OFFICE of the INSURANCE COMMISSIONER
WASHINGTON STATE

Mandated health benefits report

2025 plan year
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Mike Kreidler, *Insurance Commissioner*
www.insurance.wa.gov

OIC WA | 360-725-7009 | P.O. Box 40255 Olympia, WA 98504-0255

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Summary

Washington state will not need to defray costs that are incurred by state health insurance benefit requirements for the 2025 plan year.

Background and methodology

Under the Affordable Care Act (ACA), when a state legislature enacts a benefit mandate that exceeds the 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] Washington state's 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 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) interpreted cost-sharing, provider type, benefit delivery method and method of reimbursement as <u>not</u> constituting a new

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[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).

[6] RCW 48.47.010(7).

benefit mandate.[7]

For the purposes of this report, the OIC analyzed 2024 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.

[7] 78 F.R. 12834, at 12838 (February 25, 2013), accessed on Oct. 31, 2024, 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 Oct. 31, 2024, 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).

2024 legislation review

Relating to balance billing and coverage of transports to treatment for emergency medical conditions (Chap. 218, Laws of 2024)

In 2024, the Washington state Legislature enacted Substitute Senate Bill (SSB) 5986.[8]

The ACA requires non-grandfathered health plans in the individual and small group markets to cover emergency services 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 emergency medical services, which include transportation to an emergency room, treatment provided as a part of an ambulance service and services necessary to screen and stabilize a covered person when care is obtained from a hospital emergency department or a behavioral health emergency services provider.[10]

Under SSB 5986, nonparticipating ground ambulance services may not balance bill health plan enrollees for covered ground ambulance services. Ground ambulance services include the rendering of medical treatment and care at the scene of a medical emergency or while transporting a patient to an appropriate emergency services provider. It also includes transport between emergency services providers, emergency services and medical facilities, and medical facilities when services are medically necessary and provided by ground ambulances designed for this purpose.

SSB 5986 also requires health carriers to cover ground ambulance transports to behavioral health emergency providers for enrollees who are experiencing an emergency medical condition. Health carriers may not apply prior authorization to these services if it was reasonable to believe that an emergency medical condition existed.

SSB 5986's requirement to cover ground ambulance transport to a behavioral health crisis facility or hospital emergency room brings the law into compliance with mental health parity law. It also relates to a method of reimbursement (i.e., restriction on balance billing). These changes do not constitute a new benefit, do not exceed the existing EHB package in Washington state and do not trigger the cost defrayal requirement.

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[8] Codified at RCW 48.43.005, 48.49.003, 48.49.060, 48.49.070, 49.49.090, 48.49.100, 48.49.130, 48.49.200, 48.49.205, 48.49.210, 18.73.300, 48.43.121, and 18.73.305.
[9] 42 U.S.C. §18022(b)(1)(B).
[10] WAC 284-43-5642 and RCW 48.43.093.

Relating to physician assistant collaborative practice (Chap. 62, Law of 2024)

In 2024, the Washington state Legislature enacted Engrossed Substitute House Bill (ESHB) 2041.[11]

Under the "Every Category of Provider" law, health carriers must permit every category of health care provider to provide health services or care included in the Essential Health Benefits Benchmark Plan, if the services or care are within the providers' permitted scope of practice.[12] This law covers all medical providers who are licensed, registered or certified by the Department of Health. This law does not cover certain health plans, including limited health plans, such as dental, vision, specific disease or accident-only plans.

A physician assistant (PA) is a person licensed by the Washington Medical Commission to practice medicine according to an agreement with one or more physicians where at least one physician is working in a supervisory capacity. A collaborative agreement is a written agreement that describes how a PA will be supervised by or collaborate with at least one physician.

ESHB 2041 requires PAs to practice medicine under the terms of one or more collaboration agreements. PAs may practice in any area of medicine or surgery as long as it is not beyond the scope of expertise and clinical practice of the:

- Participating provider; or
- Group of physicians within the department or specialty in which the PA practices.

Whether a PA can collaborate with or must be supervised by a physician is dependent on the amount of postgraduate clinical practice hours they have completed and whether they practice in a rural or underserved location.

ESHB 2041 authorizes health carriers to reimburse employers of PAs for covered services rendered by PAs. Health carriers must pay for services within a PA’s scope of practice when ordered or performed by a PA if the same services would have been covered if ordered or performed by a physician. Health carriers may not impose practice, education or collaboration requirements that are inconsistent with or more restrictive than state law or regulations.

Because ESHB 2041 relates to provider type (physician assistants acting within their scope practice), 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.

Concerning audio-only telemedicine (Chap. 215, Laws of 2024)

In 2024, the Washington state Legislature enacted Senate Bill (SB) 5821.[13]

[11] Codified at RCW 18.71A.020, 18.71A.025, 18.71A.030, 18.71A.050, 18.71A.090, 18.71A.120, 18.71A.150, 51.28.100, 10.77.175, 18.71.030, 7.68.030, 51.04.030, 71.05.215, 71.05.217, 71.05.585, 71.32.110, 71.32.140, 71.32.250, 71.34.020, 71.34.755, 74.09.497, 18.71A.010, 69.50.101, 71.05.020, 71.34.750, 9.41.010, 18.71A.820, and 48.43.835.
[12] RCW 48.43.045.
[13] Codified at RCW 41.05.700, 48.43.735, and 74.09.325.

Under RCW 48.43.735, if services are covered as an essential health benefit (EHB), health carriers must reimburse providers for health care services provided through telemedicine or store-and-forward technology if certain criteria are met. Additional requirements apply to coverage of audio-only telemedicine services, one of which is a requirement related to a provider having an established relationship with a patient.

SB 5821 applies the definition of "established relationship" for behavioral health services provided via audio-only telemedicine to all covered services.

An established relationship is a covered person who must have had within the past three years at least one in-person or real-time interactive appointment with the provider:

- Or with a provider at the same medical group, clinic or integrated delivery system; or
- Who referred the covered person to the provider providing the audio-only telemedicine services. The referring provider must provide relevant medical information to the provider providing audio-only telemedicine.

Because SB 5821 relates to a benefit delivery method (i.e., the circumstances under which audio-only telemedicine will be covered for a service already considered an EHB), 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.

Relating to the cost of inhalers and epinephrine (Chap. 226, Laws of 2024)

In 2024, the Washington state Legislature enacted Substitute House Bill (SHB) 1979.[14]

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).[15] The state-designated EHB benchmark plan covers prescription drugs, medications and supplies, including self-administrable prescription medications when limited to 30-day supplies.[16]

Under SHB 1979, health plans must cap the total amount an enrollee is required to pay for:

- A 30-day supply of at least one covered inhaled corticosteroid and at least one covered inhaled corticosteroid combination at $35; and
- At least one covered epinephrine autoinjector product containing at least two autoinjectors at $35.

SHB 1979 also requires prescription asthma inhalers and epinephrine autoinjectors to be covered without being subject to a deductible. Any cost-sharing paid by an enrollee must be applied towards an enrollee's deductible obligation.

[14] Codified at RCW 48.43.780.
[15] 42 U.S.C. §18022(b)(1)(F).
[16] WAC 284-43-5642.

For health plans with an associated health savings account, health carriers must limit cost-sharing at a minimum level necessary to preserve an enrollee's ability to claim tax-exempt contributions and withdrawals for:

- Asthma inhalers that are not on the federal internal revenue preventive care services list; and
- Epinephrine autoinjectors.

Because SHB 1979 addresses cost sharing for prescription drug benefits (asthma inhalers and epinephrine) covered under the EHB, 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.

Relating to treatment of substance use disorders (Chap. 366, Laws of 2024)

In 2024, the Washington state Legislature enacted Second Substitute Senate Bill (2SSB) 6228.[17]

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).[18] 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.[19] The state-designated EHB benchmark plan also covers prescription drugs, medications and supplies.

Under 2SSB 6228, if a health plan authorizes inpatient or residential substance use disorder treatment services, the initial length of authorization must be at least 14 days from when a patient was admitted. Any reauthorization following the first 14 days must continue for no less than seven days.

2SSB 6228 prohibits health plans from using a patient's length of abstinence as the primary basis for determining that medical necessity criteria have not been met or from considering abstinence when due to certain events.

2SSB 6228 requires health carriers to reimburse hospitals that bill opioid reversal medication and the administration of long-acting injectable buprenorphine as separate reimbursable expenses.

Because 2SSB 6228 relates to benefit delivery method (length of authorization) and method of reimbursement (opioid reversal medication and injectable buprenorphine), 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.

[17] Codified at RCW 71.24.037, 41.05.526, 48.43.761, 71.24.618, 43.70.250, 41.05.527, 48.43.762, 42.56.360, 71.24.847, 28B.20.550, 71.24.621, 41.05.531, 48.43.764, 71.24.619, 71.05.765, and 74.09.559.
[18] 42 U.S.C. §18022(b)(1)(E).
[19] WAC 284-43-5642 and RCW 48.43.093.

Relating to increasing access to human immunodeficiency virus postexposure prophylaxis drugs or therapies (Chap. 251, Laws of 2024)

In 2024, the Washington state Legislature enacted Engrossed Substitute Senate Bill (ESSB) 6127.[20]

The ACA requires non-grandfathered health plans in the individual and small group markets to cover prescription drugs, preventive or wellness services and emergency services as categories of essential health benefits (EHB).[21] The state-designated EHB benchmark plan covers prescription drugs, medications and supplies, including self-administrable prescription medications when limited to 30-day supplies, and prescription medications associated with an emergency medical condition.[22]

ESSB 6127 requires hospitals to adopt policies for dispensing or delivering post-exposure prophylaxis (PEP) that are consistent with Centers for Disease Control and Prevention (CDC) guidelines. These polices also must ensure that hospital staff dispense or deliver to a patient, with their informed consent, a 28-day supply of PEP drugs or therapies following the patient's possible exposure to HIV, unless medically contraindicated, inconsistent with accepted standards of care, or inconsistent with CDC guidelines.

ESSB 6127 prohibits health carriers from imposing cost sharing or requiring prior authorization for drugs that comprise at least one regimen recommended by the CDC for HIV PEP drugs.

For health plans with an associated health savings account (HSA), health carriers must limit cost sharing at the minimum level necessary to preserve an enrollee’s ability to claim tax exempt contributions and withdrawals from the HSA.

ESSB 6127 requires health carriers to reimburse hospitals for a 28-day supply of any PEP drugs or therapies dispensed or delivered to a patient in the emergency department for take-home use, as a separate expense.

Because ESSB 6127 addresses cost-sharing for prescription drugs (PEP), benefit delivery method (no prior authorization) and method of reimbursement (separate reimbursable expense), 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.

Relating to preserving coverage of preventive services without cost sharing (Chap. 314, Laws of 2024)

In 2024, the Washington state Legislature enacted Engrossed Substitute House Bill (ESHB) 1957.[23]

[20] Codified at RCW 70.41.495, 70.41.480, 48.43.440, 74.09.665, and 41.05.017.

[21] 42 U.S.C. §18022(b)(1)(B), (F), and (I).

[22] WAC 284-43-5642.

[23] Codified at RCW 48.43.047.

The ACA requires non-grandfathered health plans in the individual and small group markets to cover preventive or wellness services as a category of essential health benefits (EHB).[24] The state-designated EHB benchmark plan requires these health plans to cover preventive and wellness services, including:

- Those given an A or B rating by the United States Preventive Services Task Force (USPSTF).
- Immunizations recommend by the Advisory Committee on Immunization Practices (ACIP) of the Centers for Disease Control and Prevention (CDC).
- Children's preventive services guidelines issued by the HHS Health Resources and Services Administration (HRSA).
- Women's health guidelines issued by HRSA.[25]

ESHB 1957 requires health plans issued or renewed on or after June 6, 2024, to provide coverage for preventive services without cost sharing when provided by an in-network provider. The following preventive services, as recommendations or guidelines existed on Jan. 8, 2024, must be covered:

- Evidence-based items or services that have a rating of A or B in the current recommendations of the USPSTF.
- Immunizations for routine use in children, adolescents, and adults recommended by the ACIP of the CDC.
- Preventive care and screenings for infants, children and adolescents provided for in comprehensive guidelines supported by the United States Health Resources and Services Administration (HRSA).
- Preventive care and screenings for women provided for in comprehensive guidelines supported by the HRSA.

As the recommendations and guidelines are revised, health carriers must annually determine whether any additional items or services must be covered without cost sharing or whether any items or services are no longer required to be covered. This determination must be included in health plan fillings submitted to the Insurance Commissioner.

If a health plan does not have in-network providers that can provide preventive services, the plan must cover the services without cost sharing when provided by an out-of-network provider. Health carriers may use reasonable medical management techniques to determine the frequency, method, treatment or setting for an item or service to the extent not specified in the relevant recommendation or guidelines.

Because ESHB 1957 imbeds current provisions of the federal Affordable Care Act related to coverage of preventive services into state law, 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.

[24] 42 U.S.C. §18022(b)(1)(I).
[25] WAC 284-43-5642.

Conclusion

Since the laws enacted by the Washington state Legislature in 2024 did not establish any new benefit mandates, the Insurance Commissioner concludes there is no obligation for the state to pay costs for QHPs complying with those laws.