

Exhibit 39



North Carolina
State Health Plan
 FOR TEACHERS AND STATE EMPLOYEES



**Affordable Care Act – Section 1557 Requirements
 Coverage for Gender Dysphoria**

Board of Trustees Meeting

December 2, 2016

A Division of the Department of State Treasurer

Gender Dysphoria Condition and Treatment



Gender Dysphoria: Diagnostic Criteria

- DSM-5 criteria for a diagnosis of gender dysphoria
 - A marked incongruence between one's experienced/expressed gender and assigned gender, of at least six month's duration
 - The condition is associated with clinically significant distress or impairment in social, occupational, or other important areas of functioning.
- The critical element of gender dysphoria is the presence of **clinically significant distress** associated with the condition.
- The term gender dysphoria replaced the term gender identity disorder used in an earlier version of DSM.
 - Per the American Psychiatric Association, replacing "disorder" with "dysphoria" in the diagnostic label is more appropriate and removes the connotation that the patient is "disordered."

Standards of Care for Gender Dysphoria

- The World Professional Association For Transgender Health (“WPATH”) established internationally accepted Standards of Care for providing medical treatment for people with Gender Identification Disorder (GID)
- Includes mental health care, hormone therapy and sex reassignment surgery
- Real-life experience: The act of fully adopting a new or evolving gender role for the events and processes of everyday life is known as the real-life experience. It is essential to the transition process to the gender role that confirms with personal gender identity
- Defines eligibility and readiness criteria for treatment.
- Aims to help reduce or remove the distressing feelings of a mismatch between biological sex and gender identity.

WPATH Standards of Care:

Criteria for Gender Confirmation Surgery

1. The patient has been diagnosed with gender dysphoria, including meeting all of the following indications:
 - a) The desire to live and be accepted as a member of the opposite sex
 - b) The gender identity dysphoria is not a symptom of a mental disorder or a chromosomal abnormality
 - c) The gender identity dysphoria causes clinical or social distress or impairment in social, occupational, or other important areas of functioning.
2. The candidate has completed a minimum of 12 months of successful continuous full time real life experience in their new gender, with no returning to their original gender.
3. If the candidate does not meet the 12 month time frame criteria, the treating clinician must submit information indicating why it would be clinically inappropriate to require the candidate to meet these criteria.

American Medical Association Resolution 122

(Removing Financial Barriers to Care for Transgender Patients)

- Issued in 2008
- Described the WPATH Standards of Care elements of care for transgender people as a “**medical necessity**” .
- “Delaying treatment for GID can cause and/or aggravate additional serious and expensive health problems, such as stress-related physical illnesses, depression, and substance abuse problems, which further endanger patients’ health and strain the health care system.”
- “If left untreated, can result in clinically significant psychological distress, dysfunction, debilitating depression and, for some people without access to appropriate medical care and treatment, suicidality and death.”

Additional National Medical Organization Endorsements

- **American College of Physicians Position Statement**

“The American College of Physicians recommends that public and private health benefit plans include comprehensive transgender health care services and provide all covered services to transgender persons as they would all other beneficiaries.”

- **American College of Obstetricians and Gynecologists Committee Opinion**

- Obstetrician–gynecologists should be prepared to assist or refer transgender individuals.
- Physicians are urged to eliminate barriers to access to care for this population through their own individual efforts.
- The American College of Obstetricians and Gynecologists urges health care providers to foster nondiscriminatory practices and policies to increase identification and to facilitate quality health care for transgender individuals, both in assisting with the transition if desired as well as providing long-term preventive health care.

ACA Section 1557 Requirements



Final Rule Implementing Section 1557 - Nondiscrimination in Health Programs and Activities

- Section 1557 prohibits discrimination based on race, color, national origin, sex, age or disability in certain health programs and activities.
- Section 1557 has been in effect since the enactment of the ACA in 2010 and the HHS Office for Civil Rights (OCR) has been enforcing the provision since it was enacted.
- The rule applies to any health program or activity, any part of which receives funding from HHS. (The Plan receives a Retiree Drug Subsidy)
- To the extent the rule requires changes to health plan benefit design, such provisions have an applicability date of the first day of the first plan year beginning on or after January 1, 2017.

Risks of Noncompliance

- The Department of Health and Human Services (HHS) Office of Civil Rights (OCR) is responsible for accepting and investigating Section 1557 complaints.
- Failure to correct noncompliance may result in:
 - Suspension of, termination of, or refusal to grant or continue to grant Federal financial assistance, i.e. loss of Retiree Drug Subsidy;
 - Referral to the Department of Justice to enforce compliance;
 - Civil action filed by an individual to challenge a Section 1557 violation.

Protections Under the Rule

- **Prohibits sex discrimination in health care**
- Requires that women be treated equally with men in the health care they receive and also prohibits the denial of health care or health coverage based on an individual's sex, including discrimination based on pregnancy, gender identity, and sex stereotyping.
- The final rule also requires covered health programs and activities to treat individuals consistent with their gender identity.

Protections Under the Rule

- **Individuals with Disabilities**
 - Requires covered entities to make all programs and activities provided through electronic and information technology accessible; to ensure the physical accessibility of newly constructed or altered facilities; and to provide appropriate auxiliary aids and services for individuals with disabilities.
 - Covered entities are also prohibited from using marketing practices or benefit designs that discriminate on the basis of disability and other prohibited bases.

Protections Under the Rule

- Limited English Proficiency
 - Covered entities must take reasonable steps to provide meaningful access to each individual with limited English proficiency eligible to be served or likely to be encountered in their health programs and activities.
 - In addition, covered entities are encouraged to develop and implement a language access plan.

Procedural Requirements

- Requires covered entities with 15 or more employees to have a grievance procedure and a compliance coordinator. *Completed*
- Covered entities must post notices of nondiscrimination and taglines that alert individuals with limited English proficiency to the availability of language assistance services. OCR has translated a sample notice and taglines for use by covered entities into 64 languages. *Completed/Ongoing*
- Taglines must be posted in at least the top 15 non-English languages spoken in the State in which the entity is located or does business. *Completed/Ongoing*

Discriminatory Actions

- The following actions, based on an individual's race, color, national origin, sex, age, or disability, are considered discriminatory under the rule:
 - Denying or limiting health coverage;
 - Denying a claim;
 - Employing discriminatory marketing or benefit designs; and
 - Imposing additional cost sharing.
- The final rule does not define benefit design or require coverage of specific services. However, it makes clear that denying coverage of transition-related services on the basis that those services are not medically necessary will be subject to “careful scrutiny” and that blanket exclusions of transgender services as “cosmetic” or “experimental” are “outdated and not based on current standards of care.”

Survey of State Coverage for Gender Dysphoria



State-by-State Response to 1557 Compliance

- Plan staff conducted basic research and outreach to other state employees' health plans to get a sense of the prevailing actions related to Section 1557
- Numerous states have previously enacted laws or regulations to prohibit discrimination related to medical procedures/treatments for gender transition or gender dysphoria – these states *may* already be in compliance with 1557
- Several state plans have taken action to ensure full compliance with 1557 in calendar year 2017
- A number of other state plans have chosen to follow compliant coverage policies adopted by third-party administrators
- Other states have not yet taken any action due to a fiscal benefit year
- While the Plan has been able to collect anecdotal evidence across multiple states, we are not able to make conclusive statements about nationwide compliance

State-by-State Summary

States with pre-existing laws prohibiting discrimination	States taking action to comply with 1557	States adopting TPA policies for 1557 compliance	States taking no action to comply with 1557 or undecided
California Colorado Connecticut Delaware District of Columbia Illinois Maryland Massachusetts Nevada New York Oregon Rhode Island Vermont Washington	Arkansas Indiana New Jersey Virginia Wisconsin	Kentucky New Hampshire Tennessee Wyoming	Alaska Georgia Louisiana New Mexico South Carolina

Proposed Benefit Change



Currently No Coverage under the State Health Plan

The current benefits provide blanket exclusions for treatment of gender dysphoria as follows:

- Treatment or studies leading to or in connection with sex changes or modifications and related care are excluded from coverage.
- Psychological assessment and psychotherapy treatment in conjunction with proposed gender transformation are excluded.

Cost of Coverage

- The Segal Company estimates that adding coverage for gender dysphoria will cost approximately \$350,000 to \$850,000 annually.
- A memo from The Segal Company in support of this estimate is included in the appendix.

Utilization Management

- As allowed by §138-48.30(a)(8), utilization management policies would apply to transition surgery and hormone therapy.
- BCBSNC's medical policy is included in the appendix and includes the following requirements in support of medical necessity:
 - Candidate must be 18 years of age; and
 - Has been diagnosed with Gender Identification Disorder (GID) and the new gender identity has been present for at least 24 months; and
 - Has undergone a minimum of 12 months continuous hormonal therapy; and
 - Has completed 12 months of successful continuous full time real-life experience in their new gender; and
 - There is provider documentation attesting to the psychological aspects of the candidates GID and that eligibility criteria for transition surgery have been met.

Recommended Coverage

Plan staff recommends approval of coverage for the treatment for gender dysphoria as follows:

- Removing the blanket exclusions resulting in the provision of medically necessary services for the treatment of gender dysphoria.

Appendix

1. BCBSNC Corporate Medical Policy
2. The Segal Company: Transgender Cost Estimate Memorandum
3. The Segal Company: Transgender Cost Estimate Memorandum Attachment