



State of New Jersey

DEPARTMENT OF BANKING AND INSURANCE

OFFICE OF THE COMMISSIONER

PO Box 325

TRENTON, NJ 08625-0325

TEL (609) 292-7272

PHIL MURPHY
Governor

SHEILA OLIVER
Lt. Governor

JUSTIN ZIMMERMAN
Acting Commissioner

BULLETIN NO. 23-05

TO: ALL INSURANCE COMPANIES AUTHORIZED TO ISSUE HEALTH BENEFITS PLANS, HOSPITAL SERVICE CORPORATIONS, MEDICAL SERVICE CORPORATIONS, HEALTH SERVICE CORPORATIONS, HEALTH MAINTENANCE ORGANIZATIONS, AND OTHER INTERESTED PARTIES

FROM: JUSTIN ZIMMERMAN, ACTING COMMISSIONER

RE: NONDISCRIMINATORY COVERAGE FOR HEALTH SERVICES PROVIDED TO TRANSGENDER INDIVIDUALS

The Department of Banking and Insurance (“Department”) is committed to ensuring that New Jersey residents do not face discrimination in accessing health coverage and health care. Regulated entities must comply with State and Federal laws against discrimination and cannot issue contracts, policies, or plans that discriminate or act to discriminate on the basis of a covered person’s or prospective covered person’s gender identity¹ or gender expression² or on the basis that the covered person or prospective covered person is a transgender person.³

Following Governor Philip J. Murphy’s issuance of Executive Order 326, Protecting Gender-Affirming Health Care in New Jersey, the Department is issuing this Bulletin to remind all insurance companies authorized to issue health benefits plans, hospital service corporations, medical service corporations, health service corporations, and health maintenance organizations, (collectively, “carriers”) of their obligations to provide and ensure nondiscriminatory coverage for transgender individuals. Specifically, this Bulletin sets forth guidance regarding the prohibitions against unfair discrimination in the issuance and administration of health benefits plans in this State, established by P.L. 2017, c. 176 (“Act”). Other applicable laws include: P.L.2019, c.58 (Requires coverage and parity for Mental Health Conditions), The Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act, 29 U.S.C. 1185a (MHPAEA), and the Patient Protection and Affordable Care Act, section 1557a (42 U.S.C. 18116).

¹ “Gender Identity” means a person’s internal sense of their own gender, regardless of the sex the person was assigned at birth. See P.L. 2017, c. 176.

² “Gender expression” means a person’s gender-related appearance and behavior, whether or not stereotypically associated with the person’s assigned sex at birth. Ibid.

³ “Transgender person” means a person who identifies as a gender different from the sex assigned to the person at birth. Ibid.

Regulated entities should note that this Bulletin shall not be interpreted to cover all possible acts of discrimination, and that the Department will examine any reported acts of discrimination to ensure compliance with State and Federal laws⁴.

Pursuant to the Act, which became effective on November 1, 2017, carriers are prohibited from discriminating on the basis of a covered person's or prospective covered person's gender identity or expression or on the basis that the covered person or prospective covered person is a transgender person. This prohibited discrimination includes, among other things, issuing or renewing health benefits plans containing provisions that discriminate, or act to discriminate, on the basis of a covered person's or prospective covered person's gender identity or gender expression or on the basis that the covered person or prospective covered person is a transgender person. Based upon these prohibitions, the Department will conclude that the following acts, if committed by carriers, would constitute unfair discrimination pursuant to the provisions of the Act and applicable laws:

- (1) Maintaining broad, blanket, or categorical exclusions, provisions, or definitions for transition-related care that effectively eliminate transition-related care from coverage⁵

A carrier may not utilize blanket, broad, or categorical exclusions, provisions, terminology, or definitions that effectively eliminate transition-related care from coverage under a health benefits plan. Determinations of medical necessity must comply with the Health Claims Authorization, Processing and Payment Act, P.L. 2005, c.352, ("HCAPPA").

Additionally, under the Act, carriers may not exclude coverage for a particular treatment for transition-related care.

- (2) Denying or limiting coverage or denying claims for health services for transition-related care if coverage is available for the same services for other types of care

A carrier may not deny coverage for medically necessary, transition-related care on the basis of the covered person's gender identity or gender expression or on the basis that the covered person is a transgender person if the covered person's health benefits plan provides coverage for the same services related to the treatment of other conditions or illnesses. Types of coverage include, but are not limited to, hormone therapy, hysterectomy, mastectomy, facial reconstruction, or vocal training.

Additionally, P.L. 2019, c. 58, which addresses coverage requirements for mental health conditions and substance use disorders, defined a "mental health condition" as any condition that is defined in the most current version of the Diagnostic and Statistical Manual of Mental Disorders, which is now the DSM-5. Among the many conditions identified in the DSM-5 is Gender Dysphoria.⁶ The Paul Wellstone and Pete

⁴ "Those laws include the New Jersey Law Against Discrimination, the Americans with Disabilities Act, the Rehabilitation Act of 1973, and the Affordable Care Act."

⁵ "Transition-related care" means any treatment or services related to gender transition or gender dysphoria. "Gender transition" means the process of changing a person's outward appearance, including physical sex characteristics, to accord with the person's actual gender identity."

⁶ The DSM-5 states that "gender dysphoria refers to the distress that may accompany the incongruence between one's experienced or expressed gender and one's assigned gender."

Domenici Mental Health Parity and Addiction Equity Act of 2008, 42 U.S.C. § 18031(j), generally requires coverage for mental health conditions subject to the same terms and conditions as applicable to other medical conditions and prohibits more restrictive qualitative and quantitative limitations.

(3) Denying or limiting coverage or denying claims for health care services that are ordinarily or exclusively available to individuals of one sex

Coverage of health care services that are ordinarily or exclusively available to individuals of one sex may not be denied or limited based solely upon the fact that the covered person is enrolled as belonging to the other sex or has undergone, or is in the process of undergoing, gender transition. The gendersex, gender expression or gender identity of the covered person, or the fact that the covered person is transgender, shall not prevent coverage for appropriate, medically necessary services that are rendered to that covered person. Carriers are prohibited from denying or limiting coverage or denying authorizations and claims for health care services that are typically or exclusively available to individuals of one sex solely on the basis that the covered person is enrolled as belonging to the other sex.

(4) Requiring extra payments or premiums for covered persons who are transgender persons

Carriers may not charge a surcharge or extra premium for covered persons who are transgender persons seeking transition-related care, or for covered persons based in whole or in part on the person's gender identity or expression. The classification of an individual as a transgender person is not a rating factor to be considered for underwriting purposes. Additionally, carriers cannot impose any requirements that covered persons or prospective covered persons seeking transition-related care pay additional out-of-pocket costs or incur expenses related to surgical or medical consultations that are not imposed for covered persons or prospective covered persons who are not transgender persons.

The Department also reminds carriers that the Act prohibits a carrier from treating a person's gender identity as a pre-existing condition for which coverage will be denied or limited. The Act also prohibits denying, cancelling, limiting or refusing to issue or renew a contract on the basis of a covered person's or prospective covered person's gender identity or expression, or for the reason that the covered person or prospective covered person is a transgender person.

Carriers should provide consumers with clear information about coverage of transition-related care, and clinical criteria guidelines related to medical necessity determinations must be posted on the carrier's website, as set forth in N.J.S.A. 17B:30-51(a)(1). Carriers may not apply a different medical necessity review process, or impose extra documentation requirements, for transgender individuals relative to other individuals seeking the same or similar services.

Lastly, in order to ensure coverage is available to a transgender person on the same terms as other covered persons, carriers must ensure that there is an adequate network of health care providers that will provide all covered services to the covered person regardless of the covered person's gender identity or gender expression, or whether the covered person is a transgender person.

The Department expects all carriers to comply with Federal and State laws and any carrier that violates the requirements of Federal or State law, including the Act, may be subject to enforcement action.

Should you have any questions, please contact the Department's Life and Health Unit at lifehealth@dobi.nj.gov.

June 28, 2023
Date



Justin Zimmerman
Acting Commissioner

AV Transgender Discrimination Bulletin/Bulletins