RCW 48.43.047 Health plans—Minimum coverage for preventive services—No cost-sharing requirements. (1) A nongrandfathered health plan issued on or after June 6, 2024, must, at a minimum, provide coverage for the following preventive services as the recommendations or guidelines existed on January 8, 2024:

(a) Evidence-based items or services that have a rating of A or B in the current recommendations of the United States preventive services task force with respect to the enrollee;

(b) Immunizations for routine use in children, adolescents, and adults that have in effect a recommendation from the advisory committee on immunization practices of the centers for disease control and prevention with respect to the enrollee. For purposes of this subsection, a recommendation from the advisory committee on immunization practices of the centers for disease control and prevention is considered in effect after the recommendation has been adopted by the director of the centers for disease control and prevention, and a recommendation is considered to be for routine use if the recommendation is listed on the immunization schedules of the centers for disease control and prevention;

(c) With respect to infants, children, and adolescents, evidence-informed preventive care and screenings provided for in comprehensive guidelines supported by the health resources and services administration; and

(d) With respect to women, additional preventive care and screenings that are not listed with a rating of A or B by the United States preventive services task force but that are provided for in comprehensive guidelines supported by the health resources and services administration.

(2) A nongrandfathered health plan must provide coverage for the preventive services required to be covered under subsection (1) of this section consistent with federal rules and guidance related to coverage of preventive services in effect on January 8, 2024.

(3) A nongrandfathered health plan must provide coverage for the preventive services required to be covered under subsection (1) of this section for plan years that begin on or after the date that is one year after the date the recommendation or guideline is issued.

(4) A nongrandfathered health plan is no longer required to provide coverage for particular items or services specified in the recommendations or guidelines described in subsection (1) of this section if such a recommendation or guideline is revised by the recommending entities described in subsection (1) of this section to no longer include the preventive item or service as defined in subsection (1) of this section.

(5) Annually, a health carrier shall determine whether any additional items or services must be covered without cost-sharing requirements or whether any items or services are no longer required to be covered as provided in subsections (2) and (3) of this section. The carrier's determination must be included in its health plan filings submitted to the commissioner.

(6)(a) Except as provided in (b) of this subsection, the health plan may not impose cost-sharing requirements for the preventive services required to be covered under subsection (1) of this section when the services are provided by an in-network provider. If a plan does not have in its network a provider who can provide an item or service described in subsection (1) of this section, the plan must

cover the item or service when performed by an out-of-network provider and may not impose cost sharing with respect to the item or service.

(b) If any portion of 42 U.S.C. Sec. 300gg-13 is found invalid, for a health plan offered as a qualifying health plan for a health savings account, the carrier may apply cost sharing to coverage of the services that have been invalidated 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 internal revenue service laws and regulations.

(7) A carrier may use reasonable medical management techniques to determine the frequency, method, treatment, or setting for an item or service described in subsection (1) of this section to the extent not specified in the relevant recommendation or guideline, federal rules and guidance related to the coverage of preventive services in effect on January 8, 2024, and any rules adopted by the insurance commissioner.

(8) The insurance commissioner shall enforce this section consistent with federal rules and guidance in effect on January 8, 2024.

(9) The insurance commissioner may adopt rules necessary to implement this section, consistent with federal statutes, rules, and guidance in effect on January 8, 2024. The insurance commissioner may also adopt rules related to any future preventive services recommendations and guidelines issued by the United States preventive services task force, the advisory committee on immunization practices of the centers for disease control and prevention, and the health resources and services administration or related federal rules or guidance. [2024 c 314 s 1; 2018 c 14 s 1.]