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Don't take "no" as the (final) answer: Overcoming insurance denials for gender-affirming care

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The basics

Trans people; trans terminology

- One's *sex assigned at birth* generally aligns with physical/external anatomy
- A person's innate sense of self as (frequently) male or female – *gender identity* - may not
- Where they do: *cisgender*
- Where they don't: *transgender or nonbinary*
- Where this non-alignment triggers clinically significant mental-health symptoms, this is *gender dysphoria (*or *gender incongruence)*
- Gender-affirming care is designed to alleviate gender dysphoria

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Basic components of gender-affirming care

- Counseling
  - Initial response to clinically-significant symptoms
  - Assessing gender dysphoria
- Medications
  - "Cross-sex" hormones for adults, older teens
  - "Blockers" for younger teens
- Surgery
  - Genital surgery
  - Chest surgery: Mastectomy/breast augmentation
  - Facial surgery: primarily feminization

NOTE: not all people do all things or in any particular order

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Barriers to care

Historical perception that "sex changes" [not a current term] were, at best, cosmetic care – and thus not covered
- Still a perception in some contexts
  - * Is facial gender-confirmation surgery gender-confirmation surgery?
- Should minors receive such care?
- Should prisoners receive such care?

Slow improvement in health plans, but inconsistent
- Acceptance of WPATH Standards of Care – 8th Edition □ medical necessity

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Letters of support/med records

Most, if not all, insurance companies have a specific policy about coverage of gender-affirming care. If you don't have it, it may be on their website or available upon request. TLDEF has a great online resource.

- Be sure to identify every criterion they articulate, and make sure someone, somewhere has documented each one that applies, including simply stating the procedure is "medically necessary." Don't assume something is too obvious to be documented!

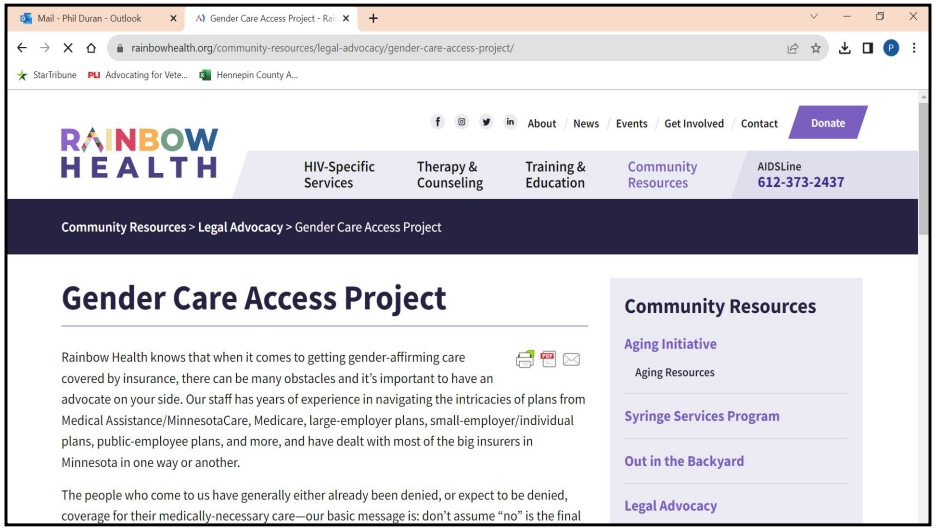
Two potentially critical documents to have

- Consider the possibility the service might be covered under a different policy that is unrelated to gender-affirming care.
- Beware: an insurance company may offer some plans subject to other limitations and these coverage policies may not apply! (for better or for worse)

Trans people still face frequent coverage denials

- "We don't cover any of that"
- "We cover some things, but not what you need"
- "We cover what you need, but you didn't meet our criteria"

Lawyers can be instrumental in reversing denials:
- Administrative law
- Contract law
- Constitutional law – public programs



three critical questions to ask to determine how best to advocate for the coverage needed

Check those criteria! Are they "valid" per WPATH?

<u>If valid</u>: (attorneys usually not needed)

- does patient meet them, but documentation doesn't reflect this?
- do patient's documents show this, but they missed* it?
- is client unable to meet them (at least at this time)?

<u>If not valid</u>:

- is client able to meet them anyway (or reasonably soon will)?
- If not valid, is unable to meet them (at least not for a while)? An attorney may be useful here.

REMEMBER: WPATH 7 ▫ WPATH 8! (are they using the right one?)

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Who controls this health plan?

Most Americans get their coverage through employer plans. These plans often take two overarching forms:

- <u>Self-insured plans</u> - usually offered by "larger" employers, which hire an insurance company (known as a third-party administrator, or TPA) to run it. The employer can request that the TPA remove a restriction from its plan. Usually regulated at federal level (except for state/local gov't employers)
- <u>Fully-insured/funded plans</u> - usually offered by smaller employers, or to individuals. These are generally regulated at the State level. Employers generally have no influence, but State regulators do.

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What's the patient up for?

In self-insured plans, an employer often can be instrumental in resolving a problem with its own plan.

- Does the employee want to come out to the employer?
- If an employer doesn't want to play ball, an employment-discrimination complaint may be viable. But does an employee want to fight their own employer?

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Scenarios!

Scenario 1: MA/Minnesota Care

- Joan is an older transgender woman who, despite many years of hormone therapy, still experiences persistent beard growth. Her providers believe that she needs hair removal to effectively treat her gender dysphoria.
- InsuraCorp, which runs Joan's MA plan through a contract with the Minnesota Department of Human Services, denies the claim. They say the DHS Provider Manual indicates that hair removal is only approved when as a preparatory step before genital surgery, not when performed on one's face.
- Is Joan out of luck?

Scenario 1: MA/Minnesota Care

- DHS rules require that DHS itself, and its contractors like InsuraCorp, make decisions about what is medically necessary (and thus what's covered) using the prevailing treatment standards in the relevant area of health care.
- The WPATH Standards of Care, which DHS uses, explicitly indicate that facial hair removal can be medically necessary, based on a case-by-case review.
- It is very likely that, on appeal, DHS will reverse InsuraCorp's denial and authorize Joan's procedure.

NOTE: DHS Provider Manual set to be updated by Sept 1, 2023!

Scenario 2: Treatment for minors

- Alex is a young trans man, age 16. He has been receiving counseling and hormones for a few months, and his doctors now believe it is medically necessary for him to get a mastectomy (top surgery). They write the appropriate letter of support and his surgeon submits an authorization request.
- Alex is insured through his mother's job at a small company with an "off-the-shelf" health plan through InsuraCorp. InsuraCorp denies the claim, saying their policy requires a person seeking surgery to be at least 18, and to have been on hormones at least a year.
- Is Alex out of luck?

Scenario 2: Treatment for minors

- Because the employer simply purchased a small-group plan through InsuraCorp, this plan is *State-regulated*.
- In 2015 and again in 2021, the Minnesota Departments of Health and Commerce instructed insurers whose plans are subject to State regulation that (a) they cannot have blanket exclusions for transition care, and (b) they must use the prevailing treatment guidelines when determining what's covered
- The WPATH Standards do not impose an age requirement when it comes to top surgery, and explicitly indicate hormones are not a prerequisite for top surgery to begin with.
- An external review is likely to reverse InsuraCorp's denial.

NOTE: Health & Commerce are expected to update their bulletin by Nov 1 2023

Scenario 3: big plan's blanket exclusion

- Sarah works for the ABC Corporation, a large employer whose health plan is self-insured, but administered by InsuraCorp. Sarah is a transgender woman and, coincidentally, her son, Michael, who is 20 and is also covered by this plan, is a transgender man. When her and Michael's requests for surgery coverage are submitted, InsuraCorp informs them that ABC's health plan does not cover any services connected with transition and denies the claims.
- Are Sarah and Michael out of luck?

Scenario 3: big plan's blanket exclusion

- Path 1: Sarah approaches ABC and asks them to drop the exclusion. Because the plan is self-insured – i.e., it's ABC's money, so ABC can make these decisions – and because ABC does not want to have bad publicity, ABC agrees to drop the exclusion and both get their care.
- NOTE: sometimes, a letter from a lawyer making this request does get a bit more attention!
  - Consider the perception that the employee has "lawyered up"

Scenario 3: big plan's blanket exclusion

- Path 2: Because self-insured plans are federally-regulated, Sarah files a Title VII sex-discrimination complaint against ABC with the Equal Employment Opportunity Commission, arguing that excluding transition care is discrimination against trans people. EEOC likely agrees and orders the exclusion removed.
  - Consider implications of an employee filing a complaint against their own employer

Scenario 3: big plan's blanket exclusion

What about Michael?

Title VII protects employees, not necessarily their dependents!

If Sarah's efforts to get rid of the exclusion are successful, Michael should benefit.

- BUT! If InsuraCorp receives federal funding, the ACA applies … and may bar it from enforcing this blanket exclusion, including against a dependent.
- Blanket exclusions like this are likely to go away in the coming years thanks to EEOC's application of the Supreme Court decision in *Bostock v Clayton County* (2020)

Scenario 4: public employer

- Tom is a trans man, age 24, whose coverage comes through his father's job with Jones County. Tom has been on testosterone for several years, and he and his doctors have now determined it to be appropriate for him to undergo top surgery.
- Jones County's health plan is a self-insured health plan, administered by InsuraCorp. Tom's surgeon submits a request for coverage to the plan.
- InsuraCorp denies the request, explaining that the County's policy excludes all coverage for transition-related care.
- Is Tom out of luck?

Scenario 4: public employer

- While the County's health plan is self-insured, an exception exists in federal law which makes the health plans of State or local governments, even where self-insured, subject to *State*, not *federal*, regulation.
- Tom files for an external review with the Minnesota Department of Commerce, which can be expected to conclude that the plan is subject to its 2021 bulletin and thus cannot contain a blanket exception for transition care, and must review coverage requests in light of the WPATH Standards. The fact Tom is a dependent, and not the employee, will not be relevant.
  - This is the path of least resistance, avoiding needing to fight lengthy fights about federal law

Scenario 4a: religious employer

- Same scenario, but now the employer is the Church of St. John, whose doctrine is not LGBTQ-friendly.
- Is Tom out of luck?
- Probably

Scenario 5: breast augmentation

- Violet works for the ABC Corporation, a (very) large employer whose self-insured plan is administered by InsuraCorp. She seeks coverage for breast augmentation, which her doctor has determined medically necessary. InsuraCorp denies the prior-authorization request, because its policy states that breast augmentation is cosmetic.
- Is Violet out of luck?

Scenario 5: breast augmentation

- Although InsuraCorp affirmed its own denial on internal appeal, the next step is an external review. InsuraCorp receives federal funds, which means the ACA applies. ACA regulations indicate that external reviewers use the prevailing medical guidelines, i.e., the WPATH Standards – and these standards establish breast augmentation as a potentially medically necessary treatment. The external reviewer is likely to reverse this denial.

Scenario 5: breast augmentation

Two additional routes forward:

- Alternative 1: Because the employer's plan is self-insured, the employer can request that InsuraCorp remove the exclusion of breast augmentation, so she can proceed.
- Alternative 2: Assuming the plan covers chest surgery for trans men (mastectomy), but claims to exclude chest surgery for trans women (breast augmentation), Violet can file (or threaten to file) a sex-discrimination complaint against her employer over this exclusion, which she would likely win.

Overcoming Barriers:

it can be done!