FINAL BILL REPORT
2SSB 5313

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Synopsis as Enacted

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.).

Senate Committee on Health & Long Term Care
Senate Committee on Ways & Means
House Committee on Health Care & Wellness

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 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, HHS issued final regulations implementing Section 1557, which significantly 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, DC have since blocked the implementation of the 2020 HHS rules relying on an August 2020 Supreme Court ruling, in

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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: 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 protected 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 medically necessary gender-affirming treatment, a health carrier must not exclude as cosmetic services facial feminization surgeries and facial gender-affirming treatment, such as tracheal shaves, hair electrolysis, and other care such as mastectomies, breast reductions, and breast implants, or any combination of gender-affirming procedures, including revisions to prior treatment;
- health carriers may not issue an adverse benefit determination denying or limiting access to gender-affirming services, unless a health care provider with experience prescribing or delivering gender-affirming treatment has reviewed and confirmed the appropriateness of the adverse benefit determination; and
- a health carrier must comply with all network access rules.

Beginning January 1, 2022, The Health Care Authority (HCA), 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. 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. HCA and Medicaid managed care plans may not issue an adverse benefit determination denying or limiting access to gender-affirming services, unless a health care provider with experience prescribing or delivering gender-affirming treatment has reviewed and confirmed the appropriateness of the adverse benefit determination. If 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. HCA

must adopt rules necessary to implement these provisions.

Gender-affirming treatment means a service or product 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.

The insurance commissioner, in consultation with HCA and the Department of Health, must report on geographic access to gender-affirming treatment across the state by December 1, 2022. The report must be updated biannually.

Votes on Final Passage:

Senate	30	17	
House	57	41	(House amended)
Senate	30	19	(Senate concurred)

Effective: July 25, 2021