FACT SHEET

JANUARY 2017

HEALTH CARE FOR ALL NEW YORK
LGBT TASK FORCE

Health Coverage for Transgender New Yorkers:
Navigating Private Insurance to Get the Care You Need

Trans and gender nonconforming New Yorkers – Does your health plan cover the care you need?

This fact sheet will help you find the answers if you have private insurance you got through your job, the NY State of Health marketplace, or an insurance broker. Different rules will apply if you have public insurance such as Medicaid or Medicare.

The good news is that health insurance coverage for the care that trans and gender nonconforming people need is gradually improving. Recent communications about New York's requirements provide better protections for people using their private insurance coverage for trans-related health care (like hormones or surgery) and sex-specific preventive and reproductive care (like Pap tests or prostate exams).

Despite these changes, using your health coverage to get these services can still be confusing.

Q. How do I find out what care my health plan covers (such as hormones or gender transition surgery)?

A. Start by reading your plan's Certificate of Coverage to find out what services are included in your plan. You can request a copy by calling the Member Services phone number on your insurance ID card. You may also be able to find your Certificate of Coverage on your health plan's website. (Be sure to search for the exact plan you have, because the company may offer several different plans on the website).

Q. What if my Certificate of Coverage does not have specific information about gender transition?

A. If it's not clear what is included, look for what is excluded. Check the "Exclusions" portion of your Certificate of Coverage for phrases like "sex reassignment," "gender reassignment," or "sex transformation." If you don't find explicit exclusions listed, your plan may cover the care you need – keep reading to find out.

If you do find exclusions in your Certificate of Coverage, don't give up! Your insurance company may not have updated the Certificate of Coverage to comply with the rules. Blanket exclusions of all coverage for gender transition-related care are not permitted in private insurance policies regulated by the **New York State Department of Financial Services (DFS).** You can find out if your health plan is regulated by DFS by consulting the information in the next section of this fact sheet.

Next, check your health plan's "medical policy" or "clinical criteria" regarding gender reassignment. It should contain the most up-to-date information about how your health plan decides whether the gender transition care you need is "medically necessary" and if it will be covered. You can get a copy of it by searching online or calling your health plan. Be persistent. It may take some time to get this. If your insurance company does not provide you with a copy of its clinical criteria, and the company is regulated by the DFS, you can file a complaint with the Department's Consumer Assistance Unit by going to its website: http://www.dfs.ny.gov/consumer/fileacomplaint.htm.

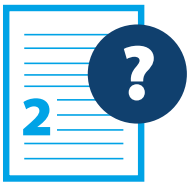
Q. What are the rules about the kinds of transgender care my plan must cover?

A. It depends what type of health plan you have. New York State rules apply to some types of plans and require them to cover "medically-necessary treatment" for people diagnosed with "gender dysphoria." Here's a run-down of the types of plans and how to figure out which one you have:

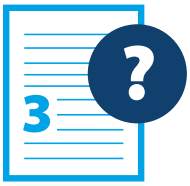
EMPLOYER-OFFERED HEALTH PLANS

If you have health insurance through your job, it may be "fully-insured" (also known as fully-funded) or "self-insured" (also known as self-funded). To find out which kind you have, ask your employer's Human Resources staff, or call the plan directly.

1. Fully-insured plan, issued in New York: This means your employer pays premiums to a health insurance company (and you probably pay a portion of the premiums yourself). The insurance company is then responsible for paying its share for your medical bills. Fully-insured health plans are regulated by DFS, and must cover medically necessary treatment for people diagnosed with gender dysphoria.



2. Fully-insured plan, NOT issued in New York: If your health plan is fully-insured but was issued in another state, it is not governed by the DFS rules. This can happen if your employer's headquarters are in a state other than New York and they provide a health plan issued in that state for all employees. A health plan issued in another state is regulated by the insurance department of that state. Some states require trans coverage, but others don't.



3. Self-insured plan: This means that your employer does NOT pay premiums to an insurance company. Instead, when you use your insurance for medical services, your employer pays its share of the medical bills directly. In 2015, more than half of private-sector workers in New York were enrolled in this type of health plan (according to a report from the U.S. Agency for Healthcare Research and Quality). Since employers and unions often hire insurance companies just to administer self-insured health plans, it is hard to know if you have one unless you ask.

Self-insured plans are NOT regulated by DFS, so they don't have to comply with New York rules. However, they may have to comply with federal laws which protect against gender discrimination, such as section 1557 of the Affordable Care Act. If your health plan is self-insured and denies you coverage for trans-related care, you will need help from an attorney. See the chart below for organizations that can help.

4 INDIVIDUAL HEALTH PLANS

If you got your plan through the New York State of Health marketplace or through a licensed broker, then you have a fully-insured plan regulated by DFS. It must cover medically necessary treatment for gender dysphoria.

Types of Private Insurance Plans and Rules They Must Follow for Trans-Related Care

TYPE OF PLAN	MUST COVER TRANS-RELATED CARE?	WHO SHOULD I CONTACT TO APPEAL?
EMPLOYER-OFFERED:		
1 • Fully-insured, issued in New York	**YES,** if it is medically necessary treatment for gender dysphoria	Your insurance company, then New York State Department of Financial Services http://www.dfs.ny.gov/insurance/extapp/extappqa.htm
2 • Fully-insured, issued in another state	**MAYBE,** depending on the rules of that state	Insurance regulators for the state in which the plan was issued
3 • Self-insured	**PROBABLY NOT,** but there are some exceptions.	You should get help from a lawyer.
4 **INDIVIDUAL PLAN**	**YES,** if it is medically necessary treatment for gender dysphoria	Your insurance company, then New York Department of Financial Services http://www.dfs.ny.gov/insurance/extapp/extappqa.htm

Q. What do you mean by 'medically necessary treatment for gender dysphoria'?

A. What is considered "medically necessary" for the treatment of gender dysphoria differs from plan to plan. Generally, someone needs to be diagnosed with gender dysphoria by a qualified medical clinician, for example, a doctor, licensed clinical social worker, or psychologist, and have letters of referral written for him or her. Even if your plan covers medically necessary treatment for gender dysphoria, this may not include the care you want or need. That is because health services such as surgery to make a person's face or body look more masculine or feminine or change a person's voice are sometimes considered to be "cosmetic," not "medically necessary." **If this is the case, or if your plan does not cover any of the care you need, read on to learn about appealing!**

Q. What if my health plan denies coverage for the care I need?

A. You can ask your health plan to reconsider the denial. To do this, you must file an "internal appeal" – a request to your health plan asking them to reconsider. If your health plan denies your internal appeal, you may be able to file an "external appeal" with the government agency that oversees your health plan – this asks the government agency to consider the case. See the chart above to determine which government agency to contact.

Note that it is important to get a coverage denial in writing, so that you can file an appeal. Some transgender New Yorkers have reported that insurance company representatives have told them over the phone that their coverage is denied, but have provided nothing in writing. If this happens to you, and your health plan is regulated by the DFS, you can file a complaint with the Department's Consumer Assistance Unit and ask them to help you obtain a written denial that can then be appealed. File a complaint here: http://www.dfs.ny.gov/consumer/fileacomplaint.htm

Q. How do I file an appeal? What's the process?

A. If you get a denial notice from your health plan, it should also tell you how you can appeal. You can also call the Member Services number on the back of your insurance ID card and say you want to know the process for filing a formal appeal.

You will need to submit your appeal in writing, so be sure to get the right address to send it to. Keep copies of everything you mail in!

For many insurance companies, you must file an appeal within a certain number of days after you receive a denial. In addition, filing an appeal triggers certain deadlines and the appeal can affect future rights.

For private health plans regulated by the DFS, you must submit an "internal appeal" of a coverage denial to your health insurance company within 180 days of receipt of your written denial. If your appeal to your health insurance company is denied, you can then file an "external appeal" with the NYS DFS within four months of the date when your internal appeal to your health insurer was denied.

GET HELP BEFORE SUBMITTING AN APPEAL ON YOUR OWN, SO THAT YOU DO NOT MISS ANY DEADLINES.

Q. What if my problem is that my health plan provider network has no surgeons qualified to perform gender transition surgery, and the insurance company is denying my request to use an experienced surgeon who is outside of my health plan network?

A. You can appeal your health plan's denial of your request to use a qualified out-of-network provider, such as a surgeon, when there is no one in your provider network who can give you the care you need. You would follow the same steps as for a denial of coverage, first filing an "internal appeal" with your health plan and then, if that is denied, filing an "external appeal" with DFS. Or, if you are self insured, file an appeal with the external reviewer listed on the Final Adverse Determination.

Q. Can I get help appealing a denial?

A. Yes! The appeals process can be complicated. You don't have to go it alone. Community Health Advocates is the statewide consumer assistance program that provides free advocacy and resources to New Yorkers having problems with their health insurance. You can call them at (888) 614-5400, or you can find them online at http://www.communityhealthadvocates.org

Another organization that may be able to help is **Transcend Legal,** which is a New York-based organization focused on helping transgender people access health care by appealing insurance denials and challenging exclusions. You can reach them at (347) 612-4312 or http://transcendlegal.org

You can also get help from a private attorney specializing in transgender health coverage cases. A private attorney will probably not be free, but some of them adjust their rates based on their client's ability to pay.