Washington State
House of Representatives
Office of Program Research

BILL ANALYSIS

Health Care & Wellness Committee

SSB 5338

Brief Description: Reviewing the state's essential health benefits.

Sponsors: Senate Committee on Health & Long Term Care (originally sponsored by Senators Cleveland, Muzzall, Conway and Randall).

Brief Summary of Substitute Bill

- Requires the Office of the Insurance Commissioner (OIC) to review the state's benchmark plan to determine whether to request approval from the Centers for Medicare and Medicaid Services to modify the benchmark plan.
- Requires the OIC to determine the impacts of coverage of certain services on individual and small group health plan design, actuarial values, and premiums if the services were included as an essential health benefit.

Hearing Date: 2/28/23

Staff: Kim Weidenaar (786-7120).

Background:

Essential Health Benefits Benchmark Plan.
Passed in 2010, the federal Patient Protection and Affordable Care Act (ACA) enacted a variety of provisions related to private health insurance coverage, including establishing essential health benefits. The ACA requires most individual and small group market health plans to cover 10 categories of essential health benefits (EHBs). To determine the specific services covered within each category, federal rules allow states to choose a benchmark plan and to supplement that plan to ensure it covers all 10 categories. State law requires the Insurance Commissioner

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(Commissioner) to select the largest small group plan in the state as the benchmark plan for individual and small group plans in rule, establishing the EHBs in Washington. The most recent designation was in 2016 and is the Regence BlueShield Direct Gold + small group plan. Legislation passed in 2022 requires that upon authorization by the Legislature to modify the state's EHB benchmark plan, the Commissioner must include donor human milk in the updated plan.

Defrayal of State-Mandated Benefits.
Under the ACA, states must defray the cost of any additional premium cost associated with new mandated benefits applicable to qualified health plans beyond what is included in the benchmark plan. The defrayal requirement applies to new benefit mandates the state imposes on small group and individual health plans but does not apply to changes in how a benefit is provided (for example, telemedicine requirements or cost sharing prohibitions) or any changes necessary to comply with federal law. If the state is required to defray the cost of a new benefit mandate, the state must defray the cost for qualified health plans, which only includes individual plans in Washington. State law requires the Office of the Insurance Commissioner to submit a report each December listing the state-mandated health benefits as well as any anticipated costs to the state and any statutory changes needed if the funds to defray the costs are not appropriated. 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.

Process to Update the State's Essential Health Benefits Benchmark Plan.
In 2019 the Department of Health and Human Services issued a notice of benefits and payment parameters that gives states an opportunity to update their EHB benchmark plans for 2020 and beyond. For the EHB benchmark plan update to be approved, states must meet two thresholds: the typicality test and the generosity test. Under the typicality test, the state must show that the benefits included in the proposed updated benchmark plan are equal to or exceed the scope of benefits provided by a typical employer plan. Under the generosity test, the state is limited in the additional benefits the states can add to the EHB benchmark plan. Under the test, the proposed updated plan must be compared to the state's benchmark plan or 10 other plan options (including a state employee plan) and cannot be any richer than the comparison plan chosen by the state. The proposed updated plan may not include any discriminatory benefit design or be unduly weighed towards a particular category

The deadline for submission of a request and supporting documents for a future plan year is May two years before the plan year the EHBs benchmark plan update would take effect. The submission must include an actuarial analysis, a report showing that the state meets both the typicality and generosity tests, and a description of the new benchmark plan, including a description of benefits and limits.

Summary of Bill:

The Office of the Insurance Commissioner (OIC), in consultation with interested persons and

entities, must review Washington's benchmark health plan to determine whether to request approval from the Centers for Medicare and Medicaid Services (CMS) to modify the state's essential health benefits (EHBs) benchmark plan. The OIC must determine the potential impacts on individual and small group health plan design, actuarial values, and premiums if coverage for the following was included in the benchmark plan:

- hearing instruments and associated services;
- fertility services;
- biomarker testing;
- contralateral prophylactic mastectomies; and
- magnetic resonance imaging for breast cancer screening.

By December 1, 2023, the OIC must report the results of the review to the relevant committees of the Legislature.

The Insurance Commissioner must include donor human milk in any update of the state's EHBs benchmark plan submitted to CMS.

Appropriation: None.

Fiscal Note: Available.

Effective Date: The bill takes effect 90 days after adjournment of the session in which the bill is passed.