
SUBSTITUTE HOUSE BILL 1222

State of Washington

68th Legislature

2023 Regular Session

By House Health Care & Wellness (originally sponsored by Representatives Orwall, Simmons, Reeves, Reed, Leavitt, Kloba, Farivar, Doglio, Morgan, Slatter, Ramel, Goodman, Callan, Fosse, Pollet, Lekanoff, and Macri)

READ FIRST TIME 01/30/23.

1 AN ACT Relating to requiring coverage for hearing instruments;
2 amending RCW 48.43.715; and adding a new section to chapter 48.43
3 RCW.

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

5 NEW SECTION. **Sec. 1.** A new section is added to chapter 48.43
6 RCW to read as follows:

7 (1) For nongrandfathered group health plans other than small
8 group health plans issued or renewed on or after January 1, 2024, a
9 health carrier shall include coverage for hearing instruments,
10 including bone conduction hearing devices. This section does not
11 include coverage of over-the-counter hearing instruments.

12 (2) Coverage shall also include the initial assessment, fitting,
13 adjustment, auditory training, and ear molds as necessary to maintain
14 optimal fit. Coverage of these services shall include services for
15 enrollees who intend to obtain or have already obtained any hearing
16 instrument, including an over-the-counter hearing instrument.

17 (3) A health carrier may establish a benefit limit for the
18 coverage required in subsection (1) of this section of no less than
19 \$2,500 per ear with hearing loss every 36 months.

20 (4) The services and hearing instruments covered under this
21 section are not subject to the enrollee's deductible unless the

1 health plan is offered as a qualifying health plan for a health
2 savings account. For such a qualifying health plan, the carrier may
3 apply a deductible to coverage of the services covered under this
4 section only at the minimum level necessary to preserve the
5 enrollee's ability to claim tax exempt contributions and withdrawals
6 from the enrollee's health savings account under internal revenue
7 service laws and regulations.

8 (5) An enrollee may choose a higher priced hearing instrument and
9 pay the difference between the price of the hearing instrument and
10 the minimum benefit amount established in subsection (3) of this
11 section, without financial or contractual penalty to the enrollee or
12 to the in-network provider of the hearing instrument.

13 (6) Coverage for a minor under 18 years of age shall be available
14 under this section only after the minor has received medical
15 clearance within the preceding six months from:

16 (a) An otolaryngologist for an initial evaluation of hearing
17 loss; or

18 (b) A licensed physician, which indicates there has not been a
19 substantial change in clinical status since the initial evaluation by
20 an otolaryngologist.

21 (7) For the purposes of this section:

22 (a) "Hearing instrument" has the same meaning as defined in RCW
23 18.35.010.

24 (b) "Over-the-counter hearing instrument" has the same meaning as
25 "over-the-counter hearing aid" in 21 C.F.R. Sec. 800.30 as of
26 December 28, 2022.

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

29 (1) The commissioner, in consultation with the board and the
30 health care authority, shall, by rule, select the largest small group
31 plan in the state by enrollment as the benchmark plan for the
32 individual and small group market for purposes of establishing the
33 essential health benefits in Washington state.

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

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

8 (a) Must ensure that the plan covers the ten essential health
9 benefits categories;

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

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

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

22 (4) Beginning December 15, 2012, and every year thereafter, the
23 commissioner shall submit to the legislature a list of state-mandated
24 health benefits, the enforcement of which will result in federally
25 imposed costs to the state related to the plans sold through the
26 exchange because the benefits are not included in the essential
27 health benefits designated under federal law. The list must include
28 the anticipated costs to the state of each state-mandated health
29 benefit on the list and any statutory changes needed if funds are not
30 appropriated to defray the state costs for the listed mandate. The
31 commissioner may enforce a mandate on the list for the entire market
32 only if funds are appropriated in an omnibus appropriations act
33 specifically to pay the state portion of the identified costs.

34 (5) Upon authorization by the legislature to modify the state's
35 essential health benefits benchmark plan under 45 C.F.R. Sec.
36 156.111, the commissioner shall include coverage for donor human milk
37 and hearing instruments in the updated plan.

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