Government of the District of Columbia
Vincent C. Gray, Mayor
Department of Insurance, Securities and Banking

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Acting Commissioner

FAQ: Nondiscrimination in Health Insurance Based on Gender Identity or Expression

The District of Columbia Department of Insurance, Securities, and Banking, known as DISB, recently announced that nondiscrimination laws in the District require private health insurers to cover care related to transition. Here are answers to some frequently asked questions about this announcement (DISB Bulletin 13-IB-01-30/15 can be found here or on disb.dc.gov.)

General

Q. What do insurers have to do to comply with nondiscrimination requirements based on gender identity or expression?

A: All insurers that write individual or group coverage in the District must do the following:

- Evaluate their practices, including covered benefits and coverage determination procedures, to ensure that they do not discriminate on the basis of gender dysphoria, and that they do not deny access to medically necessary care because of a person's gender identity or expression.

- Review all current plan documents to ensure that they are compliant with the guidance provided by DISB, and remove benefit and coverage exclusions and limitations that explicitly or otherwise target consumers on the basis of gender identity or gender expression.

- Amend health plan documents to ensure compliance with the bulletin's requirements.

Q: What kinds of coverage exclusion provisions are no longer enforceable and must be removed under this announcement?

A: All plan provisions that exclude coverage on the basis of gender identity or gender expression violate District law. That means they are no longer enforceable and must be removed from plan documents. Examples of exclusions that must be removed include but are not limited to:

- "Any treatment or procedure designed to alter an individual's physical characteristics to those of the opposite sex."
- "Sex transformation operations and related services."
- "Sex change: Any treatment, drug, service or supply related to changing sex or sexual characteristics."

Plan Offerings

Q: What health insurance plans are affected by DISB Bulletin 13-IB-01-30/15?

A: The following plans sold in the D.C. are affected by the bulletin:

- All plans (including individual and group plans) sold on DC Health Link;
- All existing individual plans sold to D.C. residents; and
- All group plans sold in D.C.

Q: What health insurance plans are NOT affected by DISB Bulletin 13-IB-01-30/15?

A: (1) Self-insured (also called "self-funded") group plans, which are arrangements in which an employer acts as an insurer covering its employees rather than purchasing coverage through an insurance company, are not affected by the announcement. These plans are regulated separately by a federal law known as ERISA. If an employee is seeking coverage for transition-related medical care under an employer's plan, it is important to first check whether the employer has a self-insured plan.

The opposite of "self-insured" is "fully-insured"—if your employer has a fully-insured plan, it is covered by the bulletin.

(2) Health plans offered to federal employees are not affected by this announcement.

(3) Medicare, Medicaid and DC Healthcare Alliance, although DC Medicaid plans, while not covered by the bulletin do also provide coverage for care related to transition.

Q: What types of services and procedures will now be covered?

A: Insurance plans regulated by DISB must cover medically necessary treatments for gender dysphoria, including gender reassignment surgeries. In determining medical necessity, insurance companies will refer to the most recent edition of the World Professional Association for Transgender Health Standards of Care (WPATH Standards of Care).

Below is a partial listing of the main benefits that must be covered for transgender enrollees in DISB-regulated plans, if they are determined to be medically necessary for the individual by a licensed medical provider.

Table 1: Selected services provided for gender dysphoria.

Please note this list is not exhaustive and is subject to change as treatments evolve and improve.

Procedure	**Example or description of procedure**
Hormone therapy	Prescription androgens and estrogens
Hormone blockers	Aromatase inhibitors or gonadotropin-releasing hormone (GnRH) analogues used to suppress hormone release
Mental health treatment	Counseling, psychotherapy
Preventive screenings	Pap tests, prostate exams, mammograms, breast exams
Laboratory screenings	Blood tests to assess hormone levels, cholesterol levels, liver function
Urethroplasty/Urethral reconstruction	Reconstruction and/or rerouting of the Urethra
Mastectomy	Removal of the breasts or breast tissue
Hysterectomy	Removal of the uterus
Phalloplasty	Construction or reconstruction of the penis
Tracheal shave	Reduction of thyroid cartilage
Vaginoplasty	Construction or reconstruction of the vagina

Q: How will the medical necessity of a service or procedure be determined?

A: The WPATH Standards of Care detail the requirements for a determination of medical necessity. In summary, medical necessity requires a referral letter (one or two, depending on the service or procedure) from a medical health professional qualified to provide such a referral. Both the content of the referral letter and the requirements for a medical

professional to be able to provide a referral letter are described in the WPATH Standards of Care which are available here or at www.wpath.org.

Q: Will there be deductibles, copayments or coinsurances applied to these benefits?

A: Yes, these services will be covered like any other covered benefit. Any applicable deductibles, copayments and other cost-sharing can be applied.

Q: Which medically necessary services to treat gender dysphoria must be pre-authorized before they will be covered?

A: If prior authorization is required for a covered procedure, it will be required for both transgender and non-transgender enrollees. Prior authorization requirements may be applied according to the terms and conditions of the individual or group contract of coverage.

Appeals

Q: What action can an individual take if they feel they have been discriminated against under a medical plan because of their gender identity or expression?

A: If your insurer denied coverage for a service, you can file an insurance complaint with DISB by calling us at 202-727-8000 or online at disb.dc.gov. DISB staff will investigate and determine if the insurer has complied with District law and the requirements of the bulletin. If the insurer is found to be in violation of District law or the bulletin, the insurer will be required to correct the discriminatory action. DISB does not address determinations of medical necessity (those are discussed below) but an individual can file a complaint with DISB and if the issue becomes one of medical necessity, DISB will work with the District of Columbia Office of Health Care Ombudsman and Bill of Rights to resolve.

Q: What action can an individual take if the medical necessity of a service has been denied?

A: Every medical plan member has the right to appeal a decision by an insurer that results in a denial, reduction, limitation, termination or delay in covered services. Under District law, each medical plan is required to provide members with the opportunity to resolve an appeal through a two-stage internal grievance process.

When a health insurer denies coverage for a service, it must immediately inform the individual of its internal appeals process. The individual should follow this process when filing any appeal, grievance or complaint. Individuals should also record the dates they provide information to the insurer and should keep a record of telephone calls and a copy of any communications, including letters and forms.

If the dispute is not resolved to the individual's satisfaction, they may exercise their right to contact the District of Columbia Office of Health Care Ombudsman and Bill of Rights regarding how to file an external appeal at 1-877-685-6391. Paperwork to file an external appeal can be found here or at ombudsman.dc.gov.

Q: How does the external appeals process work?

A: The District of Columbia Office of Health Care Ombudsman and Bill of Rights will review documents and will forward the information to an Independent Review Organization, which determines whether the individual was improperly denied coverage within 45 business days.

The Office of Health Care Ombudsman and Bill of Rights will then forward copies of the decision to the individual and the insurer. The decision of the Independent Review Organization is binding on all parties. In cases of urgent or emergency care, the Independent Review Organization has 72 hours to issue a decision.

There is no cost to file an external appeal, and insurers cannot retaliate against you for exercising the right to an appeal.

Q: Does this appeals procedure also apply to beneficiaries in Medicare or Medicaid Programs?

A: No. This program is not available to beneficiaries in the Medicare or Medicaid Programs, as these programs have their own appeals procedures.

Q: If I file an external appeal, will my information be kept private?

A: All communications with the Health Care Ombudsman will be kept private, and information will not be disclosed unless the individual waives the right to privacy.

For more information, DISB can be reached by phone at 202-727-8000, by email at disb@dc.gov or online at disb.dc.gov.