Washington State
House of Representatives
Office of Program Research

BILL ANALYSIS

Health Care & Wellness Committee

SSB 6219

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).

Brief Summary of Substitute Bill

- Requires health carriers to cover contraceptives without cost-sharing.
- Requires health plans that cover maternity care or services to cover the voluntary termination of pregnancy.
- Requires the Governor's Interagency Coordinating Council on Health Disparities to conduct a literature review on disparities in access to reproductive health.

Hearing Date: 2/7/18

Staff: Jim Morishima (786-7191).

Background:

I. Insurance Coverage for Contraception.

A. 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, such as a church, is not required to cover contraceptives. A health plan purchased or offered by a non-profit religious organization, such as a religiously affiliated hospital, is not required to cover

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contraceptives if the organization certifies that it has religious objections (in which case the carrier covers the cost of the coverage). A health plan purchased by an organization or small business that has an objection based on moral convictions is also not required to cover contraceptives.

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. However, the RFRA does not apply to state laws.

B. State Law.

Under the ACA, each state must establish a Health Benefit Exchange (Exchange) in which consumers may compare and purchase individual and small group market health insurance. Individuals between 134 and 400 percent of the federal poverty level are eligible for federal premium and cost-sharing subsidies in the Exchange on a sliding scale.

The ACA requires non-grandfathered individual and small group market health plans to offer the "essential health benefits" both inside and outside of the Exchange. 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.

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.

A health plan that offers coverage for contraceptive drugs must reimburse for a 12-month refill obtained at one time by the enrollee, unless the enrollee requests a smaller supply or the prescribing provider instructs that the enrollee receive a smaller supply. The health plan must allow the enrollee to receive the contraceptive drugs on-site at the provider's office, if available. Any dispensing practices required by the plan must follow clinical guidelines for appropriate prescribing and dispensing to ensure the health of the patient while maximizing access to effective contraceptive drugs.

II. Insurance Coverage for Abortions.

A. 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 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.

The ACA does not preempt or affect state laws regarding the prohibition of (or requirement of) coverage, funding, or procedural requirements on abortion. 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 may not 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.

B. 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 an optional benefit under those rules.

III. 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 provisions allowing the exercise of conscientious objection are not intended to result in an enrollee being denied timely access to any services in the state's Basic Health Plan. A health carrier must:

- provide enrollees written notice of the services the carrier refuses to cover for reason of conscience or religion;
- provide written information describing how an enrollee may directly access services in an expeditious manner; and
- ensure that enrollees who are refused services have prompt access to information describing how they may directly access services in an expeditious manner.

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. A religiously sponsored carrier that elects not to cover certain benefits because of religious beliefs must file a description of the process by which its enrollees will have timely access to all Basic Health Plan 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.

IV. 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.

Summary of Bill:

I. Insurance Coverage for Contraception.

A health plan issued or renewed on or after January 1, 2019, must provide coverage for:

- all FDA-approved contraceptive drugs, devices, and other products, including over-the-counter contraceptive drugs, devices, and products;
- voluntary sterilization procedures; and
- the consultations, examinations, procedures, and medical services that are necessary to prescribe, dispense, insert, deliver, distribute, administer, or remove the drugs, devices, or other products or services.

The health plan must provide coverage that:

- does not require cost-sharing;

- does not require a prescription to trigger coverage of over-the-counter, FDA-approved contraceptive drugs, devices, and products; and
- extends to all enrollees, enrolled spouses, and enrolled dependents.

A health carrier may not:
- deny an enrollee coverage because he or she changes his or her contraceptive method within a 12-month period;
- impose any restrictions or delays on the contraceptive coverage, such as medical management techniques that limit enrollee choice in accessing the full range of FDA-approved contraceptive drugs, devices, or other products; or
- deny care on the basis of race, color, national origin, sex, sexual orientation, gender expression of identity, marital status, age, citizenship, immigration status, or disability.

II. Insurance Coverage of Abortions.

If a health plan issued or renewed on or after January 1, 2019, provides coverage for maternity care or services, it must also provide substantially equivalent coverage to permit the voluntary termination of a pregnancy. The plan may not limit a woman's access to services related to the voluntary termination of a pregnancy, except for generally applicable terms and conditions, including cost-sharing. A health plan is not required to cover abortions that would be illegal under state law. The coverage requirement does not apply to a federally designated multi-state plan that does not, under federal law, cover the voluntary termination of pregnancy.

The requirement that a health plan that covers maternity care or services must also cover the voluntary termination of pregnancy is inapplicable to the extent that it results in non-compliance with federal requirements that are a prescribed condition for federal funds. In these cases, the requirement is inapplicable to the minimum extent necessary for the state to be in compliance. The inapplicability of the requirement to a specific health plan does not affect its applicability in other circumstances.

III. The Governor's Interagency Coordinating Council on Health Disparities.

The Council must conduct 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. By January 1, 2019, the Council must report the results of the literature review and make recommendations on reducing or removing the disparities to the Governor and the relevant standing committees of the Legislature.

Appropriation: None.

Fiscal Note: Available.

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