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FREQUENTLY ASKED QUESTIONS ON WASHINGTON INSURANCE COMMISSIONER LETTER ON TRANSGENDER HEALTHCARE

OVERVIEW

The Washington Insurance Commissioner's office sent a letter to Private insurers in Washington State on June 25th of 2014 announcing that in order to comply with the Washington Law Against Discrimination and the Affordable Care Act that prohibit discrimination on the basis of gender identity, health insurance plans sold in Washington can no longer deny health care to transgender policy holders which is provided to non-transgender policy holders. Removing these outdated exclusions brings Washington up-to-date with the latest information from medical experts and will provide countless Washingtonians with access to medically necessary health care. You can read more about this announcement on the Insurance Commissioner's Website:

WHAT IS INSURANCE COMMISSIONER'S OFFICE AND WHAT AUTHORITY DO THEY HAVE?

The Office of the Insurance Commissioner oversees health insurance in the state of Washington. Insurance companies must comply with the Insurance Code and Insurance Commission rules that implement the Insurance Code in order to sell insurance in the state. The letter is intended to serve as notice to insurers and others of the department's expectations about how insurers and producers must act in transacting insurance in order to comply with Washington's non-discrimination law, The Anderson-Murray non-discrimination Law of 2006. The Insurance Commission also has the power to ensure that plans offered in the state-based healthcare exchange comply with the Affordable Care Act.

WHAT KINDS OF EXCLUSIONS DOES THE DECISION IMPACT?

The bulletin specifically states that:

- Health insurers must provide coverage and cannot deny coverage of treatments for transgender policy holders if the same treatments are covered for other policy holders. If an insurer covers breast reduction surgery to lessen back pain, the insurer could not deny breast reduction surgery for gender transition if the provider deemed the treatment medically necessary. If hormone therapy is covered for other policyholders, it cannot be denied for gender transition if determined to be medically necessary. On the other hand, an insurer could exclude all coverage of breast implants or penile implants. In short, Washington law requires equality in treatment.
- Health insurers may not have riders that categorically exclude all transgender patients or treatments for Gender Dysphoria.
- The statewide mandate for coverage of mental health services must apply to transgender patients of all ages, therefore mental health care related to gender transition should be covered by insurers.

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- The designation of male or female may not be relevant to treatment (ie, a person cannot be denied an ovarian cancer screening on the basis that they identify as male).
- Transgender people will have to make the same case for ‘medical necessity’ of treatment with their medical provider to their insurance company as would anyone else seeking medical treatment.
- This letter does not guarantee any specific coverage; it does however require insurers to provide the same services to transgender people as to non-transgender people and that they treat Transgender people fairly.
- If you believe you have been discriminated against – the Insurance Commissioner’s office will assist you in filing an appeal and will investigate if the law has been broken.
- All plans in the 2015 health market exchange will be evaluated if they contain any discriminatory exclusions to make sure they cover medically necessary services equally for non-transgender and transgender enrollees

WHAT DO I DO IF I THINK AN INSURER HAS UNFAIRLY DENIED MY CLAIM?

1. **If you are denied coverage for a treatment, you must file an appeal through the insurance provider.** Your appeal may be denied by your insurance company and should include any additional steps of appealing. You must complete all levels of internal appeal with the insurer.
2. **At the same time as you are going through the appeals process, file a complaint with the Insurance Commissioner’s Office.** You may receive help with your complaint from an insurance consumer advocate by calling 1-800-562-6900 or by going to this website: <http://www.insurance.wa.gov/complaints-and-fraud/file-a-complaint/insurance-company/> Filing with the Insurance Commissioner’s office is important as it helps other Transgender community members – if an insurance company is a “bad apple” the insurance commissioner may receive a lot of complaints and can take additional actions with that insurer for violating state law.
3. The Insurance Commissioner can help follow your case with your insurance company and provide additional information to you as well as examine if the company has violated state law and tell the company to fix the problem.
4. You can also contact Q-Law, Legal Voice, or Gender Justice League for additional assistance in navigating this problem.

BUT WHAT IF THE INSURER COVERS THE SAME PROCEDURES FOR OTHERS? ISN’T THIS FLAT OUT DISCRIMINATION?

If the insurer is denying a claim for a treatment for a transgender-related condition but allows the same treatment to others for non-transgender-related condition simply by saying “this is not covered” then Insurance Commissioner may use existing non-discrimination statutes to require the insurer to provide coverage for the treatment of a transgender-related condition. The availability of this option can only

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be made on a case-by-case basis, as many things influence the outcome, such as terms of the policy itself, reasons the carrier denied the claim or refused to approve the treatment, coverage provided to others seeking the same treatment for other reasons, etc. When an insurer denies a claim based on “medical necessity,” the insurance company is essentially disagreeing with a doctor about the medical necessity of a procedure. The Insurance Company cannot enforce statute about what defines “medical necessity” because laws do not exist which define this specifically and most insurers define medical necessity in their contract. However, because of the changes in the rule and expectations set forth in the letter, most insurers will likely have to make a determination that a treatment is not medically necessary in order to deny coverage. In this case you now have access to an external review process administrated by the Insurance Commissioner. A Consumer Advocate from the Insurance Commissioner’s office can assist you through this process free of charge, but the Insurance Commissioner’s office cannot make the determination of medical necessity. The Insurance Commissioner’s Office strongly urges an insured person to participate in this process if a claim is denied on the basis of medical necessity.

WHAT CAN I DO TO PROVE MEDICAL NECESSITY?

Medical necessity is determined on a case by case basis through guidelines established by your insurer, however, we believe that if you follow the WPATH standards of care version 7 you should be able to make an argument that your care is medically necessary. While there is no guarantee that your insurance will absolutely cover your care, following the WPATH standards of care is helpful in establishing the medical necessity of your care. Discuss with your doctor or therapist what course of medical care is best in your case. You can download the WPATH standards of care here: <http://www.genderjusticeleague.org/socv7.pdf>

WHY IS THIS DECISION NEEDED?

Insurance companies routinely refuse to provide coverage for basic medical care to transgender people based on their transgender status or specifically exclude transgender-related services. Nearly all insurance plans categorically excluded coverage for transgender-related medical treatment, even when that treatment (such as mental health care or hormone replacement therapy) is covered for non-transgender people. This kind of categorical exclusion is no longer permitted.

IS THIS NECESSARY MEDICAL CARE?

Our nation’s most reputable medical bodies have identified transgender health care as being medically necessary. In 2008, the American Medical Association passed a resolution supporting public and private health insurance coverage for treatment of gender identity disorder and opposing the “exclusions of coverage for treatment of gender identity disorder when prescribed by a physician.” That same year, the

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American Psychological Association passed a resolution stating that the organization “opposes all public and private discrimination on the basis of actual or perceived gender identity and expression and urges the repeal of discriminatory laws and policies; in 2012 the American Psychiatric Association affirmed that the organization “Urges the repeal of laws and policies that discriminate against transgender and gender variant individuals.” and “Opposes all public and private discrimination against transgender and gender variant individuals in such areas as health care, employment, housing, public accommodation, education, and licensing.” In June 2014, the US Department of Health and Human Services removed similar exclusions from the federally administered Medicare program citing the medical necessity of this care.

WILL THIS RAISE INSURANCE RATES?

Past experience offers helpful information here. In 2012, the City of Seattle removed exclusions, Seattle has seen no significant cost impact to their health plan. Similarly, the City of Portland, Oregon has estimated the premium impact to be .08%. The City and County of San Francisco removed exclusions from their employee benefits plan in 2001 and have not seen any discernible increase in health care costs. 7 States including Oregon, California, Colorado, Vermont, Connecticut, and Massachusetts have all required insurers to remove these exclusions with little impact to underlying insurance rates.

HOW WILL THIS AFFECT MEDICARE AND MEDICAID?

Recently Medicare announced that they were removing categorical exclusions in health care. This decision will have no impact on Medicare which is managed by the Federal Government. Medicaid is a state administered program and unclear if this bulletin will apply. What is clear is that the ruling will apply to all private insurance companies that operate in Washington. The Coalition for Inclusive Health Care and transgender community leaders will continue working together to increase access to medically necessary care for all Washingtonians.

WHAT ABOUT FOR STATE EMPLOYEES?

The Coalition for Inclusive Healthcare has been working with the State Public Employees Benefits to bring coverage for state employees. Currently the PEBB has instructed staff to extend these benefits by January 1st, 2016. However the Coalition for Inclusive Healthcare is working with staff and the PEBB to see if these exclusions can be removed sooner. If you have questions about State Employees or have experienced a denial letter – please reach out to the coalition.

WHAT ABOUT FOR SELF-INSURED PLANS?

Some large employers self-insure, meaning they pay insurance claims themselves. These self-insured plans are often administered by large insurance companies – so it may be difficult to know if your company has a self-insured plan, but these plans

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are primarily at very large employers (more than 500 employees). Self-Insured Plans are governed by a Federal law called ERISA, which means that the Insurance Commission's Office Letter does not apply to those plans. Many Self-Insured employers are working on removing these discriminatory exclusions, please contact the Coalition if you need help working with your employer to get coverage under a self-insured plan.

WHO ELSE IS PROVIDING THIS COVERAGE AND WHY?

Currently, 25% of Fortune 100 Companies and many Washington businesses offer inclusive health care, including healthcare for transgender employees. These businesses believe that providing all employees with the medically-necessary care they need to be healthy and productive is not just good for employees and their families, they know it is good for business.

Washington businesses that offer transgender-related coverage to their employees include: Washington Education Association, Microsoft, Amazon, Boeing, Progressive Insurance, Starbucks, Alcatel-Lucent, American Express, Ameriprise Financial, AT&T, Bank of America, Chrysler Motors, IBM, Kimpton Hotel & Restaurant Group, KPMG, Kraft Foods, McGraw- Hill, and State Farm.