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FILING GUIDANCE NOTICE 2025-N

TO: Commercial Health Insurers; Blue Cross Blue Shield of Massachusetts, Inc.; and Health Maintenance Organizations Offering or Renewing Insured Health Products in Massachusetts ("Carriers") subject to M.G.L. c. 176O

FROM: Kevin Patrick Beagan, Deputy Commissioner, Health Care Access Bureau

DATE: April 10, 2025

RE: Coverage of Transgender Health Care Services

The Division of Insurance ("Division") distributes this Filing Guidance Notice 2025-xx to inform insured health carriers ("Carriers") regarding coverage requirements for transgender health care services.

Treatment for the Mental Health Condition of Gender Dysphoria, as stated in the DSM-5

As has been noted in Bulletin 2014-03 and Bulletin 2021-11, insured health plans that are issued, delivered, or renewed within the Commonwealth are expected to provide coverage for the treatment of Gender Dysphoria, as stated in the Diagnostic and Statistical Manual of Mental Disorders (DSM-5-TR) ("DSM-5"). Carriers' coverage of such treatment is expected to be consistent with current care recommendations set forth by the World Professional Association for Transgender Health ("WPATH"),[1] and medically necessary care may not be limited by the number of surgeries or procedures associated with treatment of Gender Dysphoria. Carriers are to update their policies, as WPATH care recommendations are subject to change.

If medically necessary services are not available to treat Gender Dysphoria within a Carrier's network, such services are to be made available from out-of-network providers at the in-network benefit level until such time that the services are available from in-network providers. In any situation where covered services for transgender care are unavailable within the Carrier's traditional provider network, the Carrier should provide access to pay for the services, including but not limited to, the use of a prepaid debit card or similar payment arrangement, so that the member would not be required to pay for the services upfront with the provider. Carriers are required to use a prepaid debit card in the following circumstances for medically necessary covered

[1] *See* https://www.tandfonline.com/doi/pdf/10.1080/26895269.2022.2100644, for current Standards of Care for the Health of Transgender and Gender Diverse People, Version 8, from the International Journal of Transgender Health.

treatment for gender dysphoria: (1) if the covered services are not available through an in-network provider, and (2) if the member can otherwise only access the out-of-network covered services by paying for services and then seeking reimbursement from the member's Carrier.

If a Carrier uses a prepaid debit card, the Carrier is to ensure that the prepaid card has sufficient funds so that the member is reasonably able to use the card to obtain the medically necessary care that is unavailable through the Carrier's traditional provider network. Any member obligations for cost sharing under the card shall be clear and apparent to the member that uses the prepaid card, and cost-sharing for services covered by the prepaid card shall not be so great as to create a benefit that is not of genuine value to the member. The Division would consider that a Carrier may not be compliant with transgender care requirements if the Carrier requires a covered person to pay for the out-of-network care and then submit a request for reimbursement from the Carrier.

Carriers are reminded that the copay for all behavioral health services is regulated by federal parity regulations and can be no greater than the lowest copay used 50% or more of the time by plan members for services to treat medical conditions. Overall, Carriers must ensure that the obtaining and use of the prepaid card do not unreasonably burden the member's access to medically necessary covered Gender Dysphoria services.

Filing Requirements

As required under 211 CMR 52.05(7), Carriers are to submit material change materials - including the Carrier's Evidence of Coverage as described in 211 CMR 52.05(4)(i) - that are to be part of insured health coverage offered or renewed in Massachusetts. Carriers must explicitly state within their Evidences of Coverage that all medically necessary treatment for Gender Dysphoria is a covered service. Within its Evidence of Coverage, a Carrier is not permitted to state that cosmetic services are not covered, unless such a statement is qualified with an adjoining statement that an exception is for covered cosmetic services that are medically necessary for the treatment of Gender Dysphoria. Carriers must forward all form filings to update the Evidence of Coverage on file using SERFF (the System for Electronic Rate and Form Filing), with the SERFF Project Name: "Gender Dysphoria Coverage."

Carriers are expected to review and modify their utilization systems to ensure that requests for the required services are processed in accordance with the medically necessary requirements identified in M.G.L. c. 176O and 211 CMR 52.00, including required review of utilization requests within statutory timeframes, notification of all utilization review decisions, and notification to members regarding their rights to internal and external appeals when there has been an adverse determination of a request for services.

If you have any questions about Filing Guidance Notice 2025-N, please contact Niels Puetthoff at Niels.Puetthoff@mass.gov.