WAC 284-43-5940 Nondiscrimination in health plans, short-term limited duration medical plans and student-only health plans. (1) An issuer offering a plan, and the issuer's officials, employees, agents, or representatives may not:

(a) Design plan benefits, or implement its plan benefits, in a manner that results in discrimination against individuals because of their age, expected length of life, present or predicted disability, degree of medical dependency, quality of life, or other health conditions; and

(b) With respect to the plan including, but not limited to, administration, member communication, medical protocols or criteria for medical necessity or other aspects of plan operations:

(i) Discriminate on the basis of race, color, national origin, sex, gender identity, sexual orientation, age, or disability;

(ii) Deny, cancel, limit, or refuse to issue or renew a plan, or deny or limit coverage of a claim, or impose additional cost sharing or other limitations or restrictions on coverage, on the basis of race, color, national origin, sex, gender identity, sexual orientation, age, or disability;

(iii) Have or implement marketing practices or benefit designs that discriminate on the basis of race, color, national origin, sex, gender identity, sexual orientation, age, or disability. In reviewing plan design, plan features that attempt to circumvent coverage of medically necessary benefits such as by labeling a benefit as a pediatric service, and thereby excluding adults, or by placing all or most drugs for a specific condition in the highest cost-sharing tier, absent an appropriate reason for the exclusion, are potentially discriminatory. In these or other instances, the commissioner may request a justification for the practice. If requested, issuers must identify an appropriate nondiscriminatory reason that supports their benefit design;

(iv) Deny or limit coverage, deny or limit coverage of a claim, issue automatic denials of coverage or impose additional cost sharing or other limitations or restrictions on coverage, for:

(A) Any health services that are ordinarily or exclusively available to individuals of one sex, based on the fact that an individual's sex assigned at birth, gender identity, or gender otherwise recorded is different from the one to which such health services are ordinarily or exclusively available. For example, a denial of coverage for medically necessary hormone prescriptions for transgender, gender nonconforming, or intersex individuals because the dosages exceed those typically prescribed for cisgender people would be discriminatory against transgender, nonbinary, gender nonconforming, or intersex individuals; or

(B) Gender affirming treatment, as defined in RCW 48.43.0128, when that treatment is:

(I) Prescribed to an individual because of, related to, or consistent with a person's gender expression or identity, as defined in RCW 49.60.040;

(II) Medically necessary; and

(III) Prescribed in accordance with accepted standards of care;

(v) Have or implement a categorical coverage exclusion or limitation for all medical, surgical, or behavioral health services related to a person's gender identity or sexual orientation, including gender affirming treatment; or

(vi) When prescribed as medically necessary, exclude facial gender affirming treatment (such as tracheal shaves), hair removal procedures, and other care (such as mastectomies, breast reductions, breast

implants, or any combination of gender affirming procedures, including revisions to prior treatment) as cosmetic services; or

(vii) Otherwise deny or limit coverage, deny or limit coverage of a claim, or impose additional cost sharing or other limitations or restrictions on coverage, for specific medical, surgical, or behavioral health services related to a person's gender identity or sexual orientation if such denial, limitation, or restriction results in discrimination against a transgender, nonbinary, gender nonconforming or intersex individual.

(2) The enumeration of specific forms of discrimination in subsection (1)(b)(ii) through (vii) of this section does not limit the general applicability of the prohibition in subsection (1)(b)(i) of this section.

(3) Nothing in this section may be construed to prevent an issuer from appropriately utilizing fair and reasonable medical management techniques. Appropriate use of medical management techniques includes use of evidence based criteria for determining whether a service or benefit is medically necessary and clinically appropriate.

(4) An issuer's obligation to comply with these requirements is nondelegable; an issuer is obligated to ensure compliance with WAC 284-43-5935 through 284-43-5980, even if they use a third-party vendor or subcontracting arrangement. An issuer is not exempt from any of these requirements because it relied upon a third-party vendor or subcontracting arrangement for administration of any aspect of its benefits or services.

(5) The commissioner may determine whether an issuer's actions to comply with this section are consistent with current state law, the legislative intent underlying RCW 48.43.0128 to maintain the enrollee protections of the Affordable Care Act, and the federal regulations and guidance in effect as of January 1, 2017, including, but not limited to, those issued by the U.S. Department of Health and Human Services Office of Civil Rights and federal regulations implementing 42 U.S.C. Sec. 18116 (Sec. 1557 of the Affordable Care Act) as set forth in 81 Fed. Reg. 31375 et seq. (2016).

[Statutory Authority: RCW 48.02.060, 48.43.515 and 2021 c 280. WSR 21-24-072 (Matter No. R 2021-14), § 284-43-5940, filed 11/30/21, effective 1/1/22. Statutory Authority: RCW 48.02.060, 48.20.460, 48.43.0128, 48.44.050, and 48.46.200. WSR 20-24-040, § 284-43-5940, filed 11/23/20, effective 12/24/20. Statutory Authority: RCW 48.02.060, 48.43.012, 48.43.01211, 48.43.0123, 48.43.0124, 48.43.0126, 48.43.0127, 48.43.0128, and 48.43.715. WSR 20-03-114 (Matter No. R 2019-10), § 284-43-5940, filed 1/16/20, effective 2/16/20.]