COMMERCE DEPARTMENT

Evaluation of HF 2607 – Coverage for Gender-Affirming Care

Report to the Minnesota Legislature Pursuant to Minn. Stat. § 62J.26

01/29/2024

This report was prepared by the American Institutes for Research (AIR), with actuarial analysis by Actuarial Research Corporation (ARC), at the request of the Minnesota Department of Commerce. AIR and ARC created this document for internal use by the Minnesota Department of Commerce pursuant to Contract No. 216732. The document assumes reader familiarity with the proposed mandated health benefits currently under consideration by the Minnesota State Legislature. The document was prepared solely to assist the Minnesota Department of Commerce. No other use of this document or the information or conclusions contained herein is authorized.

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Contents

Executive Summary

House File 2607 would require health carriers providing health insurance coverage for physical or mental health services to also provide coverage for gender-affirming care. The bill also adds language stating that health insurance plans must cover gender-affirming care as medically necessary with regard to the procedures and criteria recognized within professional standards, guidelines, or practices in relevant fields of medicine.

Gender dysphoria is defined as psychological distress that results from an incongruence between one's sex assigned at birth and one's gender identity. Gender-affirming care is a multi-step and multidisciplinary process intended to reduce or eliminate gender dysphoria experienced by transgender or gender-diverse individuals. Gender-affirming care includes but is not limited to hormone therapy, feminizing vaginoplasty, masculinizing phalloplasty/scrotoplasty, and transgender affirmative cognitive behavioral therapy.

Public comment respondents confirmed that the proposed mandate follows the approach of the Minnesota Department of Human Services regarding coverage for gender-affirming care but noted that the bill language is unclear on the specific services and procedures that would be covered if this bill was enacted. One respondent stated that transgender and nonbinary Minnesotans face multiple barriers to equitable and inclusive care that are not directly addressed by this proposed mandate.

Overall, the mandate is projected to result in a net increase of $0.05 per member per month (PMPM) for the total non-public insured population in Year 1 of the projection, growing to $0.91 PMPM in the 10th and final year of the projection.

The potential state fiscal impact of this mandate is as follows:

- There is no estimated cost for the State Employee Group Insurance Program because the required gender-affirming services associated with the bill are covered in the program's medical benefits package.
- The Minnesota Department of Commerce has determined that this proposed mandate would not require defrayal under the Patient Protection and Affordable Care Act.
- There is no estimated cost for state public programs.

Please refer to the Minnesota Department of Health's report to the governor, lieutenant governor, and legislature for a summary of the literature and scientific evidence about the safety and effectiveness of gender-affirming care and its public health effects.[1]

Introduction

In accordance with Minn. Stat. § 62J.26, the Minnesota Department of Commerce (Commerce), in consultation with the Minnesota Department of Health (MDH) and Minnesota Management and Budget (MMB), performs a detailed evaluation of all relevant benefit mandate proposals. For evaluation criteria and required evaluation components, please review the Evaluation Report Methodology, available at https://mn.gov/commerce/insurance/industry/policy-data-reports/62j-reports/.

Bill Requirements

House File (HF) 2607 is sponsored by Rep. Finke and was introduced in the 93rd Legislature (2023–24) on March 6, 2023.

If enacted, this bill would require health carriers providing health insurance coverage for physical or mental health services to also provide coverage for gender-affirming care. This bill adds language stating that health insurance plans must cover gender-affirming care as medically necessary. The covered gender-affirming care must satisfy the definition of medically necessary care proposed in the bill.

For the purposes of this mandate, "medically necessary care" means health care services appropriate in terms of type, frequency, level, setting, and duration to the enrollee's diagnosis or condition and diagnostic testing and preventive services. Medically necessary care must be consistent with generally accepted practice parameters as determined by health care providers in the same or a similar general specialty that typically manages the condition, procedure, or treatment at issue and must (a) help restore or maintain the enrollee's health or (b) prevent deterioration of the enrollee's condition.

This proposed mandate would apply to fully insured small and large group commercial health plans, individual market plans, Medicare supplemental policies, and Minnesota public health coverage programs. This would not apply to self-insured employer plans, grandfathered plans, and Medicare.

This mandate amends the gender-affirming care coverage requirement for health plans offered under Minn. Stat. § 256B.0625, subdivision 3a.

Related Health Conditions and Associated Services

Individuals identifying as transgender experience a misalignment between their sex assigned at birth and their gender identity.[1] Some individuals who identify as transgender experience gender dysphoria, which is defined as psychological distress that results from an incongruence between one's sex assigned at birth and one's gender identity.[2] While the exact number of individuals experiencing gender dysphoria is unknown, gender-affirming care can help to align a person's outward physical traits with their gender identity. Gender-affirming care is a multi-step and multidisciplinary process intended to reduce or eliminate gender dysphoria experienced by "transgender or gender-diverse" individuals.[2] Examples of gender-affirming care include[3,4]

- hormone therapy,
- feminizing vaginoplasty,
- masculinizing phalloplasty/scrotoplasty,
- metoidioplasty (e.g., clitoral release/enlargement and possibly urethral lengthening),
- reduction thyrochondroplasty (i.e., tracheal cartilage shave), and
- transgender affirmative cognitive behavioral therapy.

Related State and Federal Laws

There are no federal laws requiring health coverage for gender-affirming care. Please refer to the MDH's report to the governor, lieutenant governor, and legislature for a review of approaches that other jurisdictions have taken to support gender-affirming health care services.[1]

Public Comments Summary

Commerce solicited public input on the potential health benefit mandate through a request for information (RFI) posted to Commerce's website and the Minnesota State Register. The summary below represents only the opinions and input of the individuals and/or organizations that responded to the RFI.

Key Stakeholder Comment Themes

For this proposed mandate, Commerce received comments from four commercial health carriers that provided information related to insurance coverage.

One respondent noted that transgender and nonbinary Minnesotans face multiple barriers to equitable and inclusive care that are not directly addressed through this proposed mandate. These barriers include but are not limited to varied provider competency in gender-affirming care, sparse accurate and meaningful data to drive decision-making, limited providers who perform these services in the state or who are willing to join health plan networks, and laws in other states that limit access to and availability of gender-affirming care.

Multiple respondents cited lack of clarity in the bill's language on the specific services and procedures that would be covered and stated that the bill is open to interpretation as written. Several respondents highlighted that due to data challenges related to utilization, projected utilization, and the wide range of potential costs, predicting cost estimates is complicated. Many respondents noted that several health plans in Minnesota already adhere to the coverage requirements of the mandate, although it is difficult to discern exactly what services and procedures will be covered based on the bill's language. One organization cited current recognized guidelines that could guide coverage decisions, such as those set forth by the World Professional Association for Transgender Health (WPATH),[a] and another confirmed that the proposed mandate follows the approach to coverage used by the Minnesota Department of Human Services.

Cost Estimates Provided in Stakeholder Comments

Stakeholders and MMB provided the following cost estimates related to the proposed benefit mandate:

- The State Employee Group Insurance Program (SEGIP) does not estimate any state fiscal impact on the state plan from this legislation, as gender-affirming services are already covered in the Advantage Plan (see the Fiscal Impact section).
- Two organizations noted that there will be no increase in the per member per month (PMPM) given that current coverage aligns with the mandate's coverage requirement.
- One organization noted that due to lack of clarity in the bill's language concerning covered services, there may be cost implications. Potential cost increases are estimated to be less than $0.65 PMPM, although the increases will depend on how the current language on covered services is interpreted.

Cost estimates shared in RFI responses may reflect different methodologies, data sources, and assumptions than those used in the actuarial analysis for this evaluation. Stakeholders' results may or may not reflect generalizable estimates for the mandate.

[a] Coleman E, Radix AE, Bouman WP, et al. Standards of Care for the Health of Transgender and Gender Diverse People, Version 8. Int J Transgend Health. 2022;23(Suppl 1):S1-S259. Published 2022 Sep 6. doi:10.1080/26895269.2022.2100644

Evaluation of Proposed Health Benefit Mandate

Please refer to the MDH's report to the governor, lieutenant governor, and legislature for a summary of the literature and scientific evidence about the relevant population statistics, the safety and effectiveness of gender-affirming care, and its public health effects.[1]

Economic Impact

Actuarial Analysis[b]

Objective

This section includes an actuarial analysis of the current prevalence of related diagnoses, the current levels of utilization, and the potential effects of increased utilization on cost-sharing, expenditures, and overall premiums if coverage is expanded.

Assumptions and Approach

MDH provided tabulations of the Minnesota All Payer Claims Database (MN APCD) for all applicable enrollees with 12 months of continuous commercial coverage, including tabulations of associated National Drug Codes (NDCs) and procedure codes. These tabulations served as a snapshot of current prevalence, utilization, expenditures, and cost-sharing for gender-affirming care for Minnesota commercial health plan enrollees.[5] Per MDH, the MN APCD includes approximately 40% of the total commercial market in Minnesota.[6]

To identify applicable enrollees and claims for associated drugs and procedures, MDH used codes provided by the evaluation team and supplemented those with additional codes through a general internet search, the Current Procedural Terminology (CPT®) list, and Medi-Span®. Broadly speaking, gender-affirming care consists of psychotherapy and gender-affirming surgical procedures that are indicated in the MN APCD by CPT codes and hormone therapies that are indicated in the MN APCD by both NDCs and Healthcare Common Procedure Coding System (HCPCS) codes.

- Applicable enrollees were identified based on the diagnosis codes in Appendix B.
- Claims were analyzed for the CPT procedure codes for psychotherapy and surgical procedures found in Appendix B. A larger set of codes was initially included, but only these 56 codes were found in the MN APCD.
- Claims for the HCPCS and NDC hormone therapy codes in Appendix B were analyzed. A larger set of codes was initially included, but only these 349 codes were found in the MN APCD.

MDH tabulated all enrollees in the full commercial population in the MN APCD with an applicable diagnosis for 2019–2022, including total utilization, expenditures, and enrollee cost-sharing for gender-affirming care. While there are no data available to identify and track existing coverage levels for gender-affirming care, we conducted a review of literature addressing coverage and prevalence of need in projections.

[b] Michael Sandler and Anthony Simms are actuaries for the Actuarial Research Corporation (ARC). They are members of the American Academy of Actuaries and meet the qualification standards of the American Academy of Actuaries to render the actuarial opinions contained herein.

The proportion of enrollees with an applicable diagnosis doubled from 0.10% in 2019 to 0.21% in 2022, with an average annual growth of 28%. This significant growth is consistent with the findings of Herman et al., which observed that while overall prevalence among adults has been stable, prevalence in younger age brackets is significantly higher than prior estimates, leading to an increase in prevalence over time.[7] These researchers also estimate that 0.63% of Minnesotans aged 13 and older identify as transgender, which indicates potential future growth in this cohort. Estimates from the literature indicate that between 48.7%[8] and 61%[5] of transgender and/or gender-diverse people have private insurance.

Utilization of psychotherapy among applicable enrollees varied only slightly (from 61.4% to 63.7%) and exhibited no discernable directional trend. In 2015, 77% of U.S. Transgender Survey (USTS) respondents sought therapy related to their condition at some point in life, but only 58% ever received therapy.[9]

Between 6.9% and 7.5% of applicable enrollees utilize gender-affirming surgical procedures, with no apparent directional trend. These numbers align closely with the 8% prevalence of gender-affirming surgery found in one study for a commercially insured population of transgender people.[10] This suggests only a small coverage gap, but the 8% was a significant increase from just 0.5% in 2011. While growth in most surgery rates leveled off by 2019, the most prevalent procedure, mastectomy, was still trending upward, though growth was slowing.

In the tabulations, hormone therapy claims were separated into three classes: male to female transition (MTFT), which can involve estrogen therapy, progesterone therapy, and anti-androgen therapy; female to male transition (FTMT), which involves testosterone therapy; and puberty blockers (PBs). The claims in these classes were further divided into medical and pharmacy claims. MTFT classes for pharmacy claims were not tabulated in aggregate, so unique enrollee counts were not available. However, MTFT entails treatment with both estrogen and anti-androgen therapy and is sometimes supplemented by progesterone.[11] Additionally, enrollee counts for estrogen therapy were always largest among MTFT drugs and were comparable to FTMT counts, which aligns with findings in the literature indicating relative parity between the two classes.[7,10] Therefore, unique enrollees receiving estrogen therapy were assumed to represent unique enrollees receiving any MTFT.

MDH noted that all medications analyzed are used “off label,” which means that they are approved for conditions and treatments other than gender-affirming care. Claims were included in tabulations even if they were not associated with an applicable diagnosis code, entailing that the prevalence could have been overstated. However, given the relative alignment of these data with figures found in the literature, overstatement was not treated as a concern. We found the following prevalence of pharmacy and medical service use in the claims:

- The pharmacy claims for MTFT among relevant diagnoses dropped from 28.4% to 22.7% between 2019 and 2020 before rebounding and leveling off at 28.7% in 2021 and 29% in 2022. MTFT from medical claims fluctuated between 2.3% and 3%.
- The pharmacy claims for FTMT also decreased from 30.4% to 24.2% from 2019 to 2020, with a smaller rebound to 27.3% in 2021 and 26.1% in 2022. Medical claims for FTMT also fluctuated between 1.5% and 2.5%.
- PB data from pharmacy claims were redacted for 2019 and 2020 due to small cell sizes, leaving little room for trend analysis, and medical claims for PB use fluctuated between 1.6% and 2%. In aggregate, utilization of all hormone therapies was lowest in 2020 (at 53%) and otherwise ranged from 62.2% to 66%.

These numbers resemble the findings of Baker and Restar, who observed a 65% utilization rate of hormone therapy for a commercially insured population of transgender people in 2019.[10] According to James et al., 78% of USTS respondents seek hormone therapy at some point in their life, and 92% of those who have ever received hormone therapy were currently still receiving it, indicating potential unmet need due to level of coverage.[9]

For the purposes of this analysis, numbers of enrollees utilizing gender-affirming care, as well as total plan expenditures and enrollee cost-sharing, were projected under the proposed mandate. The population of enrollees who might utilize gender-affirming care was projected to increase by 10.4% per year. Koma et al. found that 19% of transgender adults reported cost-related barriers to care.[12] It was therefore assumed that 10% of non-utilizing enrollees would not be helped by expanded coverage, and utilization levels for psychotherapy, hormone therapy, and gender-affirming surgery were projected to increase from current levels to 75.5%, 76%, and 9%, respectively, with two thirds of growth occurring in the first 3 years.

The overall Minnesota population projections for 2025 (the base year) through 2034 are based on Minnesota State Demographic Center data and the historical non-public health insurance coverage levels from Minnesota Public Health Data Access. Sixty-five percent of the total state population was assumed to be included in the non-public insured population. Cost trends were derived from National Health Expenditure data (see the Data Sources section). Other professional service expenditure trends and prescription drug expenditure trends were used to project costs for psychotherapy and hormone therapy, respectively. For gender-affirming surgery, physician and clinical trends were blended with hospital expenditure trends at 78% and 22%, respectively, based on bed use numbers for gender-affirming surgery found by Wright et al.[13] We project costs under current law and under the proposed mandate. Mandate projections include the estimated impact of induced utilization in addition to the cost and prevalence trends, which are used in the analysis under both current law and the proposed mandate. This isolated the impact of the mandate for the purposes of calculating a change in the PMPM.

Results

Tables 1 and 2 show the results of the total projected population of applicable enrollees and gender-affirming care prevalence for associated diagnoses, utilization, and expenditures under current law and the proposed mandate. Table 2 shows the net projected effect on the total non-public insured population PMPM under the proposed mandate's expanded coverage.

Table 1. Total Projected Prevalence, Utilization, and Expenditures Under Current Law[c]

	Population		Prevalence rates	Utilization			Plan paid expenditures			Total cost-sharing		
	Total MN population	Non-public insured population	Associated diagnosis enrollees	Psycho-therapy	Hormone therapy	Surgical procedures	Psycho-therapy	Hormone therapy	Surgical procedures	Psycho-therapy	Hormone therapy	Surgical procedures
2025	5,833,655	3,101,454	9,095	5,684	5,553	643	$14,741,320	$11,788,733	$9,789,780	$4,138,783	$906,616	$397,001
2026	5,863,731	3,107,430	10,121	6,325	6,180	715	$16,947,339	$13,501,388	$11,320,169	$4,804,136	$1,007,344	$460,520
2027	5,893,080	3,112,920	11,261	7,037	6,875	796	$19,730,126	$15,838,358	$13,205,415	$5,590,716	$1,116,330	$535,393
2028	5,921,625	3,117,886	12,527	7,828	7,648	885	$22,981,732	$18,508,046	$15,397,622	$6,509,765	$1,244,685	$621,934
2029	5,949,303	3,122,300	13,932	8,706	8,506	984	$26,721,312	$21,531,082	$17,934,645	$7,573,162	$1,399,014	$721,831
2030	5,976,058	3,126,137	15,492	9,681	9,459	1,095	$31,117,241	$25,232,394	$20,922,346	$8,821,271	$1,570,217	$839,129
2031	6,001,850	3,139,298	17,279	10,797	10,550	1,221	$36,258,327	$29,804,128	$24,418,952	$10,280,741	$1,777,183	$976,242
2032	6,026,651	3,151,878	19,267	12,040	11,764	1,361	$42,250,429	$34,895,770	$28,499,119	$11,991,215	$1,999,542	$1,136,379
2033	6,050,458	3,163,936	21,481	13,423	13,115	1,518	$49,223,874	$40,849,849	$33,255,013	$13,983,736	$2,249,314	$1,322,546
2034	6,073,273	3,175,472	23,944	14,962	14,619	1,692	$57,338,033	$47,811,291	$38,797,627	$16,304,430	$2,529,833	$1,538,935

[c] The state health benefit mandates generally only apply to fully insured individual and small group health plans regulated in Minnesota, except where explicitly indicated. However, the actuarial analysis is based on gross expenditures for all non-public insurance in Minnesota. Although the analysis was not limited to individual and small group data, this does not affect the accuracy of the PMPM estimates. Using all non-public claims improves the robustness and accuracy of the PMPM estimates because the analyses rely on a larger, more representative set of data.

Table 2. Total Projected Prevalence, Utilization, Expenditures, and Non-Public Insured PMPM Impact of Mandate[d]

	Population		Prevalence rates	Utilization			Plan paid expenditures			Total cost-sharing			
	Total MN population	Non-public insured population	Associated diagnosis enrollees	Psycho-therapy	Hormone therapy	Surgical procedures	Psycho-therapy	Hormone therapy	Surgical procedures	Psycho-therapy	Hormone therapy	Surgical procedures	Total non-public insured PMPM change
2025	5,833,655	3,101,454	9,095	5,928	5,835	678	$15,376,390	$12,387,548	$10,330,801	$4,317,086	$952,668	$418,941	$0.05
2026	5,863,731	3,107,430	10,121	6,881	6,823	796	$18,439,009	$14,907,844	$12,605,936	$5,226,986	$1,112,280	$512,826	$0.11
2027	5,893,080	3,112,920	11,261	7,986	7,977	935	$22,391,538	$18,376,585	$15,517,985	$6,344,853	$1,295,231	$629,153	$0.20
2028	5,921,625	3,117,886	12,527	8,964	8,969	1,052	$26,318,559	$21,703,325	$18,303,867	$7,454,949	$1,459,571	$739,321	$0.25
2029	5,949,303	3,122,300	13,932	10,060	10,081	1,184	$30,878,943	$25,517,763	$21,566,911	$8,751,488	$1,658,054	$868,022	$0.31
2030	5,976,058	3,126,137	15,492	11,289	11,330	1,331	$36,285,326	$30,223,604	$25,451,389	$10,286,345	$1,880,821	$1,020,774	$0.39
2031	6,001,850	3,139,298	17,279	12,705	12,771	1,502	$42,664,140	$36,080,724	$30,049,280	$12,097,055	$2,151,449	$1,201,336	$0.49
2032	6,026,651	3,151,878	19,267	14,295	14,393	1,695	$50,166,252	$42,695,555	$35,476,799	$14,237,827	$2,446,473	$1,414,609	$0.60
2033	6,050,458	3,163,936	21,481	16,082	16,218	1,911	$58,976,855	$50,513,956	$41,877,049	$16,754,406	$2,781,448	$1,665,442	$0.74
2034	6,073,273	3,175,472	23,944	18,090	18,271	2,155	$69,322,449	$59,753,375	$49,423,109	$19,712,274	$3,161,724	$1,960,402	$0.91

[d] The state health benefit mandates generally only apply to fully insured individual and small group health plans regulated in Minnesota, except where explicitly indicated. However, the actuarial analysis is based on gross expenditures for all non-public insurance in Minnesota. Although the analysis was not limited to individual and small group data, this does not affect the accuracy of the PMPM estimates. Using all non-public claims improves the robustness and accuracy of the PMPM estimates because the analyses rely on a larger, more representative set of data.

The total statewide non-public insured population expenditures for gender-affirming care are projected to be $43.8 million in Year 1, with $38.1 million to be paid by plans. This is projected to increase to $203.3 million in the 10th year of the projection period, with $178.5 million to be paid by plans. There is an increase from $41.8 million to $164.3 million between Years 1 and 10 under current law, with similar cost-sharing levels. Overall, the mandate is projected to result in a net increase of $0.05 PMPM for the total non-public insured population in Year 1 of the projection, growing to $0.91 PMPM in the 10th and final year of the projection.

A more comprehensive actuarial analysis and modeling of all services related to and associated with gender-affirming care, including downstream effects, was not possible with the available data. A literature review was conducted to assess the potential long-term effects, including savings and improved health outcomes. The literature review for this analysis included select relevant articles from outside the United States due to the limited domestic literature addressing the economic impact of the proposed mandate.

- An article published on Stanford Medicine by E. Digitale describes research published in 2022 that was based on the 2015 U.S. Transgender Survey. This research was specific to individuals using hormone therapy and found that hormone therapy significantly reduced mental health problems and thoughts of suicide and that these reductions were more pronounced when treatment began at a younger age. The study also found that while hormone therapy during adolescence decreases the rate of substance abuse, beginning hormone therapy in adulthood increases the likelihood of substance abuse versus not taking hormones at all.[14]
- A 2022 study by Tordoff et al. assessed the short-term mental health effects of gender-affirming care over 1 year after beginning treatment and found lower odds of mental health issues and suicidal thoughts among users of hormone therapy versus non-users. No association was found between hormone therapies and anxiety.[15]
- A Swedish study published in 2019 by Branstrom and Pachankis researched the patterns of mental health care for people with gender disorders in the Swedish Total Population Register linked to the National Patient Register and the Prescribed Drug Register between 2005 and 2015. The study found that people with gender-related diagnoses were far more likely than the general population to see a doctor about mood disorders, take medication for mood disorders, and be admitted after a suicide attempt. The study initially found an 8% annual decrease in mood disorder treatment following gender-affirming surgery, but this finding was withdrawn in response to criticisms of the study's methods.[16]
- A review published in 2023 by Levine and Abbruzzese found that research on health improvements following gender-affirming care is inconclusive. The review cited long-term studies and reviews indicating potential harm resulting from gender-affirming care, such as elevated rates of suicide, HIV, cardiovascular disease, and substance abuse.[17]

Data Sources

- Minnesota state population projections are from the "Long-Term Population Projections for Minnesota" published by the Minnesota State Demographic Center.[18]
- Minnesota non-public health insurance coverage levels are from Minnesota Public Health Data Access.[19]
- Trends and projection factors are derived from the National Health Expenditure data compiled by CMS.[20]
- MDH tabulations of MN APCD data from 2019–2022 were used for the estimation of the prevalence of need for gender-affirming care and associated historical utilization, expenditures, and enrollee cost-sharing.[5]

State Fiscal Impact

The potential state fiscal impact of this legislation includes the estimated cost to SEGIP as assessed by MMB in consultation with health plan administrators, the cost of defrayal of benefit mandates as understood under the Patient Protection and Affordable Care Act (ACA), and the estimated cost to state public programs.

- This mandate is estimated to have no fiscal impact on SEGIP.
- There are no estimated defrayal costs associated with this proposed mandate.
- The proposed mandate applies to Minnesota state public programs.

Fiscal Impact Estimate for SEGIP

MMB does not estimate any state fiscal impact on the state plan from this legislation. SEGIP currently provides coverage in its medical benefits package for the gender-affirming services required by the proposed mandate.

Affordable Care Act Mandate Impact and Analysis

States may require qualified health plan issuers to cover benefits in addition to the 10 essential health benefits (EHBs) defined by the ACA but must defray the costs, either through payments to individual enrollees or directly to issuers, and can partially defray the costs of proposed mandates if some of the care, treatment, or services are already covered in the state's benchmark plan or mandated by federal law, pursuant to section 1311(d)(3)(b) of the ACA.[21,22] For further defrayal requirements and information on the methodology, please visit https://mn.gov/commerce/insurance/industry/policy-data-reports/62j-reports/.

If the mandate is enacted, Commerce assumes there would be no defrayal requirements associated with HF 2607. The state prohibits discrimination against individuals based on their gender identity or expression, including the exclusion of coverage for medically necessary treatment for gender dysphoria and related health conditions, such as gender confirmation surgery and medically necessary procedures to conform secondary sex characteristics to a person's gender identity or expression.[23] Additionally, the ACA requires nondiscriminatory medical coverage based on “medical necessity.” [24]

Fiscal Impact on State Public Programs

This proposed health benefit mandate would apply to Medicare supplemental policies and Minnesota public health coverage programs (e.g., Medical Assistance and MinnesotaCare).

Appendix A. Bill Text

A bill for an act relating to health care; clarifying that health plans must cover gender-affirming care; clarifying that medical assistance covers gender-affirming care; amending Minnesota Statutes 2022, section 256B.0625, subdivision 3a; proposing coding for new law in Minnesota Statutes, chapter 62Q.

BE IT ENACTED BY THE LEGISLATURE OF THE STATE OF MINNESOTA:

Section 1. **[62Q.585] GENDER-AFFIRMING CARE COVERAGE; MEDICALLY NECESSARY CARE.**

Subdivision 1. **Requirement**. No health plan that covers physical or mental health services may be offered, sold, issued, or renewed in this state that:

(1) excludes coverage for medically necessary gender-affirming care; or

(2) requires gender-affirming treatments to satisfy a definition of "medically necessary care," "medical necessity," or any similar term that is more restrictive than the definition provided in subdivision 2.

Subd. 2. **Minimum definition**. "Medically necessary care" means health care services appropriate in terms of type, frequency, level, setting, and duration to the enrollee's diagnosis or condition and diagnostic testing and preventive services. Medically necessary care must be consistent with generally accepted practice parameters as determined by health care providers in the same or similar general specialty as typically manages the condition, procedure, or treatment at issue and must:

(1) help restore or maintain the enrollee's health; or

(2) prevent deterioration of the enrollee's condition.

Subd. 3. **Health plan; definition**. For purposes of this section, "health plan" has the meaning given in Section 62Q.01, subdivision 3, but includes the coverages listed in section 62A.011, subdivision 3, clauses (7) and (10).

Sec. 2. Minnesota Statutes 2022, section 256B.0625, subdivision 3a, is amended to read:

Subd. 3a. **~~Sex reassignment surgery.~~ Gender-affirming care**. ~~Sex reassignment surgery is not covered~~. Medical assistance covers gender-affirming care, as determined medically necessary pursuant to the procedures and criteria recognized within the prevailing professional standards, guidelines, or practices in this field of medicine.

Appendix B. Associated Codes

International Classification of Disease (ICD-10) Code(s):

Name	Code
Transsexualism	F64.0
Dual role transvestism	F64.1
Gender identity disorder of childhood	F64.2
Other gender identity disorders	F64.8
Gender identity disorder unspecified	F64.9
Pseudohermaphroditism unspecified	Q56.3
Personal history of sex reassignment	Z87.890

CPT/HCPCS Code(s):

Name	Code(s)
Blepharoplasty	15822, 15823
Rhytidectomy	15824, 15825
Lipectomy	15876, 15877
Electrolysis epilation	17380
Mastectomy	19303
Breast augmentation or reconstruction	19325, 19350, 19357, 19380
Genioplasty	21120, 21122
Reduction forehead contouring	21137, 21139
Osteoplasty, facial bones	21208, 21209
Rhinoplasty	30420
Unlisted procedure, larynx	31599
Urethroplasty	53410, 53430
Amputation and straightening of the penis	54125, 54300
Orchiectomy and testicular prosthesis	54520, 54660
Scrotoplasty	55175, 55180
Intersex surgery	55970, 55980
Vulvectomy and vaginectomy	56620, 57110
Construction or repair of vaginal canal, introitus, clitoris, or perineum	57335, 56800, 56805, 56810
Vaginal prosthetic graft or revision	57292, 57295
Hysterectomy	58260, 58262, 58552, 58570, 58571, 58573
Repair of brow ptosis	67900
Psychotherapy	90832, 90833, 90834, 90836, 90837, 90838, 90839, 90840, 90846, 90847, 90849

HCPCS Code(s):

Drug category	Description	Code
Anti androgen	Goserelin acetate implant	J9202
Estrogen	Estradiol injection	J1380
Progesterone	Medroxyprogesterone injection	J1050
Anti androgen	Testosterone cypionate injection	J1071
Testosterone	Testosterone undecanoate injection	J3145
	Testosterone pellet	S0189
	Leuprolide acetate injection	J1950
Puberty blockers	Triptorelin pamoate injection	J3315
	Triptorelin injection	J3316
	Leuprolide acetate	J9217, J9218
	Histrelin implant	J9225, J9226

NDC Code(s):

Drug category	Generic drug name	Code(s)
Anti androgen	Dutasteride	31722013130, 31722013190, 42806054909
	Finasteride	00093735505, 00093735556, 16729009001, 16729009010, 16729009015, 16729009016, 31722052530, 57237006205, 57237006230, 65862014905, 65862014930, 65862014990, 67877028890, 68645054154, 76282041205, 76282041290, 16729008910, 31722052630, 65862092730, 65862092790, 67877045590
	Spironolactone	00378024301, 00378024305, 00378043701, 00378214601, 00378214605, 16714008402, 16714008501, 16714008502, 16714008601, 16714008602, 16714008603, 16714008604, 16729022501, 16729022516, 16729022601, 16729022616, 16729022701, 16729022716, 46287002001, 53489014301, 53489014305, 53489032801, 53489032805, 53489032901, 53489032905, 53489032907, 53746051101, 53746051105, 53746051110, 53746051401, 53746051405, 53746051501, 53746051505, 59746021601, 59746021605, 59746021701, 59746021801, 63739054510, 68382066001, 68382066005, 68382066010, 68382066101, 68382066105, 68382066201, 68382066205
Estrogen	Desogestrel-ethinyl estradiol	00093330416, 00254203380, 00555904358, 16714046404, 70700011385, 00378729653, 16714040404, 68462031829
	Drospirenone-ethinyl estradiol	00093400062, 00093542328, 00093542362, 00378729953, 00378730053, 00555913167, 31722094531, 50419040503, 59651002988, 68180088613, 68180088673, 68180090213, 68462072029, 70700011485, 70700011584, 70700011585

Drug category	Generic drug name	Code(s)
	Drospirenone-ethinyl estradiol-levomefolate calcium	00781407515
	Estradiol	00023588811, 00078034342, 00078034442, 00078034642, 00078034645, 00078036542, 00378145405, 00378145801, 00378145877, 00378334999, 00378335099, 00378335199, 00378335299, 00378336099, 00378461926, 00378462026, 00378462126, 00378462326, 00378464026, 00378464126, 00378464226, 00378464326, 00378464426, 00555088602, 00555088604, 00555088702, 00555088704, 00555089902, 00781710454, 00781711954, 00781712983, 00781713354, 00781713654, 00781713883, 00781714483, 00781715683, 00781716783, 42806008701, 42806008801, 42806008901, 42806008905, 51862033301, 51862033305, 51862033401, 51862033405, 60429083501, 60429083505, 65162022808, 65162098908, 65162099308, 65162099508, 65162099704, 65162099708, 68025006730, 68968341008, 68968345008, 68968347508, 68968661008
	Estradiol cypionate	00009027101
	Estradiol vaginal	00013215036, 00093322308, 00093322397, 00093354143, 00115151866, 00378877035, 45802009735, 47781010444, 65162022621, 66993000210, 68462071171, 68462071188
	Estradiol valerate	00143929001, 00143929101, 00517042001, 00517044001, 00574087005, 00574087205, 42023011001, 42023011101, 42023011201
	Estrogens, conjugated	00046110281
	Estrogens, conjugated vaginal	00046087221
	Etonogestrel-ethinyl estradiol	00052027301, 00052027303, 00093767902, 65162046935, 66993060536, 78206014603
	Levonorgestrel-ethinyl estradiol	00378728753, 00555901467, 00555902058, 00555904558, 16714035903, 16714035904, 50102022021, 51862002806, 51862054506, 68180084413, 68180084473, 68180085473, 68462038829, 69238153106, 70700011685, 70700011885, 00378728153, 00378728590, 00378731685, 00555912366, 65862086495, 68180084313, 68180084613, 68462067295, 70700011787, 68462063729
	Norelgestromin-ethinyl estradiol	00378334053, 65162035803
	Norethindrone-ethinyl estradiol	00555900942, 00555901058, 16714034804, 16714037003, 51862031803, 51862089203, 68180087513, 68180089373, 68462031629, 68462039429

Drug category	Generic drug name	Code(s)
	Norgestimate-ethinyl estradiol	00555901658, 16714036004, 65862077685, 68180084073, 68462030929, 70700011984, 70700011985, 00093214062, 00555901858, 16714036304, 68180083713, 68180083773, 68180083873, 68462056529, 68462071929, 69238160706, 70700012185
	Norgestrel-ethinyl estradiol	00555904958, 16714036504, 51862056406
Progesterone	Progesterone	16714015701, 16714015801, 17478076610, 17478076710, 43598034901, 43598035001, 59651015201, 59651015301, 65162080710, 65162080810, 69452023320, 69452023420, 69543037410, 69543037510, 70700016201, 70700016301
Testosterone	Testosterone	00023599060, 00023599230, 00051845030, 00051846233, 00254101211, 00591236360, 00591292102, 00591292418, 00591292530, 00591292630, 00591321630, 00591321730, 00591352430, 00603783188, 00832112005, 00832112035, 00832112142, 16714096701, 16714096802, 21922001902, 24979007815, 43598030488, 45802028139, 45802036665, 45802061001, 45802075401, 49884041872, 49884051072, 64380015102, 64380015202, 66887000105, 68180094111, 68180094311, 68382036211, 69238101302, 70700011221
	Testosterone cypionate	00009008601, 00009008610, 00009034702, 00009041701, 00009041702, 00143965901, 00143972601, 00409655701, 00409656201, 00409656202, 00409656220, 00409656222, 00517183001, 00574082001, 00574082010, 00574082701, 00574082710, 00591412879, 52536062501, 52536062510, 62756001540, 62756001640, 62756001740, 64980046799, 69097053731, 69097080232, 69097080237
	Testosterone enanthate	00143975001, 00591322126, 54436020004, 54436025004, 54436027504
	Testosterone undecanoate	69087023712
Puberty blockers	Histrelin acetate	67979000201
	Leuprolide acetate	00074334603, 00074366303, 62935022305, 00074368303, 62935030330, 00074228203, 00074244003, 00074377903, 00074969403
	Triptorelin pamoate	24338015020

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