Washington State
House of Representatives
Office of Program Research

BILL ANALYSIS

Health Care & Wellness Committee

2SSB 5313

Brief Description: Concerning health insurance discrimination.

Sponsors: Senate Committee on Ways & Means (originally sponsored by Senators Liias, Randall, Darneille, Das, Dhingra, Frockt, Hunt, Keiser, Kuderer, Lovelett, Nguyen, Nobles, Pedersen, Robinson, Stanford, Van De Wege and Wilson, C.).

Brief Summary of Second Substitute Bill

- Establishes that health carriers, public employee health plans, the Health Care Authority, and Medicaid programs may not deny coverage for medically necessary gender affirming treatment or apply categorical or blanket exclusions to gender affirming treatment.

Hearing Date: 3/15/21

Staff: Kim Weidenaar (786-7120).

Background:

Section 1557 of the federal Patient Protection and Affordable Care Act (ACA) prohibits discrimination on the basis of race, color, national origin, sex, age, or disabilities in health programs receiving federal funding, health programs administered directly by the federal government, and qualified health plans offered on health benefit exchanges. Federal rules implementing this requirement prohibit discrimination in the issuance of health plans, the denial or limitation of coverage, and marketing practices. Rules also prohibit discrimination against transgender individuals and prohibit insurers from categorically excluding gender transition services.

In 2016 a federal district court issued a nationwide injunction enjoining the enforcement of the

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This analysis was prepared by non-partisan legislative staff for the use of legislative members in their deliberations. This analysis is not part of the legislation nor does it constitute a statement of legislative intent.

federal rules prohibiting discrimination on the basis of gender identity or termination of pregnancy—*Franciscan Alliance, Inc. v. Burwell* (2016). The court subsequently stayed its ruling and in 2019, the United States Department of Health and Human Services (HHS) proposed rules clarifying the scope of the ACA's nondiscrimination provisions. In June 2020 the HHS issued final regulations implementing Section 1557, which narrows the scope of a rule issued in 2016 by the Obama Administration. The rules, among other provisions, removed gender identity and sex stereotyping from the definition of prohibited sex-based discrimination and eliminated the provision that prohibits a health plan from categorically or automatically excluding or limiting coverage for health services related to gender transition. Federal courts in New York and Washington, D.C. have since blocked the implementation of the 2020 HHS rules relying on an August 2020 Supreme Court ruling, in *Bostock v. Clayton County, Georgia* (2020), that found discrimination based on sex, encompasses sexual orientation and gender identity in the context of employment.

State law prohibits a health carrier offering a non-grandfathered health plan in the individual or small group market from discriminating against individuals because of age, expected length of life, present or predicted disability, degree of medical dependency, quality of life, or other health conditions. Such a health carrier may not, with respect to the health plan, discriminate on the basis of race, color, national origin, disability, age, sex, gender identity, or sexual orientation. Further, health plans and state Medicaid services may not discriminate on the basis of gender identity or expression, or perceived gender identity or expression, in the provision of non-reproductive health care services.

Summary of Second Substitute Bill:

For health plans issued on or after January 1, 2022:

- A health carrier must not deny or limit coverage for gender affirming treatment when that care is prescribed to an individual because of, related to, or consistent with a person's gender expression or identity, is medically necessary, and is prescribed in accordance with accepted standards of care.
- A health carrier must not apply categorical cosmetic or blanket exclusions to gender affirming treatment. When prescribed as medically necessary gender affirming treatment, a health carrier must not exclude as cosmetic services facial feminization surgeries, other facial gender affirming treatment, and other care such as mastectomies and breast implants, including revisions to prior treatment.
- Health carriers must ensure that prior to making an adverse determination, health care providers who have experience delivering gender affirming treatment review and approve all adverse benefit determinations for gender affirming treatment.
- A health carrier must comply with all network access rules and requirements established by the Insurance Commissioner.

The Insurance Commissioner must adopt rules necessary to implement these provisions. The Insurance Commissioner, in consultation with the Health Care Authority (HCA) and the Department of Health, must report on the geographic access to gender affirming treatment across

the state. The report must be updated biannually.

These discrimination and coverage provisions are applied to health plans offered to public employees and their dependents in addition to the state's prohibited discrimination provisions for non-grandfathered health plans.

The HCA and Medicaid programs (including managed care plans) and providers that administer or deliver gender affirming care services through Medicaid programs may not discriminate in the delivery of a service based on the covered person's gender identity or expression. The HCA and Medicaid programs may not apply categorical cosmetic or blanket exclusions to gender affirming treatment. When prescribed as gender affirming treatment, facial feminization surgeries, facial gender affirming treatment, and other care such as mastectomies and breast implants, including revisions to prior treatment, may not be excluded as cosmetic.

The HCA and Medicaid programs must ensure, prior to making an adverse determination, health care providers who have experience prescribing or delivering gender affirming treatment conduct utilization reviews for any claim for gender affirming treatment. If the HCA and Medicaid programs do not have an adequate network for gender affirming treatment, they must ensure timely and accessible delivery of care at no greater expense to the enrollee had the care been provided by an in-network provider.

"Gender affirming treatment" means a service or product that a health care provider prescribes to an individual to treat any condition related to the individual's gender identity and is prescribed in accordance with generally accepted standards of care.

Appropriation: None.

Fiscal Note: Available.

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