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Transgender Inclusion STL

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PRESENTER BIO
André Wilson is an experienced policy consultant and cultural competency educator, specializing in fostering a welcoming and supportive workplace and institutional environments for diverse populations.

A Senior Associate with Jamison Green & Associates, André's unique expertise in transgender inclusive health care and health benefit plans has served corporate and small employers, unions, policy makers, advocacy groups, health professionals, and educational institutions in achieving their goals of inclusion.

Based in Ann Arbor, Michigan, André works with clients across the entire country. André serves on the Ann Arbor Human Rights Commission, the Michigan Department of Education on Sexual Minority Youth Working Group, and the Michigan Department of Community Health Family Planning Advisory Council. André holds a Master of Science in Environment and Behavior Research.

TRANSCRIPTION:

This has been a tremendous experience already to be able to speak to so many different audiences about transgender insurance issues and I know that some people have been already to two presentations or maybe one presentation and I'll warn you there is some repeat here. But actually my experience is that [with] the density of information means that people often need a refresher in order to remember things. I want to apologize for the repeat.

What I want to talk about this morning really focuses on the kinds of issues that we face particularly with employers seeking to make changes. So I want to address some of the concerns and questions that come up for HR professionals and for people working with HR professionals as they're working to make change.

I want to talk for a moment about who I am and what we do at Jamison Green & Associates.
I'm Senior Associate with a very small consulting group and we work on all sorts of transgender related concerns and LGB [lesbian gay bisexual] related policy issues. We do everything from train medical providers to working with legislators, policy development, working with HR professionals.

One of the areas we really specialize in is transgender inclusive health insurance. Jamison Green has been doing this work since the early 90s when he went to the city and county of San Francisco and worked with them to change their coverage which became trans inclusive in 2001. I began working with Jamison in 2004, when I worked to change coverage at the University of Michigan. So we really are specialized in that area and I am actually the specialist [on this topic] at Jamison Green & Associates.

A lot of the work I'm going to talk about today i work we've actually been involved in either behind-the-scenes-- often behind-the-scenes because we contract with corporations and we don't talk about our contracts with them-- but a lot of policy development that has happened has been as the result of our consulting work.

So today we're going to talk about first the progress that we've seen, where we are today and how this has happened, but also some challenges. I want to get to some challenges that we have in negotiating plans. We have a lot of experience as employers with how health plans are working. And to be very honest, much of the inclusive coverage we have today is not working well. [And] this is a problem both for

the employees who are seeking to get access to healthcare under these benefits and it's also a problem for the employer because they spent time and energy investing in changes that they really want to have work.

What we're trying to do now is to go back and work with employers to resolve some of those issues, but also to let employers who are going to be re negotiating coverage to upfront know what are some of the issues that you need to resolve in order for your benefits to work well. And by "work well" I mean to get access to the care that people need in order to be productive in the workplace and to succeed in life.

We're talking about an area of healthcare that has been subject to stigma and marginalization for decades. This is crystallized in transgender exclusions that have been nearly ubiquitous in American health plans and US health plans for at least since the 1980s. And these are some examples of transgender exclusions. They vary enormously. Some of them are much shorter than others; some of them seem to only exclude surgical sex reassignment and others are broader, like these, and they may exclude many, many services.

What's important to note about this is that these exclusions can be mobilized narrowly or broadly, essentially at the will of the insurance administrators. It's difficult to know how any of these exclusions might perform based on the wording. One has to actually interview employees, interview the people who are effected, to really know how on a day-to-day basis how this is working. And they [employees] may not know because they may read the exclusion and make every effort not to trigger that.

So what does it mean? What might happen under these exclusions? "Transition-related care"—so hormone-replacement therapies, surgeries and other procedures, mental health services might all be excluded. So might sex/gender-specific services, like pelvic exams for trans men or prostate exams for trans women or ay kind of cancers that are sex-specific. So for example, that would be ovarian cancer that occurred in a trans man at any point in a lifetime. So those services, because they are sex-coded, they can get excluded. Any medical services might be excluded.

We have a number of cases that keep coming up where people have had medical services completely unrelated to transition medical care excluded. For example, just an incredible [case] you might not want to believe, a trans woman who transitioned many, many years before the medical service, went in and needed a blood transfusion for some non-trans medical condition, and they refused to cover her blood transfusion because transfusion blood in a trans person was "transgender." So this is what the problem is for some of these health insurance plans: any medical service for a transgender person counts as "transgender-related." We actually won the appeal on that blood transfusion case. But if you can imagine, if you need a blood transfusion, you pretty much need it right away. And you can't wait for it. And you had a major medical procedure done and all of a sudden you're being billed for a major medical expense, and you're trying to recover.

This is the situation many transgender people find themselves in. You might be able to win on appeal but you're actually not in a position to effectively fight that appeal. Many, many people don't even know how to do a appeal. And to be very frank, the patient who actually has to fight that appeal, they're not in control of the medical records, the medical providers are. So then the medical providers have to become engaged, and if they're not actively engaged in the process and making sure the records come through in a timely way, the appeal won't be able to be seen and it will get denied and the patient will be discouraged. It's really not a good situation, whether it's an appeal for that blood transfusion or for any of these other things, it's an onerous process.

So this is the kind of thing as employers, we actually have an interest in making sure people get access to medical care and are not burdened by some of this process because we want the focus to be participating

in the workplace. Or if we're dealing with student plans, we want the focus of the students to be on succeeding in the classroom. So whenever we are changing those health benefits, our goal is to provide health benefits that enable people to succeed in the context where they are trying to perform. Or if it is a dependent, if it' somebody's child, a parent needs to be able to feel that their child, or adult child, has the medical care they need otherwise they're not being taken care of in their workplace or school life.

We've had a lot of change. A decade ago, there were four medical plans that I could identify and employers that had transgender inclusion. Everybody else had exclusions for sex reassignment services. But now we have an enormous number of employers. So we'll go over where change has happened. I'm not going to really talk—or talk a little about not so much who did it and how but we're going talk more about the kinds of business cases that people make in order to get this to happen. There are real reason why this is advantageous for employers to do.

Now I just want to ask, how many people in this room have health coverage or access to health coverage that is transgender inclusive?... I see two hands. So where do people work that they have transgender inclusive coverage? What's the coverage through?

[Audience Member 1: "I'm a student here (Washington University in St. Louis)."]

Wash U student plans are transgender-inclusive and have been for a number of years.

[Audience Member 2: "Thompson Coburn. A law firm."]

So, a law firm. Thompson Coburn is, and a number of major law firms in the country have transgender-inclusive coverage and Thompson Coburn is one of them. And I think there are actually a couple other people in the room who probably have access to transgender-inclusive healthcare; we'll talk about some of those employers in a moment.

These are the 340 corporate employers that have transgender-inclusive plans and Thompson Coburn is listed somewhere up here [gestures], right up there. You can't read it because there's so many of them. This is as o the January 2014 benefits year; this is the report from the Corporate Equality Index. This includes many Fortune 500 companies and a number of major law firms.

I just want to say, who is really kicking butt on this issue, in terms of smaller employers, are the law firms. For some anomalous reason that I'm not really sure of, are included in the Corporate Equality Index, big law firms are a part of it. And they have really taken up that challenge and are providing inclusive benefits.

One of the reasons for this—and I don't know how this happened at Thompson Coburn—but other law firms have told us that they're being interviewed by the law students, who they're trying to attract as employees, and not the transgender law students but law students who are coming in and they're seeing transgender-inclusive benefits as a kind of bellwether for how an employer is doing on diversity and inclusion. We've heard from African American law students and other professionals from other professional programs that many people of color are using transgender inclusion as a bellwether for how well any minority issue is being dealt with. The thinking is, if you can do transgender issues well, you're probably going to be able to deal with some other minority issues-- maybe not now, but there's a sensitivity that's indicated by this. And I just want to say, I don't know how if there are any other professional programs or professional, um, professions that this has happened with. We know it's happened with law students and its logical to think that actually this is something we're going to see [more of].

If you're trying to attract young talent, this is really one of the moves employers should be making.

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Now—hmm, there should be another slide in there.

Now I just want to talk about the bigger picture. There's a lot of other insurance, not just those group plans at the big employers or the student plans, and I just want to give a picture of where the change has happened. You've got public plans, individual plans, and insurance exchange plans and I'll go over all of those areas.

There's a big divide we need to pay attention to here. So those big employers, most of those that we've seen, those 340 employers, most of those are self-insured. Now that's not true for every one of them, but self-insured means that the employer's taking a risk. They're not actually an insurance, they're health benefits plans, and an employer fund is paying the benefits and they're being administrated by a third-party administrator. For the employee, you really don't know the difference, because that third-party administrator might be Anthem, it might be Aetna, Cigna, it might be an HMO, it looks just like another insurance company as far as the employee is concerned.

But the difference [between self-insured and fully-insured] is because they're self-insured, they have a lot of leverage to change their plans. And they also fall under Federal regulation—and this is a generalization, there's nothing that can be said that is absolutely true about insurance regulations—but by and large, the self-insured plans fall under the Employment Retirement Income Security Act (ERISA), which is really about insurance.

[video cut out]

…various different providers in this [Affordable Care Act]. I had to give my name and I had to tell Blue Cross Blue Shield whether I was currently a plan member or not, which I happen to be since I had bought individual insurance the year before. So there's no way to actually enter those interfaces anonymously to get information. There should be, but there isn't. And if you refuse to provide them information, you are on day-long hold and they close. Literally, [I was] eight hours on hold because I wouldn't provide information. So one of the reasons I do this is to find out what happens. What happens is you cannot get information unless you provide information; they want extensive information to find out who you are.

So what this means is that people seeking services are in fear, they're not able to get information. I can't find out information for other people about these exchanges [Affordable Care Act insurance exchanges]. So: a problem. However, the Affordable Care Act doesn't mandate that all medically necessary services be covered; it mandates that essential health benefits be covered. And we don't know whether those health benefits includes, whether EHBs include transgender-related services or not. What we do know is that many of those state plans that states have adopted and they presume meet ACA standards, that they do have exclusions.

Section 1557 of the Affordable Care Act prohibits discrimination on the basis of sex and Health and Human Services has defined that that includes gender identity. That's not surprising because all across the Federal government we're seeing that [interpretation]. So the question is: are trans-specific exclusions considered discriminatory and there has been no opinion about that yet.

People are making complaints to the Health and Human Service Office for Civil Rights, and those are people [in the Office for Civil Rights] who are looking at whether or not those exclusions are discriminatory. They will be making some kind of statement about that; we don't know if its tomorrow, next week, next month, early next year—but they will say something at some point. What we have been advising people to do is if you are in a plan that is in some way covered by the Affordable Care Act, not just the health exchange plans but the employer plans, because employers' plans also have to meet that

EHB level and they have to not discriminate on the basis of sex. That's part of the whole picture with the Affordable Care Act is that employer plans have mandates under the Affordable Care Act as well.

So anybody who is in a health plan in this country potentially falls under the Affordable Care Act and if there's an exclusion, my advice would be complain to Health and Human Services Office for Civil Rights. There is an easy online interface to make that complaint, and tell them why the exclusions are a problem. In fact, medical providers can also say, "My patient has an exclusion and didn't buy a health exchange plan for that reason and can't get services."

Will all of those complaints be addressed in an individual basis? We don't know. But the information has to get out there somehow, and it's [filing complaints] is one way to get it there. Because at some point there will be a national determination about whether those trans exclusions are discriminatory.

Hmm, well Powerpoint fails at some place. The type is coming through…

So, I just want to say, whether or not employers have to do this, have to provide inclusive coverage, whether there's a law that says you have to, it's not clear at this point. But there have been some very persuasive rulings recently that I think suggest to employers that the tide is turning and bringing your benefits into line may protect you from going under sex discrimination complaints.

For example, there's been an IRS ruling, this is actually very important for employers, where the IRS had said some individual transgender person could not deduct their expenses related to sex reassignment because these were not [considered] medically necessary services and that case got fought all the way up to the top and O'Donaghue won.

What this means is that those services are considered medically necessary by the IRS and in fact they didn't appeal the final step and they allowed this to become a decision that now translates to the entire IRS. It was a statewide decision but because they didn't appeal it, it now applies to everyone. So what this means for employers is that the IRS actually does consider sex reassignment services to be medically necessary. And an argument we here form employers is "we can't do this because it somehow would damage our tax-exempt status of our benefits"—well that's just not true, the IRS does consider these to be medically necessary. And in fact, the IRS cites the WPATH [World Professional Association for Transgender Health] Standards of Care, so the services that specifically are obtained under the WPATH Standards of Care are going to be considered medically necessary by the IRS. And a very important ruling, a recent ruling, Macy versus Holder, an EEOC ruling, also holds that discrimination on the basis of gender identity is sex discrimination.

…We have a creative videotaping that has just arrived… We have a laptop taped to a chair, I love this…

[Audience member: "Between one and the other, we're getting this"]

This is great…

So what's important about this is, again, if gender identity discrimination is sex discrimination, if it is determined it is discrimination on the basis of gender identity to have transgender exclusions, what it means for employers is that it becomes sex discrimination. The problem for employers there is sex discrimination falls under what Title?

[Audience member: "Title VII."]

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It falls under Title VII. You have all these Titles… so sex discrimination falls under Title VII, and it's a big problem if you discriminate on the basis of sex. So, I think we're going to see, since these are the same services provided to other people under other diagnoses, is gender identity as part of sex, it seems fairy obvious that what's coming down the pipe is transgender exclusions are sex discrimination.

So I would advise employers—and I am not a lawyer, I'm an advocate—but I would advise employers to begin to consider this. We're actually seeing some law firms come out with, those who do employment law, coming out with and begin to advise their employer client to really consider this seriously.

I also want to say there's been some very interesting similar stuff in relation to the custodial setting, specifically in relation to prisons. Now, nobody in this country has a right to healthcare, except for if you're in a custodial setting, and the people responsible for you are actually responsible for providing healthcare. And in prison you have the right to not have "cruel and unusual punishment" which is the Eighth Amendment. And so what has happened is the Federal courts have said it is "cruel and unusual punishment" to deny medically necessary healthcare related to sex reassignment to people who are in these custodial settings.

People who are our employees are not in custodial settings, we hope, but we have to imagine if the Federal Bureau of Prisons and Federal courts believe that these are medically necessary services that they are probably medically necessary for employees as well. And, again, I think this reinforces the question about medically necessary services falling under sex discrimination.

There are a host of complaint processes. I just want to say—so the EEOC [Employment Equal Opportunity Commission] will address issues related to employer plans, I think we'll get to see complaints not only under ACA [Affordable Care Act], I think we'll begin to see EEOC complaints—and I also think there's avenues under the Department of Labor for challenges to ERISA [Employment Retirement Income Security Act] plans, so those big self-insured plans with exclusions, and I think within the Department of Labor there actually may be interest in taking those complaints. This is different than what we saw several years ago but the entire framework has changed, as we begin to—for example, with Macy versus Holder, the framework has changed because we now understand this to be sex discrimination. And there are some other avenues people also have for complaints [gestures to slide].

Now I don't actually advising people to file complaints against their companies, but what I want to say is that companies are vulnerable to these complaints at this point. And it would be much better if companies and other managers of health plans actually went out in front and covered services.

I'm going to actually skip to that… [skips some slides]

When we're working in the workplace, we basically have to address five basic questions that always come at us. People want to know what's the impact of the exclusions, what is transgender care, is it medically necessary, who else is doing this—so benchmarking is really important—and there's always the question is how much does it cost.

And there's also a few other questions that we often hear positionally from HR departments—there are other people who are trying to get health plans expanded to cover their medically necessary care, for example, so if you're "get in line/behind, who else is asking for things" so the two things we hear about most often right now are services for autism, so there's some autism-related services and assisted reproductive services, So, when we're told to "get in line" it's get in line or in front of those people. And in fact there are many reasons why those two particular populations are actually at-front allies to transgender people seeking to get services. But we all have to be prepared to have answer to all of these questions.

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So we've already talked about the health impact of exclusions. And the real issue here for employers is that there really are necessary health impacts to these denials of care. There are higher costs, you can't get the right medical services—they are going to have consequences, health consequences of denials of coverage and you're going to have costs associated with those—unnecessary costs because if you covered the right services people would not have these other illnesses. People are stressed, it effects well-being, it effects their performance at work, and it also—you have employee disengagement.

So people are not able to get their services covered, they're paying into the same health plan everybody else is. This is a benefits equity issue. They're not getting the same benefits everybody else is getting. If you're a parent of a transgender kid, of a transgender young adult, of a transgender college student, and they're not able to get services, you are focused on that problem, and you're not focused on the workplace. You're not getting the same benefits other people are getting for their dependents.

Medically necessary transition-related care includes all of these services [indicates slide] and I want to underscore that transition can involve any of these services, all of these services—usually not all of these services for any individual because there are different services, surgical services, for trans men and for trans women, but also because not everybody is going to have the same pathway. Not everybody needs surgery to accomplish their transition, not everybody needs hormones to accomplish their transition, not everybody needs both surgery and hormones, and not everybody actually needs mental health services. And that's recognized in the [World Professional Association for Transgender Health] Standards of Care.

But some people may need some of the services that we're having difficulty getting covered. Facial reconstruction, also known as facial feminization, is a really important surgery, or set of surgeries, for many, many trans women, particularly those that are transitioning when they're older. And one of the reasons, for example, to cover growth hormones, is puberty blockers is because when trans kids are actually able to delay puberty and able to make that decision, when they're able to make that decision, to begin the right hormones as opposed to the endogenous hormone, is what happens is they don't undergo development on the wrong hormone. Testosterone is very powerful, it changes bone structure—if you don't have to go through puberty on testosterone, you are able to actually mitigate a lot of those effects and you may not need the facial reconstruction that actually undoes a lot of the effects of testosterone. So really early intervention is very powerful but not everybody has early intervention and they may need some of these other services.

So who says they're medically necessary? WPATH Standards of Care, the World Professional Association for Transgender Health, has been issuing Standards of Care since 1979, now in the seventh edition. And I wanted to underscore this is a professional association—medical professionals, mental health professionals, public health professionals, and also people involved in anthropology, sociology, anybody who is touching on transgender care as a professional, can be involved in the World Professional Association for Transgender Health. It is largely for mental health professionals. It is not an advocacy organization anymore than is the AMA [American Medical Association]. And all of our medical association actually do advocacy, o behalf of their physicians or their members, but also relevant to the client populations.

Why do I underscore this? Well because when we're talking to some of the health insurance carriers, they're claiming that WPATH [World Professional Association for Transgender Health] is an advocacy organization and not a professional association—simply not true. This is a professional association dedicated to the management of care for people who are presented with gender dysphoria. That's what they do.

Medical consensus is also growing. All of these [gestures to slide] organizations have said that health insurance coverage has to eliminate exclusions and cover medically necessary care. Most of them actually refer to WPATH [World Professional Association for Transgender Health] in their statements. These aren't radical organizations; these are medical and mental health associations who don't actually make these kinds of pointed statements lightly. It's difficult to get them to make these decisions.

So, in addition, we have 340 companies that don't cover services that aren't medically necessary for their employees. They just don't. So they, too, assessed this and they also have figured out that these are medically necessary services. And I just want to say a number of them are important in the Saint Louis area [gestures to slide]. There's probably others on that list. Some of these are big companies—most of these are big companies—and all of these have transgender-inclusive coverage.

They in large part have it because the Human Rights Campaign Corporate Equality Index required it as of the 2012 benefit year. They required it in order to get 10 points of that 100 point Corporate Equality Index score. When they required it we saw a jump in the employers that had fully inclusive coverage—went from 85 to 204 and is still going up. The survey for this year, for the January 2015 benefits year will come up in probably a week or two. We hope to add maybe another hundred, two hundred—I'd like to see a thousand more employers on there—I don't think a thousand employers participate in the index yet, but we'll see. With bated breath, we're waiting.

The case really for this, that we have to make for this, is: access to the right medical care supports your employees, its consistent with workplace policy, its probably consistent with the latest labor law that's coming out. It really is important to employers that employees be able to function and bring their whole selfs to work. We are really seeing a difference when people don't have to hide who they are, when people are not afraid.

People—transgender people—don't have to self-disclose who they are. It's different, coming out, really is a different issue for transgender people than it is sometimes for LGB [lesbian, gay, bisexual] people. It's not necessarily affirming to come out as a transgender person. But even if you don't self-disclose, knowing that your workplace supports means that you don't live in fear of somebody finding out in that same way.

So one of the reasons employers are doing this is because it really enables them to attract and retain talent. It's one of the reasons colleges and universities are doing it, its one of the reasons the Federal government is doing it, and personally I'm thrilled because I think our Federal government should have the best and brightest people working for it. No question in my mind that we need a government that works well. So I'm thrilled that we're actually having Federal benefits covered, because I want people to work for the Federal government.

One of the employers that we talked to, one of the big medical technology employers, they looked at the positions they had not been able to fill for 5 years—technology positions, fairly specialized, an they'd not been able to fill them—and one of the arguments that was made to HR and the corporate board was, "Look, if a transgender person was the person with those skills we want them here, and not at our competitors." And I think that's a narrow way of thinking about it but we also want the parent of a transgender person there, we want the person who cares about diversity and inclusion there, not just the transgender person, we want that person who is going to care and we want to fill whatever job it is that we have.

I'm going to move through some of this…

In terms of the cost, and this is always a question that we come back to, which is a little sad because being the right thing to do, it should suffice but it doesn't suffice because in the corporate world we're always concerned about cost and actually that bottom line. But it turns out that when we look at of those employers, we actually see that fully-insured and self-insured plans are able to do it. They've been able to do it without raising their premiums, by and large, they've been able to do it mostly without separate lifetime caps—and this is really quite important—so there hasn't been a need to manage the so-called risk. And why is this?

Well, because it turns out, the utilization is really low. This is actually a report [gestures to slide] from 2007 by the city and country of San Francisco, on their first five years of utilization. So there's been very few utilizers at all the corporate employers and the reason for this is there's few transgender people. There's many more transgender people than we used to think. We used to think that being transgender was—specifically what I cal being transsexual, which is people who would benefit from the services that we're talking about, the services related to transition. So there are very few—we used to think there was about 1 in 30,000 but its probably closer to 1 in 1,000 maybe, 1 in 500, maybe 1 in 100, we don't know, but it's certainly more than we thought. But most of these people are not having all procedures, and they're certainly not having all in one year. And the treatments are phased. Many people who are in employment have already had services and paid for them.

So: utilization is low, there's few people, the costs are much lower than people thought, and the costs are even lower for bigger employers.

I have a dorky data slide that compares people in the city and county of San Francisco to utilization that—we interviewed 15 employers back in 2009 about utilization that they had seen. So basically what this means, this is claimants per 1,000 employees per year. Basically the take-away from this horrible slide, and you will have it when you get the slide-set, is that the utilization is so low that it's a rounding error for most big employers. We talked to the folks at Alcoa, big lining and aluminum company, about their decision to offer trans-inclusive benefits and they looked at this slide and they said, "This is so close to zero, it is zero, as far as we're concerned." And basically that's the report that we've had.

The California Department of Insurance figured that same thing and the Williams Institute just came out with a report. They essentially re-did the survey Jamison Green & Associates did with the Human Rights Campaign back in 2009—we actually worked with the Williams Institute on their survey, developing the survey instrument. And they found exactly the same thing: minimal utilization and what was interesting is that the utilization is low everywhere. It is lower for larger employers, so per thousand employee rate, is lower for large employers than it is for smaller employers, as we would expect because there's a higher risk for any health service at smaller employers than bigger employers. It's just a function of scale. So it does track that our biggest employers have been the ones to adopt things like low caps, that's lifetime maximums, presumably in order to control cost. Well that's completely unnecessary because the utilization of those employers is much, much lower on a per thousand employee per year basis. So you'll have access to all of this as you make this.

So in terms of the elevator pitch, so it depends on what your elevator pitch is, what're you going to say to address the five big concerns that your CO has. Obviously how long your elevator pitch is depends on whether you're going to floor 1 or floor 100 of the Empire State Building—or whatever the big building is here in St. Louis, what is it? Can you go to the top of the Arch?

[Audience members: "Yes."]

Alright, so if you've got to go to the top of the Arch, it's a longer pitch. This is all of the things we've just been saying [gestures to slide]. Now I'm not going to repeat them, but just to say—the questions are all

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the same. Which questions are most important in your context are going to determine where you put your emphasis.

This actual slide comes out of a document that we prepared for HRC [Human Rights Campaign] on transgender-inclusive coverage of the Corporate Equality Index, I think is what's its called—informally called "the White Paper." This actually is in revision and we should be seeing a revised version go up online pretty soon. I've sent in the final draft to HRC. That document does actually answer at greater length all kinds of questions that do come up.

The healthcare sector is particularly important as a rating. One of the things that's important about these surveys is its delivering information to employers about the importance of adding benefits. And I really want to underscore the healthcare sector because in St. Louis, in Missouri, as in almost every other state —I think Wyoming is the only state I haven't been able to determine, where only a small fraction of the biggest employers are the healthcare industry—in every state practically, healthcare employers are probably between 20 and 50% of the major employers. And in St. Louis they certainly do rank high. Transforming the policies at those facilities, those employers, is a major, major step. Most of them are not rated in the Corporate Equality Index, because of the kind of employer they are. Most of them are not rated in the Health Equality Index yet because they haven't had people inside who have figured out that it's getting rated. Participating in the surveys is an important tool for making change at those employers.

The Corporate Equality Index has been the driving force for the changes we've seen in corporate and we see that in the healthcare sector. There's also a Municipal Equality Index for municpal employers that could serve the same purpose.

So, details. I want to talk for a moment about some of the problems we're seeing with these plans that are —it's fantastic that they've changed, that they're now inclusive—but there are very, very few that are working well. And we're trying to address those problems. I just want to outline some of the issues that we're seeing so as HR professionals, as activists, or wherever you are, that you're thinking about how you're going to manage those problems, either upfront or over time, as you're implementing your plan.

One of the biggest challenges is some or many services are not covered in most of these plans. So, for example, CalPERS, the second largest set of plans in the country, they said they were going to cover all medically necessary services. And that's that full, comprehensive list that I showed you. That's all the services, including electrolysis. It includes facial feminization; it includes all the genital reconstruction procedures, not just some of them. It includes all of these services, but this wasn't actually implemented by the plan.

CalPERS administrators, when they talked to the unions, that's what they agreed on [covering all of these services], but the plans—when Anthem came back, when Kaiser came back, when all these things came back and they said what they were going to cover, these services were not included and CalPERS administrators said nothing [about the discrepancy in covered services]. Because it wasn't their [CalPERS administrators'] practice to say anything back to the health plans. And this is true for many HR professionals. Many HR professionals don't question what comes back from the medical plans in terms of medical policy.

The problem that we face here is that stigma and marginalization has been painfully evident in the medical practices and the medical policies that come out from these insurance administrators when they have medical policies related to transgender services. I don't think this is intentional, but it's really where we've been, in this country, around the world, around transgender services, that people who in many ways should know better are influenced by all of the ignorance and stigma that surrounds transgender

issues. Our job, our task really, has been to fight against that ignorance and to help people understand that actually, this is a real medical condition.

We have faced the same problem with respect to domestic partner benefits, even in the insurance industry. I talked to a medical director, who came in—he was a major medical director of one of the statewide Blues [Blue Anthem Blue Shield] and he said, "When I got this job as a medical director, we did not have domestic partner benefits." And the ignorance and stigma that surrounded the issue of being gay—and this was in the late 90s and early 2000s, so we're not talking about the 80s or the 70s—about being gay and being a professional at a major company… He had to do several years of work to dismantle the myths about being a gay man [such as] that everybody had AIDs, that domestic partners would have HIV/AIDs and would be costly, that this was a lifestyle choice—all that he had to undo.

We were talking about this because he said, "The same ignorance and stigma exists in the insurance industry, as anywhere else, within the medical directors about transgender issues, as I faced as a gay man." Unfortunately, he had to retire. But he had begun the fight as a medical director to get transgender inclusion there. But just to say, it's not that people are bad or companies are bad; we have ignorance and stigma and we have to fight it.

So, this is what happened with CalPERS. It [the comprehensive coverage of all services] wasn't implemented by the plans. Now every single one of these plans—actually not every single one—but an increasing number of insurance carriers and third-party administrators have some kind of medical policy utilization management guideline, whatever they want to call it, that is related to "gender reassignment surgery," "sex reassignment surgery," "transgender surgery"—whatever their term is—and it specifies what's covered, and under what conditions.

So this [gestures to slide] is a little chart, it's actually a little old so I'm not going to focus on it. These are updated periodically; some of them are updated more often than others. They don't tell me or Jamison Green & Associates when they're updating, though I go online every couple of months, to make sure I'm up with the latest, always hoping to see something more.

I just want to focus on—they vary quite considerably—but there are some commonalities. One of the commonalities is that the vast majority of them, all but one that I've ever seen, have a long list of what is not covered and usually they say that they are "considered cosmetic." Among these things is always a long list of all the procedures related to what is sort of generally called "facial feminization." Things like electrolysis are usually excluded. One of the things that often is excluded is something called "nipple-areolar reconstruction" which is the reconstructive procedures related to chest reconstruction for trans men. Trans men, for chest reconstruction, have a mastectomy and they need the reconstruction portion. In fact, the reconstruction portion is federally mandated by the federal law that mandates reconstruction post-mastectomy for any woman that has a mastectomy. Well trans men would be covered under that, yet that code is excluded. You can't tell in the 0615 Aetna Policy that it's excluded because they just list the codes that are excluded, they don't tell you what the code is for. So you actually have to go back on and check all of the codes to find out what they're actually excluding. This is something that we do at Jamison Green & Associates. I have a long list of all the possible codes. And so, boy, do I wish Aetna would just say what it is, but they don't. They also exclude liposuction, which is also always a component of FTM [female to male] chest reconstruction; it's not some separate cosmetic procedure. It's a fundamental part of that chest reconstruction procedure. Electrolysis is not only a fundamental component for just about every trans woman in transition; I don't personally know any trans women who successfully socially transition without facial hair removal. I fail to understand how any company can think that they're actually supporting their employees' transitions and medical transitions without covering this, but very few companies yet do. It's [electrolysis] also a component of many genital surgeries and if it's not covered for genital surgery, it might not be done and that actually creates serious complications both for trans men

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and trans women, with their genital surgeries that require permanent hair removal. If you don't do it for trans men, you might have hair inside your urethra and that is a serious medical problem.

As HR professionals, we're often not used to talking about hair in your urethra or phalloplasties or vaginectomies or vaginoplasties. These are words that we may be uncomfortable with but in order to address the details we actually have to begin to be comfortable with them and use them and understand that these details have a profound impact on the successful outcome of the medical care we're trying to get things covered for.

So Cigna [gestures to slide], they do have a long list of exclusions, and it involves a lot of those facial feminization procedures. But they also exclude a number of FTM genital procedures that are not excluded typically in other plans. So if you're negotiating with Cigna, and you're an employer, and you accept their medical policy, which is what they call a utilization management—they all have a different name for these types of things, I forget what they call theirs—but if you accept their boilerplate, what you're accepting is that your employees will not have access to services that they may need. Not every trans man is going to have a phalloplasty, not every trans man is going to need a penile prosthesis as part of that process. Most trans men who have genital surgery are probably going to want have that scrotoplasty with testicular implants; that is a fairly common thing, certainly not everybody, but it is pretty common. But, they're not going to be able to get it. We don't actually know what "second stage phalloplasty" means [gestures to slide], and I've actually asked them and they haven't told us. So we don't know what that means but I can imagine most phalloplasties are actually multiple stages. So if you're going to just have the first stage, you're really not going to have a successful outcome. What you're going to have is an individual who is profoundly depressed and not able to function; that's a problem. But just to say, I highlight these things because Cigna is a little bit different in those [procedure exclusions] but that is true for ANY of these other procedures. When people aren't able to access those procedures, they're not actually going to have successful outcomes.

Now, United Healthcare, they're a little bit different. Again, they have other exclusions. They also exclude a long list of services. They specifically exclude what some people call "reversal surgeries." This is unusual. They're not usually excluded in the medical policies persay, we often see these exclusions in actual benefit designs in the plan brochures.

And I just want to say, it is very unusual for services to be excluded if the initial treatment didn't work, if it wasn't right. If it turned out to be the wrong thing, the wrong intervention for the patient, you usually don't leave that person just hanging there. Somebody who needs reversal surgery is just as dysphoric as the person who needs the initial surgery. A limit like this actually condemns somebody who desperately needs services to a lifetime of gender dysphoria. I don't think that's our goal. United Healthcare may be alone in putting it into its medical policy, but they're not alone, because many of those boilerplate plans that you would see from Aetna, from Anthem—they're also going to include it but not in their medical policy.

United Healthcare also excludes puberty blockers; in contrast, Aetna actively includes them. One of the things I like about Aetna's plan, actually their medical policy, is they follow the Standards of Care very closely in terms of eligibility. They're much better than some of the other medical policies with adhering to the Standards of Care version 7 with respect to eligibility. They [Aetna] also have some nice language about sex/gender mismatches and that those need to be addressed. So those services, for example the pelvic exams for trans men, prostate/cancer for trans women, Aetna specifies that that needs to be handled. And so we presume that they're figuring out how to do that. I think that's a pretty big assumption but there's a clear statement of intent in their medical policy, the others have yet to do that.

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As you're thinking about this, whoever you're negotiating with, they actually have a boilerplate they're going to try to give you, and the message here is that they're different from each other and they basically at this point all have problems. So people are going to actually have to begin negotiating, pushing back, in order to get coverage for the full range of services that people need. And just to underscore, the items in red [gestures to slide], are the ones that probably represent the most difficult areas, in terms of all of them, in the medical plans. So these are the areas where HR folks do the most work around getting services covered.

What they're doing [HR professionals] is designing their own medical policies. Typically we are seeing this with big self-funded plans; there's a number of employers that are actually taking a list like this and they're going and saying, "These are the services we want covered." Johnson & Johnson for example has done a fantastic job of doing that. Some of the big tech companies—Google has done work on this. What's difficult about this is we haven't seen this as much with the public employers. And most of these private employers does this and Johnson & Johnson does this but Johnson & Johnson's benefits plans are not up online for us to see. I can't send you to their website. It's on their intranet, it's not on the internet. So it's available inside the company, but not outside. But if you're working on plans, there certainly are companies, companies I can refer folks to, that are out and proud about it. And other companies actually don't want their names mentioned at this point, because they don't talk about their benefits in a public way. But we know on an informal basis that they have services covered and we also at Jamison Green & Associates, we also work with companies on this so we have a very clear picture of what their benefits actually look like.

So many of these insurers are using outdated medical standards, and this is usually with regard to not only services covered but eligibility. I'm not actually going to go into the details of that, but we also have issues with prior authorization, and access to out-of-network providers. What I want to say about out-of-network providers is the importance of out-of-network providers is we have this many [holds up nine fingers] surgeons doing genital reconstruction in this country, maybe. So it's less than ten. And in most states, there isn't anybody. In New England there is nobody doing genital surgeries for transgender women. This means that people have to go out of state. Most of the providers who are expert and competent in these services, they are not participating with insurance. Why? Because insurance didn't cover this. So they're not working at major hospital systems. Why? Because major hospital systems' liability insurance wouldn't cover them when they did it. So these are providers—they are not fly-by-night providers. These are major surgeons performing at major surgery centers, but they're usually stand-alone practices. So they don't have the infrastructure to be in-network. And they don't actually have a lot of experience with billing.

The other issue is that each surgeon is performing the techniques that they perform. And there are different techniques that are going to be useful or applicable to different trans people. So for example there's two major pathways for genital surgery for trans men. There's phalloplasty, and there's actually multiple kinds of phalloplasty, and then there's a metoidioplasty, which is a very different surgery. There's also multiple kinds of metoidioplasty. Some people may need a vaginectomy, the removal of the vagina and closure of the vagina as part of their genital surgical process, some trans men need that. There's only a couple of surgeons in the entire country who do that procedure. So if they're not in your network and you can't figure out a way to cover them, those people will not be able to get those surgeries. And this is not a "one size fits all" process. If a trans man needs a phalloplasty, they don't need a metoidioplasty, they don't need a surgeon who only does metoidioplasty. If they need a vaginectomy, they don't need to go the surgeon who doesn't do that procedure; in fact, if they're in your network it's not going to do them any good. And if they go t the surgeon who doesn't do what they need and they get a surgery that isn't right, they're not going to have the successful outcome that is the whole point of offering the coverage.

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So dealing with the out-of-network provider issue in some way is crucial for companies [in order] to make sure their benefits work properly. So the strategy really is to tell the insurance plan, the insurance administrator, upfront, who has to come into network, and that it is your company's policy that people get access to the services they need.

Probably the biggest issue is that employees can't find information.

[Question from audience member: Regarding the in-network/out-of-network, our plans permit out-of-network benefits 50%. So for all practical purposes would it be safe to say that most of those were complex procedures, are going to be out-of-network and be half paid by the company's insurance?]

So that's a problem. So 50% is practically worthless—when you're talking about appendicitis, the company's going to pay 50% for it, really? Acute appendicitis, $60,000, you're going to pay $30,000? But actually what that means it's not 50%. It's 50% of the "usual and customary." And so what happens to people when they go out-of-network and they have to do that is the assessments on "usual and customary" for genital reconstruction surgery are so low that people get reimbursed pennies on the dollar. This is a massive problem. If there is no provider in-network who can provide the surgical services that somebody needs, people should be allowed to get, in fact so it's facilitated, people need to get access to those providers and at in-network rates. There's an adequacy of network issue and people need to have access to providers. If your insurance plan doesn't have a provider in-network who can treat the cancer that your employee has, there's probably a provision that allows people to go out-of-network at in-network rates, and the plan will do that. This is exactly what needs to happen when the providers are out-of-network because they don't have a provider in-network that does a vaginectomy or that does a metoidioplasty or that does a phalloplasty or does whatever the patient needs.

This isn't a free-for-all, if there is somebody in-network that does it and is competent at doing it, then by all means, have people stay in-network. There are good reasons to have people stay in-network. But if it's not in-network, then people have to be able to go out-of-network at in-network rates. We have to understand that the issue is that these services are not one-size-fits-all; we need to know this upfront. Because that's the danger here if people are forced to stay in-network. The issue of competent providers is huge. Some who knows how to do a mastectomy may not know how to do a chest reconstruction for trans men; it's not terribly difficult but it is moderately specialized. And if they're offering to do that service, they're going to do damage. You're going to have scar tissue, you're going to have somebody who's body is contributing to continuing gender dysphoria on a ongoing basis. That doesn't give you a successful outcome.

That's really the big issue. Genital surgeries, they're complicated. They're not dangerous, but they're complicated. There is a learning curve and if you don't stay on top of the game, you probably will have complications. People who don't know how to do genital surgeries and aren't familiar with transgender patients are probably going to have higher complication rates. And we all know that complications are where the costs really are when you have complications. Genital surgery is not simple, they do have complications, and when you have people that don't know how to deal with the complications, then you're looking at higher costs. To allow people, figuring out how to allow people to go out-of-network with competent providers that can provide the service they need and who actually are less likely to have complications because they know to do this stuff, that's what's going to be cost-effective.

A big problem is that people don't know where to get information. They need information for when they look for benefits. So for example when I said before the health exchanges, people have no idea where to get information and the advocates can't get information. This is also true in our employer plans. The Corporate Equality Index, the part of that score, the point of that score is that companies have to actually make information accessible to employees. They vary in their success of that. Basically some of them

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made a one-time announcement when they changed the benefits, but it needs to be accessible to every employee before they make that enrollment decision. And it is very, very difficult. Not just whether the plan is inclusive, but also which providers are in-network or out-of-network. Because there are so few providers and people's services can be so specific, the choice between a Kaiser or an Anthem or an Aetna plan, if you have multiple plan options, can mean access to one provider or another provider. The choice between a United Healthcare Coverage and an Aetna coverage is that United Healthcare will cover tracheal shave, the adam's apple reduction, they will cover breast implants for trans women under their boilerplate inclusion policy—Aetna and Anthem are not going to do that.

So depending on who the person is and what their needs are, the provider network and the services covered can vary. But the big question is: who can people ask?

People live in fear. Trans people live in fear and their parents live in fear and they don't know who to ask. And they don't know if they can trust the answer to be honest. Most of the time they can't trust the answer. So who they need to be able to ask are HR managers. And it has to be safe to ask the HR managers. It has to be a culture of safety. Better than being able to ask, information should just be out there and readily available at the moment you are making your plan choices. The Employee Resource Groups, they often work to leverage the coverage, but most employees don't know there is an Employee Resource Group, if there is one, like an LGBT advocacy group within the company. The Insurance Administrator may give the wrong answer; they often do—call centers are terrible at this.

People typically turn to community groups and list servs. Big email list servs. The FTM [female to male] surgery group that has thousands of people on it. I see the questions about insurance, "Does anybody have Aetna? Does it cover services?" The questions are so general that there's no way to answer in an informed way. People do answer and the person asking the question and everybody else on that list serv has no idea how to assess the answer, have no idea whether it's right or wrong. Some of them are experts, there are very few of us out there, but I get a lot of emails. I do sometimes, you know, I can't be everywhere, I do usually go on the list servs and try to see what questions are coming up. It is very difficult to actually provide the information on the servs because everybody argues. It's a very difficult place.

I work with employees form just about every single on of those 340 companies [listed on the Corporate Equality Index]; I've gotten a call or email from somebody there trying to get information, unable to get information. Right now, we're doing a bunch of that work. But I don't have access to information inside the company. I can't look at the benefits plan from inside the company. I can only provide strategies and help people figure out where they need to go. I can't tell a person who's working at an Apple outlet at some mall somewhere, I can't tell them which plan to elect, I can't tell them whether their HR company at this company will follow the company non-discrimination policy or knows anything. I can't assess the safety of a workplace situation, so I am very limited. What we need the companies to do is to first make it safe, make the information available, on an ongoing basis.

I just want to say, disability leave can actually be really important. We've got people who were fired because even after their health plan approved the services and they went out and got those services, the disability leave turned out not to be approved and they found out they didn't have a job when they came back, because they were essentially "AWOL" as far as the company was concerned.

The company's disability leave is often covered by a different insurance carrier. Typically, it's a different insurance carrier and so that carrier need to be up to speed on what services are medically necessary and that people need to be on leave.

So the best practices really are you have to engage with the details, whether you're the HR person or whether you're in the LGBT Employee Resource Group hounding the HR person, whoever you are, you've got to keep track of it, you have to negotiate with those insurers because they're going to offer something that doesn't really meet the needs of employees. You need the plan to adhere to the Standards of Care, both in terms of what is covered and eligibility for coverage. And when I say the Standards of Care, Version 7, not Version 6 from ten years ago—the version that is the medical practices now. And deal with those out-of-network issues.

Pre-pay is going to be the cheapest option for you at this time. If you're a big employer, just pay that out-of-network surgeon the upfront money. Because if you bill it through your insurance, you will be dealing with hospital billings that are three- and four-times more the amount than the negotiated by that amazing out-of-network surgeon who's done a fantastic job negotiating rates. So that's my hot tip for employers now. You're so much better off if you pre-pay those out-of-network rates. It's not possible for everybody because of the contracts you have with you carriers, but that's what I would say.

And you've got to train everybody. Everybody at the interface, and you've got to help people not have to ask anybody. Because right now people are so fearful they don't want to ask. They do not want to ask the HR person. As much as I tell people that they're going to have to ask somebody at some point, we can only do so much. Making the workplace welcoming and safe for people to be able to ask, a culture where the information is just out there, everybody gets the same information. We talk about transgender issues to non-transgender people in our trainings. Every time we talk about benefits we talk about and we include transgender-inclusive benefits. We don't care whether a transgender person is in the room, we don't care if a transgender person in the audience. I don't know if there is a transgender person in the audience here. It doesn't matter. I don't know if people here are parents or not parents of a transgender person, I don't know if your spouse of domestic partner is transgender. We don't know this about people so we need to assume this matters to everybody when we deliver information. That's what makes a place welcoming.

There are resources. This [gestures to slide] is the paper I referred to; it's in a revision right now and hopefully it will be out shortly. If you give me your email address or you give the organizer of the Summit your email address we will get this Powerpoint to you.

And now, questions. Sorry, the food is gone.

[Audience member question: So if I'm a small business owner and I have like 6 employees, and we're in the fully-insured category there, what, if anything, can I do? I'm completely convinced I want to be inclusive. Is there anything I can do? Do I have to wait for the Federal government to tell insurance companies they have to make those plans inclusive?]

This is a great question. This is a huge problem. If you're one of the employers in one of those 8 states or in DC, then you just have a boilerplate plan available to you right now that does not have an exclusion. So one thing that can be done is figure out in Missouri who actually could make such as—*[video cuts out]*

END OF TRANSCRIPTION

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Important changes to note since the 2014 Transgender Inclusive Health Insurance Summit:

- **Dec 2014**
  - New York State Dept of Financial Services, which regulates the NY insurance industry, issued guidance stating that the law requires health insurance companies to cover transgender health care on the same terms as other care. *(Does not apply to NY State Medicaid nor to self-funded plans because those plans are not regulated by the NY State Dept of Financial Services.)* (link)
- **March 2015**
  - New York State Medicaid lifts ban on transition-related care (link)
  - Connecticut State Medicaid lifts ban on transition-related care (link)
- **May 2015**
  - US Dept Health & Human Services (HHS) issues guidance that under the Affordable Care Act, all insurance companies must cover sex-specific preventive care, including mammograms and pap smears, for transgender people, and that that care must be provided without regard to "sex assigned at birth, gender identity, or recorded sex." (link)
- **June 2015**
  - Office of Personnel Management (OPM) issues guidance effective Jan 1 2016, insurers in the Federal Employment Health Benefits (FEHB) Program may not exclude transition-related coverage (link)
  - Nevada State Division of Insurance issues bulletin on transgender inclusive health coverage (link)
- **July 2015**
  - New York State Department of Health issues guidance clarifying NY State Medicaid coverage to ensure that "medically necessary procedures affecting appearance" are covered (including those associated with medical transition) (link)