HOUSE BILL REPORT
SSB 5338

As Reported by House Committee On:
Health Care & Wellness

Title: An act relating to a review of the state's essential health benefits.

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 History:
Committee Activity:
Health Care & Wellness: 2/28/23, 3/10/23 [DPA].

Brief Summary of Substitute Bill
(As Amended By Committee)

- 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.

HOUSE COMMITTEE ON HEALTH CARE & WELLNESS

Majority Report: Do pass as amended. Signed by 17 members: Representatives Riccelli, Chair; Bateman, Vice Chair; Schmick, Ranking Minority Member; Hutchins, Assistant Ranking Minority Member; Barnard, Bronoske, Davis, Graham, Harris, Macri, Maycumber, Mosbrucker, Orwall, Simmons, Stonier, Thai and Tharinger.

This analysis was prepared by non-partisan legislative staff for the use of legislative members in their deliberations. This analysis is not part of the legislation nor does it constitute a statement of legislative intent.

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 (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 Amended Bill:

The Office of the Insurance Commissioner (OIC), in consultation with interested persons and entities, must review Washington's benchmark 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:

- donor human milk;
- treatment for Pediatric Acute-onset Neuropsychiatric Syndrome and Pediatric Autoimmune Neuropsychiatric Disorders Associated with Streptococcal Infections;
- hearing instruments and associated services;
- fertility services;
- biomarker testing;
- contralateral prophylactic mastectomies; and
- magnetic resonance imaging for breast cancer screening.

By December 31, 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 and hearing instruments and associated services in any update of the state's EHBs benchmark plan submitted to CMS.

Amended Bill Compared to Substitute Bill:

The amended bill:

- adds donor human milk and treatment for Pediatric Acute-onset Neuropsychiatric Syndrome and Pediatric Autoimmune Neuropsychiatric Disorders Associated with Streptococcal Infections (known as PANS/PANDAS) to the benefits that the Office of the Insurance Commissioner (OIC) must review;
- adds hearing instruments and associated services to the benefits that the Insurance Commissioner must include in any update of the state's essential health benefits benchmark plan;
- moves back the date the OIC must report the results of the review from December 1,

2023, to December 31, 2023;
- makes technical corrections, such as referencing statutes and bills before the Legislature; and
- adds an emergency clause.

Appropriation: None.

Fiscal Note: Available.

Effective Date of Amended Bill: The bill contains an emergency clause and takes effect immediately.

Staff Summary of Public Testimony:

(In support) The Legislature has continually been asked this session to take a complete look at the cumulative impact of all of the bills that mandate coverage and their impact on health insurance premiums and the cost of care. This bill does just that. It looks at the impact of adding additional benefits to plan design, actuarial values, and premiums.

The implementing agency has a few technical amendment requests to merge language with other bills as well as to push back the date of the report to December 31, 2023, to give an extra month. The agency will need to set up a competitive procurement and the actual actuarial work is extensive and will take time. There is hope that the bill will move quickly so that this work can be started soon.

Hearing loss creates significant health consequences for adults and children. Children in particular must have access to hearing instruments in order to learn in school and function well in society. Hearing instruments allow children to interact with their peers, friends, and family. Hearing health care for adults means employment opportunities, staying out of unaffordable assisted living, and easily being able to access education and health. Seventeen other states have included hearing coverage for children in their essential health benefits and five more have included coverage for both adults and children. Currently there is very minimal coverage for hearing instruments and some have been told that hearing instruments are considered cosmetic.

It is important to revisit the state's essential health benefits benchmark plan. The decision of what to cover in the plan is a complicated one and medicine advances all the time. This bill directs the Office of the Insurance Commissioner to engage stakeholders in the process. This bill is the next step to make sure people have access to quality health coverage.

(Opposed) None.

Persons Testifying: Cynthia Stewart, Hearing Loss Association of Washington; Christine

Griffin; Brett Gramer; Jane Beyer, Office of the Insurance Commissioner; Stephanie Simpson, Bleeding Disorder Foundation of Washington; and Jennifer Ziegler, Association of Washington Health Care Plans.

Persons Signed In To Testify But Not Testifying: None.