S-0820.1

SUBSTITUTE SENATE BILL 5338

State of Washington 68th Legislature 2023 Regular Session

By Senate Health & Long Term Care (originally sponsored by Senators Cleveland, Muzzall, Conway, and Randall)

AN ACT Relating to a review of the state's essential health benefits; amending RCW 48.43.715; and creating a new section.

BE IT ENACTED BY THE LEGISLATURE OF THE STATE OF WASHINGTON:

NEW SECTION. **Sec. 1.** (1) The office of the insurance commissioner, in consultation with relevant interested persons and entities, shall review Washington's benchmark health plan establishing the state's essential health benefits to determine whether to request approval from the centers for medicare and medicaid services under 45 C.F.R. Sec. 156.111 to modify the state's essential health benefits benchmark plan.

(2) As part of its review, the office shall determine the potential impacts on individual and small group health plan design, actuarial values, and premium rates if coverage for each of the following was included as an essential health benefit:

(a) Hearing instruments and associated services;

(b) Fertility services;

(c) Biomarker testing;

(d) Contralateral prophylactic mastectomies; and

(e) Magnetic resonance imaging for breast cancer screening.

(3) By December 1, 2023, the office shall report the results of the review to the relevant committees of the legislature, including

any findings related to modifying the state's essential health benefits.

Sec. 2. RCW 48.43.715 and 2022 c 236 s 2 are each amended to read as follows:

(1) ((~~The~~)) Until the effective date of an updated essential health benefits benchmark plan submitted under section 1 of this act, the commissioner, in consultation with the board and the health care authority, shall, by rule, select the largest small group plan in the state by enrollment as the benchmark plan for the individual and small group market for purposes of establishing the essential health benefits in Washington state.

(2) If the essential health benefits benchmark plan for the individual and small group market does not include all of the ((~~ten~~)) 10 essential health benefits categories, the commissioner, in consultation with the board and the health care authority, shall, by rule, supplement the benchmark plan benefits as needed.

(3) All individual and small group health plans must cover the ((~~ten~~)) 10 essential health benefits categories, other than a health plan offered through the federal basic health program, a grandfathered health plan, or medicaid. Such a health plan may not be offered in the state unless the commissioner finds that it is substantially equal to the benchmark plan. When making this determination, the commissioner:

(a) Must ensure that the plan covers the ((~~ten~~)) 10 essential health benefits categories;

(b) May consider whether the health plan has a benefit design that would create a risk of biased selection based on health status and whether the health plan contains meaningful scope and level of benefits in each of the ten essential health benefits categories;

(c) Notwithstanding (a) and (b) of this subsection, for benefit years beginning January 1, 2015, must establish by rule the review and approval requirements and procedures for pediatric oral services when offered in stand-alone dental plans in the nongrandfathered individual and small group markets outside of the exchange; and

(d) Must allow health carriers to also offer pediatric oral services within the health benefit plan in the nongrandfathered individual and small group markets outside of the exchange.

(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.

(5) ((~~Upon authorization by the legislature to modify the state's essential health benefits benchmark plan under 45 C.F.R. Sec. 156.111, the~~)) The commissioner shall include coverage for donor human milk in ((~~the updated plan~~)) any update of the state's essential health benefits benchmark plan submitted to the centers for medicare and medicaid services under section 1 of this act.

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