Gender Dysphoria (Gender Identity Disorder) Treatment (for Oregon Only)

Policy Number: BIP198.K
Effective Date: January 1, 2025

Instructions for Use

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Related Medical Policies

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Federal/State Mandated Regulations

Oregon Division of Financial Regulation Bulletin DFR 2016-1, Gender Identity Issues in the Transaction and Regulation of Insurance in Oregon

http://dfr.oregon.gov/laws-rules/Documents/Bulletins/bulletin2016-01.pdf

House Bill, 2002, Gender-Affirming Treatment

https://olis.oregonlegislature.gov/liz/2023R1/Downloads/MeasureDocument/HB2002/Enrolled

Section 20

(1) As used in this section:
  (a) "Carrier" has the meaning given that term in ORS 743B.005.
  (b) "Gender-affirming treatment" means a procedure, service, drug, device or product that a physical or behavioral health care provider prescribes to treat an individual for incongruence between the individual's gender identity and the individual's sex assignment at birth.
  (c) "Health benefit plan" has the meaning given that term in ORS 743B.005.
(2) A carrier offering a health benefit plan in this state may not:
  (a) Deny or limit coverage under the plan for gender-affirming treatment that is:
    (A) Medically necessary as determined by the physical or behavioral health care provider who prescribes the treatment; and
    (B) Prescribed in accordance with accepted standards of care.
  (b) Apply categorical cosmetic or blanket exclusions to medically necessary gender affirming treatment.
  (c) Exclude as a cosmetic service a medically necessary procedure prescribed by a physical or behavioral health care provider as gender-affirming treatment, including but not limited to:
    (A) Tracheal shave;
    (B) Hair electrolysis;
    (C) Facial feminization surgery or other facial gender-affirming treatment;
    (D) Revisions to prior forms of gender-affirming treatment; and
    (E) Any combination of gender-affirming treatment procedures.
  (d) Issue an adverse benefit determination denying or limiting access to gender-affirming treatment unless a physical or behavioral health care provider with experience prescribing or delivering gender-affirming treatment has first reviewed and approved the denial of or the limitation on access to the treatment.

(3) A carrier described in subsection (2) of this section must:
  (a) Satisfy any network adequacy standards under ORS 743B.505 related to gender affirming treatment providers; and
  (b) (A) Contract with a network of gender-affirming treatment providers that is sufficient in numbers and geographic locations to ensure that gender-affirming treatment services are accessible to all enrollees without unreasonable delay; or
    (B) Ensure that all enrollees have geographical access without unreasonable delay to out-of-network gender-affirming treatment services with cost-sharing or other out-of-pocket costs for the services no greater than the cost-sharing or other out-of-pocket costs for the services when furnished by an in-network provider.
(4) The Department of Consumer and Business Services shall:
  (a) Evaluate compliance with this section in each examination or analysis of the market conduct of a carrier under ORS 731.300; and
  (b) Adopt rules to implement the provisions of this section.
(5) This section is exempt from ORS 743A.001.

Section 21

The Department of Consumer and Business Services shall conduct a targeted market conduct examination of all carriers that are subject to the requirements of section 20 of this 2023 Act to ensure compliance with section 20 of this 2023 Act. The examinations must be completed no later than January 2, 2027.

Section 22

No later than December 31, 2026, the Department of Consumer and Business Services shall report to the interim committees of the Legislative Assembly related to Enrolled House Bill 2002 (HB 2002-C) Page 8 health, in the manner provided in ORS 192.245, on the implementation of section 20 of this 2023 Act.

Section 23

Section 24 of this 2023 Act is added to and made a part of ORS chapter 414.

Section 24

(1) As used in this section, “gender-affirming treatment” means a procedure, service, drug, device or product that a physical or behavioral health care provider prescribes to treat an individual for incongruence between the individual’s gender identity and the individual’s sex assignment at birth.
(2) Notwithstanding ORS 414.065 and 414.690, medical assistance provided to a member of a coordinated care organization or a medical assistance recipient who is not enrolled in a coordinated care organization shall include gender-affirming treatment.
(3) The Oregon Health Authority or a coordinated care organization may not:
  (a) Deny or limit gender-affirming treatment that is:
    (A) Medically necessary as determined by the physical or behavioral health care provider who prescribes the treatment; and
    (B) Prescribed in accordance with accepted standards of care.
  (b) Deny as a cosmetic service a medically necessary procedure prescribed by a physical or behavioral health care provider as gender-affirming treatment, including but not limited to:
    (A) Tracheal shave;
    (B) Hair electrolysis;
    (C) Facial feminization surgery or other facial gender-affirming treatment;
    (D) Revisions to prior forms of gender-affirming treatment; and
    (E) Any combination of gender-affirming treatment procedures.
  (c) Deny or limit gender-affirming treatment unless a physical or behavioral health care provider with experience prescribing or delivering gender-affirming treatment has first reviewed and approved the denial of or the limitation on the treatment.
(4) A coordinated care organization must:
  (a) Contract with a network of gender-affirming treatment providers that is sufficient in numbers and geographic locations to meet the network adequacy standards prescribed by ORS 414.609 (1); and
  (b)(A) Ensure that gender-affirming treatment services are accessible to all of the coordinated care organization’s members without unreasonable delay; or
    (B) Ensure that all members have geographical access to non-contracting providers of gender-affirming treatment services without unreasonable delay.
(5) The authority shall monitor coordinated care organization compliance with the requirements of this section and may adopt rules necessary to carry out the provisions of this section.

State Market Plan Enhancements

None

Covered Benefits

Important Note: Covered benefits are listed in *Federal/State Mandated Regulations*, *State Market Plan Enhancements*, and *Covered Benefits* sections. Always refer to the *Federal/State Mandated Regulations* and *State Market Plan Enhancements* sections for additional covered services/benefits not listed in this section.

Refer to the member's EOC/SOB or contact the Customer Service Department to determine coverage eligibility.

Refer to the Medical Policy titled Gender Dysphoria Treatment.

Benefits for the treatment of gender dysphoria provided by or under the direction of a physician.

Coverage is available for medical, behavioral, or pharmacological treatment that is medically necessary for gender dysphoria. UnitedHealthcare does not exclude or deny covered health care benefits based on an associated diagnosis of gender dysphoria, or otherwise discriminate against the member on the basis that treatment is for gender dysphoria. For the purpose of this benefit, "gender dysphoria" is a disorder characterized by the specific diagnostic criteria classified in the current edition of the Diagnostic and Statistical Manual of the American Psychiatric Association.

Not Covered

None

Policy History/Revision Information

Date	Summary of Changes
01/01/2025	**Template Update** • Modified font style • Updated reference links to related Medical Policies (previously classified as Medical Management Guidelines) **Supporting Information** • Archived previous policy version BIP198.J

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Covered benefits are listed in three (3) sections: *Federal/State Mandated Regulations*, *State Market Plan Enhancements*, and *Covered Benefits*. All services must be medically necessary. Each benefit plan contains its own specific provisions for coverage, limitations, and exclusions as stated in the member's Evidence of Coverage (EOC)/Schedule of Benefits (SOB). If there is a discrepancy between this policy and the member's EOC/SOB, the member's EOC/SOB provision will govern.