Center for American Progress

FAQ: Health Insurance Needs for Transgender Americans

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Transgender people face tough realities across the United States in routine areas of life that most people take for granted, including rights to employment, housing, and personal safety. Health care, particularly health insurance coverage, is another area where transgender people routinely experience serious and potentially life-threatening discrimination on the basis of gender identity.

- Transgender people are more likely to be without health insurance than nontransgender people.[1]
- Transgender people of color are especially impacted by insurance discrimination—one in every three black transgender respondents in a nationwide survey of more than 6,400 transgender people reported being uninsured.[2]
- Nearly half of transgender survey respondents reported delaying seeking care when they were sick or injured because of inability to afford treatment.[3]
- Even if transgender people have health insurance coverage, most policies contain transgender-specific exclusions that deny them coverage routinely provided to nontransgender people.[4]

To ensure that transgender people can access the care they need to stay healthy, insurers need to be held to appropriate standards of nondiscrimination, and health plan benefit designs must be based on medical science and sound actuarial data rather than on outdated assumptions.

This FAQ provides information on transgender health issues and the obstacles that transgender people face in accessing insurance coverage for even the most basic health care needs.

Who are transgender people?

A transgender person is someone whose internal sense of gender, also known as "gender identity," is different from what is typically associated with his or her assigned sex at birth. Let's take, for example, a person who was assigned female at birth but who lives and identifies as male: This person is a transgender man.

Some transgender people need to take social, legal, and/or medical steps to outwardly affirm their gender identity. These steps might include changing their name, changing the sex designation on personal identification documents, dressing in a way typically associated with a different gender, or undergoing medical treatment to transition from one gender to another. These medical services may include mental health services, hormone therapy, and surgery, but the exact steps involved in transition are different for every person.

What are the health care needs of transgender people?

Transgender people require much of the same medical care that is provided to nontransgender people. Transgender people need acute care when they are sick and preventive care to keep from becoming ill, including services that are traditionally considered to be gender specific—such as Pap smears, prostate exams, and mammograms. Transgender patients may require a mix of such screenings. Medically necessary preventive screenings for a transgender woman, for example, may include both a mammogram and a prostate exam.

Transgender people who use medical treatments as part of gender transition also require access to many of the same services that are regularly provided to nontransgender people. The same hormone therapy used in gender transition, for example, is provided to patients with endocrine disorders and to women with menopausal symptoms.

Are services related to gender transition medically necessary?

Yes. Major expert associations agree that transition-related medical services, including mental health services, hormone therapy, and surgery, are medically necessary for many transgender people. The American Medical Association; the American Psychological Association; the American Psychiatric Association; the American Academy of Family Physicians; the American Congress of Obstetricians and Gynecologists; the Endocrine Society; the National Association of Social Workers; and the World Professional Association for Transgender Health have all issued public statements to this effect. According to these expert associations, determination of the medical necessity of any particular transition-related service for an individual patient properly rests with medical providers, not insurance companies.

Do insurance plans usually cover care for transgender people?

Unfortunately, despite significant advances, many insurers continue to rely on outdated assumptions about transgender people to justify discriminatory transgender-specific exclusions in their policies.

Still, the trend of offering nondiscriminatory, comprehensive coverage for transgender people is growing. An increasing number of health insurers are offering plans without transgender-specific exclusions, and many are also including affirmative statements of coverage for treatments needed for gender transition.

Some of the insurers offering inclusive plans include Aetna, Blue Cross Blue Shield, Cigna, Kaiser Permanente, and UnitedHealthcare. Many employers are also offering comprehensive coverage to their transgender workers. Currently, more than 25 percent of Fortune 100 employers, including Kraft Foods, Microsoft, and Nike, offer equal coverage for their transgender employees.[5]

What are transgender-specific exclusions?

Many health insurers specifically target the transgender population for denial of services provided to nontransgender people under the same plan. In some instances these exclusions apply only to surgical treatments while permitting coverage for other benefits, such as mental health services and hormone therapy. In many cases, however, the exclusions are sweeping, excluding, for example, coverage of any "services, drugs, or supplies related to sex transformation."[6]

Transgender-specific exclusions are unacceptable on both medical and ethical grounds. They arbitrarily target transgender people for discrimination by forcing them to pay out-of-pocket for the same medically necessary services provided to nontransgender people.

As discussed above, many medical services needed by transgender people during transition and at other points in their lives are part of the course of care required for other medical conditions and are routinely covered by health insurance plans. Hormone therapy, for instance, may be utilized for patients with low testosterone or estrogen levels or other endocrine disorders. Preventive care services such as pelvic or prostate exams are an important part of an overall health regimen for all individuals, while various surgeries and reconstructive procedures are commonly covered for treating injuries and intersex conditions, or for cancer treatment or prevention.

Moreover, insurers frequently expand such exclusions in practice to deny transgender people coverage for basic services that are unrelated to gender transition. Take the outrageous example of a transgender woman in New Jersey who was denied coverage

for a mammogram on the basis that it fell under her plan's sweeping exclusion for all treatments "related to changing sex." It took a two-year appeal process and intervention from the Transgender Legal Defense and Education Fund before the insurer agreed that the exclusion had unfairly prevented her from receiving medically necessary care and reimbursed her for the mammogram.[7]

Are insurers being honest when they classify transition-related care as "experimental" or "cosmetic"?

No. The idea that transition-related care is experimental or cosmetic reflects assumptions that are out of step with medical knowledge. For more than half a century, medical professionals have researched and provided care to support gender transition that is safe, effective, and necessary for many people. The American Medical Association has specifically rejected classifying transition-related care as either experimental or cosmetic, and the U.S. Tax Court has likewise held that transition-related care is not cosmetic.[8]

If transgender exclusions are removed from a plan, does it then have to cover any service provided to a transgender patient?

No. Removing transgender exclusions simply recognizes that coverage determinations and benefits design must be based on medically and actuarially sound principles, rather than on outdated assumptions. Removing transgender-specific exclusions also does not prohibit plans from denying coverage for services that are not medically necessary, that are experimental, or that are comparatively more expensive than other treatments.

If exclusions for transition-related care are removed from an insurance plan, does that create a new set of benefits that must be covered?

No. Eliminating discriminatory benefits exclusions does not mandate coverage for a new set of services in addition to those already covered by a given plan. Removing these exclusions guarantees that transgender people will be able to get equal coverage for the same medically necessary services that are covered for nontransgender people. The only requirement that would be placed on insurers is common sense: They must base their coverage determinations on sound medical and financial grounds rather than on arbitrary discrimination against transgender people.

Will removing exclusions for transition-related care increase costs?

No. The California Department of Insurance released an economic impact assessment in April 2012 comparing the costs and benefits of a California law prohibiting insurance discrimination against transgender people. The Department concluded, "the benefits of eliminating discrimination far exceed the insignificant costs," and that there was an "immaterial" impact on premium costs.

Actuarial projections of the cost of removing exclusions frequently employ incorrect assumptions about cost and utilization. In 2001 the city of San Francisco, for example, removed transgender-specific exclusions from the coverage it offers to its employees and introduced a rider for medically necessary care related to gender transition. To meet the high cost projections, which were based on faulty expectations of a large number of transgender people requiring numerous surgical procedures, the city charged $1.70 more per month for each enrollee. Over the next several years, the city experienced a net surplus resulting from the premium increase: From 2001 to 2006 San Francisco collected $5.6 million in excess premiums and paid out only $386,417 on 37 claims. As a result, the rider was dropped and the city affirmed coverage for medically necessary transition-related care as part of its core benefit package.[9]

Other jurisdictions covering transition-related care have had similar experiences. In 2011 the city of Portland determined that the cost of offering equal coverage for transgender employees would only amount to .08 percent of the city health insurance budget, and the city now provides these benefits to its employees.[10]

Are there benefits to removing transgender-specific exclusions?

Yes. Removing transgender-specific exclusions improves the health of transgender people. The California Department of Insurance assessment found improved outcomes for some of the most significant health problems facing the transgender population, including reduced suicide risk, lower rates of substance abuse, improved mental health outcomes, and increased adherence to HIV treatment regimens. Removing exclusions is also important for employers, as it helps attract and retain a diverse and talented workforce, increases employee comfort and productivity, and eliminates time wasted on time-intensive appeals and negotiations regarding reimbursement for health care services.

Right now, arbitrary and outdated insurance exclusions are preventing transgender people from accessing the health care they need to be safe, happy, and whole. But it doesn't have to be like this. All it takes to help end insurance discrimination against transgender people is a simple change that doesn't impact the bottom line, but that makes a world of difference for transgender people.

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Endnotes

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