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 contraceptive services and supplies, voluntary sterilization, and abortion under RCW 48.43.072 and RCW 48.43.073.

(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, voluntary sterilization, and abortion. 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.

(3) Effective January 1, 2021, except as otherwise provided, this subchapter applies to all student health plans deemed by the insurance commissioner to have a short-term limited purpose or duration, including short-term limited purpose student health plans and guaranteed renewable plans while the covered person is enrolled student as a regular full-time undergraduate or graduate student at an accredited higher education institution.

WAC 284-43-XXX

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 voluntary sterilization. This includes prescribing, dispensing, inserting, delivering, distributing, administering, or removing contraceptive supplies and voluntary 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.

(4) “Covered person” or “enrollee” has the same meaning as defined in RCW 48.43.005.

(5) “Gender expression” has the same meaning as defined in Section 3, Chapter 399, Laws of 2019.

(6) “Gender identity” has the same meaning as defined in Section 3, Chapter 399, Laws of 2019.

(7) “Medical management” or “medical management techniques” has the same meaning as defined in RCW 48.165.010.

(8) “Reproductive health care services” has the same meaning as defined in Section 3, Chapter 399, Laws of 2019.

(9) “Reproductive system” has the same meaning as defined in Section 3, Chapter 399, Laws of 2019.

(10) “Well-person preventative visits” has the same meaning as defined in Section 3, Chapter 399, Laws of 2019.

WAC 284-43-XXX

Coverage required

A health plan must provide coverage for all services and supplies required under RCW 48.43.072 and RCW 48.43.073. Effective January 1, 2021, a student health plan must also provide coverage for all services and supplies required under RCW 48.43.072.

(1) Required coverage of contraceptive services and supplies includes, but is not limited to:

   (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 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, a health plan must not apply cost-sharing or coverage limitations differently for abortion and related services than for maternity care and its related 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) This subchapter does not diminish or affect any rights or responsibilities provided under RCW 48.43.065.
Services provided without discrimination, prohibited limitations, and confidentiality

(1) All services and supplies required under RCW 48.43.072 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. Health plans and student health plans must ensure that all enrollees have access to these services and supplies regardless of gender or gender identity. This includes, but is not limited to, coverage of any method of over-the-counter contraception without regard to the sex, or gender identity or expression, of the covered person.

(2) Reproductive health care, voluntary sterilization, abortion or contraceptive services or contraceptive supplies provided under a health plan or a student health plan are health care services related to reproductive health and protected by the confidentiality requirements of WAC 284-04-510, and other relevant statutes and regulations providing for enrollee confidentiality.

Access to Contraceptive Services and Supplies

(1) Health plans and student health plans 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 contraceptive services and all federal food and drug administration approved contraceptive supplies without unreasonable delay or burden.

(2) If a health plan or student health plan limits coverage of contraceptive services and supplies to in-network providers, the carrier must demonstrate that 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 or student 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 service or supply, including over-the-counter contraceptives, in a timely manner appropriate for the enrollee’s condition, the carrier must ensure that the covered person obtains the covered service or supply from a provider or facility within reasonable proximity of the enrollee at no greater cost to the enrollee than if the service or supply 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 or student health plan limits the quantity of covered contraceptive supplies or services, the carrier must have a written process for covered persons to request coverage of additional services or supplies. The process may not impose any restriction or delay on the coverage of contraceptive supplies in violation of RCW 48.43.072, RCW 48.43.195, or any other state or federal law.

(5) Effective January 1, 2021, contraceptive supplies must also be covered when used exclusively for the prevention of sexually transmitted infections.
Filing requirements

(1) For health plans subject to RCW 48.43.072 and RCW 48.43.073, the carrier must ensure that the health plan forms clearly inform covered persons of their rights to access contraceptive services and supplies, voluntary sterilization and abortion. The health plan forms must clearly inform covered persons how they access these services and supplies.

(2) For student health plans subject to RCW 48.43.072, the carrier must ensure that the plan forms clearly inform covered persons of their rights to access contraceptive services and supplies, voluntary sterilization. The plan forms must clearly inform covered persons how they access these services and supplies.

(3) A health plan’s forms and student health plan’s forms must include a detailed description of the plan’s benefits provided to covered persons that specifically instructs covered persons where and how they access coverage of contraceptive 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.

(4) If a health plan or student health plan limits the number of covered over-the-counter contraceptive supplies, 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 supplies in violation of RCW 48.43.072 or any other state or federal law.

(5) If a health plan or student health plan limits the number of covered contraceptive services or supplies, the plan forms must include a detailed description of the plan’s benefits that specifically instructs covered persons how to request coverage of additional contraceptive services or supplies. The process may not impose any restrictions or delays on the coverage or access of contraceptive services or supplies in violation of RCW 48.43.072, or any other state or federal law.
Deductibles for over-the-counter contraceptives and voluntary male sterilization in HSA qualifying plans

(1) A qualifying health plan and a qualifying student 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 voluntary male sterilization only at the minimum level necessary to preserve the enrollee’s ability to claim tax exempt contributions and withdrawals from the enrollee’s 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 service laws, regulations, and guidance. For the 2019 plan year, 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 standard minimum deductible for the 2019 plan year only. Therefore, for 2019, HSA-qualifying 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 services and supplies 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 services and supplies and male sterilization have been reached, all over-the-counter contraceptive services and supplies and male sterilization must be covered with no cost-sharing, even if the overall plan deductibles have not yet been met.

(c) No person covered under an HSA-qualifying individual plan may be required to pay a higher deductible for over-the-counter contraceptive services and supplies and male sterilization than the minimum individual deductible set by the federal internal revenue service for a plan to be an HSA-qualifying plan. No person covered under an HSA-qualifying family plan may be required to pay a higher deductible for over-the-counter contraceptive services and supplies and male sterilization than the minimum family deductible set by the federal internal revenue service for a plan to be an HSA-qualifying plan, even if the applicable plan’s family deductible has not yet been met. Example: a plan’s family deductible for an HSA-qualifying family plan may be more than the minimum family deductible. However, the deductible applicable to over-the-counter contraceptive supplies and services and male sterilization must be at the minimum family deductible, which is two thousand seven hundred dollars in 2019.

Access to Prenatal Vitamins and Breast Pumps

(1) Effective January 1, 2021, health plans and student plans are required under RCW 48.43.072 to cover prenatal vitamins for covered persons expecting the birth of a child and breast pumps for covered persons expecting the birth or adoption of a child.
a. Pursuant to RCW 48.43.072, prenatal vitamins and breast pumps can be subject to copayment, deductibles and other forms of cost sharing, except:
   i. In accordance with the Affordable Care Act and the Women’s Preventative Services Guidelines, folic acid is currently required to be covered as a preventative service without copayment, deductibles, or other forms of cost sharing for covered persons. This requirement does not apply to grandfathered plans.
   ii. In accordance with the Affordable Care Act and the Women’s Preventative Services Guidelines, breast pumps are currently required to be covered as a preventative service without copayments, deductibles, or other forms of cost-sharing for covered persons. This requirement does not apply to grandfathered plans.

b. A prescription can be required to trigger coverage of prenatal vitamins, including folic acid and breast pumps.

WAC 284-43-5150

Unfair practice relating to health coverage.

(1) It is an unfair practice for any health carrier to restrict, exclude, or reduce coverage or benefits under any health plan on the basis of sex. By way of example, a health plan providing generally comprehensive coverage of prescription drugs and prescription devices restricts, excludes, or reduces coverage or benefits on the basis of sex if it fails to provide prescription contraceptive coverage that complies with this regulation.

An example of a plan that provides generally comprehensive coverage of prescription drugs is a plan that covers prescription drugs but excludes some categories such as weight reduction or smoking cessation.

(2)(a) Health plans providing generally comprehensive coverage of prescription drugs and/or prescription devices shall not exclude prescription contraceptives or cover prescription contraceptives on a less favorable basis than other covered prescription drugs and prescription devices. Coverage of prescription contraceptives includes coverage for medical services associated with the prescribing, dispensing, delivery, distribution, administration and removal of a prescription contraceptive to the same extent, and on the same terms, as other outpatient services.

(b) Health plans may not impose benefit waiting periods, limitations, or restrictions on prescription contraceptives that are not required or imposed on other covered prescription drugs and prescription devices.

(c) Health plans may not require cost sharing, such as copayments or deductibles, for prescription contraceptives and for services associated with the prescribing, dispensing, delivery, distribution, administration, and removal of the prescription contraceptives, to the same extent that such cost sharing is required for other covered prescription drugs, devices or services.

(d) Health carriers may use, and health plans may limit coverage to, a closed formulary for prescription contraceptives if they otherwise use a closed formulary, but the formulary shall cover each of the types of prescription contraception as defined in (f) of this subsection.
(e) If a health plan excludes coverage for nonprescription drugs and devices except for those required by law, it may also exclude coverage for nonprescription contraceptive drugs and devices.

(f) For purposes of subsections (1) and (2) of this section, “prescription contraceptives” include United States Food and Drug Administration (FDA) approved contraceptive drugs, devices, and prescription barrier methods, including contraceptive products declared safe and effective for use as emergency contraception by the FDA.

(g) This section applies prospectively to health plans offered, issued, or renewed by a health carrier on or after January 1, 2002.

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