requires health plans covering medical and surgical services to cover mental health and substance use disorder (SUD) services. When covering mental health and SUD services, the following applies to health carriers. They must:

- Not conduct utilization reviews or apply clinical review criteria that deviate from generally accepted standards of mental health and SUD care.
- Apply nonprofit professional association criteria under certain circumstances.
- Provide meaningful benefits for covered mental health and SUD conditions in every classification in which medical or surgical benefits are covered.

E2SHB 1432 incorporates the final rules related to the federal Mental Health Parity and Addiction Equity Act (MHPAEA) into Washington state law. It also defines the following terms:

- Mental health and substance use disorder services
- Medically necessary
- Generally accepted standards of mental health and SUD care
- Clinical review criteria
- Nonprofit professional association
- Core treatment

Because E2SHB 1432 relates to benefit delivery method (i.e., how mental health and substance use disorder services, which are already an EHB, must be covered) and broadens coverage of mental health and substance use disorder services to comply with federal law, it does not constitute a new benefit,

⁸ Codified at RCW 48.43.016, 48.43.410, 48.43.520, 48.43.535, 49.43.600, 48.43.766, and 48.43.830.

⁹ 42 U.S.C. §18022(b)(1)(E).

¹⁰ WAC 284-43-5642.

does not exceed the existing EHB package in Washington state, and does not trigger the cost defrayal requirement.

Relating to coverage requirements for prosthetic limbs and custom orthotic braces (Chap. 96, Law of 2025)

In 2025, the Washington state Legislature enacted Substitute House Bill (SHB) 1669.¹¹

This law requires large and small group health plans issued or renewed after Jan. 1, 2026, to include coverage for one or more prostheses per limb and custom orthotic braces per limb when medically necessary to participate in the following:

- Completing activities of daily living or essential job-related activities.
- Performing physical activities for maximizing the enrollee's limb function, including running, biking, swimming, and strength training.

The coverage must also include:

- Materials, components, and related services necessary to use the devices for their intended purposes.
- Instructions on how to use the device.
- Reasonable repair or replacement of the device or any part of the device.

SHB 1669 requires coverage of prostheses and orthotic braces, but the mandate applies only to the large and small group market. The ACA cost defrayal requirements apply only to qualified health plans sold on the individual and small group markets.

Washington state does not operate a SHOP (Small Business Health Options Program), so a small group plan sold in the state and not offered on the Exchange would not:

- Meet the definition of qualified health plan under federal law.
- Have the necessary certifications issued or recognized by the Exchange.

Because the mandate does not apply to the individual market, and the health plans sold in Washington state's small group market do not meet the definition of qualified health plans, this does not trigger the cost defrayal requirement.

¹¹ Codified at RCW 48.43.840.

Relating to increasing access to prescription hormone therapy (Chap. 171, Laws of 2025)

In 2025, the Washington state Legislature enacted Engrossed Substitute House Bill (ESHB) 1971.¹²

The ACA requires non-grandfathered health plans in the individual and small group markets to cover prescription drugs as a category of essential health benefits (EHBs).¹³ The state-designated EHB benchmark plan covers prescription drugs, medications, and supplies, including self-administrable prescription medications when limited to 30-day supplies.¹⁴ This 30-day supply limitation is a minimum standard. An issuer may permit prescription drug supplies of greater than 30 days as part of its health benefit plan.¹⁵

Under ESHB 1971, health plans issued or renewed on or after Jan. 1, 2026, that include coverage for prescription hormone therapy must provide reimbursement for a 12-month refill of covered hormone therapy obtained at one time by an enrollee. Reimbursement for a 12-month refill is not required for all of the following if:

- The enrollee requests a smaller supply.
- The prescribing provider instructs that the enrollee must have a smaller supply.
- The prescription hormone therapy is a controlled substance.
- The health plan limits refills that may be obtained in the last quarter of a plan year when a 12-month supply has already been dispensed during the plan year.
- A prescribing provider temporarily limits refills to a 90-day supply due to an acute dispensing shortage during the plan year.

The 12-month refill requirement only applies to prescription hormone therapy that can be safely stored at room temperature. If the prescription drug is a controlled substance, then the health plan must provide reimbursement for the maximum refill allowed by state and federal law.

ESHB 1971 defines prescription hormone therapy as all drugs approved by the U.S. Food and Drug Administration that are used to medically suppress, increase, or replace hormones that the body is not producing at intended levels. This does not include glucagon-like peptide-1 and glucagon-like peptide-1 receptor agonists.

Because ESHB 1971 relates to method of reimbursement (i.e., when a health plan must reimburse for prescription hormone therapy, an already covered benefit), 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.

¹² Codified at RCW 41.05.017 and 48.43.845.

¹³ 42 U.S.C. §18022(b)(1)(F).

¹⁴ WAC 284-43-5642.

¹⁵ WAC 284-43-5642.

Relating to contraceptive coverage (Chap. 147, Laws of 2025)

In 2025, the Washington state Legislature enacted Senate Bill (SB) 5498.¹⁶

The ACA requires non-grandfathered health plans in the individual and small group markets to cover prescription drugs as a category of essential health benefits (EHBs).¹⁷ The state-designated EHB benchmark plan covers prescription drugs, medications, and supplies, including all FDA-approved contraception methods.¹⁸

Under SB 5498, health plans must provide reimbursement for a 12-month supply of contraceptive drugs obtained at one time by the enrollee, as either a new prescription or a refill, unless the enrollee requests a smaller supply or the prescriber instructs the enrollee to receive a smaller supply.

Because SB 5498 relates to method of reimbursement (i.e., how and when a health plan must reimburse for contraceptive drugs, an already covered benefit), it does not constitute a new benefit, does not exceed the existing EHB package in Washington, and does not trigger the cost defrayal requirement.

Relating to correcting obsolete or erroneous references in statutes administered by the insurance commissioner (Chap. 243, Laws of 2025)

In 2025, the Washington state Legislature enacted Substitute Senate Bill (SSB) 5262.¹⁹

In 2023, the Washington state Legislature enacted Engrossed Substitute House Bill (ESHB) 1222, which required non-grandfathered large group health plans issued or renewed on or after Jan. 1, 2024, to include coverage for hearing instruments at no less than \$3000 per ear with hearing loss every 36 months.²⁰

In 2024, the federal Centers for Medicare and Medicaid services approved an update to Washington state's EHB benchmark plan, which requires individual and small group health plans to cover hearing instruments starting Jan. 1, 2026.²¹ Under the ACA (45 CFR 147.126), individual and group health plans (both small and large) are prohibited from establishing any annual or lifetime dollar limits for services that are considered essential health benefits under a state's EHB benchmark plan. As of Jan. 1, 2026, coverage of hearing instruments will be an essential health benefit. Thus, federal law prohibits annual or lifetime limits on the hearing instrument benefit as of Jan. 1, 2026, for any plan that covers hearing instruments. As a result, coverage is limited to one hearing instrument per ear every three years with no annual or lifetime dollar limit on the benefit.

¹⁶ Codified at RCW 48.43.195.

¹⁷ 42 U.S.C. §18022(b)(1)(F).

¹⁸ WAC 284-43-5642.

¹⁹ Codified at RCW 42.56.400, 48.14.070, 48.19.460, 48.19.540, 48.37.050, 48.38.010, 48.38.012, 48.43.0128, 48.43.135, 48.43.743, 48.135.030, 48.140.050, 48.150.100, and 48.160.020.

²⁰ ESHB 1222

²¹ Updated [Washington benchmark plan](#)

SSB 5262 expands coverage of hearing instruments to individual, small, and large group health plans, and aligns Washington state law with federal law by removing the \$3,000 cap on hearing instruments.

Because hearing instruments are now an essential health benefit and the ACA prohibits annual and lifetime dollar benefit limits, requiring health plans to cover hearing instruments does not exceed the existing EHB package in Washington state, and does not trigger the cost defrayal requirement.

Marketplace Integrity and Affordability Final Rule

In June 2025, the Department of Health and Human Services Centers for Medicare and Medicaid Services issued the Patient Protection and Affordable Care Act; Marketplace Integrity and Affordability Final Rule. Under the rule, non-grandfathered individual and small group plans are prohibited from covering sex-trait modification procedures as an essential health benefit beginning January 1, 2026. The rule states that if a state requires these plans to cover sex-trait modification as a part of the state's essential health benefit benchmark plan, the state is required to defray the cost of the benefit.

Sex-trait modification is defined as any pharmaceutical or surgical intervention that is provided for the purpose of attempting to align an individual's physical appearance or body with an asserted identity that differs from the individual's sex either by intentionally:

- Disrupting or suppressing the normal development of natural biological functions, including primary or secondary sex-based traits; or
- Altering an individual's physical appearance or body, including amputating, minimizing or destroying primary or secondary sex-based traits such as the sexual and reproductive organs.

RCW 48.43.0128 prohibits health carriers from denying or limiting coverage for gender-affirming treatment when:

- That treatment is prescribed to an individual because of, related to, or consistent with a person's gender expression or identity,
- Is medically necessary, and
- Is prescribed in accordance with accepted standards of care.

RCW 48.43.0128 requires gender-affirming treatment to be covered in a manner compliant with the federal mental health parity and addiction equity act of 2008 (MHPAEA) and the federal affordable care act (ACA).²² It also defines gender affirming treatment as a service or product that a health care provider prescribes to an individual to treat any condition related to the individual's gender identity and is prescribed in accordance with generally accepted standards of care.²³

Prior to the adoption of the Marketplace Integrity and Affordability Final Rule, the Office of Insurance Commissioner interpreted the state law requirement for cover gender-affirming treatment as necessary to comply with Section 1557 of the ACA and MHPAEA.

Section 1557 of the ACA prohibits discrimination on the basis of color, national origin, sex, age, and disability.²⁴

²² RCW 48.43.0128

²³ RCW 48.43.0128

²⁴ 42 U.S.C. 18116 and 45 CFR 92.1

A disability is a physical or mental impairment that substantially limits one or more major life activities including caring for oneself, communicating, thinking, eating, or sleeping.²⁵ Gender dysphoria which is defined in the diagnostic and statistical manual of mental disorders (DSM-5), may result in physical impairments²⁶ and substantially limit the major life activities of an individual with this condition. Gender dysphoria may cause depression, anxiety, suicidal ideation, or even suicide. As a result, limiting or denying coverage of a service or product when it is medically necessary to treat a condition related to an individual's gender expression or identity, such as gender dysphoria, is also likely discrimination based on disability.

MHPAEA prohibits group health plans and health insurance issuers from imposing less favorable benefit limitations on mental health and substance abuse benefits as compared to medical/surgical benefits.²⁷ Gender dysphoria is a mental health condition defined in the (DSM-5) as a serious medical condition characterized by distress due to incongruence between the patient's gender identity and sex. OIC has taken the position that allowing health insurers to limit or deny coverage of a service or product to treat mental health conditions like gender dysphoria, would conflict with MHPAEA.

Given the state's interpretation of federal law, Washington state joined 20 other states in filing a lawsuit challenging the final rule.²⁸ The suit argues that the sex-trait modification provision along with other provisions of the final rule are unlawful and should not be enforced. Although a motion for preliminary injunction was denied, the case is ongoing.

Until a decision is made regarding the validity of the rule, Washington state is likely required to comply with the final rule beginning Jan. 1, 2026. Washington state's essential health benefits benchmark plan requires individual and small group health plans to cover gender-affirming treatment. Since a subset of gender-affirming care services would fall under the final rule's definition of sex-trait modification procedures, the rule would require the state to defray the cost of those services.

For the 2026 plan year, the legislature appropriated \$1.1 million to cover the cost of defrayal, so that the benefit can continue to be offered.

²⁵ DSM-5 Criteria for Gender Dysphoria. National Library of Medicine (Accessed April 8, 2025): https://www.ncbi.nlm.nih.gov/books/NBK577212/table/pediat_transgender.T.dsm5_criteria_for_g/

²⁶ Williams v. Kincaid

²⁷ 29 CFR 2590.712 and 45 CFR 146.136

²⁸ State of California et al. v. Kennedy et al., Docket No. 1:25-cv-12019 (2025)

Conclusion

The laws enacted by the Washington state Legislature in 2025 did not establish any new benefit mandates requiring defrayal. However, given the provision of the final rule related to sex-trait modification, and the inclusion of gender-affirming care in Washington state's essential health benefits benchmark plan, Washington state may be obligated to defray the costs of services that meet the definition of sex-trait modification, depending upon the outcome of the lawsuit challenging the rule.