



Transgender Health Benefits in California

How to appeal your health care denial



Transgender Law Center

Making Authentic Lives Possible

Transgender Health Benefits

Overview of California State Law

For years, most health care plans in the U.S. have categorically excluded most health care for transgender people. In 2012 and 2013, as a result of intensive advocacy, both the Department of Managed Health Care (DMHC) and the California Department of Insurance (CDI) issued directives requiring health insurers to provide coverage for medically necessary health care procedures for transgender people that are covered services for non-transgender people. Medi-Cal, California's Medicaid program, has covered transition-related care for transgender people for many years.

About this Brochure

This brochure was created to help people understand the procedural steps one should consider to appeal a health care denial for health care plans that are managed by the California Department of Managed Health Care (DMHC), the California Department of Insurance (CDI) or Medi-Cal. This handout does not provide the substantive points you should include as part of your appeal. For assistance regarding what documents should be included or for tips negotiating for health care with your employer, see our website:

www.transgenderlawcenter.org/issues/health

California law states that “the benefits or coverage of any insurance 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...gender identity[.]” Cal. Health & Safety Code Sec. 1365.5(b).

About Health Insurance

Many transgender people will access health insurance for the first time as a result of expanded Medicaid and subsidized private health plans through the Affordable Care Act. For those of us who are used to paying cash for health services (or not being able to access them at all), adding insurance to the mix can be confusing, overwhelming, and frustrating. The biggest difference between a cash model and a health insurance model is that insurance plans put limits on which health care providers you can go to, for both regular health care (primary care) as well as specialists such as surgeons. Further, insurance companies usually put a policy in place that outlines requirements for eligibility and documentation for accessing transition-related care. It is essential to **follow these requirements to the letter** in order for the insurance company to approve your treatment.

We encourage everyone seeking transition-related care to ask your primary care provider to submit a **preauthorization request** to your insurance company for the procedures you are seeking. This allows you the peace of mind of engaging in any appeals that may be necessary before any expense has been incurred. Once your provider's office has submitted paperwork to the insurance company, either for a preauthorization or for as a bill after the procedure, the insurer will send an Explanation of Benefits (EOB) to you and your provider, either along with payment to the provider, or with a notice saying payment has been denied. If payment has been denied, we refer to this as an “insurance denial”.



Photo by Linda Stevens at 4Trans Productions

Appealing denials

Transgender people are often denied medical care either because it is related to their gender transition or solely because they are transgender. These types of denials may be unlawful, depending upon where you live and what kind of plan you have. Fortunately, there are remedies for appealing denials of medically necessary care.

The information listed below and the flowchart on the last page outline the process for appealing your health care denial. The first section discusses steps for appeals with private insurance plans and Medi-Cal managed care plans, and the second section addresses additional considerations for Medi-Cal plans.

Acronym Guide:

- ACA: Affordable Care Act
- ALJ: Administrative Law Judge
- CDI: California Department of Insurance
- DMHC: Department of Managed Health Care
- GD: Gender Dysphoria
- HHS: Health and Human Services
- HMO: Health Maintenance Organizations
- IMR: Independent Medical Review
- OCR: Office of Civil Rights
- PPO: Preferred Provider Organization



Determine what kind of plan you have

If you have been denied, it is important to determine whether your employer health plan is a private plan managed by the Department of Managed Health Care (DMHC) or California Department of Insurance (CDI), a self-funded plan, or a Medi-Cal managed care plan. Contact your employer's Human Resources department or the plan's member services to determine that information.

A “self funded” health plan is usually offered by larger companies, government entities, and unions. Under these plans, the employer itself takes on the responsibility of paying employees’ medical claims. This brochure does not outline the appeals process for appealing denials from self-funded plans. Contact us if you need assistance in filing an appeal under a self-funded plan.

Talk to your provider

Make sure the treatment request was properly submitted to the plan by your provider by calling the customer service number found in your plan documents. If there was an issue with the submission, contact your provider and ask them to contact the plan about the error and/or resubmit the request.

First steps

Determine if a denial has occurred.

Have you received a denial notice from your insurer? To appeal a denial, you must first receive notification that your treatment has actually been denied based upon an exclusion in the plan. Verbal communication is not enough to show proof, you need a written document from your insurer showing the denial has occurred.

Find out why your claim was denied

If your plan is managed by DMHC/CDI and you are denied care, find out why it was denied. It may be that your doctor did not sufficiently establish why the care was necessary for you. In this case, you or your doctor can resubmit the claim with information establishing why it is medically necessary for you. Often, this means that you must first be diagnosed with Gender Dysphoria.

Transgender Health Benefits

File an internal appeal

If after resubmitting your claim your insurance upholds the denial, you may appeal internally with your insurer. The process should be outlined in the benefits booklet you received from your insurer.

In most cases, you must first follow the insurance plan's procedures for appealing your denied care until you receive a 'final denial'. Health plans are required by law to have an appeals process in place to resolve member complaints within 30 days. You may file by phone or mail.

Request an Independent Medical Review

Once you have received a final denial, you can contact either the DMHC helpline or the CDI helpline to discuss the denial and see if they can resolve the conflict informally. If you don't know whether DMHC or CDI covers your plan, you can call either the DMHC Helpline Center at 1-888-466-2219 or the CDI helpline Center at 1-800-927-4357 and either helpline should help clarify which agency manages your health care plan.

If the denial is based on an assertion that the benefit requested is not covered under the plan, the DMHC or CDI helpline should be able to assist you.

If the denial is based on medical necessity, either the DMHC or the CDI can help you file a complaint, also called a request for an Independent Medical Review (IMR). During this process, an independent medical reviewer will determine whether the treatment is medically necessary to treat your condition.

If you don't know whether DMHC or CDI manages your health plan, you can contact either the DMHC Helpline Center: 1-888-466-2219 or the CDI Helpline Center: 1-800-927-4357 for assistance.

To file a complaint for a DMHC managed plan, you can request an IMR here:

<http://www.dmhc.ca.gov/fileacomplaint.aspx>

To file a complaint for a CDI managed plan you can place a request an IMR

here: <http://www.insurance.ca.gov/01-consumers/101-help/index.cfm>

Note: If the IMR complaint is filed with the CDI, you are not required to complete the internal appeals process to begin the IMR process. You must complete the internal appeals process for plans managed by DMHC.



Photo by Linda Stevens at 4Trans Productions



IMPORTANT NOTE:

Consider filing a discrimination complaint based on sex (gender identity) with the

Department of Health and Human
Services Agency's Office of Civil Rights.
You can file a complaint by mail, fax or
email. For more information:

<http://www.hhs.gov/ocr/office/file/index.html>

How to appeal your health care denial

Talk to a lawyer

If the IMR denies your appeal, you may consider obtaining legal counsel. For a list of trans friendly attorneys, please contact us:

www.transgenderlawcenter.org/help

Medi-Cal

Medi-Cal is California's Medicaid program. It is a government health care program jointly funded by federal and state money that generally provides health care to qualified individuals (generally this is people who are very low income, or have a qualifying disability, are a minor, or over the age of 65) and is administered by individual states, districts, and territories. Currently, the Medi-Cal program provides transition related health care services when determined to be medically necessary.

Only your medical provider can determine what is medically necessary for you. But once your provider has determined that you require a transition related treatment, they must follow the process laid out by the Medi-Cal Managed Care Plan, including making a referral to a specialist who is qualified to perform the treatment you need.

In some cases, your managed care plan may deny coverage for treatment that should be covered. Listed below are some steps to consider when appealing a denial.

Talk to your provider


Make sure the treatment request was properly submitted to the plan by your provider by calling the customer service number found in your plan documents. If there was an issue with the submission, contact your provider and ask them to contact the plan about the error and/or resubmit the request.

File an internal appeal

File an internal appeal of the treatment denial with your managed health care plan. The Medi-Cal Managed Care plan must make a decision on the appeal within 30-calendar days.

Request an Independent Medical Review

If the managed care plan upholds the denial, you may file a request an independent medical review (IMR) with the Department of Managed Health Care (The DMHC must give you a written decision on your IMR within 30 days.)



IMPORTANT NOTE: You may not simultaneously file an IMR complaint *and* request a state hearing while either is pending. While you have 6 months to file an IMR complaint, you only have 90 days to ask for a Medi-Cal fair hearing.

Request a fair hearing

You may request a Medi-Cal fair hearing with the California Department of Social Services (CDSS). A Medi-Cal hearing is held before an Administrative Law Judge (ALJ) who works for the Department of Social Services. The CDSS hearing website is here: <http://www.dhcs.ca.gov/services/medi-cal/Pages/Medi-CalFairHearing.aspx>.

There are two ways to file for a Medi-Cal fair hearing: completing the Request for State Hearing form, or calling the Department of Social Services. You may complete the "Request for State Hearing" on the back of the Notice of Action (the notice letter from Medi-Cal telling you that your treatment will not be covered under your plan). You may attach a letter in which you explain why you believe the county action is not correct. It is always a good idea to keep a copy of your hearing request. You may submit your request **in** of the following ways:

Transgender Health Benefits

- » Mail the request to the county welfare department at the address shown on the Notice of Action.
- » Mail the request to the California Department of Social Services, State Hearings Division, P.O. Box 944243, Mail Station 9-17-37, Sacramento, California 94244-2430
- » Fax the request to the State Hearings Division at fax number 916-651-5210 or 916-651-2789. (NOTE: The State Hearings Division cannot accept requests by e-mail)

You may also make a toll-free call to request a State Hearing at the following number. If you decide to make a request by telephone, you need to be aware that the telephone lines are very busy.

California Department of Social Services
Public Inquiry and Response
Phone: 1-800-952-5253 (Voice)
1-800-952-8349 (TDD)

After a State Fair Hearing, the judge has 75 days to submit his/her decision.

Talk to a lawyer

If the IMR or Medi-Cal fair hearing decision denies your appeal, you may want to consider obtaining legal counsel. For help finding trans friendly attorneys, please contact us:

www.transgenderlawcenter.org/help

Medi-Cal Resources

- » File a formal complaint with Medi-Cal: www.dss.cahwnet.gov/shd/PG1108.htm
- » File a discrimination complaint with Medi-Cal: www.dss.cahwnet.gov/shd/PG1109.htm
- » Additional hearing information: www.dss.cahwnet.gov/shd/PG1094.htm
- » The ombudsman office helps people solve problems from a neutral standpoint to ensure that members receive all medically necessary covered services for which plans are contractually responsible. You can learn more and file a complaint here: <http://goo.gl/lmX7ch>

Frequently Asked Questions

Q: What plans do the directives apply to?

A: *Every plan bought and sold in California, including Medi-Cal managed care plans, plans purchased on the individual market or through Covered California, and employer-sponsored plans, with the exception of self-funded employer plans. The directives do not apply to Medicare Advantage plans, TriCare, or health benefits plans through the Department of Veterans Affairs.*

Q: Do the DMHC/CDI directives apply to minors?

A: *Yes, if that care is medically necessary, but there are still age restrictions.*

Q: Are Covered California (Affordable Care Act) plans impacted by the directives?

A: *Yes. The directives mean that all insurance companies participating in California's health exchange, Covered California, will need to comply with the directive.*

Q: When did the directives go into effect?

A: *The DMHC directive went into effect on April 9, 2013. The CDI directive went into effect on September 2, 2012.*

Q: What is an Independent Medical Review (IMR)?

A: *An IMR involves 1-3 physician reviewers with relevant experience in the area of medicine who have no conflicts of interest. The panel will review the relevant science and standards of care, the individual medical record and the denied treatment.*

Q: Does this apply to my health care plan that is offered through my employer?

A: *This depends on whether your employer's health plan is self-funded, and whether the plan is administered in California. To determine who the regulatory agency is for your health plan, look in the first few pages of your plan documents. If you are not sure where to find this information, call the DMHC's Helpline Center at 1-800-927-4357 or go online: <http://goo.gl/HR4KtP>.*

Q: What other states have policies similar to the DMHC and CDI directives in California?

A: *Besides California, the insurance divisions in Colorado, Connecticut, District of Columbia, Illinois, Maryland, Massachusetts, , New York, Oregon, Vermont, and Washington have all issued similar directives.*

Q: What if my company is not based in California but my health plan is administered in California – is it subject to the directives?

A: Yes.

Q: Do the directives apply to mental health care?

A: Yes.

Q: What if my insurance company refuses to cover breast augmentation or facial reconstruction surgery?

A: They should cover it. Contact us if it is excluded.

Resources

- » California Department of Managed Health Care (DMHC) Help Center:
www.HealthHelp.ca.gov
- » California Department of Insurance (CDI) Help Center:
<http://goo.gl/HR4KtP>
- » Transgender Law Center Helpline:
www.transgenderlawcenter.org/help

Transgender Health Benefits

