Department of Legislative Services

Maryland General Assembly
2023 Session

FISCAL AND POLICY NOTE
Third Reader - Revised

House Bill 283 (Delegate Kaiser, *et al.*)
Health and Government Operations Finance

Maryland Medical Assistance Program - Gender-Affirming Treatment (Trans Health Equity Act)

This bill requires Medicaid, beginning January 1, 2024, to provide coverage for "gender-affirming treatment." By December 1 each year, beginning in 2024, each Medicaid managed care organization (MCO) must submit a specified report to the Maryland Department of Health (MDH). By January 1 each year, beginning in 2025, MDH must compile an annual report on geographic access to gender-affirming treatment across the State. MDH and each MCO must include the name, location, and types of services offered by each provider offering gender-affirming treatment in their provider directories. The bill expresses the intent of the General Assembly that Medicaid provide gender-affirming treatment to all Medicaid recipients for whom gender-affirming treatment is medically necessary, including transgender, nonbinary, intersex, two-spirit, and other gender diverse individuals.

Fiscal Summary

State Effect: Medicaid expenditures increase by an indeterminate but likely significant amount beginning in FY 2024. This analysis assumes services are eligible for federal matching funds of 90% for fertility preservation and 64.5% for other services; federal matching funds increase accordingly. **This bill increases the cost of an entitlement program beginning in FY 2024.**

Local Effect: None.

Small Business Effect: Meaningful.

Analysis

Bill Summary:

Gender-affirming Treatment

"Gender-affirming treatment" means any medically necessary treatment consistent with current clinical standards of care prescribed by a licensed health care provider for the treatment of a condition related to the individual's gender identity. Gender-affirming treatment includes (1) hormone therapy, hormone blockers, and puberty blockers; (2) hair alteration for the purposes of altering secondary sex characteristics and surgical site preparation; (3) alterations to voice, voice therapy, and voice lessons; (4) alterations to abdomen, chest, trunk, and buttocks; (5) alterations to the face and neck; (6) alterations to the genitals and gonads; (7) laser treatment for scars from gender-affirming treatment; (8) standard fertility preservation procedures, as specified; (9) revisions to previous treatments and reversal of treatments; (10) combinations of gender-affirming procedures; and (11) other treatments as prescribed to suppress the development of endogenous secondary sex characteristics, align the individual's appearance or physical body with gender identity, and alleviate symptoms of clinically significant distress resulting from gender dysphoria.

Gender-affirming treatment may include treatment described in the current clinical standards of care for gender-affirming treatment published by the World Professional Association for Transgender Health.

Medicaid must provide coverage for medically necessary gender-affirming treatment in a nondiscriminatory manner. Gender-affirming treatment must be assessed according to nondiscriminatory criteria consistent with current clinical standards of care. Medicaid may not deny or limit coverage for gender-affirming treatment when that treatment is (1) prescribed because of, related to, or consistent with the recipient's gender identity; (2) medically necessary; and (3) prescribed in accordance with current clinical standards of care.

Medicaid may not:

- deny or limit coverage for gender-affirming treatment based on the recipient's gender identity;
- exclude gender-affirming treatment on the basis that the treatment is a cosmetic service;
- establish a categorical exclusion for a particular gender-affirming treatment; or

- issue an adverse benefit determination denying or limiting access to gender-affirming treatment unless a health care provider with experience prescribing or delivering gender-affirming treatment has reviewed and confirmed the appropriateness of the adverse benefit determination.

Reporting Requirements

Each MCO must submit a report to MDH that includes, for each health care provider offering gender-affirming treatment with which the MCO has an active contract and who consents to the inclusion, (1) the name and location of the health care provider; (2) the types of gender-affirming treatment provided by the health care provider; and (3) whether the health care provider consents to being publicly listed as part of MDH's annual report.

MDH must compile an annual report that includes, for each health care provider offering gender-affirming treatment to Medicaid recipients and whose consent to the inclusion has been submitted to MDH, (1) the name and location of the health care provider; (2) the MCOs that have active contracts with the health care provider; and (3) the types of gender-affirming treatment provided by the health care provider. MDH must publish the report in a conspicuous manner on the department's website.

Current Law: Medicaid generally provides health coverage to children, pregnant women, elderly or disabled individuals, low-income parents, and childless adults. To qualify for Medicaid, applicants must pass certain income and asset tests. Effective January 1, 2014, Medicaid coverage was expanded to persons with household incomes up to 138% of federal poverty guidelines, as authorized under the federal Patient Protection and Affordable Care Act. Most Medicaid recipients are required to enroll in a Medicaid MCO.

Maryland Medicaid currently covers gender-affirming treatments for individuals that (1) are age 18 and older; (2) have the capacity to make fully informed decisions and consent for treatment; (3) have a diagnosis of gender dysphoria; and (4) undergo a minimum of 12 months of continuous hormonal therapy when recommended by a mental health professional (excluding individuals seeking mastectomy surgery). The individual must also have two referrals from qualified mental health professionals who independently assess the individual. The following treatments are currently reimbursable by Medicaid for eligible participants: (1) outpatient psychotherapy or mental health services for gender dysphoria and associated comorbid psychiatric diagnoses; (2) continuous hormone replacement therapy; (3) outpatient laboratory testing to monitor continuous hormone therapy; (4) gender reassignment surgery; (5) specified procedures for individuals transitioning from male to female (MTF) and from female to male (FTM); and (6) post-transition services as medically necessary for transgender persons appropriate to their anatomy.

The following services (which are required to be covered under the bill) *are not* covered by Medicaid: (1) hair alteration; (2) voice modification surgery and therapy/lessons; (3) alterations to the abdomen, trunk, and buttocks; (4) alterations to the face and neck; (5) fertility preservation services (which are not covered for any Medicaid participants for any reason); and (6) revisions and reversal of prior treatments.

State Fiscal Effect: In 2022, the Williams Institute reported that there were 24,000 transgender adults in Maryland. An estimated 6,000 of these adults are enrolled in Medicaid. The number of nonbinary, intersex, two-spirit, and other gender diverse individuals enrolled in Maryland Medicaid is not currently available. In calendar 2022, 98 individuals received gender-affirming treatment through Medicaid.

MDH advises that utilization of gender-affirming treatments increases under the bill due to the availability of services not currently covered and greater awareness of services, which often are covered on only a limited basis by other payors. MDH advises that the number of Medicaid enrollees seeking gender-affirming treatment under the bill is estimated to increase by approximately 25 individuals per year.

MDH further advises that, based on publicly available estimates of the cost for *new* services covered under the bill, individual procedures range from less than $800 for voice therapy/voice lessons to more than $25,000 for facial feminization or masculinization surgeries. Medicaid expenditures increase by as much as $52,743 per person for individuals transitioning from MTF and by as much as $52,493 per person for individuals transitioning from FTM for most of the newly available services under the bill. However, this estimate does not include an average of $8,000 per person for cryopreservation of either ova, embryo, or sperm, as well as an ongoing annual cost to store the ova/embryo/sperm of $500 per year. Costs per person may be lower depending on the individual's utilization of covered services.

MDH advises that, while there appears to be an extremely low prevalence of regret in transgender patients after receiving gender-affirming surgeries, approximately 1% may seek reversal of treatments. As this is not currently covered by Medicaid (and Medicaid cannot establish a categorial exclusion for a particular treatment under the bill), to the extent Medicaid recipients seek reversal of treatments, Medicaid expenditures increase by an additional indeterminate amount.

Assuming the federal Centers for Medicare and Medicaid Services approve coverage for fertility preservation services for this population, such services would be subject to a 90% federal matching rate; all other services would be subject to a federal matching rate of 64.5% in fiscal 2024 and 63.9% in fiscal 2025 and thereafter.

Thus, Medicaid expenditures increase by an indeterminate but likely significant amount beginning in fiscal 2024. Federal fund revenues increase accordingly. Actual expenditures depend on the number of individuals seeking services who would not have done so absent the bill, the number of individuals already receiving services who obtain additional services, and the specific gender-affirming services provided.

For illustrative purposes only, if 125 individuals (reflecting utilization in calendar 2022 and assumed growth of 25 additional individuals) received *all* of the new services available under the bill, including fertility preservation, Medicaid expenditures increase by $7.6 million (68% federal funds, 32% general funds). If 125 individuals received only some services, in this example, hair alterations and laryngoplasty/voice modification surgery (totaling $17,000 per person), Medicaid expenditures increase by $2.1 million (64.5% federal funds, 35.5% general funds).

This estimate does not reflect any administrative costs for MCOs to submit annual reports on gender-affirming services or for MDH to compile an annual report on geographic access to gender-affirming treatment across the State.

Small Business Effect: Small business health care providers that provide gender-affirming treatment may receive additional reimbursement from Medicaid.

Additional Comments: MDH notes that fertility preservation services are currently not covered for Medicaid participants for any reason. Expanding coverage for this service for gender-affirmation purposes may lead to pressure to cover the benefit for other populations, such as those with cancer. Provision of fertility preservation services for all Medicaid participants could significantly increase costs (an estimated $8.1 million annually based on 0.07% of total enrollment utilizing the services).

MDH advises that the bill creates a new appropriateness standard for review of adverse benefit decisions for gender-affirming services. MDH would be prohibited from issuing an adverse benefit determination denying or limiting access to gender-affirming treatment unless a health care provider with experience prescribing or delivering gender-affirming treatment has reviewed and confirmed the appropriateness of the adverse benefit determination. Given the limited number of specialists in this area, it is unclear whether there is a sufficient network of providers for this process. If a sufficient network is not available for review, enforcement of medical necessity criteria will not be feasible.

Additional Information

Prior Introductions: Similar legislation has been introduced within the last three years. See HB 746 and SB 682 of 2022.

Designated Cross File: SB 460 (Senator M. Washington, *et al.*) - Finance.

Information Source(s): Maryland Department of Health; Department of Legislative Services

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