



NEW YORK STATE
DEPARTMENT *of*
FINANCIAL SERVICES

Andrew M. Cuomo
Governor

Maria T. Vullo
Superintendent

Insurance Circular Letter No. 12 (2017)
August 16, 2017

TO: All Insurers Authorized to Write Accident and Health Insurance in New York State, Article 43 Corporations, Health Maintenance Organizations (“HMOs”), Student Health Plans Certified Pursuant to Insurance Law § 1124, and Municipal Cooperative Health Benefit Plans

RE: Coverage for Health Services Provided to Transgender Individuals

STATUTORY AND REGULATORY REFERENCES: N.Y. Ins. Law §§ 3224 and 3224-a; and 45 C.F.R. § 92.206

Introduction

The purpose of this circular letter is to provide guidance to insurers authorized to write accident and health insurance in New York State, article 43 corporations, health maintenance organizations, student health plans certified pursuant to Insurance Law § 1124, and municipal cooperative health benefit plans (collectively, “issuers”) related to covering health services provided to transgender individuals. It has come to the attention of the Superintendent of Financial Services (“Superintendent”) that issuers may be denying claims of transgender individuals because the gender with which the individual identifies does not match the gender of someone to whom those services are typically provided. For instance, a female who identifies as a male may be denied a claim for cervical cytology screening because the issuer’s information indicates that the insured is anatomically a male. Similarly, a male who identifies as a female may be denied a claim for prostate cancer screening because the issuer’s information indicates that the insured is anatomically a female.

Discussion

Ins. Law § 3224(a) requires the Superintendent to establish standard accident and health insurance claim forms for the services of hospitals, physicians and other health care providers. Section 3224(b) provides that the adoption of any uniform claim form by the Superintendent does not preclude an insurer from obtaining any necessary information regarding a claim from the claimant, provider of health care or treatment, or certifier of coverage.

Ins. Law § 3224-a sets forth the standards for prompt, fair and equitable settlement of claims for health care and payments for health care services. Section 3224-a(b) permits an issuer to request additional information if the obligation of the issuer to pay the claim is not reasonably clear due to a good faith dispute regarding the eligibility of the insured for coverage, the liability of another insurer or corporation or organization for all or part of the claim, the amount of the

claim, the benefits covered under the contract or agreement, or the manner in which services were accessed or provided.

By explicitly providing the right of the issuer to request additional information, both sections of the Insurance Law referred to above are intended to ensure that an issuer does not deny a claim because it does not have sufficient information to pay the claim. Transgender persons should not be discriminated against because of their transgender status nor denied coverage for treatment because of coding issues. As such, an issuer who receives a claim from an insured of one gender or sex for a service that is typically or exclusively provided to an individual of another gender or sex should take reasonable steps, including requesting additional information, to determine whether the insured is eligible for the services prior to denying the claim.

Additionally, when processing claims for health services provided to transgender individuals, issuers should consider 45 C.F.R § 92.206, which provides in relevant part that “a covered entity shall treat individuals consistent with their gender identity, except that a covered entity may not deny or limit health services that are ordinarily or exclusively available to individuals of one sex, to a transgender individual based on the fact that the individual’s sex assigned at birth, gender identity, or gender otherwise recorded is different from the one to which such health services are ordinarily or exclusively available.”

Conclusion

In order to ensure that transgender individuals are able to access covered services, an issuer should not deny a claim for a health service provided to an individual because the individual is seemingly not of the gender to whom the service is typically or exclusively provided without seeking additional information to determine whether the service was appropriately provided to the individual.

Please direct any questions regarding this circular letter to Thomas Fusco, Supervising Insurance Attorney, Health Bureau, New York State Department of Financial Services, Walter J. Mahoney Office Building, 65 Court Street, Room 7, Buffalo, New York 14202 or by e-mail at thomas.fusco@dfs.ny.gov.

Very truly yours,

Lisette Johnson
Bureau Chief, Health Bureau