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Health Insurance Coverage for Transgender People in Massachusetts

On June 20, 2014, the Patrick Administration announced reforms to health coverage policies to ensure that transgender Massachusetts residents have full access to treatments they need. On the same day, the Division of Insurance issued a bulletin[1] that bars private health insurers from excluding medically necessary care for gender dysphoria from private health insurance plans.

What does the announcement mean for individuals covered by MassHealth?

The Patrick Administration statement made clear that MassHealth, the Massachusetts Medicaid program, would be issuing regulations that remove existing exclusions for both medically necessary hormone treatment and for sex reassignment surgery. MassHealth has not yet issued updated regulations but is anticipated to do so within a few months. Once that happens, there will be a period of time for public input on the proposed regulations and then the new regulations would go into effect. Once the exclusionary language is removed from the regulations, you should work with your doctor to make sure you submit the appropriate documentation to support your request. If you file a claim and are denied, you can request a hearing to review your claim.

What does the announcement mean for individuals who have private insurance?

The Division of Insurance bulletin applies to fully-insured health plans issued by private health insurance companies that are licensed to operate in the Commonwealth of Massachusetts. These insurance companies should not deny requests for coverage of medically necessary gender transition treatment, and their fully-insured plans cannot categorically exclude coverage for such treatment. The bulletin does not apply to "self-insured" plans, which are offered primarily by large employers and unions. If you are not sure if your plan is fully-insured or self-insured, you should ask your Human Resources Department or contact your health plan directly.

What if I have a self-insured plan?

A self-insured (also called self-funded) plan is an insurance plan set up by an employer to pay the health claims of its employees. The employer sets aside funds to pay for the health claims

[1] *See* http://www.mass.gov/ocabr/docs/doi/legal-hearings/bulletin-201403.pdf.

instead of paying a health insurance company to accept the risk of paying the claims. The employer assumes the risk of providing the benefits. Even though self-insured plans are not covered by the DOI bulletin, some self-insured plans do cover gender transition treatment. You should check with your plan or your Human Resources department if you are not sure if these benefits are covered under your insurance plan. If you have a self-insured plan, there may be other actions you can take, including appealing through your insurance plan if your insurer denies coverage for gender transition treatment. You should contact one of the organizations listed in this FAQ if you have a question about what you can do.

What happens if my insurance policy still says that it excludes coverage for gender transition treatment?

The Division of Insurance bulletin (2014-03) states that exclusions for medically necessary gender transition treatment violate Massachusetts law. Insurance companies should be sending information to health plan members making it clear that any existing exclusions for medically necessary gender transition treatment in the insurance plan will not be used. If you require treatment for gender dysphoria going forward, you should follow the appropriate method under your insurance policy to file a claim for that treatment. If your claim is denied, you should review your policy and follow the procedure for appeal. You should also call one of the organizations listed in this FAQ.

Can insurers offer plans that have exclusions for gender transition treatment going forward?

Health insurance companies providing plans regulated by the Massachusetts Division of Insurance and Massachusetts insurance laws can no longer offer plans to consumers that contain discriminatory exclusions for medically necessary gender transition treatment.

What evidence do I need to support a request for coverage?

Most insurance plans require that you get prior authorization for certain services, such as surgery, before the service takes place. You should review your plan carefully before scheduling any service to make sure that you follow your plan's requirements. Some insurance policies have specific information about the documentation required. Make sure that any letters or documentation you present from your medical providers contain information about why the service is medically necessary for you. It may be helpful for the doctor to refer to the most recent version of the World Professional Association for Transgender Health WPATH Standards of Care[2] and any relevant medical research.

What if I have a transgender child and need coverage for hormone blockers or other treatment?

The Insurance Division was clear that all exclusions of medically necessary treatment for gender dysphoria are not permitted under current law. Insurance policies have different requirements

[2] *See* http://www.wpath.org/uploaded_files/140/files/IJT%20SOC,%20V7.pdf.

for coverage of particular treatments and you should refer to your policy. If your child's medical providers support the medical necessity of the particular treatment for gender dysphoria for your child, and you are denied, you can appeal by following the procedure in your insurance policy. You should contact one of the organizations listed in this FAQ for information.

How do I find a surgeon who will take insurance?

More and more surgeons who perform sex reassignment surgeries take health insurance. You should research surgeons carefully to find one who is a good fit for you. You can look at the list of in-network providers provided by your plan to see if they are included or if it includes any surgeons in your area, and if not, you can contact the surgeon's office to determine if they accept your insurance. Most health insurance plans require that you use a medical provider in your network, but if your network does not include a surgeon who performs the services you need, you may be able to go out of network if you seek prior authorization from your plan.

I was denied coverage in the last year and I paid out of pocket for the services. Can I still appeal?

If you paid out of pocket for medically necessary gender transition services after July 1, 2012, you should contact one of the organizations listed in this FAQ to learn more about what you can do.

I work for a municipality and get my insurance through the Group Insurance Commission. Are they bound by these new rules as well?

The Group Insurance Commission offers both fully-insured and self-insured plans. Self-insured plans are not covered by the insurance bulletin. If you are employed by the Commonwealth or by a municipality and are insured through the Group Insurance Commission, please reach out to one of the organizations to find out what you can do.

Where can I get more information or help understanding what is covered?

GLBTQ Legal Advocates & Defenders: (800) 455-GLAD (4523) or www.GLADAnswers.org.

Health Law Advocates: (617) 338-5241. Offers representation in health insurance appeals to low-income Massachusetts residents. For more information go to: www.healthlawadvocates.org.

Health Care For All: (800) 272-4232 (English, Spanish, Portuguese) or www.hcfama.org/helpline.

MassEquality: (617) 878-2300.

Massachusetts Transgender Political Coalition: 617-778-0519.

AIDS Action Committee: (617) 450-1317.