Transgender Health Care

Ashton Nichols

Youngstown State University

Abstract

The transgender population is gaining acceptance and rights around the world. Despite recent legal and social improvements for individuals with gender dysphoria- a condition categorized as a incongruence between mental perception of gender and biological sex of an individual- insurance companies in the United States still refuse coverage of transgender healthcare such as hormone therapy and surgical procedures to transition. The transgender community has some of the highest suicide and depression rates of the population, and for many trans individuals, medical transition is not a choice, but rather a matter of life and death. Recent studies have found both the necessity of transitong, the mental health benefits experienced by post-transitions trans individuals, and the cost of foregoing translation. Additionally, studies have proven the cost-effectiveness of covering trans-specific healthcare and procedures.

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In recent decades, the prevalence of transgender people- individuals who experience an incongruence between their gender identity and sex assigned at birth resulting in gender dysphoria, or negative thoughts and feelings surrounding their secondary sex characteristics leading to significant psychological damage- is becoming more well known and accepted. Despite legal strives to protect transgender people from discrimination based on their gender identity as well as social efforts to create better understanding of this marginalized community, there are still many hurdles faced by trans men and women in their daily lives. One of the most impactful of these is the lack of medical coverage from insurance companies in regard to transgender health services, such as hormone therapy and reassignment surgeries. For many transgender people, gender reassignment therapies are quintessential aspects of transitioning, and highly necessary to promote both good physical and mental health.

In regards to medical treatment, it is important to define what being transgender actually is. In this case, it will not refer to simply going outside of male and female gender roles, but rather defined by the presence of gender dysphoria. According to the *Diagnostic and Statistical Manual of Mental Disorders* (the DSM-5) gender dysphoria is defined as, “clinically significant distress that, for many transgender people, accompanies a profound misalignment between gender identity and assigned sex at birth”. This inclusion of dysphoria classifies being transgender a medical issue, much in the same way that being autistic, having depression, or experiencing Post Traumatic Stress Disorder are, and as such shows that treatment is in the best interest of patients. In the article “The Future of Transgender Coverage”, Kellan E. Baker explains, “The current standard of care for treating gender dysphoria is gender transition, which may include mental health counseling, hormone therapy, and reconstructive surgeries affecting primary and secondary sex characteristics” (2017, p. 1801). Being the standard of care, medical transition is considered by mental health professionals to be a completely medically necessary procedure rather than a choice.

The reason that healthcare is such a huge issue for the trans community overcome from the price of gender reassignment therapies when payed out of pocket, which can be in the tens to hundreds of thousands of dollars. When comparing the treatment of gender dysphoria through gender reassignment therapies to the treatment of mental and physical illnesses associated with not transitioning, it quickly becomes clear that covering transgender health services is not only in the best interest of trans men and women, but also in the best interest of insurance companies. Pre-transition trans individuals have some of the highest rates of suicide attempts (both successful and unsuccessful), self-harm, drug abuse, and HIV, all of which stem from untreated gender dysphoria. The DSM-5 recommends surgical and hormonal transition for trans patients for this exact reason. As the trans community becomes more present and accepted, insurance companies must take into consideration the care of these individuals, and the cost of denying them these medically necessary services.

In the peer reviewed “Prescribing for Transgender Patients” Louise Tomlins, a sexual health physician, addresses the definition of dysphoria in line with the DSM-5, then using it to explain the protocol in place to make sure that only trans people facing dysphoria are getting this form of treatment, rather than those confused or experimenting with their identity. According to the World Professional Association for Transgender Health, “medical treatment should only occur after a thorough psychosocial assessment has been undertaken by a clinician experienced in the field” (Tomlins, 2019, p. 10). This protocol of requiring a diagnosis before being able to medically transition is a safeguard put in place to prevent people who do not experience dysphoria from transitioning, making things safer not only for them but also by showing the medical importance of transitioning. This also addresses the idea of “detransitioners”; or people getting gender reassignment therapy only to regret it and wanting to go back to their original gender, which is a common misconception sensationalized by media and the non-trans public. This very rarely occurs in trans people with dysphoria, as explained in a gender dysphoria study performed by CM Wiepjes and associates over a course of 42 years, whose findings state “Only 0.6% of transwomen and 0.3% of transmen who underwent [surgical transition] were identified as experiencing regret” (Wiepjes CM et. al, 2018). Tomlins also explains that very similar treatments such as breast augmentation and hormone therapy, are in fact covered by insurance companies for breast cancer patients, postmenopausal women, and hypogonadal men; If these same therapies can be provided for cisgender individuals with insurance coverage, why can they not be covered for transgender individuals with diagnosed dysphoria?

There is fear that extending insurance coverage to gender reaffirming therapies would be a large toll on insurance companies, but this fear has no real grounds. In the research study “Exploring Rates of Transgender Individuals and the Mental Health Concerns in an Online Sample” findings show that “the prevalence estimate of individuals identifying as transgender was 0.8%” (Dawson et. al, 2017, . 295). This study shows that less than 1% of the population identifies as transgender, and with such a small population, the financial burden on insurance companies would be practically non-existent. If you take into regard the population of women diagnosed and treated for breast cancer, which is around 12%, it would make no large impact to cover transgender care. This is further backed up by the 2016 research study “Societal Implications of Health Insurance COverage for Medically Necessary Services in the U.S. Transgender Population: A Cost-Effectiveness Analysis”, which looks into the financial side of transgender coverage. The findings show that transgender coverage is extremely cost effective and that the overall coverage cost would be less than one cent per month per member:

“Compared to no health benefits for transgender patients ($23,619; 6.49 QALYs), insurance coverage for medically necessary services came as a greater cost and effectiveness ($31816; 7.37 QALYs), with an incremental cost-effectiveness ratio (ICER) of $9314/QALY. The budget impact of this coverage is approximately $0.016 per member per month. Although the cost for transition is $10,000-22,000 and the cost of provider coverage is $2175/year, these additional expenses hold value for reducing the risk of negative endpoints-- HIV, depression, suicidality, and drug abuse” (Padula et. al, 2016, p. 394).

This study concludes by finding a cost-effectiveness of 85%, showing that coverage of transgender services has a “low budget impact on U.S. society” (Padula et. al, 2016, p. 394).

Most important in transition is the mental health benefit; as dysphoria is a mental condition, it is greatly linked to other mental illnesses such as depression, anxiety, self-harm, and suicidal ideation. In fact, transgender individuals have some of the highest suicide rates (in bot attempts and success) in any given population. In “Exploring Rates of Transgender Individuals and the Mental Health Concerns is an Online Sample”, researchers found that “individuals identifying as transgender were significantly more likely than individuals identifying as men or women to report having had a single diagnosis or co-occurring diagnosis for all three disroders examined [depression, anxiety, and ADHD]” (Dawson et. al, 2017, p. 295). All three of these conditions have treatments, including therapeutic and pharmaceutical, that are covered by insurance companies. It is often found that depression and anxiety rates go down when transition is sought out; therefore, transitioning would potentially lessen the cost being put into mental healthcare.

And lastly is the physical cost chest binding- the act of using restricting bandaging, fabric, or clothing to make the chest look flat, commonly used in trans males and masculine-presenting non binary folk, and according to the research team of Sarah Peitzmeier, “for many transmasculine people, chest binding is considered a necessity rather than elective” (2017, p. 65). Additionally she adds, that “nearly all respondents have experienced one negative health effect” (Peitzmeier et. al, 2017, p.68)which ranges from dermatological issues, lung issues including bruising and gas buildup (pneumothoraces), and infection of the lungs. All of the following can be life threatening, and are expensive to treat, making surgery cheaper and safer in the long run.

It may be argued that people may come to regret their transitioning and the irreversible changes made to their bodies. However, with the current DSM-5 safeguards in place, requiring at least 18 months of consistent diagnosed dysphoria, this is rarely the case. Most cases of “detransitioners” or people who come to regret their decision of transitioning, have gotten surgery and/ or hormones early on, without having certain dysphoria. Additionally, many others will argue that transitioning is but an optional and cosmetic procedure, much like elective plastic surgeries such as rhinoplasty and breast augmentation among cisgender females. While some procudeures in the treatment of transgender patients may be very similat to elective cosmetic surgeries, such as top-surgery and genitoplasty, these procedures are documented in the DMS-5 as being very important to the mental health of transgender patients. And with the inclusion of dysphoria and it’s treatment in the fifth version of the DSM, insurance companies have little to no reason to decline coverage of transgender treatments such as hormones and surgery. According to the “DSM-5: Frequently Asked Questions” on the American Psychiatric Association’s website, “[the] *DSM–5* is completely compatible with the HIPAA-approved *ICD-9-CM* coding system now in use by insurance companies”; this means that conditions covered by the DSM-5 as diagnosable and treatable follow the same criteria as the current coding system universally used by American Insurance Companies. If conditions such as anorexia nervosa, suicidal ideation, self-harm, psychosis, and other mental illnesses and disorders that cause distress to the patient are covered through treatment through both in and outpatient centers as well as psycho-pharmaceuticals, why should gender dysphoria be any different? Some would argue that as the treatment is largely physical while other psychiatric conditions are treated through medications. However, psycho-pharmaceuticals work by changing or regulating the chemical balances and signals of the brain; some common ways that these drugs function is through the increase or inhibition of serotonin and dopamine production. Hormones are but another chemical in the brain that are also present throughout the body, so the changes made through hormone therapy are very much comparable to those made through the use of psychiatric medication.   
 In short, the transgender population is making strives in both acceptance and rights given, but insurance coverage is still very limited and scarce, especially in the United States. This poses a great risk to an already marginalized group, as unalleviated dysphoria, a diagnosable and treatable psychiatric condition, correlates greatly with higher rates of depression, anxiety, self-harm, adn suicide. Multiple studies have been conducted showing the importance of transgender healthcare, and others have found that the it is extremely cost-effective for insurance companies to cover these treatments. Similar physical and mental health conditions are covered; these include mental illnesses such as depression, anxiety, and suicidal ideation, as well as common physical illnesses like post-breast cancer treatments and hormone therapies in cisgender patients. The number of transgender individuals has continued to be proven as a small portion of the population, and even fewer (less than 2%) come to regret physical transition. The DSM-5 not only provides guidelines for both diagnosis and treatment procedure, but also matches the guidelines used by insurance companies to approve coverage. With this in mind, it is in the best interest of insurance companies both ethically and financially to provide coverage of medical transition for transgender patients.

Annotated Bibliography

Baker, K. (2017). The Future of Transgender Coverage. *New England Journal of Medicine, Vol. 376* (Issue 19), p. 1801-1804. DOI: 10.1056/NEJMp1702427

“The Future of Transgender Coverage” by Kellan E. Baker supports the idea of insurance companies covering the cost of transgender therapies and surgeries. Baker analyzes the increase in transgender health insurance coverage in the United States, including the medical necessity of transition as well as the benefits to both the economic system and transgender individuals as a whole. The definition of gender dysphoria and its significance in accordance to the DSM-V is explained, as well as the common physical and mental health issues associated with it. The common consensus among mental health professionals in regards to transgender services- that being that medical transition is completely medically necessary- is explained. Baker then goes into the legality of transgender insurance rights, in regards to discrimination and services offered to cisgender individuals. To support his argument, Baker gives information on States such as California that have mandated insurance companies to provide transgender health care. Lastly, Baker speaks of the economic findings of these transgender-supportive states and explains that there have been minimal to no negative financial impacts associated with transgender health coverage.

“The Future of Transgender Coverage” is a secondary source. I know this because throughout the article, Baker compiles information to support his case. One example of this is in her quoting the California Department of Insurance in, “the benefits of eliminating discrimination far exceed the insignificant cost” (Baker, 2017, p. 1801). Baker is biased in his argument due to his views on the LGBT Community: as a Senior Fellow with the LGBT Research and Communications Project at the Center for American Progress, Baker will naturally advocate for transgender rights. Despite this, he does do a decent job in instead using information from both governmental and mental health professionals to make his point, rather than relying on his own opinions and emotional appeal. The only time where he allows his own views to bleed into the article is in the final paragraph. This article supports my topic, as it points out the medical necessity to transition, as explained by mental health professionals, as well as addressing both the personal health benefits that come to the community through transgender health coverage and the lack of a negative financial impact associated with extended transgender coverage. In regards to professional views on transition, Baker explains the current standard treatment of gender dysphoria in accordance to the DSM-V including mental health care, hormone replacement therapy, and gender reassignment surgeries. Baker additionally includes information on the state of California, which has extended health insurance to cover transgender services and has seen little to no negative effects in doing so.

Dawson, A., Wymbs, B., Gidycz, C., Pride, M., Figueroa, W. (2017). Exploring Rates of Transgender Individuals and Mental Health Concerns in an Online Sample. *International Journal of Transgenderism, Vol. 18* (Issue 3), p. 295-304. DOI: 10.1080/15532739.2017.1314797

“Exploring Rates of Transgender Individuals and the Mental Health Concerns in an Online Sample” by Anne E. Dawson et. al is a research study showing both the number of trans individuals as well of the rates of three mental illnesses (depression, anxiety, and attention-deficit/ hyperactivity disorder) in trans individuals as well as non-trans men and women. The findings of this study show the actual percent of transgender individuals, which is less than 1% of the population. This percentage shows that the actual number of those who identify as transgender is actually a rather small portion of the population, under one percent. Despite the small percent of trans individuals among the population, the study found disproportionately high levels of mental illness among transgender individuals. The conclusion of this study states, “Given the prevalence of transgender individuals and the associations with common mental health conditions, clinicians must be informed and competent to care for their clinical needs” (Dawson et. al, 2017, p. 295).

“Exploring Rates of Transgender Individuals and the Mental Health Concerns in an Online Sample” is a primary source, as it is simply stating the findings of a research study. The article itself only consist of an abstract explaining what was being tested, the results, and a conclusion based on the findings, as well as the data collected. As a research study, there is no bias, since everything in it is based on hard numbers rather than being able to fall under one specific opinion. Being from 2017, this article is still relevant and credible. It supports my topic, as the findings of this study show that the actual number of transgender people is extremely small in our population. With less than 1% of the population being transgender, the burden put on insurance companies by covering the medical expenses of transgender services would be extremely small, therefore not being a financial issue.

Tomlins, L. (2019).Prescribing for Transgender Patients. *Australian Prescriber, Vol. 42* (Issue 1), p. 10-13. DOI: 10.18773/austprescr.2019.003

“Prescribing for Transgender Patients” by Louise Tomlins covers the list of transgender therapies as well as some basic guidelines for treatment. She starts off with defining what it means to be transgender, explaining the discrepancy of gender identity and sex assigned at birth as well as the presence of gender dysphoria. She further explains the treatment of gender dysphoria, “many require masculinising or feminising hormones and in some cases surgery to address the psychological distress of their gender dysphoria” (Tomlins, 2019, p. 10) before further explaining the necessary procedures before medical transition can be started in accordance to the World Professional Association for Transgender Health. This pre-transition protocol is followed up by an explanation of the different medical transition options, including hormone therapies and gender reassignment surgeries, of both trans men and women.

“Prescribing for Transgender Patients” is a primary source, written by a medical professional for medical professionals in a peer-reviewed journal. Given the author, Louise Tomlins, is a sexual health physician and general practitioner writing in a medical journal for other medical professionals, there is no bias, only factual information within the article. This article is from February of 2019 and is peer-reviewed, making it extremely credible. “Prescribing for Transgender Patients” supports my topic, as it covers not only the medical necessity of transitioning, but also the protocol for pre-transition treatment. Tomlins compares “gender-affirming therapy” to the treatment of postmenopausal women and hypogonadal men throughout the article, two common ailments currently covered by most insurance companies. With this comparison, it strengthens the argument that transgender therapies should also be covered.

Padula, W., Heru, S., Campbell, J. (2016). Societal Implications of Health Insurance Coverage for Medically Necessary Services in the U.S. Transgender Population: A Cost-Effectiveness Analysis. *Journal of General Internal Medicine, Vol. 31* (Issue 4), p. 394-401. DOI: 10.1007/s11606-015-3529-6

“Societal Implications of Health Insurance Coverage for Medically Necessary Services in the U.S. Transgender Population: A Cost-Effectiveness Analysis” by William Padula et. al is a research study of the cost-effectiveness of Insurance companies covering transgender services. “The Massachusetts Group Insurance Commission (GIC) prioritized research on the implications of a clause expressly prohibiting the denial of health insurance coverage for transgender-related services. These medically necessary services include primary and preventive care as well as transitional therapy.” (Padula et. al, 2016, p. 394). The findings of this study show that it is more cost effective for insurance companies to provide coverage for transgender services, with the overall cost being less than one cent a month per member and the reduction of related and covered negative medical issues. “Compared to no health benefits for transgender patients ($23,619; 6.49 QALYs), insurance coverage for medically necessary services came at a greater cost and effectiveness ($31,816; 7.37 QALYs), with an incremental cost-effectiveness ratio (ICER) of $9314/QALY. The budget impact of this coverage is approximately $0.016 per member per month. Although the cost for transitions is $10,000-22,000 and the cost of provider coverage is $2175/year, these additional expenses hold good value for reducing the risk of negative endpoints--HIV, depression, suicidality, and drug abuse” (Padula et. al, 2016, p. 394). The overall findings of this study show that it is in fact more cost-effective for insurance companies to cover transgender services, “The probabilistic sensitivity analysis showed that provider coverage was cost-effective in 85% of simulations” (Padula et. al, 2016, p. 394).

“Societal Implications of Health Insurance Coverage for Medically Necessary Services in the U.S. Transgender Population: A Cost-Effectiveness Analysis” is a primary source. As a research study, it is all based on hard numbers, with no influence from personal opinions. As a research study, there is additionally no bias. being from 2016, this study is still credible. “Societal Implications of Health Insurance Coverage for Medically Necessary Services in the U.S. Transgender Population: A Cost-Effectiveness Analysis” supports my topic, as it shows the benefits insurance companies would face if they covered gender transition. “Health insurance coverage for the U.S. transgender population is affordable and cost-effective, and has a low budget impact on U.S. society” (Padula et. al, 2016, p. 394).

Peitzmeier, S., Gardener I., Weinand, J., Corbet, A., Acevedo, K. (2017). Health Impact of Chest Binding Among Transgender Adults: a Community-Engaged, Cross-Sectional Study. *Culture, Health & Sexuality, Vol. 19* (Issue 1), p. 64-75. DOI: 10.1080/13691058.2016.1191675

“Health Impact of Chest Binding Among Transgender Adults: a Community-Engaged, Cross-Sectional Study” by Sarah Peitzmeier et. al is a research study surrounding the prevalence and health risks of chest binding. The importance and view of chest binding in the eyes of transgender men is explained, as well as the use of binding to ease dysphoria when top surgery is not a feasible option. “For many transmasculine people, chest binding is considered a necessary rather than elective daily activity due to associated mental and emotional health benefits. For transmasculine people who desire chest reconstructive surgery ('top surgery') binding it typically used as an interim measure until surgery can be obtained” (Peitzmeier et. al, 2017, p. 65). Possible health risks, including overall pain, dermatological issues, lung issues including bruising and pneumothoraces (build up of gas between the lungs and pleural cavity, and infection are explained, further showing the prevalence of these issues in stating that those who bind will likely experience at least one adverse health effect.

“Health Impact of Chest Binding Among Transgender Adults: a Community-Engaged, Cross-Sectional Study” is a primary source. As a research study, nothing is based on opinion, with the content instead consisting on hard numbers and medical accounts from research participants. Because of this, there is no bias. Being from 2017, this article is credible. This article supports my topic, as it shows the health effects that insurance companies will have to pay for in place of transgender services. For example, if an insurance company refuses to cover chest surgery, they very well may have to instead pay for related health issues and injuries associated with chest binding. According to the research study’s findings, “The majority had not undergone a chest reduction or reconstruction surgery (86.9%), but many were interested in or planning to obtain surgery in the future (66.6%)” (Peitzmeier et. al, 2017, p. 68).

C.M. Wiepjes, N.M. Nota, C.J.M. de Blok, M. Klaver, A.L.C. de Vries, S.A. Wensing-Kruger,

R.T. de Jongh, M.B. Bouman, T.D. Steensma, P. Cohen-Kettenis, L.J.G. Gooren, B.P.C.

Kreukels, M. den Heijer. (2018). The Amsterdam Cohort of Gender Dysphoria Study

(1927-2015): Trends in Prevalence, Treatment, and Regrets. *International Study for*

*Sexual Medicine.* DOI: 10.1016/j.jsxm.2018.01.016

“The Amsterdam Cohort of Gender Dysphoria Study” by C.M. Wiepjes and associates highlights the findings of a 42-year long study involving the the prevalence and treatment of the transgender community as well as the prevalence of regrets among those who have sought medical transition. 6,792 individuals were studied, providing important insight on a group of otherwise unstudied individuals with very specific mental and physical health care needs. The findings report a “20-fold increase” in the number of those assessed as being transgender from the 1980s to the conclusion of the study in 2015, showing a greatly increasing prevalence of transgender people. Despite this, the study also found a decrease of almost 35% in the number of patients seeking medical transition.

This study is important as it provides insight into a group surrounded by a plethora of misconceptions and with few documented studies. It additionally highlights that the trans population is already small, despite growth, and that the number of trans people seeking transition is even smaller. However, this study focuses on the statistics, adn does not provide insight on the underlying causes of not transitioning; the trans community is known to face higher levels of violence, unjust unemployment, abandonment from family, and eviction, and is documented to go without healthcare out of fear of these repercussions. With a community increasing in numbers, these fears could potentially increase, and could be a factor in the declining number of people foregoing translation. Overall, this study is important in highlighting facts on the trans community, and does so through unbiased statistics.

DSM-5: Frequently Asked Questions. (2019). Retrieved April 24, 2019, from

<https://www.psychiatry.org/psychiatrists/practice/dsm/feedback-and-questions/frequently-asked-questions>

On the American Psychiatric Association’s website, they provide a frequently asked questions portion covering the DSM-5. In it, questions such as what the DSM-5 is and why it’s important, the process of its revision, changes made, and use for insurance purposes are addressed.