Health Plan Coverage of Reproductive Healthcare & Contraception Rulemaking

Stakeholder draft | September 20, 2018

Comments due to the OIC by October 23, 2018

New Subchapter Title: Access to Reproductive Health Care and Contraception

WAC 284-43-XXX

Purpose and Scope

(1) The purpose of this subchapter is to establish uniform regulatory standards for required coverage of reproductive health care, contraceptive services and supplies, sterilization, and termination of pregnancy.

(2) This subchapter applies to all health plans, except as otherwise expressly provided in this subchapter. Health carriers are responsible for compliance with the provisions of this subchapter and are responsible for the compliance of any person or organization acting on behalf of or at the direction of the carrier, or acting pursuant to carrier standards or requirements concerning the coverage of, payment for, or provision of contraceptive services and supplies, sterilization, and termination of pregnancy. A carrier may not offer as a defense to a violation of any provision of this subchapter that the violation arose from the act or omission of a participating provider or facility, network administrator, claims administrator, or other person acting on behalf of or at the direction of the carrier, or acting pursuant to carrier standards or requirements under a contract with the carrier rather than from the direct act or omission of the carrier.

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Definitions

(1) “Cost-sharing” means any expenditure required of a covered person for covered services or supplies, including applicable taxes. Cost-sharing includes deductibles, coinsurance, copayments, or similar charges. Cost-sharing does not include premiums, balance billing amounts for non-network providers, or spending for non-covered services or supplies.

(2) “Contraceptive services” means consultations, examinations, procedures, and other health care services to obtain contraceptive supplies or sterilization. This includes prescribing, dispensing, inserting, delivering, distributing, administering, or removing contraceptive supplies and any sterilization procedures.

(3) “Contraceptive supplies” means all contraceptive drugs, devices, and other products approved by the federal food and drug administration. This includes over-the-counter contraceptive drugs, devices, and products approved by the federal food and drug administration used to prevent conception or sexually transmitted diseases.
(4) “Reproductive health care” means the reproductive processes, functions and system at all stages of life. Reproductive health care includes, but is not limited to, maternity care, reproductive health services, gynecological care, general examination of the reproductive system, contraceptive supplies including those used for the prevention and treatment of disease, and medically appropriate follow-up visits for these services.

(5) “Medical management techniques” means carrier practices to control expenditures or promote cost-efficiency. Examples of medical management techniques include, but are not limited to, denials, step therapy, and prior authorization.

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Coverage required

(1) A health plan issued or renewed on or after January 1, 2019, must provide coverage for all reproductive health services required under RCW 48.43.072 and RCW 48.43.073. These services include:

(a) All prescription and over-the-counter contraceptive drugs, devices, and other products approved by the federal food and drug administration;

(b) Voluntary sterilization procedures; and

(c) The consultations, examinations, procedures, and medical services that are necessary to prescribe, dispense, insert, deliver, distribute, administer, or remove the drugs, devices, and other products or services in (a) and (b) of this subsection.

(2) A health plan issued or renewed on or after January 1, 2019 that provides coverage for maternity care or services must also provide a covered person with substantially equivalent coverage to permit the abortion of a pregnancy. For the coverage to be substantially equivalent, an health plan must not apply cost-sharing or coverage limitations differently for termination of pregnancy services than for maternity care or services unless the difference provides the enrollee with access to care and treatment commensurate with the enrollee's specific medical needs, without imposing a surcharge or other additional cost to the enrollee beyond normal cost-sharing requirements under the plan.

(3) The coverage required by this section must be provided according to the terms and requirements set forth in RCW 48.43.072 and RCW 48.43.073.

(4) This subchapter does not diminish or affect any rights or responsibilities provided under RCW 48.43.065.

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Services provided without discrimination, prohibited limitations, and confidentiality

(1) All available methods of contraception must be covered without discrimination on the basis of race, color, national origin, sex, sexual orientation, gender expression or identity, marital status, age, citizenship, immigration status, or disability. This includes coverage of any method of over-the-counter contraception without regard to the gender of the covered person, such as the obtaining of condoms by women.
(2) Health plans are prohibited from including the following limitations:

(a) A health plan may not require a prescription to trigger coverage of over-the-counter contraceptive drugs, devices, and products, approved by the federal food and drug administration.

(a) A health plan may not deny coverage of contraceptive supplies or services because an enrollee changed contraceptive methods within a twelve-month period.

(b) Except as specifically authorized under RCW 48.43.072 or 48.43.073, a health plan may not impose any restrictions or delays on required coverage of contraceptive drugs, devices and products approved by the federal food and drug administration, such as medical management techniques that limit enrollee choice in accessing the full range of these items.

(c) Benefits required under RCW 48.43.072 and RCW 48.43.073 must be extended to all enrollees, enrolled spouses, and enrolled dependents; and

(d) Except as specifically authorized under RCW 48.43.073, a health plan may not limit in any way a person's access to services related to the abortion of a pregnancy.

(3) Reproductive healthcare, sterilization, termination of pregnancy or contraception services or supplies provided under a health plan are healthcare services related to reproductive health and protected by the confidentially requirements of WAC 284-04-510, and other relevant statutes and regulations providing for enrollee confidentiality.

**WAC 284-43-XXX**

**Access to Contraceptive Services and Supplies**

(1) A health plan must provide covered persons access to sufficient numbers and types of providers and facilities to assure that covered persons are able to access all covered contraception services and supplies without unreasonable delay or burden.

(2) If a health plan limits coverage of contraception services and supplies to in-network providers, the carrier must demonstrate its network for these services and supplies meets the access and adequacy standards set forth in Chapter 284-170 WAC.

(3) In any case where the health plan’s network has an absence of or an insufficient number or type of participating providers or facilities to provide a particular covered contraceptive supply or service, the carrier must ensure that the covered person obtains the covered service from a provider or facility within reasonable proximity of the enrollee at no greater cost to the enrollee than if the service were obtained from network providers and facilities. The carrier must satisfy this obligation even if an alternate access delivery request under WAC 284-170-210 has been submitted and is pending approval by the insurance commissioner.

(4) If a health plan limits the number of covered contraceptive items or services, the carrier must have a written process for covered persons to request coverage of additional items or services. The process may not impose any restriction or delay on the coverage of contraceptive items in violation of RCW 48.43.072(4) or any other state or federal law.
Filing requirements

(1) For health plans subject to RCW 48.43.072, the health plan must ensure that the form filing and plan clearly informs enrollees of their rights to access reproductive healthcare services, contraception, sterilization and termination of pregnancy and how they access these items and services.

(2) A health plan’s form filing must include a detailed description of the plan’s benefits provided to enrollees that specifically instructs covered persons where and how they access coverage of contraception supplies (including over-the-counter supplies). This information must include:
   (a) Whether covered supplies are available from in-network and out-of-network providers; and
   (b) How to submit a claim, including, at a minimum:
      (i) Whether covered persons may purchase covered supplies and seek reimbursement from the carrier;
      (ii) How to access and submit any necessary claim forms; and
      (iii) Where to send a claim (such as a mailing address or instructions for submitting a claim electronically).

(3) If a health plan limits the number of covered contraceptive items or services, the health plan must include with its filing supporting evidence showing that the limitation does not impose any restriction or delay on the coverage of contraceptive items or services in violation of RCW 48.43.072(4) or any other state or federal law.

(3) If a health plan limits the number of covered contraceptive items or services, the detailed description of the plan’s benefits provided to enrollees must specifically instruct covered persons how to request coverage of additional items or services. The process may not impose any restrictions or delays on the coverage or access of contraceptive items in violation of RCW 48.43.072(4) or any other state or federal law.

Deductibles for over-the-counter contraceptives and male sterilization in HSA qualifying health plans

(1) A qualifying health plan for a Health Savings Account (“HSA-qualifying plan”) is subject to all of the requirements under RCW 48.43.072. An HSA-qualifying plan may apply a deductible to coverage of over-the-counter contraceptive supplies or services and male sterilization only at the minimum level necessary to preserve the enrollee's ability to claim tax exempt contributions and withdrawals from his or her health savings account under federal internal revenue service laws and regulations.

(2) The individual and family deductibles applied to over-the-counter contraceptive supplies and services and male sterilization under an HSA-qualifying plan must be the minimum deductibles set by the federal internal revenue service for a plan to be an HSA-qualifying plan under 26 USC §223(c)(2)(A) and other internal revenue laws and regulations. In the event the IRS establishes a single minimum deductible that applies to all services, that deductible will apply to
over-the-counter contraceptive supplies and services and male sterilization. To the extent the IRS provides a transitional or temporary change in the minimum deductible permitted for over-the-counter contraceptive supplies and services and male sterilization that service specific deductible will be applied. Example: the minimum deductible for an HSA-qualifying plan in 2019 is one thousand three hundred fifty dollars for individuals and two thousand seven hundred for families. However, IRS Bulletin 2018-12 allows HSA-qualifying plans to offer benefits for male sterilization or male contraceptives without a deductible or with a deductible below the minimum deductible for the 2019 plan year only. Therefore, for 2019, HSA-qualifying health plans sold in this state may decide not to charge any deductible for male sterilization or male contraceptives for the 2019 plan year.

(a) The deductibles, if any, applied to over-the-counter contraceptive items and services and male sterilization must accrue to the overall individual and family plan deductibles.

(b) Once the individual and family plan deductibles that may apply to over-the-counter contraceptive items and services and male sterilization have been reached, all over-the-counter contraceptive items and services and male sterilization must be covered with no cost-sharing, even if the overall plan deductibles have not yet been met.

(c) No individual covered under an HSA-qualifying plan may be required to pay a higher deductible for over-the-counter contraceptive items and services and male sterilization than the minimum individual deductible set by the federal internal revenue service for a plan to be an HSA-qualifying plan, even if the applicable family deductible applicable to these benefits has not yet been met.

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