Washington State
House of Representatives
Office of Program Research

BILL ANALYSIS

Health Care & Wellness Committee

HB 2148

Brief Description: Concerning health plan coverage for the voluntary termination of a pregnancy.

Sponsors: Representative Cody.

Brief Summary of Bill

- Requires health plans that cover maternity care or services to cover the voluntary termination of pregnancy.

Hearing Date: 1/13/14

Staff: Jim Morishima (786-7191).

Background:

I. Insurance Coverage of Abortion Under State Law.

Under 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.

II. Right of Conscience 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

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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 Office of the Insurance Commissioner (OIC) must establish a mechanism to recognize the right of conscience while ensuring enrollees timely access to services and to ensure prompt payment to serviced providers.

In 2006 the Attorney General issued an opinion regarding an OIC rule that required 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.

III. Insurance Coverage of Abortion under Federal Law.

A. Federal Funding of Abortion.

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.

B. Abortion under the Patient Protection and Affordable Care Act.

Under the federal Patient Protection and Affordable Care Act (PPACA), each state must establish a Health Benefit Exchange (Exchange) in which consumers will be able to compare and purchase individual and small group market health insurance. Individuals between 134 and 400 percent of

the federal poverty level will be eligible for federal premium and cost-sharing subsidies in the Exchange on a sliding scale.

Under the PPACA, 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 PPACA 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.

The PPACA requires individual and small group market health plans to offer the "essential health benefits" both inside and outside of the Exchange. A health carrier inside the Exchange cannot be required to offer abortion coverage as part of its essential health benefits. Under proposed federal rules implementing the PPACA, this prohibition would apply to health carriers outside the Exchange as well. For 2014 and 2015, the essential health benefits will be established on a state-by-state basis using a benchmark plan. 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.

Summary of Bill:

If a health plan issued or renewed on or after January 1, 2015, 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.

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 Office of the Insurance Commissioner must establish a mechanism to recognize the right of conscience while ensuring enrollees timely access to services and to ensure prompt payment to serviced providers.

Appropriation: None.

Fiscal Note: Requested on January 8, 2014

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