Gender Dysphoria (Gender Identity Disorder) Treatment

Policy Number: BIP185.K
Effective Date: May 1, 2021

Instructions for Use

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Federal/State Mandated Regulations

CA Health and Safety Code, Article 5. Standards 1367.042

http://leginfo.legislature.ca.gov/faces/codes_displaySection.xhtml?lawCode=HSC&sectionNum=1367.042.

(a) A health care service plan shall notify enrollees and members of the public of all of the following information:

(3) The health plan does not discriminate on the basis of race, color, national origin, ancestry, religion, sex, marital status, gender, gender identity, sexual orientation, age, or disability.

(4) The availability of the grievance procedure described in Section 1368, how to file a grievance, including the name of the plan representative and the telephone number, address, and email address of the plan representative who may be contacted about the grievance, and how to submit the grievance to the department for review after completing the grievance process or participating in the process for at least 30 days.

(5) How to file a discrimination complaint with the United States Department of Health and Human Services Office for Civil Rights if there is a concern of discrimination based on race, color, national origin, age, disability, or sex.

(b) The information required to be provided pursuant to this section shall be provided to an enrollee with individual coverage upon initial enrollment and annually thereafter upon renewal, and to enrollees and subscribers with group coverage upon initial enrollment and annually thereafter upon renewal. A health care service plan may include this information with other materials sent to the enrollee. The information shall also be provided in the following manner:

(1) In a conspicuously visible location in the evidence of coverage.

(2) At least annually, in or with newsletters, outreach, or other materials that are routinely disseminated to the plan's enrollees.

(3) On the Internet Web site published and maintained by the health care service plan, in a manner that allows enrollees, prospective enrollees, and members of the public to easily locate the information.

(c) (1) A specialized health care plan that is not a covered entity, as defined in Section 92.4 of Title 45 of the Code of Federal Regulations, subject to Section 1557 of the federal Patient Protection and Affordable Care Act (42 U.S.C. Sec. 18116) may request an exemption from the requirements under this section.

(2) The department shall not grant an exemption under this subdivision to a specialized health care service plan that arranges for mental health benefits except for employee assistance program plans.

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(3) The department shall provide information on its Internet Web site about any exemptions granted under this subdivision.

(d) This section does not apply to Medi-Cal managed care plan contracts entered into with the State Department of Health Care Services pursuant to Chapter 7 (commencing with Section 14000) or Chapter 8 (commencing with Section 14200) of Part 3 of Division 9 of the Welfare and Institutions Code.

[Amended by Stats. 2018, Ch. 92, Sec. 132. (SB 1289) Effective January 1, 2019.]

CA Health and Safety Code, Solicitation and Enrollment, Section 1365.5

http://leginfo.legislature.ca.gov/faces/codes_displaySection.xhtml?lawCode=HSC&sectionNum=1365.5.

(a) No health care service plan or specialized health care service plan shall refuse to enter into any contract or shall cancel or decline to renew or reinstate any contract because of the race, color, national origin, ancestry, religion, sex, marital status, sexual orientation, or age of any contracting party, prospective contracting party, or person reasonably expected to benefit from that contract as a subscriber, enrollee, member, or otherwise.

(b) The terms of any contract shall not be modified, and the benefits or coverage of any contract shall not be subject to any limitations, exceptions, exclusions, reductions, copayments, coinsurance, deductibles, reservations, or premium, price, or charge differentials, or other modifications because of the race, color, national origin, ancestry, religion, sex, marital status, sexual orientation, or age of any contracting party, potential contracting party, or person reasonably expected to benefit from that contract as a subscriber, enrollee, member, or otherwise; except that premium, price, or charge differentials because of the age of any individual when based on objective, valid, and up-to-date statistical and actuarial data are not prohibited.

(c) It shall be deemed a violation of subdivision (a) for any health care service plan to utilize marital status, living arrangements, occupation, sex, beneficiary designation, ZIP Codes or other territorial classification, or any combination thereof for the purpose of establishing sexual orientation. Nothing in this section shall be construed to alter in any manner the existing law prohibiting health care service plans from conducting tests for the presence of human immunodeficiency virus or evidence thereof.

(d) This section shall not be construed to limit the authority of the director to adopt or enforce regulations prohibiting discrimination because of sex, marital status, or sexual orientation.

(e) “Sex” as used in this section shall have the same meaning as “gender,” as defined in Section 422.56 of the Penal Code.

(f) The changes made to this section by the act adding this subdivision shall only apply to contracts issued, amended, or renewed on or after January 1, 2011.

State Market Plan Enhancements

Effective April 9, 2013

DMHC Director’s Letter 12K “Gender Non-Discrimination Requirements”
https://www.dmhc.ca.gov/Portals/0/LawsAndRegulations/DirectorsLettersAndOpinions/dl12k.pdf

DMHC All Plan Letter: Health and Safety Code Section 1365.5 Compliance (refer to Appendix)

Covered Benefits

Important Note: Covered benefits are listed in *Federal/State Mandated Regulations*, *State Market Plan Enhancements*, and *Covered Benefits* sections. Always refer to the *Federal/State Mandated Regulations* and *State Market Plan Enhancements* sections for additional covered services/benefits not listed in this section.

Prior authorization of medically necessary services must be done by UnitedHealthcare or delegated Providers as determined by UnitedHealthcare.

Treatment for Gender Dysphoria is sometimes referred to as: Gender Identity Disorder treatment, sex transformation surgery, sex change, sex reversal, gender change, transsexual surgery, transgender surgery and sex or gender reassignment. These terms are used interchangeably throughout this document, and, for purposes of this document, are intended to have the same meaning.

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Throughout this document the abbreviation WPATH refers to an advocacy group called the World Professional Association for Transgender Health. WPATH notations in this policy refer to the publication *Standards of Care for the Health of Transsexual, Transgender, and Gender Nonconforming People, 7th Version*.

The Eligibility Qualifications for continuous hormone therapy and surgical treatment of Gender Dysphoria are in addition to the plan's overall eligibility requirements as shown in the Plan document.

Authorization for Coverage: Authorization of medically necessary services must be done by UnitedHealthcare Medical Director or Delegated Medical Providers as determined by contractual agreement.

California Signature Value (HMO) plans include medically necessary coverage for the treatment of Gender Dysphoria according to the terms and conditions of the benefit plan.

Non-Surgical Treatments for Gender Dysphoria

The following non-surgical treatment of Gender Dysphoria may be provided:

- Psychotherapy for Gender Dysphoria and associated co-morbid psychiatric diagnoses; If mental health services are not covered on the UnitedHealthcare plan (for example when mental health services are carved out of the plan design) the Plan will not cover psychotherapy for Gender Dysphoria.
- Continuous Hormone Replacement Therapy: Hormones of the desired gender. Hormones injected by a medical provider (for example hormones injected during an office visit) are covered by the medical plan. Benefits for these injections vary depending on the plan design. Other outpatient prescription drugs may be covered as determined by the employer's sponsored Pharmacy Benefit Manager. Refer to the member's outpatient prescription drug benefit.
- Eligibility Qualifications for Continuous Hormone Replacement Therapy: The covered person must meet all of the following eligibility qualifications for hormone replacement.
  - Persistent, well documented Gender Dysphoria (refer to definition of Gender Identity Disorder below; and
  - Capacity to make a fully informed decision and to consent for treatment; and
  - Age of majority in a given country
    Note: WPATH guidelines address age of majority in a given country. For the purposes of this guideline, the age of majority is age 18. However, this refers to chronological age and not biological age. Where approval or denial of benefits is based solely on the age of the individual a case-by-case medical director review is necessary.
    and
  - If significant medical or mental health concerns are present, they must be reasonably well controlled.
    Note: Refer to the Outpatient Prescription Drug benefit for specific prescription drug product coverage and exclusion terms. If pharmacy benefits are carved out of the plan design, the Plan will not cover outpatient prescription drugs for Gender Dysphoria.
- Puberty Suppressing Hormone Therapy. Reviewed and approved on a case by case basis. Medical history should reflect well documented history of Gender Dysphoria that meets the DSM 5 Criteria, meets the assessment of Tanner 2 pubertal development, is prescribed by a pediatric endocrinologist and is contingent upon the request of an FDA approved medication that suppresses puberty.
- Laboratory testing to monitor the safety of continuous hormone therapy is covered.
- Speech Therapy
- Fertility Preservation (Sperm preservation in advance of hormone treatment or gender surgery, cryopreservation of fertilized embryos)

Covered Surgical Treatments for Gender Dysphoria

Surgical treatment for Gender Dysphoria is covered when the Eligibility Qualifications for Surgery are met:

- Genital Surgery (by various techniques which must be appropriate to each member), including: complete hysterectomy; orchiectomy; penectomy; vaginoplasty; vaginectomy; clitoroplasty; labiaplasty; salpingo-oophorectomy; metoidioplasty; scrotoplasty; urethroplasty; placement of testicular prosthesis; phalloplasty.
- Surgery to change specified secondary sex characteristics, specifically:
  - Thyroid chondroplasty (removal or reduction of the Adam's Apple); and
  - Bilateral mastectomy; and

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- Augmentation mammoplasty (including breast prosthesis if necessary) if the Physician prescribing hormones and the surgeon have documented that breast enlargement after undergoing hormone treatment for 18 months is not sufficient for comfort in the social role.
- Related Services: In addition to the surgeon fees, the benefit applies to the services related to the surgery, including but not limited to: anesthesia, laboratory testing, pathology, radiologic procedures, hospital and facility fees, and/or surgical center fees.
- Hair Removal: Hair removal related to genital reconstruction (e.g. electrolysis or laser) when part of a complete care plan and ordered by a physician.

Eligibility Qualifications for Surgery

The following criteria apply to genital surgery, and to surgery to change specified secondary sex characteristics listed above. It is our expectation that surgery be performed by a qualified provider at a facility with a history of treating individuals with Gender identity disorder.

The Covered Person must meet all of the following eligibility qualifications prior to surgery:

- Persistent, well-documented Gender Dysphoria (refer to definition of Gender Identity Disorder below); and
- Capacity to make a fully informed decision and to consent for treatment; and
- Age of majority in a given country
  Note: WPATH* guidelines address age of majority in a given country. For the purposes of this guideline, the age of majority is age 18. However, this refers to chronological age, not biological age. Where approval or denial of benefits is based solely on the age of the individual a case-by-case medical director review is necessary.
  and
- If significant medical or mental health concerns are present, these must be reasonably well-controlled; and
- The covered person must complete 12 months of successful continuous full time real life experience in the desired gender, and
- The covered person may be required to complete continuous hormone therapy (for those without contraindications). In consultation with the member's physician, this should be determined on a case-by-case basis through the notification process; and
- The treatment plan must conform to identifiable external sources including the World Professional Association for Transgender Health Association (WPATH) standards, and/or evidence-based professional society guidance.

Clarifications for Breast/Chest Surgery

In addition to the Eligibility Qualifications listed above note the following:

- A biologic female member that is only requesting a bilateral mastectomy:
  - Does not need to complete hormone therapy in order to qualify for the mastectomy
  - Although not a requirement for coverage, UnitedHealthcare recommends that the member complete at least 3 months of psychotherapy before having the mastectomy.
- A biologic male member that is only requesting a breast augmentation:
  - If able to take female hormones, the member should take the female hormones for at least 12-24 months* before being considered for bilateral breast augmentation since the member may achieve adequate breast development without surgery.
  - Although not a requirement for coverage, UnitedHealthcare recommends that the member complete at least 3 months of psychotherapy before having the breast augmentation.

  *12 months is listed by WPATH v7, whereas, 2 years is listed by, Endocrine Treatment of Transsexual Persons: An Endocrine Society Clinical Practice Guideline (2009).

Note the following:

- Benefits are limited to one sex transformation reassignment per lifetime which may include several staged procedures.
- Check the benefit plan document for any applicable prior authorization or notification requirements.
- Sterilization surgery is not required in order to receive the covered services under this benefit.
- Member cost sharing (copayments, coinsurance and/or deductibles) apply as identified in the member's Plan materials.

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Not Covered

The following are not covered:

- Reversal of genital surgery or reversal of surgery to revise secondary sex characteristics
- Surgical or cross-gender hormone treatment for members under 18 years of age. Hormone therapy for Members under 18 years of age is reviewed on a case-by-case basis by UnitedHealthcare.
- Surgical treatment not prior authorized by UnitedHealthcare or the delegated participating medical group/IPA
- Drugs for hair loss
- Drugs for sexual performance for members that have undergone genital reconstruction
- Drugs or devices not approved by the FDA for use in the United States (Drugs or devices approved by the FDA will be considered for off-label use according to the Benefit Interpretation Policy titled Medications and Off-Label Drugs)
- Treatment received outside the United States
- GnRH/Gonadotropin-Releasing Hormone Agonist (i.e. Lupron Depot, Vantas/Histrelin) drugs for use in puberty suppression are considered to be off- label; Refer to the Benefit Interpretation Policy titled Medications and Off-Label Drugs to determine coverage for the use of these drugs for Gender Dysphoria
- Drugs when prescribed for cosmetic purposes
- Coverage does not apply to members that do not meet the criteria listed in the eligibility qualifications for surgery section above.
- Surrogate parenting, donor eggs, donor sperm and host uterus (refer to member EOC).
- Transportation, meals, lodging or similar expenses unless Medically Necessary treatment outside the state of California is authorized and directed by Plan's Medical Director. (Travel expense reimbursement is limited to reasonable expenses for transportation, meals, and lodging for the Member to obtain authorized surgical consultation, surgical procedure(s), and follow-up care, when the authorized surgeon and facility are located outside the state of California. The transportation and lodging arrangements must be arranged by or approved in advance by UnitedHealthcare. Reimbursement excludes coverage for alcohol and tobacco. Food and lodging expenses are not covered for any day a Member is not receiving authorized surgical services.)

Note: The drug related exclusions listed above apply to drugs administered by provider in a medical setting (including, but not limited to, office, outpatient, or inpatient facility). For drugs obtained at a pharmacy, check with the pharmacy plan administrator for information on covered and excluded drugs.

Definitions

Gender Identity Disorder / Gender Dysphoria: A disorder characterized by the following diagnostic criteria:

- A strong and persistent cross-gender identification (not merely a desire for any perceived cultural advantages of being the other sex).
- Persistent discomfort with his or her sex or sense of inappropriateness in the gender role of that sex.
- The disturbance is not concurrent with a physical intersex condition.
- The disturbance causes clinically significant distress or impairment in social, occupational, or other important areas of functioning.
- The transsexual identity has been present persistently for at least two years.
- The disorder is not a symptom of another mental disorder or a chromosomal abnormality.

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Policy History/Revision Information

Date	Summary of Changes
05/01/2021	• Updated policy header to reflect the most current UnitedHealthcare West product application; added "UnitedHealthcare Insurance Company" **Related Policies** • Added reference link to the Benefit Interpretation Policy titled *Family Planning: Infertility Services* **Covered Benefits** ***Non-Surgical Treatments for Gender Dysphoria*** • Revised list of covered services; added: ○ Speech Therapy ○ Fertility Preservation (sperm preservation in advance of hormone treatment or gender surgery, cryopreservation of fertilized embryos) **Not Covered** • Revised list of non-covered services; removed: ○ Sperm preservation in advance of hormone treatment or gender surgery ○ Cryopreservation of fertilized embryos ○ Reproduction Services including, but not limited to: ▪ Sperm preservation in advance of hormone treatment or Gender Dysphoria surgery, ▪ Cryopreservation of the fertilized embryos, and ▪ Oocyte preservation **Supporting Information** • Archived previous policy version BIP185.J

Instructions for Use

Covered benefits are listed in three (3) sections: *Federal/State Mandated Regulations*, *State Market Plan Enhancements*, and *Covered Benefits*. All services must be medically necessary. Each benefit plan contains its own specific provisions for coverage, limitations, and exclusions as stated in the member's Evidence of Coverage (EOC)/Schedule of Benefits (SOB). If there is a discrepancy between this policy and the member's EOC/SOB, the member's EOC/SOB provision will govern.

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State of California
Health and Human Services Agency
Department of Managed Health Care

DEPARTMENT OF Managed Health Care

ALL PLAN LETTER

DATE: February 5, 2015

TO: All Full-Service Health Plans

FROM: Nancy Wong
Deputy Director, Office of Plan Licensing

SUBJECT: HEALTH AND SAFETY CODE SECTION 1365.5 COMPLIANCE

The Director of the Department of Managed Health Care (the "Department") issued Letter No. 12-K ("Director's Letter"), which was effective on April 9, 2013. Subsequent to the implementation of the Director's Letter, the Department monitored consumer complaints, Independent Medical Review ("IMR") data, and input received from stakeholders, including the transgender community and the California Association of Health Plans.

Enrollees diagnosed with gender dysphoria must be treated in the same manner as any other enrollee when a service is requested. Health plans are required to apply clinical standards consistently. The appropriate grievance, appeal and IMR[1] processes will continue to be available to all enrollees. No individual, other than a licensed physician competent to evaluate the specific clinical issues involved in the care requested, may deny initial requests for authorization of coverage for treatment.

The Department is now directing health plans to review their EOCs, including riders, even if previously approved or not objected to by the Department, and to revise their EOCs if necessary to be consistent with the following:

- Define the terms "cosmetic surgery" and "reconstructive surgery" consistently with section 1367.63 of the Act. "Cosmetic surgery" means surgery that is performed to alter or reshape normal structures of the body in order to improve appearance. "Reconstructive surgery" means surgery performed to correct or repair abnormal structures of the body caused by congenital defects, developmental abnormalities, trauma, infection, tumors, or disease to do either of the following: (A) To improve function; (B) To create a normal appearance, to the extent possible.

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[1] The Department confirms that medical professionals selected to review medical treatment decisions in the Independent Medical Review (IMR) process shall be clinicians knowledgeable in the treatment of the enrollee's medical condition, knowledgeable about the proposed treatment and familiar with the guidelines and protocols in the area of treatment under review as required by section 1374.32(d)(4)(A). Pursuant to SB 1410, the standard as of July 1, 2015, will change to the following: "The medical professional shall be a clinician expert in the treatment of the enrollee's medical condition and knowledgeable about the proposed treatment through recent or current actual clinical experience treating patients with the same or a similar medical condition as the enrollee."

(continued on next page)

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- Omit lists of surgeries that are universally excluded from coverage or examples of non-covered surgeries in both the reconstructive surgery benefit and the cosmetic surgery exclusion.
- Omit limitation of surgery to "one per lifetime" or any other limitation that is not supported by sound clinical principles or that creates unreasonable barriers to receiving medically necessary or reconstructive surgery.[2]

Health plans should e-file their EOCs as an Amendment within ninety (90) days of the date of this letter, revising any impermissible language. The title of the filing should be "IGNA EOC Compliance." Please file the entire EOC, including riders, and not just the pages the plan is revising. If the plan believes its documents do not require revision, the plan should file an E-1 confirming that belief and either file a current EOC or refer to a filing number with a current complete EOC so that the Department can confirm compliance. All filings should highlight as well as underline the changes to the text as required by Rule §1300.52(d).

If you have any questions about submitting your health plan's filing, please don't hesitate to contact the Office of Plan Licensing through your assigned counsel.

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