FINAL BILL REPORT
SSB 6219

Synopsis as Enacted

Brief Description: Concerning health plan coverage of reproductive health care.

Sponsors: Senate Committee on Health & Long Term Care (originally sponsored by Senators Hobbs, Saldaña, Dhingra, Ranker, Carlyle, Takko, Kuderer, Hasegawa, Palumbo, Chase, Nelson, Frockt, Keiser, Wellman, Darneille, Mullet, Billig, Pedersen, Rolfes, Hunt and Liias).

Senate Committee on Health & Long Term Care
Senate Committee on Ways & Means
House Committee on Health Care & Wellness

Background: Insurance Coverage for Contraception. *Federal Law*. Under the federal Patient Protection and Affordable Care Act (ACA), all group health plans must cover preventive services with no cost-sharing. Under federal rules, preventive services include all federal Food and Drug Administration (FDA) approved contraceptive methods. Drugs that induce abortions and vasectomies are not included in this coverage mandate.

Pursuant to federal rules, a health plan purchased or offered by a religious employer, is not required to cover contraceptives. A health plan purchased or offered by a non-profit religious organization, is not required to cover contraceptives if the organization certifies that it has religious objections—in which case the carrier covers the cost of the coverage. In *Burwell v. Hobby Lobby*, the United States Supreme Court ruled that requiring a closely held corporation to cover contraceptives with no cost-sharing violates the Religious Freedom Restoration Act (RFRA) when such coverage violates the corporation's religious beliefs. RFRA does not apply to state laws.

Pursuant to federal rules, a health plan is also not required to cover contraceptives if an organization or small business has an objection on the basis of moral conviction, not based in any particular religious belief. Federal courts in Pennsylvania and the Northern District of California issued preliminary injunctions, blocking implementation of this rule, in December 2017.

State Law. The ACA requires non-grandfathered individual and small group market health plans to offer the essential health benefits. The essential health benefits are established by the states using a supplemented benchmark plan. Prescription drugs, including all FDA-approved contraceptive methods and prescription-based sterilization procedures for women, are included in Washington's essential health benefits package. A health carrier may subject this contraceptive coverage to cost-sharing requirements.

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

Rules adopted by the Office of the Insurance Commissioner (OIC) require a state-regulated health plan to cover prescription contraceptives if it provides generally comprehensive coverage of prescription drugs. This requirement applies to all state-regulated health plans, regardless of whether they are subject to the essential health benefits requirement. A health carrier may subject this contraceptive coverage to cost-sharing requirements.

Insurance Coverage for Abortions. *Federal Law*. Under the federal Hyde Amendment, a provision that has historically been added to most federal appropriations bills, federal funds may not be used for abortions, except for pregnancies resulting from rape or incest or if the pregnancy would endanger the woman's life. Most abortions are therefore not covered by federal programs such as Medicaid. However, states have the option to cover abortions under Medicaid as long as only state funds are used for such coverage.

The federal Weldon Amendment, which has also historically been added to federal appropriations bills, prohibits federal funds from going to a state that subjects any institutional or individual health care entity to discrimination on the basis that the health care entity does not provide, pay for, provide coverage of, or refer for abortions. Health care entity includes both health maintenance organizations and health insurance plans.

Under the ACA, a state has the option to prohibit coverage of abortions in its Health Benefit Exchange Exchange (Exchange). If a state chooses to allow coverage for abortions in the Exchange, at least one federally designated multi-state plan must not provide coverage for abortions beyond what is allowed by the Hyde Amendment. Premium and cost-sharing subsidies may not be used to purchase abortion coverage.

Under the ACA any plan in the Exchange that covers abortions must collect two separate payments, one for the abortion services and one for all other benefits. A plan that covers abortions must segregate the funds attributable to the abortion benefit in a separate account. The actuarial value of the abortion benefit must be at least $1 per month and may not take into account any savings that may accrue due to an abortion.

A health carrier inside the Exchange cannot be required to offer abortion coverage as part of its essential health benefits. Under federal rules implementing the ACA, this prohibition applies to health carriers outside the Exchange as well.

State Law. The state may not deny or interfere with a woman's right to choose to have an abortion prior to viability or to protect the woman's life or health. All other types of abortions are unlawful and any person who performs such an abortion is guilty of a class C felony.

If the state provides, directly or by contract, maternity care benefits, services, or information to women through any program administered by the state, the state must also provide women otherwise qualified for the program with substantially equivalent benefits, services, or information to permit them to voluntarily terminate their pregnancies.

Washington's Benchmark Plan, the largest small group market plan in the state, covers abortion, so the termination of pregnancy is included in the rules defining Washington's

essential health benefits package, although it is currently an optional benefit under those rules.

Objections Based on Conscience or Religion Under State Law. No individual health care provider, religiously sponsored health carrier, or health care facility may be required by law or contract in any circumstances to participate in the provision of or payment for a specific service if they object to so doing for reason of conscience or religion. No person may be discriminated against in employment or professional privileges because of such objection. No individual or organization with a religious or moral tenet opposed to a specific service may be required to purchase coverage for that service or services if they object to doing so for reason of conscience or religion.

The OIC must establish a mechanism to recognize the right of conscience while ensuring enrollees timely access to services and to ensure prompt payment to providers. Under rules adopted by the OIC, all carriers are required to file a description of the process they will use to recognize an organization or individual's exercise of conscience when purchasing coverage; the process may not affect a non-objecting enrollee's access to coverage for those services.

In 2006, the attorney general issued an opinion regarding the OIC rule that requires carriers that cover prescription drugs to also cover contraceptives. According to the attorney general's opinion, the rule did not supersede the statutory right of conscience; it only limited one of the ways in which the right could be exercised. This is because the rule did not require prescription drug coverage and did not apply directly to employers.

The Governor's Interagency Coordinating Council on Health Disparities. Created in 2006, the Governor's Interagency Coordinating Council on Health Disparities (Council) promotes and facilitates communication, coordination, and collaboration among state agencies, communities of color, the private sector, and the public sector to address health disparities. The Council creates and updates an action plan for eliminating health disparities and contributes to the health impact review process. The Council will be subject to a sunset review in 2016.

Summary: Health plans issued or renewed on or after January 1, 2019, are required to provide coverage for all contraceptive drugs, devices and other products approved by the FDA, voluntary sterilization, and any consultations, examinations, procedures and medical services that are necessary. The coverage may not require copayments, deductibles, or other forms of cost-sharing and may not require a prescription to trigger coverage of over-the-counter drugs, devices, or products. Health plans offered as a qualifying health plan for a health savings account are not prohibited from charging cost-sharing for coverage, but must establish the plan's cost-sharing at the minimum level necessary to preserve the enrollee's ability to utilize the tax benefits of his or her health savings account. Coverage may not be denied because an enrollee changes their contraceptive method within a 12-month period.

A health plan may not impose restrictions or delays on the required coverage, such as medical management techniques that limit enrollee choice, and benefits must be extended to all enrollees.

If a health plan, other than a multistate health plan, issued or renewed on or after January 1, 2019, provides coverage for maternity care, the health plan must also provide a substantially equivalent coverage to permit the abortion of a pregnancy. The health plan may not limit the way in which a person can access services related to the abortion of a pregnancy, but the coverage for the abortion may be subject to terms and conditions generally applicable to the health plan's coverage of maternity care, including applicable cost sharing. A health plan is not required to cover abortions that would be unlawful.

If the application of the contraceptive coverage or abortion coverage requirements would result in noncompliance with federal requirements that are a prescribed condition to the allocation of federal funds to the state, then the requirement will be deemed inapplicable to the affected health plan to the minimum extent necessary for the state to be in compliance.

The Council is directed to do a literature review on disparities in access to reproductive health care based on socioeconomic status, race, sexual orientation, gender identity, ethnicity, geography, and other factors. The Council shall report the results of the review to the Governor and relevant committees of the Legislature by January 1, 2019.

Votes on Final Passage:

Senate	26	22	
House	50	48	(House amended)
Senate	27	22	(Senate concurred)

Effective: Ninety days after adjournment of session in which bill is passed.