H-1715.1

SUBSTITUTE HOUSE BILL 1846

State of Washington 63rd Legislature 2013 Regular Session

By House Health Care & Wellness (originally sponsored by Representatives Schmick, Cody, and Ryu)

READ FIRST TIME 02/22/13.

AN ACT Relating to stand-alone dental coverage; and amending RCW 48.43.715.

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

Sec. 1. RCW 48.43.715 and 2012 c 87 s 13 are each amended to read as follows:

(1) Consistent with federal law, 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 under P.L. 111-148 of 2010, as amended.

(2) If the essential health benefits benchmark plan for the individual and small group market does not include all of the ten benefit categories specified by section 1302 of P.L. 111-148, as amended, the commissioner, in consultation with the board and the health care authority, shall, by rule, supplement the benchmark plan benefits as needed to meet the minimum requirements of section 1302.

(3) A health plan required to offer the essential health benefits, other than a health plan offered through the federal basic health

program or medicaid, under P.L. 111-148 of 2010, as amended, 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 ((~~must~~)):

(a) Must ensure that the plan covers the ten essential health benefits categories specified in section 1302 of P.L. 111-148 of 2010, as amended; ((~~and~~))

(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 benefit categories specified by section 1302 of P.L. 111-148 of 2010, as amended; and

(c) Notwithstanding the foregoing, for benefit years beginning January 1, 2015, and only to the extent permitted by federal law and guidance, 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.

(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.

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