District of Columbia Guidelines for Private Insurance Carriers and Medicaid

Government of the District of Columbia
Vincent C. Gray, Mayor
Department of Insurance, Securities and Banking

William P. White
Commissioner

BULLETIN
13-IB-01-30/15

TO: **ALL INSURANCE COMPANIES, HEALTH MAINTENANCE ORGANIZATIONS AND HOSPITAL AND MEDICAL SERVICE CORPORATIONS AUTHORIZED TO WRITE HEALTH INSURANCE IN THE DISTRICT**

FROM: **WILLIAM P. WHITE, COMMISSIONER** 3/15/13

SUBJECT: **PROHIBITION OF DISCRIMINATION IN HEALTH INSURANCE BASED ON GENDER IDENTITY OR EXPRESSION**

DATE: **MARCH 15, 2013**

The intent of this bulletin is to communicate to insurance companies writing health insurance in the District of Columbia the Department's position regarding the prohibition of discrimination based on gender identity or expression. District of Columbia Official Code § 31-2231.11(c), codifying what is commonly known as the District's Unfair Insurance Trade Practices Act, states:

> "No person shall refuse to insure, refuse to continue to insurer, or limit the amount of coverage available to an individual because of marital status, race, color, personal appearance, sexual orientation, gender identity or expression, matriculation, political affiliation, or an individual's status as a victim of an intrafamily offense, sexual assault, dating violence, or stalking."

Section 31-2231.11(c) applies to health insurance policies and the practices of health insurance companies writing individual or group coverage in the District of Columbia. An example of such a discriminatory provision could be an exclusionary provision that has the effect, intended or otherwise, of targeting one or more of the protected classes enumerated in § 31-2231.11(c). Examples of such language might include:

"Any treatment or procedure designed to alter an individual's physical characteristics to those of the opposite sex."

"Sex transformation operations and related services."

"Sex change: Any treatment, drug, service or supply related to changing sex or sexual characteristics"

Discriminatory language of this nature shall no longer be enforceable and companies employing such language should file updated policy forms within 90 days of the issuance of this bulletin.

Please note however that this bulletin is not intended to mandate or require the expansion of coverage or benefits, except to the extent that covered services are currently being denied on the basis of exclusionary provision specifically prohibited by this bulletin. Should you have any questions regarding this bulletin, please contact Philip Barlow, Associate Commissioner of Insurance, at (202)442-7823 or philip.barlow@dc.gov.

GOVERNMENT OF THE DISTRICT OF COLUMBIA
Department of Insurance, Securities and Banking

Chester A. McPherson
Interim Commissioner

BULLETIN
13-IB-01-30/15
REVISED

TO: **ALL INSURANCE COMPANIES, HEALTH MAINTENANCE ORGANIZATIONS AND HOSPITAL AND MEDICAL SERVICE CORPORATIONS AUTHORIZED TO WRITE HEALTH INSURANCE IN THE DISTRICT OF COLUMBIA**

FROM: **CHESTER A. MCPHERSON, INTERIM COMMISSIONER**

Feb 27, 2014

SUBJECT: **PROHIBITION OF DISCRIMINATION IN HEALTH INSURANCE BASED ON GENDER IDENTITY OR EXPRESSION**

DATE: **FEBRUARY 27, 2014**

This Bulletin is being reissued with revisions to clarify the Department of Insurance, Securities and Banking's ("Department") position regarding the application of D.C. Official Code § 31-2231.11, Unfair Discrimination, as it pertains to insurance companies writing health insurance in the District of Columbia.[1] On March 15, 2013, the Department first issued this Bulletin announcing that D.C. Official Code § 31-2231.11(c), the Unfair Discrimination provision of the District's Unfair Insurance Trade Practices Act,[2] prohibits discrimination in health insurance based on gender identity or expression.

Section 31-2231.11(c) states in relevant part:

> No person shall refuse to insure, refuse to continue to insure, or limit the amount of coverage available to an individual because of marital status, race, color,

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[1] The Department's reference to "writing health insurance in the District of Columbia" would include policies sitused, delivered or negotiated in the District of Columbia and subject to its health insurance laws. Such policies would include those commercial policies issued in the individual and small and large group markets, including those issued to associations. Qualified plans under ERISA remain exempt from state health insurance laws.

[2] Enacted as the Insurance Trade and Economic Development Amendment Act of 2000, effective April 3, 2001 (D.C. Official Code § 31-2231.01 *et seq.*) ("Unfair Insurance Trade Practices Act").

> personal appearance, sexual orientation, gender identity or expression, matriculation, political affiliation, or an individual's status as a victim of an intrafamily offense, sexual assault, dating violence, or stalking.

Id. (emphasis added). Section 31-2231.11(c) applies to health insurance policies and the practices of health insurance companies writing individual or group coverage in the District of Columbia. Based on the application of § 31-2231.11(c), the Department further stated that an example of such discriminatory conduct could be exclusionary provisions that had the effect, intended or otherwise, of targeting one or more of the protected classes enumerated in § 31-2231.11(c). Thus, the Department determined, and more fully clarifies here, that examples of such exclusionary clauses that it would likely deem *prima facie* discriminatory, include:

> "Any treatment or procedure designed to alter an individual's physical characteristics to those of the opposite sex."
>
> "Sex transformations and related services."
>
> "Sex change: Any treatment, drug, service or supply related to changing sex or sexual characteristics."

The Department further advised that discriminatory language of this nature should no longer be enforced, and companies employing such language should file updated policy forms within 90 days of the March 15, 2013 original issuance date of this Bulletin.

As further clarification, and to advance the remedial goals of anti-discrimination provisions in the Unfair Insurance Trade Practices Act, the Department offers the following additional guidance. First, it is the position of the Department that "gender dysphoria" (also known as "gender identity disorder") is a recognized medical condition under health insurance policies covering medical and hospital expenses, regardless of whether explicitly referenced.[3] Second, persons diagnosed with gender dysphoria fall squarely within the protected class of "gender identity or expression" as provided in § 31-2231.11(c).

Moreover, the anti-discrimination mandate in § 31-2231.11(c) is bolstered by a second mandate in § 31-2231.11(b), which prohibits companies from discriminating "between individuals of the same class and of essentially the same hazard . . . in the benefits payable under a policy or contract of accident or health insurance; in any of the terms or conditions policy or contract of accident or health insurance; or in any other manner."

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[3] The Department's conclusion is consistent with the Essential Health Benefits standards established in the District. The District adopted a CareFirst, BluePreferred group plan for small employers as the benchmark plan for benefits that must be provided in individual and small group policies written in the District of Columbia. The benchmark plan covers conditions classified on Axes I and II of the DSM, for which gender dysphoria is a listed condition.

Thus, in order to achieve the remedial goals of the anti-discrimination provisions, the Department is obliged to construe and apply the provisions broadly.[4]

As for interpreting the provisions, § 31-2231.11(c) makes clear that "[n]o person shall . . . limit the amount of coverage available to an individual because of . . . gender identity or expression . . . ." Nothing in § 31-2231.11(c) suggests that it should not apply to health insurance. Further, § 31-2231.11(b) makes unambiguous its application to health insurance policies while implicitly incorporating the protected class from § 31-2231.11(c) through its reference to "unfair discrimination." The only interpretive question that remains for § 31-2231.11(c) is whether gender dysphoria diagnosed individuals and non-gender dysphoria diagnosed individuals seeking health insurance are "of the same class and essentially the same hazard." Because both sets of individuals are seeking coverage under the same health insurance policies offering benefits and services for recognized medical conditions, generally, it is the Department's position that for purposes of § 31-2231.11(b), the individuals are "of the same class and essentially the same hazard."

Therefore, in applying the statutes and adhering to the intent of the Council, the Department, upon further consideration, not only concludes that exclusionary clauses that discriminate on the basis of "gender identity or expression" are *prima facie* prohibited, but also would view attempts by companies to limit or deny medically necessary treatments for gender dysphoria, including gender reassignment surgeries, to be discriminatory. Accordingly, it is the position of the Department that treatment for gender dysphoria, including gender reassignment surgeries, is a covered benefit, and individuals diagnosed with gender dysphoria are entitled to receive medically necessary benefits and services under individual and group health insurance policies covering medical and hospital expenses.[5]

In determining the medical necessity of services and benefits provided to such patients, insurance companies should refer to the recognized professional standard of medical care for transgender individuals requiring treatment for gender dysphoria, which is enumerated in the most recent edition of the World Professional Association for

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[4] The Unfair Trade Practices Act was amended to include the terms "gender identity or expression" by the Prohibition of Discrimination on the Basis of Gender Identity and Expression Amendment Act of 2008, effective June 25, 2008 (D.C. Law 17-177; D.C. Official Code § 31-2231.11(c)). D.C. Law 17-177 was expressly enacted to address the discriminatory practices of companies writing health insurance in the District. *See* Report on Bill 17-330, the Prohibition on Discrimination on the Basis of Gender Identity and Expression Amendment Act of 2008 (January 31, 2008). D.C. Law 177 was enacted to mirror the protected classes in the District's Human Rights Act, *see* Human Rights Act Clarification Amendment Act of 2005, effective March 8, 2006 (D.C. Law 16-58; D.C. Official Code § 2-1402.31(a)), and using the same principles, to remediate the same harms occasion by such discriminatory practices in the insurance field. *See* D.C. Official Code § 31-2231.-01(3A) incorporating by reference the same definition for "gender identity or expression" as provided in § 2-1402.02(12A).

[5] For example, the District's mandated coverage for medical and psychological treatment of drug abuse, alcohol abuse, and mental illness includes services the "treatment of clinically significant mental illnesses identified in the most recent edition of the . . . Diagnostic and Statistical Manual of the American Psychiatric Association." *See* D.C. Official Code § 31-3104(a).

Transgender Health Standards of Care ("WPATH Standards").[6] Inasmuch as the WPATH Standards indicate that the appropriate course of treatment for individuals diagnosed with gender dysphoria may vary between patients, determinations of medical necessity for coverage purposes must also be guided by providers in communication with individual patients.

Finally, the benefits afforded to individuals seeking treatment for gender dysphoria, including gender reassignment surgeries, should not be construed as newly mandated benefits. Rather, the Department is merely enforcing District law to ensure that individuals diagnosed with gender dysphoria are afforded the same right to obtain the full measure of benefits under health insurance policies as individuals seeking medically necessary treatment for non-gender identity or expression related conditions.

Based on the authorities cited above and the guidance provided in this Bulletin, the Department directs companies writing individual and group health insurance policies in the District to:

(1) Evaluate their practices, including benefit design and coverage determination procedures, to ensure that they neither discriminate against insured individuals in any protected class, including those diagnosed with gender dysphoria, nor deny access to medically necessary care because of an individual's gender identity or expression;

(2) Review all current relevant health policy documents to ensure that they are compliant with the guidance provided in this Bulletin, including policies that have been previously approved by the Department; and

(3) File any appropriate amendments or endorsements to health plan documents to ensure compliance with the guidance in this Bulletin.

Any riders that charge an additional premium for the benefits that are determined under this Bulletin to be covered by an individual or group insurance policy should be eliminated no later than the next renewal period.

Should you have any questions regarding this Bulletin, please contact Philip Barlow, Associate Commissioner of Insurance, at (202) 442-7823 or philip.barlow@dc.gov.

[6] The most recent version of the WPATH *Standards of Care* was released on September 25, 2011.

GOVERNMENT OF THE DISTRICT OF COLUMBIA

Department of Health Care Finance

NON-DISCRIMINATION IN THE DISTRICT'S STATE MEDICAID PROGRAM BASED ON GENDER IDENTITY OR EXPRESSION

Consistent with **BULLETIN 13-IB-01-30/13 REVISED** issued by the Department of Insurance, Securities and Banking (DISB), the Department of Health Care Finance (DHCF) issues a clarifying statement of policy pertaining to the District of Columbia's Medicaid program, gender identity or expression, and access to care.

Medicaid covers approximately one-third of District residents, making it a major contributor to the high insurance coverage rates enjoyed by the District of Columbia. Additionally, the comprehensive benefits provided by Medicaid are essential to the health and well-being of some of the District's most vulnerable residents. DHCF endorses the District's prohibition of discrimination in health insurance based on gender identity or expression, and further states that, while there is no evidence that there are policy barriers to access to care for District Medicaid beneficiaries seeking medically necessary sexual reassignment treatment, surgery, or other therapeutic services, the perception of providers and beneficiaries may be that Medicaid does not cover such services. Through this statement, DHCF confirms and clarifies that treatments and services related to the treatment of gender dysphoria are covered by Medicaid when they are determined to be medically necessary.

The benefits afforded to individuals seeking treatment for gender dysphoria, including gender reassignment surgeries, should not be construed as newly-mandated Medicaid benefits. As with all covered services provided through Medicaid, the District of Columbia will continue to cover medically necessary transgender health services to the extent permissible through Federal and local law. Rather, DHCF is committed to ensuring that individuals diagnosed with gender dysphoria are afforded the same right to obtain benefits under health insurance policies as individuals seeing medically necessary treatment for non-gender identity or expression related conditions; or as they themselves would experience for any other health care concerns.

Medically Necessary Services and Medicaid

If a District resident is eligible for Medicaid coverage in the District, and enrolls in the Medicaid program as a participant, that individual is eligible for all medically necessary covered services, as defined by the Medicaid State Plan. Key points pertaining to medical necessity in Medicaid include:

- There are express terms and limits on State discretion with regards to medical necessity in Medicaid programs. The first such limit is a requirement that a State's medical necessity standard be reasonable (42 U.S.C. § 1396a(a)(17)(A). The second limit requires that a State's medical necessity standard be consistent with the purpose of a particular Medicaid benefit. The third limit prohibits States from arbitrarily denying coverage on the basis of a condition in the case of a required service.
- The Early Periodic Screening, Diagnosis, and Treatment (EPSDT) provisions of federal law create a unique medical necessity standard for children under age 21(42 U.S.C. §§ 1396d(a)(4)(B) and 1396d(r)). The standard requires States to provide any "necessary health care, diagnostic services, treatment, and other measures" that are needed to "correct or ameliorate defects and physical and mental illnesses and conditions."
- In determining the medical necessity of services and benefits provided to individuals enrolled in Medicaid, providers should refer to recognized professional standards of medical care. For transgender individuals requiring treatment for gender dysphoria, such standards are detailed in the most recent edition of the World Professional Association for Transgender Health Standards of Care ("WPATH Standards")[1]. Inasmuch as the WPATH Standards indicate that the appropriate course of treatment for individuals diagnosed with gender dysphoria may vary between patients, determinations of medical necessity for coverage purposes must also be guided by providers in communication with individual patients.
- For surgical procedures that are determined to be medically necessary, but may be cosmetic in nature :
    - Section 9 (Clinic Services) Part A in Supplement 1 to Attachment 3.1-B in the DC Medicaid State Plan states "Surgical procedures for medically necessary cosmetic purposes (except for emergency repair of accidental injury) will be provided only by prior authorization issued by the State Agency.[2]

[1] The World Professional Association for Transgender Health (WPATH). Standards of Care for the Health of Transsexual, Transgender, and Gender Nonconforming People.

[2] In its review of claims data from the Medicaid Management Information Systems (MMIS), DHCF has found no indication or pattern of denying claims on the basis of gender identity. Many procedures in the MMIS system that a provider may bill for throughout the course of offering treatment to a patient in transition do not require prior authorization.

Maryland
Developments for State Government Workers and Medicaid

SETTLEMENT AGREEMENT AND RELEASE

THIS SETTLEMENT AGREEMENT AND RELEASE (the "Agreement"), is entered into by and between the Maryland Department of Budget and Management ("DBM"), the University System of Maryland ("USM"), the University of Maryland, Baltimore ("UMB") (collectively "the State") and Sailor Holobaugh ("Holobaugh"). The State and Holobaugh shall be referred to collectively as the "Parties" and each individually as a "Party".

WHEREAS, at all times relevant to this Agreement, Holobaugh has been employed by UMB and has been a participant in the Maryland State Employee and Retiree Health and Welfare Benefits Program (the "Program"), which includes a selection of health benefit plans, administered by third-party administrators under contract with DBM, in which an employee (the "Program participant") and his or her spouse and dependents ("Program beneficiaries") may choose to participate; and

WHEREAS, Holobaugh filed a claim for Program benefits premised on his gender identity as a transgender man. In other words, although he was assigned the sex of female at birth, he identifies psychologically and emotionally as male on a longstanding and permanent basis; and

WHEREAS, Holobaugh presented evidence that he was diagnosed with gender dysphoria (also known as gender identity disorder), which is a diagnosis associated with transgender status; and

WHEREAS, by Executive Order 01.01.2007.16, discrimination on the basis of "gender identity and expression" is prohibited in State employment; and

WHEREAS, a dispute arose between Holobaugh and the State regarding whether health benefit plan coverage of a procedure performed on or about November 20, 2012, which was related to Holobaugh's diagnosis of gender dysphoria, was precluded based on a then-effective exclusion under the Program excluding benefits for gender reassignment procedures (the "Benefits Dispute"); and

WHEREAS, the particular health benefit plan in which Mr. Holobaugh participated had implemented the exclusion by excluding coverage for any "procedure or treatment designed to alter an individual's physical characteristics to those of the opposite sex" (hereinafter, for purposes of convenience only, the "Sex Reassignment Exclusion"). Other health benefit plans in the Program contained language to the same effect; and

WHEREAS, on or about November 12, 2013, based on the Benefits Dispute, Holobaugh filed a "Discrimination Complaint Form" with DBM's Office of the Statewide Equal Employment Opportunity Coordinator and with UMB's Equal Employment Opportunity Coordinator, alleging discrimination on the basis of "Gender Identity and Expression" (hereinafter referred to as the "EEO Complaint"). Additionally, on or about January 9, 2014, Holobaugh filed a Charge of Discrimination against DBM, USM and UMB with the Maryland Commission on Civil Rights, alleging sex, disability and gender identity discrimination, which

was docketed by the Commission as *Sailor Holobaugh v. State of Maryland*, No. 12F-2014-00260 (hereinafter referred to as the "MCCR Charge"); and

WHEREAS, the Secretary of DBM has the authority to establish health insurance benefit options and other benefit options offered in the Program; and

WHEREAS, in the exercise of that authority, the Secretary of DBM has eliminated the Sex Reassignment Exclusion underlying the Benefits Dispute from all plans in the Program and will be implementing a new gender dysphoria benefit (the "Gender Dysphoria Benefit") in all plans in the Program, effective July 1, 2014. The Gender Dysphoria Benefit to be implemented and to which Holobaugh and DBM have agreed is attached hereto as Exhibit 1; and

WHEREAS, the State has denied, and continues to deny, any and all wrongdoing, discrimination, violation of law and/or liability to Holobaugh; and

WHEREAS, Holobaugh and the State desire to compromise and settle all disputes, claims and potential claims relating in any way to the Benefits Dispute, including all issues concerning the Benefits Dispute that were raised or that could have been raised in the aforementioned EEO Complaint and MCCR Charge; and

WHEREAS, no determination has been made on the merits any of Holobaugh's allegations; and

WHEREAS, the Parties desire to document the terms of their compromise and settlement in this Agreement, with the Parties agreeing that the State does not admit any wrongdoing, fault, or liability whatsoever; and

WHEREAS, nothing in this Agreement is to be construed or interpreted as an admission or acknowledgment of any fault, liability, or wrongdoing by the State, including any admission or acknowledgment of liability or wrongdoing to Holobaugh, or any admission or acknowledgment of liability or wrongdoing concerning any of the allegations in the EEO Complaint and MCCR Charge.

NOW, THEREFORE, in consideration of the mutual promises, covenants, and conditions set forth herein, and other good and valuable consideration, the receipt and sufficiency of which are hereby acknowledged, the Parties, intending to be legally bound hereby, agree as follows:

1. Payment and Implementation of Gender Dysphoria Benefit

(a) In consideration for the Release included in Section 3 of this Agreement and other obligations under this Agreement, and provided that Holobaugh satisfies and remains in full compliance with his obligations under this Agreement, the State of Maryland shall pay Holobaugh the total gross sum of Four Thousand Four Hundred Forty-Five Dollars and Thirty-

Three Cents ($4,445.33) without withholding, within seven business days after the Effective Date of this Agreement. The State will include this payment in an IRS Form 1099 to be issued to Holobaugh in the normal course of the State's issuance of IRS Form 1099s.

(b) This payment shall not be construed or interpreted as an admission of any wrongdoing, fault, or liability by the State.

(c) Holobaugh acknowledges and agrees that he is solely and entirely responsible for the payment and discharge of all federal, state, and local taxes, if any, which may, at any time, be found to be due upon or as a result of the payments described above, and he agrees to indemnify, and hold the State harmless from any claim or liability for any such taxes and related penalties and/or interest, in the event such taxes, penalties, and/or interest are assessed by the United States Internal Revenue Service or any other taxing authority.

(d) The State is implementing the Gender Dysphoria Benefit attached to this Agreement as Exhibit 1. Holobaugh agrees and acknowledges, based on his understanding of applicable current medical standards of care as of the Effective Date of this Agreement, that the Gender Dysphoria Benefit (in the form attached to this Agreement) provides coverage for medically necessary care for gender dysphoria without discrimination on the basis of gender identity. While the State is implementing the Gender Dysphoria Benefit effective July 1, 2014, Holobaugh acknowledges and agrees that, for legal, medical, or programmatic reasons, the Gender Dysphoria Benefit is not static and may change (although Holobaugh makes no acknowledgment or representation as to the legal sufficiency, under antidiscrimination law or otherwise, of any changes to the Gender Dysphoria Benefit that the State may later implement). The State does not anticipate any changes as of the Effective Date of this Agreement.

(e) Holobaugh acknowledges and agrees that the rights flowing to him under this Agreement flow to him and his Program beneficiaries, if any, alone. No third-party rights flow to any other Program participant or beneficiary under this Agreement.

(f) Holobaugh expressly agrees and acknowledges that he is entitled to no damages, payments, benefits, compensation, remuneration, back pay, front pay, lost wages, attorneys' fees, costs or fees of any kind arising out of the Benefits Dispute, other than the payment described in Section 1(a) above and the implementation of the Gender Dysphoria Benefit described in Section 1(d) above, and the remedy a court or other adjudicative body orders in the event of a dispute to enforce this Agreement.

2. Dismissal/Withdraw of Claims

Within seven business days after the Effective Date of this Agreement, Holobaugh shall dismiss or otherwise withdraw all claims currently pending against the State, specifically including the aforementioned EEO Complaint and the MCCR Charge.

3. **Release**

(a) In consideration of the payment described in Section 1(a) above and the implementation of the Gender Dysphoria Benefit described in Section 1(d) above, Holobaugh, for himself and his heirs, personal representatives, and assigns, hereby releases and forever discharges the State of Maryland, DBM, USM, UMB, and the Program (including without limitation their agencies, divisions, units, departments, employees, officers, officials, employee benefit plans, plan administrators, and plan personnel) (collectively, the "Released Parties") from and against all liability, damages, actions, and claims of any kind whatsoever, known and unknown, that he now has or may have had, or hereafter may claim to have, on behalf of himself or any other person or entity, at any time, arising out of, or relating in any way to, the Benefits Dispute, gender dysphoria benefits pre-dating the Effective Date of this Agreement, or any related acts or omissions done or occurring in whole or in part prior to and including the Effective Date of this Agreement, and including all issues concerning the Benefits Dispute that were raised or that could have been raised in the EEO Complaint or MCCR Charge. Without in any way limiting the generality of the foregoing, to the maximum extent permitted by law, Holobaugh hereby releases any claims related to the Benefits Dispute and gender dysphoria benefits pre-dating the Effective Date of this Agreement under Title VII of the Civil Rights Act of 1964 and 1991, as amended, 42 U.S.C. § 2000(e) *et seq.*, 42 U.S.C. § 1981, the Americans With Disabilities Act, 42 U.S.C. § 12101 *et seq.*, the Rehabilitation Act of 1973, as amended, 29 U.S.C. § 794, the Employee Retirement Income Security Act of 1974, as amended, 29 U.S.C. § 1001 *et seq.*, the Family and Medical Leave Act of 1993, 29 U.S.C. § 2601 *et seq.*, and all other federal, state and local laws pertaining to employment, employee benefits, and/or employment discrimination, including, but not limited to, Title 2 of the State Personnel and Pensions Article of the Maryland Code, Title 20 of the State Government Article of the Maryland Code and Maryland Executive Order 01.01.2007.16.

(b) Although the scope of the above release is more limited, Holobaugh expressly acknowledges and represents that, as of the date that he signs this Agreement, to the best of his knowledge, information, and belief, he (i) has suffered no injuries or occupational diseases arising out of or in connection with his employment with UMB; (ii) has received all wages to which he was entitled as an employee of UMB; and (iii) is not currently aware of any facts or circumstances constituting a violation of the Fair Labor Standards Act ("FLSA").

(c) Holobaugh expressly represents that as of the date that he signs this Agreement, he has not filed any grievances, claims, complaints, administrative charges (including, but not limited to, charges of discrimination filed with the Maryland Commission on Civil Rights or the Equal Employment Opportunity Commission) or lawsuits against the State or any Released Party, with the exception of the aforementioned EEO Complaint and the MCCR Charge.

(d) Notwithstanding anything in this Release to the contrary, nothing in this Release will waive, relinquish, diminish, or in any way affect any rights or claims that, as a matter of law, have not accrued or cannot be released or waived.

(e) Subject to Paragraph 3(d) above and 4 below, Holobaugh agrees not to participate as a party in or solicit any person to file or maintain a claim or lawsuit against the State or any of

the other Released Parties relating in any way to the Benefits Dispute. This provision shall not be construed as limiting Holobaugh's right or ability to refer potential clients to legal counsel.

4. Governing Law and Enforcement of this Agreement

This Agreement shall be construed and enforced in accordance with, and governed by, the laws of the State of Maryland.

5. Miscellaneous

(a) This Agreement sets forth the entire agreement between the Parties with respect to the matters addressed, and Holobaugh will not be entitled to any compensation, remuneration, benefits or other payments related to the Benefits Dispute, except as specifically provided in this Agreement. This Agreement may not be modified except by a new written agreement signed by both Parties. Holobaugh's signature below will confirm that he has not relied on any representation or statement not set forth in this Agreement.

(b) In the event that a court holds any provision of this Agreement to be invalid or unenforceable, that provision shall be severed or otherwise conformed to the degree necessary to render it valid and enforceable without affecting the rest of this Agreement. Any provision of this Agreement which is prohibited or unenforceable in any jurisdiction shall, as to such jurisdiction, be deemed severable from the remainder of this Agreement, and the remaining provisions contained in this Agreement shall be construed to preserve to the maximum permissible extent the intent and purposes of this Agreement. Any such prohibition or unenforceability in any jurisdiction shall not invalidate or render unenforceable such provision in any other jurisdiction.

(c) Any failure or forbearance by either Party to exercise any right or remedy with respect to enforcement of this Agreement will not be construed as a waiver of any rights or remedies. No waiver of any of the terms of this Agreement will be valid unless in writing and signed by both Parties.

(d) Holobaugh and the State mutually acknowledge that each of their obligations, as set forth herein, is deemed by the Parties to be material to this Agreement.

(e) Holobaugh represents and warrants that he has fully discussed this Agreement with his attorney, that all terms are understood, and that the execution of this document is completely voluntary.

(f) This Agreement is a compromise freely and voluntarily entered into by each of the Parties, and shall not be construed as an admission of liability, or as a violation of any applicable law, rule, regulation or order of any kind, by any Party.

(g) This Agreement shall be binding upon, and shall inure to the benefit of, the Parties and their respective heirs. personal representatives, legal representatives, successors and assigns.

(h) This Agreement may be executed in identical counterparts, each of which shall constitute an original and all of which shall constitute one and the same agreement.

(i) The "Signatories" to this Agreement shall be Holobaugh, his legal counsel, the Secretary of DBM, the Chancellor of USM, and the President of UMB (the "Signatories"). This Agreement shall not be effective until its "Effective Date," which shall be the date on which a copy of the Agreement (including any counterparts), has been signed by each of the Signatories (the "Executed Agreement"). Whichever Party is in possession of the Executed Agreement on the Effective Date shall provide each other Party with a copy of the Executed Agreement as promptly as practicable and in any event within two business days after the Effective Date.

HOLOBAUGH IS HEREBY ADVISED TO CONSULT WITH AN ATTORNEY PRIOR TO EXECUTING THIS AGREEMENT.

WHEREFORE, having fully read and understood the terms of this Agreement, the Parties sign their names below with the intention that they shall be bound by it.

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***** SIGNATURES APPEAR ON FOLLOWING PAGE *****

SAILOR HOLOBAUGH

Sailor Holobaugh

9 July 2014
Date

APPROVED BY:

FREESTATE LEGAL PROJECT, INC.

By: Jer Welter
Managing Attorney
as Counsel for Holobaugh

7/9/2014
Date

STATE OF MARYLAND

MARYLAND DEPARTMENT OF BUDGET AND MANAGEMENT

By: T. Eloise Foster
Secretary

7/10/14
Date

UNIVERSITY SYSTEM OF MARYLAND

By: William E. Kirwan
Chancellor

7/14/14
Date

UNIVERSITY OF MARYLAND, BALTIMORE

By: Jay A. Perman
President

7/11/14
Date

Exhibit 1

GENDER DYSPHORIA COVERAGE UNDER
THE STATE EMPLOYEE AND RETIREE HEALTH AND WELFARE BENEFITS PROGRAM

Covered Services:

1) **Outpatient psychotherapy/mental health services for gender dysphoria and associated co-morbid psychiatric diagnoses.** The benefits are the same as any other outpatient mental health service in the Program.

2) **Continuous hormone replacement therapy.** The benefits are the same as any other eligible drug in the Program. Note the following clarifications:

   - Hormones injected by a medical provider (for example during an office visit) are covered by the medical plan. Benefits for these injections vary depending on the plan design.

   - Oral and self-injected hormones from a pharmacy are not covered under the medical plan. Refer to the Benefit Guide for specific prescription drug product coverage and exclusion terms. They are covered under the separately provided prescription drug plan, if enrolled.

3) **Outpatient laboratory testing to monitor continuous hormone therapy**. The benefits are the same as any other outpatient diagnostic service in the Program.

4) **Gender reassignment surgery.** Medically necessary gender reassignment procedures are covered, as follows. The procedures identified in this paragraph and any combination of procedures within each type of transition – *male-to-female transition*: orchiectomy, penectomy, clitoroplasty, labiaplasty, vaginoplasty, thyroid chondroplasty; *female-to-male transition:* vaginectomy, hysterectomy, mastectomy, salpingo-oophorectomy, ovariectomy, metoidioplasty, phalloplasty, scrotoplasty, placement of testicular prostheses; *either:* urethroplasty – are considered medically necessary for treatment of gender dysphoria when *all* of the following criteria are met:

a. The individual is at least 18 years of age; and

b. The individual has capacity to make fully informed decisions and consent for treatment; and

c. The individual has been diagnosed with gender dysphoria and exhibits all of the following:

   1. The desire to live and be accepted as a member of the opposite sex, usually accompanied by the wish to make his or her body as congruent as possible with the preferred sex through surgery and hormone treatment; and

2. The gender dysphoria (pre and post diagnosis) has been present persistently for at least two years; and

3. The gender dysphoria is not a symptom of another mental disorder; and

4. The gender dysphoria causes clinically significant distress or impairment in social, occupational, or other important areas of functioning; and

d. For individuals without a medical contraindication or not otherwise unable to take hormones, the individual has undergone a minimum of 12 months of continuous hormonal therapy when recommended by a mental health professional and provided under the supervision of a physician. (Hormonal therapy is not required as a prerequisite to a mastectomy.); and

e. Documentation that the individual has completed a minimum of 12 months of successful continuous, substantially full time real-life experience in their new gender, across a wide range of life experiences and events that may occur throughout the year. (The real-life experience is not required as a perquisite to a mastectomy, augmentation mammoplasty, thyroid chondroplasty, hysterectomy, salpingo-oophorectomy, or orchiectomy.); and

f. Regular participation in psychotherapy and/or ongoing clinical treatment throughout the real-life experience may be required when recommended by a treating medical or behavioral health practitioner or when medically necessary; and

g. If the individual has significant medical or mental health issues present, they must be reasonably well controlled. If the individual is diagnosed with severe psychiatric disorders and impaired reality testing (e.g., psychotic episodes, bipolar disorder, dissociative identity disorder, borderline personality disorder), an effort must be made to improve these conditions with psychotropic medications and/or psychotherapy before surgery is contemplated; and

h. Two referrals from qualified mental health professionals who have independently assessed the individual. If the first referral is from the individual's psychotherapist, the second referral should be from a person who has only had an evaluative role with the individual. Two separate letters, or one letter signed by both (e.g., if practicing within the same clinic) are required.

   At least one of the professionals submitting a letter must have a doctoral degree (Ph.D., M.D., Ed.D., D.Sc., D.S.W., or Psy.D) and be capable of adequately evaluating co-morbid psychiatric conditions. One letter is sufficient if signed by two providers, one of whom has met the doctoral degree specifications, in addition to the specifications set forth above. One letter signed by an appropriate provider is sufficient to support benefits for a mastectomy.

The medical documentation should include the start date of living full time in the new gender, when applicable.

5) **Augmentation mammoplasty.** Provided the criteria above for gender reassignment surgery have been satisfied, augmentation mammoplasty (including breast prosthesis if necessary) may be covered for male-to-female transgender individuals if the Physician prescribing hormones and the treating surgeon have documented that, after undergoing hormone treatment for 12 months, breast size continues to cause clinically significant distress in social, occupational, or other areas of functioning.

Note on gender specific services for post-transition transgender persons:

Gender-specific services may be medically necessary for transgender persons appropriate to their anatomy. Examples include:

- Breast cancer screening may be medically necessary for female to male transgender persons who have not undergone a mastectomy;
- Prostate cancer screening may be medically necessary for male to female transgender individuals who have retained their prostate.

Notes:

- For individuals considering hysterectomy/salpingo-oophorectomy, orchiectomy, vaginectomy or vaginoplasty procedures a total of 12 months of continuous hormonal sex reassignment is required.
- Cryopreservation, storage, and thawing of reproductive tissue (i.e., oocytes, ovaries, testicular tissue) and the charged associated therewith (e.g., office, hospital, ultrasounds, laboratory tests, etc.) are not covered.

Coverage Limitations and Exclusions

The surgeries and procedures identified below are excluded from coverage. (This list may not be all-inclusive):

1) Nipple/areola reconstruction, except in connection with a covered augmentation mammoplasty or mastectomy
2) Breast enlargement procedures, except in connection with a covered augmentation mammoplasty
3) Brow lift

4) Cheek implants
5) Chin/nose implants
6) Collagen injections
7) Electrolysis
8) Facial bone reconstruction
9) Face/forehead lift
10) Hair removal/hairplasty/hair transplantation
11) Jaw shortening/sculpturing/facial bone reduction
12) Lip reduction/enhancement
13) Liposuction
14) Neck tightening
15) Reversal of genital or breast surgery or reversal of surgery to revise secondary sex characteristics.
16) Voice modification surgery
17) Voice therapy/voice lessons
18) Rhinoplasty
19) Removal of redundant skin, except in connection with a covered surgery
20) Replacement of tissue expander with permanent prosthesis testicular insertion, except as a component of a covered placement of a testicular prosthesis
21) Second stage phalloplasty
22) Surgical correction of hydraulic abnormality of inflatable (multi-component) prosthesis including pump and/or cylinders and/or reservoir
23) Testicular prostheses, except as a component of a covered placement of a testicular prosthesis (subsequent replacement or correction of such prosthesis subject to rules and limitations applicable to all prosthetic devices)
24) Blepharoplasty
25) Penile prosthesis (non-inflatable/inflatable), except in connection with a covered phalloplasty (implantation of the prosthesis shall not be considered a second stage phallioplasty) in a female-to-male transition (subsequent replacement or correction of such prosthesis subject to rules and limitations applicable to all prosthetic devices)
27) Testicular expanders, except as a component of a covered placement of a testicular prosthesis
26) Laryngoplasty
27) Mastopexy
28) Abdominoplasty

Gay Matters
News important to Maryland's LGBT community

Maryland to expand Medicaid coverage for transgender patients

By Kevin Rector

NOVEMBER 21, 2014, 8:46 AM

Health officials in Maryland are moving for the first time to provide transition-related health care coverage to low-income transgender residents who receive Medicaid in the state.

"We are in the process of submitting state regulations and will seek federal approval for the expansion of transgender health care coverage by April 1, 2015," a Department of Health and Mental Hygiene spokeswoman confirmed.

The action mirrors a similar move the state took this summer, amid negotiations with advocacy organizations, to provide state employees access to gender reassignment surgery, hormone therapy and other transition-related care under their state-provided health insurance plans.

The "same terms" of coverage will now be provided to Medicaid patients, said Karen Black, the spokeswoman. The state expects fewer than five people to request reassignment surgery under the new policy per year, and the associated costs to remain less than $325,000.

The move continues a trend toward greater recognition of transgender rights following the state's passage of the Fairness for All Marylanders Act of 2013, which banned transgender discrimination in employment and other public accommodations. The law does not specifically address health insurance, but has "communicated a strong public policy in the state against discrimination based on gender identity" in all public arenas, said Jer Welter, managing attorney at Free State Legal, one of the lesbian, gay, bisexual and transgender advocacy organizations that has been pushing the state on transgender insurance issues.

"We're seeing that public policy reflected now in other areas," he said, calling the Medicaid expansion effort a "tremendous move" by the state.

"We're very excited about this development," he said.

Maryland became the third state in the country to remove transgender care exclusions from its employees' state health plans in July, after Oregon and California. That change came about after Free State Legal brought a discrimination case against the state on behalf of Sailor Holobaugh, at the time a clinical research assistant in neurology at the University of Maryland School of Medicine in Baltimore.

Holobaugh's case began in November 2012, when Holobaugh paid more than $6,000 out of pocket for a bilateral mastectomy as part of his transition, then said he was denied reimbursement for the surgery by provider BlueCross BlueShield based on coverage restrictions under his state-provided policy.

This latest move by Maryland to extend such coverage to Medicaid recipients as well was more "proactive," Welter said. It was made with the recommendation of the state's Medicaid Advisory Committee and in consultation with Free State Legal and other LGBT advocacy groups -- including Equality Maryland, the state's largest.

In a statement, Equality Maryland said it will continue to work with the state to ensure the new regulations "are consistent with recognized standards of care for transgender patients."

Welter said there was no vocal opposition to the change, but he expects there may be some when the new regulations are finalized and made available for public comment.

He said he does not expect the change to face opposition at the federal level. Such exclusions were removed for Medicare patients in May, and from federal employees' health insurance plans in June.

"We have been seeing a shift on the issue of these outdated insurance exclusions, both at the federal level and at the state level in Maryland and in several other states, over the past year, year and a half," he said.

Similar changes have taken effect in the District of Columbia and in California, Massachusetts, Vermont and Oregon. A lawsuit seeking a similar change has been filed in New York.

Welter said policy shifts in other localities, including San Francisco, have been shown to have "negligible" costs, in part because transgender people make up a small percentage of the overall population.

Also, while procedures related to transition care "are very expensive for an individual to self-fund," they are not more expensive than other procedures patients routinely undergo, he said.

Welter said Free State Legal's next target will be insurance providers regulated by the Maryland Insurance Administration, including those on the state's health exchange.

In January, the insurance administration issued a "clarification" of essential health benefits in the state, saying providers could not discriminate against transgender patients seeking "medically necessary items or services," but could deny coverage of care "directly related to the gender reassignment process."

CODE OF MARYLAND REGULATIONS

* This document is current through the 5/1/2015 issue of the Maryland Register *

TITLE 10. DEPARTMENT OF HEALTH AND MENTAL HYGIENE
SUBTITLE 09. MEDICAL CARE PROGRAMS
CHAPTER 02. PHYSICIANS' SERVICES

COMAR 10.09.02.05 (2015)

.05 Limitations.

A. Services which are not covered are:

(1) Physician services not medically justified;

(2) Nonemergency dialysis services related to chronic kidney disorders unless they are provided in a Medicare-certified facility;

(3) Physician inpatient hospital services rendered during any period that is in excess of the length of stay authorized by the Utilization control agent (UCA);

(4) Physician services denied by Medicare as not medically necessary;

(5) Services which are investigational or experimental;

(6) Autopsies;

(7) Physician services included as part of the cost of an inpatient facility, hospital outpatient department, or free-standing clinics;

(8) Payment to physicians for specimen collections, except by venipuncture, and capillary or arterial puncture;

(9) Immunizations required for travel outside the continental United States;

(10) Injections, and visits solely for the administration of injections, unless medical necessity and the patient's inability to take appropriate oral medications are documented in the patient's medical records;

(11) Visits solely to accomplish one or more of the following:

(a) Prescription, drug or food supplement pick-up, collection of specimens for laboratory procedures,

(b) Recording of an electrocardiogram,

(c) Ascertaining the patient's weight;

(12) Interpretation of laboratory tests or panels;

(13) Medical Assistance prescriptions and injections for central nervous system stimulants and anorectic agents when used for weight control;

(14) Drugs and supplies dispensed by the physician which are acquired by the physician at no cost;

(15) Disposable medical supplies;

(16) Services prohibited by the Board of Physician Quality Assurance;

(17) Services which are provided outside the United States;

(18) Services which do not involve direct (face-to-face) patient contact;

(19) Sterilization reversal procedures;

(20) Gender change or sex reassignment procedures;

(21) Prescriptions for drugs written on prescription pads that do not prevent copying, modification, or counterfeiting; and

(22) Physician-administered drugs from manufacturers that do not participate in the Federal Drug Rebate Program.

B. Preoperative evaluations for anesthesia are included in the fee for administration of anesthesia and the provider may not bill them as consultations.

C. Referrals from one physician to another for treatment of specific patient problems may not be billed as consultations.

D. The operating surgeon may not bill for the administration of anesthesia or for an assistant surgeon who is not in the operating surgeon's employ.

E. Payment for consultations provided in a multispecialty setting is limited by criteria established by the Department.

F. The Department will not pay a provider for those laboratory or x-ray services performed by another facility. The Department will pay directly the facility performing those services.

G. The Program does not cover services rendered to an inpatient before one preoperative inpatient day, unless preauthorized by the Program.

H. The provider may not bill the Program for services rendered under the supervising physician's provider number by an employed nonphysician extender, such as:

(1) A physical therapist;

(2) An occupational therapist;

(3) A speech language pathologist;

(4) An audiologist; or

(5) A nutritionist.

MARYLAND REGISTER

ISSUE: Volume 42, Issue 2

ISSUE DATE: January 23, 2015

SUBJECT: PROPOSED ACTION ON REGULATIONS

AGENCY: DEPARTMENT OF HEALTH AND MENTAL HYGIENE

42-2 Md. Reg. 181

Title 10 DEPARTMENT OF HEALTH AND MENTAL HYGIENE

Subtitle 09 MEDICAL CARE PROGRAMS

[AP> UPPERCASE TEXT BETWEEN THESE SYMBOLS IS ADDED AT THE TIME OF PROPOSED ACTION <AP]
[DP> Text between these symbols is deleted at the time of proposed action <DP]

10.09.02 Physicians' Services

Authority: Health-General Article, §§ 2-104(b), 15-103, and 15-105, Annotated Code of Maryland

Notice of Proposed Action
[15-032-P]

The Secretary of Health and Mental Hygiene proposes to amend Regulation .05 under COMAR 10.09.02 Physicians' Services.

Statement of Purpose

The purpose of this action is to align Medicaid coverage of gender reassignment with the Maryland State Employees' Health Benefit program and recent changes in Medicare policy.

Comparison to Federal Standards

There is a corresponding federal standard to this proposed action, but the proposed action is not more restrictive or stringent.

Estimate of Economic Impact

I. Summary of Economic Impact. The Department is proposing the removal of limitations on gender reassignment surgery. The additional coverage represents an overall cost to the Department.

II. Types of Economic Impact.	Revenue (R+/R-) Expenditure (E+/E-)	Magnitude
A. On issuing agency:	(E+)	$ 120,000
B. On other State agencies:	NONE	
C. On local governments:	NONE	
	Benefit (+) Cost (-)	Magnitude
D. On regulated industries or trade groups:	(+)	$ 120,000
E. On other industries or trade groups:	NONE	
F. Direct and indirect effects on public:	NONE	

III. Assumptions. (Identified by Impact Letter and Number from Section II.)

A. and D. There are an estimated 400 transgender individuals currently enrolled in the Maryland Medical Assistance (MA) Program. If approximately two and a half percent of this population request the procedure(s) and meet the prior authorization criteria for the surgery, this could result in 10 gender reassignments. At the estimated cost of $ 65,000 per surgery, this would be an additional cost of $ 650,000 over the next 5 years. Not all individuals will have the surgery in the first year it is covered. We estimate that two individuals will have the surgery in the remaining part of FY15 at a cost of $ 120,000 and 4 individuals will have the surgery in FY16 at a cost of $ 240,000.

Economic Impact on Small Businesses

The proposed action has minimal or no economic impact on small businesses.

Impact on Individuals with Disabilities

The proposed action has no impact on individuals with disabilities.

Opportunity for Public Comment

Comments may be sent to Michele Phinney, Director, Office of Regulation and Policy Coordination, Department of Health and Mental Hygiene, 201 West Preston Street, Room 512, Baltimore, MD 21201, or call 410-767-6499 (TTY 800-735-2258), or email to dhmh.regs@maryland.gov, or fax to 410-767-6483. Comments will be accepted through February 23, 2015. A public hearing has not been scheduled.

.05 Limitations.

A. Services which are not covered are:

(1)-(19) (text unchanged)

[DP>(20) Gender change or sex reassignment procedures;<DP]

[DP>(21)<DP] [AP>(20)<AP]-[DP>(22)<DP] [AP>(21)<AP] (text unchanged)

B.-H. (text unchanged)

JOSHUA M. SHARFSTEIN, M.D.
Secretary of Health and Mental Hygiene

Maryland
Insurance Regulations

* This document is current through the 5/1/2015 issue of the Maryland Register *

TITLE 31. MARYLAND INSURANCE ADMINISTRATION

SUBTITLE 11. HEALTH INSURANCE -- GROUP

CHAPTER 06. COMPREHENSIVE STANDARD HEALTH BENEFIT PLAN

COMAR 31.11.06.06 (2015)

.06 Limitations and Exclusions.

A. A carrier shall apply the limitations and exclusions specified in § B of this regulation to the covered services specified in Regulation .03 of this chapter.

B. The following are exclusions and limitations to the covered services:

(1) Services that are not medically necessary;

(2) Services performed or prescribed under the direction of a person who is not a health care practitioner;

(3) Services that are beyond the scope of practice of the health care practitioner performing the service;

(4) Services to the extent they are covered by any government unit, except for veterans in Veterans' Administration or armed forces facilities for services received for which the recipient is liable;

(5) Services for which a covered person is not legally, or as a customary practice, required to pay in the absence of a health benefit plan;

(6) The purchase, examination, or fitting of eyeglasses or contact lenses, except for aphakic patients and soft or rigid gas permeable lenses or sclera shells intended for use in the treatment of a disease or injury;

(7) Personal care services and domiciliary care services;

(8) Services rendered by a health care practitioner who is a covered person's spouse, mother, father, daughter, son, brother, or sister;

(9) Experimental services;

(10) Practitioner, hospital, or clinical services related to radial keratotomy, myopic keratomileusis, and surgery which involves corneal tissue for the purpose of altering, modifying, or correcting myopia, hyperopia, or stigmatic error;

(11) In vitro fertilization, ovum transplants and gamete intrafallopian tube transfer, zygote intrafallopian transfer, or cryogenic or other preservation techniques used in these or similar procedures;

(12) Services to reverse a voluntary sterilization procedure;

(13) Services for sterilization or reverse sterilization for a dependent minor;

(14) Medical or surgical treatment or regimen for reducing or controlling weight, unless otherwise specified in the covered services;

(15) Services incurred before the effective date of coverage for a covered person;

(16) Services incurred after a covered person's termination of coverage, including any extension of benefits;

(17) Surgery or related services for cosmetic purposes to improve appearance, but not to restore bodily function or correct deformity resulting from disease, trauma, or congenital or developmental anomalies;

(18) Services for injuries or diseases related to a covered person's job to the extent the covered person is required to be covered by a workers' compensation law;

(19) Services rendered from a dental or medical department maintained by or on behalf of an employer, mutual benefit association, labor union, trust, or similar persons or groups;

(20) Personal hygiene and convenience items, including, but not limited to, air conditioners, humidifiers, or physical fitness equipment;

(21) Charges for telephone consultations, failure to keep a scheduled visit, or completion of any form;

(22) Inpatient admissions primarily for diagnostic studies, unless authorized by the carrier;

(23) The purchase, examination, or fitting of hearing aids and supplies, and tinnitus maskers, except as provided in Regulation .03A(34) of this chapter;

(24) Except for covered ambulance services, travel, whether or not recommended by a health care practitioner;

(25) Except for emergency services, services received while the covered person is outside the United States;

(26) Immunizations related to foreign travel;

(27) Unless otherwise specified in covered services, dental work or treatment which includes hospital or professional care in connection with:

(a) The operation or treatment for the fitting or wearing of dentures,

(b) Orthodontic care or malocclusion,

(c) Operations on or for treatment of or to the teeth or supporting tissues of the teeth, except for removal of tumors and cysts or treatment of injury to natural teeth due to an accident if the treatment is received within 6 months of the accident; and

(d) Dental implants;

(28) Accidents occurring while and as a result of chewing;

(29) Routine foot care, including the paring or removing of corns and calluses, or trimming of nails, unless these services are determined to be medically necessary;

(30) Arch support, orthotic devices, in-shoe supports, orthopedic shoes, elastic supports, or exams for their prescription or fitting, unless these services are determined to be medically necessary;

(31) Inpatient admissions primarily for physical therapy, unless authorized by the carrier;

(32) Treatment leading to or in connection with transsexualism, or sex changes or modifications, including but not limited to surgery;

(33) Treatment of sexual dysfunction not related to organic disease;

(34) Services that duplicate benefits provided under federal, State, or local laws, regulations, or programs;

(35) Organ transplants except those included under Regulation .03 of this chapter;

(36) Nonhuman organs and their implantation;

(37) Nonreplacement fees for blood and blood products;

(38) Lifestyle improvements, including nutrition counseling, or physical fitness programs, unless included as a covered service;

(39) Wigs or cranial prosthesis;

(40) Weekend admission charges, except for emergencies and maternity, unless authorized by the carrier;

(41) Out-patient orthomolecular therapy, including nutrients, vitamins, and food supplements;

(42) Temporomandibular joint syndrome (TMJ) treatment and treatment for craniomandibular pain syndrome (CPS), except for surgical services for TMJ and CPS, if medically necessary and if there is a clearly demonstrable radiographic evidence of joint abnormality due to disease or injury;

(43) Services resulting from accidental bodily injuries arising out of a motor vehicle accident to the extent the services are payable under a medical expense payment provision of an automobile insurance policy;

(44) Services for conditions that State or local laws, regulations, ordinances, or similar provisions require to be provided in a public institution;

(45) Services for, or related to, the removal of an organ from a covered person for purposes of transplantation into another person, unless the:

(a) Transplant recipient is covered under the plan and is undergoing a covered transplant, and

(b) Services are not payable by another carrier;

(46) Physical examinations required for obtaining or continuing employment, insurance, or government licensing;

(47) Nonmedical ancillary services such as vocational rehabilitation, employment counseling, or educational therapy;

(48) Private hospital room, unless authorized by the carrier;

(49) Private duty nursing, unless authorized by the carrier;

(50) Treatment for mental health or substance abuse not authorized by the carrier through its managed care system, or a mental health or substance abuse condition determined by the carrier through its managed care system to be untreatable; and

(51) Services related to smoking cessation.

C. A religious organization may request and a carrier shall grant the request for an exclusion from coverage for a service mandated under the plan if the service is in conflict with the religious organization's bona fide religious beliefs and practices.

D. A religious organization that obtains an exclusion from coverage for a service mandated under the plan shall provide its employees reasonable and timely notice of this exclusion.

E. The carrier's premium rate for the plan may not be affected by the religious organization's exclusions from coverage for a service mandated under the plan.

F. An insurer or non-profit health service plan may impose a preexisting condition exclusion as specified in Regulation .11 of this chapter.

NOTES:

LexisNexis 50 State Surveys, Legislation & Regulations

Healthcare Insurance

MARTIN O'MALLEY
Governor

ANTHONY G. BROWN
Lt. Governor

THERESE M. GOLDSMITH
Commissioner

KAREN STAKEM HORNIG
Deputy Commissioner

MARYLAND INSURANCE ADMINISTRATION

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BULLETIN 14-02

Date: January 27, 2014

To: Insurers, Nonprofit Health Services Plans, and Health Maintenance Organizations ("Carriers")

Re: Clarification of Coverage for Transgender Individuals

The purpose of this Bulletin is to clarify the scope of the exclusion in the benchmark plan selected to define essential health benefits (EHB) in Maryland for "treatment leading to or in connection with transsexualism, or sex changes or modifications, including but not limited to surgery."

The exclusion is based upon COMAR 31.11.06.06B(32), applicable to carriers that offered the comprehensive standard health benefit plan in the small employer market for plan years prior to 2014. Under applicable State law, as incorporated in the State's EHB benchmark plan, the exclusion should be narrowly applied to items and services that are directly related to the gender reassignment process. It does not exclude coverage for medically necessary items or services, including medically necessary preventive services, solely on the grounds that the person receiving the services is a transgender individual.

Section 27-208(b)(1) of the Insurance Article, Annotated Code of Maryland,[1] prohibits unfair discrimination between individuals of the same class and of essentially the same hazard (1) in the amount of premium, policy fees, or rates charged for a policy or contract of health insurance; (2) in the benefits payable under a policy or contract of health insurance; (3) in any of the term or conditions of a policy or contract or health insurance; or (4) in any other manner. Furthermore, under § 27-303, it is an unfair claim settlement practice and a violation of the Unfair Claim Settlement Practices subtitle of the Insurance Article to refuse to pay a claim for an arbitrary or capricious reason based on all available information or to fail to meet the requirements of Title 15, Subtitles 10A (related to the complaint process for adverse decisions) and 10B (related to determinations by private review agents).

Read together, these provisions prohibit a carrier from discriminating among insureds under a

[1] Unless otherwise noted, all statutory references in this Bulletin are to the Insurance Article, Annotated Code of Maryland, 2011 Replacement Volume and Supplements thereto.

health benefit plan on the basis of the insured's actual or perceived gender identity, or on the basis that the insured is a transgender individual.

Questions concerning this Bulletin should be directed to the Life/Health Section of the Maryland Insurance Administration at 410-468-2170.

Signature on original

Therese M. Goldsmith
Commissioner