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Costs and Benefits of Providing Transition-Related Health Care Coverage in Employee Health Benefits Plans

FINDINGS FROM A SURVEY OF EMPLOYERS

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EXECUTIVE SUMMARY

A growing number of employers, both public and private, are providing coverage in employee health benefits plans for transition-related health care to treat gender dysphoria. In order to inform employer-based decisions and current policy debates regarding provision of this coverage, this study describes the experiences of 34 employers who provide transition-related coverage in their health benefits plans. Overall, we find that transition-related health care benefits have zero or very low costs, have low utilization by employees, and yet can provide benefits for employers and employees alike.

Employers report very low costs, if any, from adding transition-related coverage to their health benefits plans or from actual utilization of the benefit after it has been added – with many employers reporting no costs at all.

Based on data collected in this study, costs of providing transition-related health care coverage are very low, including for employers that cover a wider range of medical treatments or surgical procedures for transition.

Overall, we find that transition–related health care benefits have zero or very low costs, have low utilization by employees, and yet can provide benefits for employers and employees alike.

Twenty-six of the 34 employers in this study provided information about the cost of adding transition-related coverage to existing health care plans.

- Eighty-five percent (85%) of these 26 employers reported no costs associated with adding the coverage, such as increases in premiums in the first year.
- Four employers (15%) reported costs due to adding the coverage. Three employers provided information about the costs they incurred from adding the coverage based on projections of utilization. These costs based on projections seem high in light of the findings from prior research and this study regarding actual costs and utilization rates. These projections may reflect actuarial overestimates of the utilization of these benefits and subsequent cost of claims. For instance, two employers reported a 1 percent increase in total cost to their transition-inclusive plans, based on projected benefit utilization, whereas two similarly-sized employers reported lower costs due to actual benefit utilization.

Twenty-one of the 34 employers in the study provided information about the actual costs from employees utilizing the transition-related health care coverage.

- Two-thirds (14 employers) reported no actual costs resulting from employees utilizing the coverage.
- One-third (7 employers) reported some actual costs related to utilization by employees.
- However only three of the seven employers reported the actual costs with any degree of specificity. All three of these employers reported that their actual costs from utilization are very low:
  - In one case, actual cost over two years was only $5500, which comprised only 0.004 percent of total health care expenditures. The other two employers characterized the costs as "negligible" and "minimal" at less than 1 percent of total costs or total claims paid.

Few people will utilize transition-related health care benefits when they are provided.

When an employee utilizes transition-related health care benefits, their claims may result in costs to their employer. The type, number and cost of services accessed by individuals will vary, yet as described above, the costs of these benefits, if any, are very low, as is the utilization of the benefit. While utilization rates depend on the size of the employer, estimates based on the best data gathered in the survey result in annual utilization rates of approximately:

- 1 out of 10,000 employees for employers with 1,000 to 10,000 employees, and
- 1 out of 20,000 employees for employers with 10,000 to 50,000 employees.

More specifically:

- Two employers with less than 1,000 employees reported zero transition-related claims over a combined six years of providing this type of coverage in their health benefits plans.
- For employers with 1,000 to 9,999 employees, average annualized utilization was 0.107, with a lower bound of 0.027 and an upper bound of 0.214 claimants per 1,000 employees.
- For employers with 10,000 to 49,999 employees, average annualized utilization was 0.044, with an upper bound of 0.054 claimants per thousand employees.

Employers reported that providing transition-related health care coverage benefits them in a variety of ways. Employers reported that they

provide the coverage in order to:

- Make them competitive as an employer within their industries and help them with recruitment and retention of employees (60%);
- Reflect their corporate values, including equality and fairness (60%);
- Provide for the health care needs of their employees and improve employee satisfaction and morale (48%); and
- Demonstrate their commitments to inclusion and diversity (44%).

Not surprisingly, then, a majority of employers also reported that they would encourage other employers to add the coverage, and none would advise against adding the coverage.

With regard to the scope of transition-related health care coverage that employers are providing, while many transition-related claims would be covered under these employers' plans, some do not provide coverage for many medical treatments or surgical procedures that the WPATH *Standards of Care* describe as medically necessary when clinically indicated for an individual.

- Employers provide coverage in their health benefits plans that cover many medical treatments and surgeries that an individual may need for treatment of gender dysphoria. For most of the hormone therapies and genital surgeries asked about in the survey, 100 percent of transition-related benefits plans provide coverage.
- Plans are less likely to cover certain reconstructive procedures such as breast/chest surgeries, electrolysis, facial surgeries and related procedures, and voice-related care.
- Only 59 percent of employers cover breast or chest reconstruction, with only a quarter covering electrolysis, certain facial procedures, and voice-related procedures.
- Plans also have other specified limitations in coverage:
  - Forty-eight percent (48%) of transition-inclusive plans have some type of restriction on access to transition-related healthcare provided out-of-network, including restrictions of services provided outside of the United States. These restrictions may limit access to transition-related care since providers in the United States may not participate in certain health benefits plans. In this case, employees may seek services outside of their plan, elsewhere in the U.S., or in another country.
  - However, twenty-five employers (74%) offer transition-related benefits with no dollar limit. Almost all employers with a limit reported a $75,000 lifetime limit or higher (21%).
- In this sample, there was no relationship between the scope of the coverage provided and reported costs of adding the coverage, meaning providing broader coverage did not result in higher costs for surveyed employers.

In one case, actual cost over two years was only $5500, which comprised only 0.004 percent of total health care expenditures. The other two employers characterized the costs as "negligible" and "minimal" at less than 1 percent of total costs or total claims paid.

Of the 33 employers responding to questions about the process of adding transition-related health care benefits, 94 percent (31 employers) reported that there were no significant barriers to adding the coverage. Employers also provided practical guidance to other employers to aid them in adding the coverage for their employees. Employers recommended that other employers:

- Work with their insurers and Third Party Administrators to discuss the coverage they can offer and to address any shortcomings in their medical guidelines.
- Conduct research and consult with other employers that provide the coverage to better understand costs they may incur and to be better informed to negotiate with their insurers.
- Work with benefits administrators to make sure they are providing competent customer service to employees who inquire about transition-related health care benefits.

Overall, we find that transition-related health care benefits have very low costs, have low utilization rates by employees, and yet can provide benefits for employers and employees alike. Future research regarding transition-related health care coverage should consider the negative impact on employees, and therefore on employers, of not providing medically necessary care for treatment of gender dysphoria. Future research should also consider the cost savings to employers over time that result from providing the health care that their employees need.

INTRODUCTION

A growing number of employers, both public and private, are providing coverage in employee health benefits plans for transition-related health care to treat gender dysphoria. Since 2008, the Human Rights Campaign has collected data for its Corporate Equality Index (CEI) on the provision of transition-related health care benefits by the largest U.S. employers (Fortune 1000 and AmLaw 200).[1] A total of 49 employers reported providing this coverage in 2009. That number has grown to 287 as of the 2013 CEI, a nearly 600 percent increase over four years. Growing numbers of cities and universities are providing coverage for employees as well. Currently nine cities, three counties, and fourteen universities are known to provide this benefit to employees.[2] California, Colorado, Oregon, Vermont, and the District of Columbia have also issued insurance regulations, directives, or bulletins informing private insurers and managed care plans that discrimination against transgender people in health care is not permissible.[3]

The increasing number of employers providing transition-related health care coverage as part of their benefit suite may be related to new requirements for earning points in the CEI's rating system. Beginning with the 2012 CEI, the Human Rights Campaign has required participating employers to make available to employees at least one transition-inclusive health benefits plan in order to receive full credit, and a possible score of 100, in the CEI.[4] In addition to the CEI requirements, recent statements by professional associations, such as the American Medical Association (AMA) and the American Psychological Association (APA), explain that care for the treatment of gender dysphoria is a medical necessity and coverage should be included in health benefits plans.[5]

Despite these statements and the increasing number of employers providing this coverage, treatment for gender dysphoria is still rarely covered by health benefits plans, including both public plans and employer-based plans. Surgeries and other medical treatments to treat gender dysphoria are often explicitly excluded from health benefits plans or are determined to be cosmetic and, therefore, not medically necessary.[6] While coverage for transition-related health care remains rare in health benefits plans, employers are being encouraged to provide it. In order to come into compliance with the determinations of the AMA, APA, and other professional associations and to meet the requirements of the CEI, employers must remove existing exclusions to transition-related health care from health benefits plans. In most cases, employers will also need to provide a defined benefit for transition-related care that meets current medical standards of care.[7] A "defined benefit" means that the scope and limitations of this coverage are described in plan documentation.

Since 1979, the World Professional Association for Transgender Health (WPATH), formerly the Harry Benjamin International Gender Dysphoria Association, has established standards for appropriate and medically necessary care for the treatment of gender dysphoria.[8] The most recent edition of the *Standards of Care*, the 7th edition, describes an individualized program of treatment based on a person's particular mental health and medical needs in consultation with their health care providers. The *Standards of Care* describe the individual treatments and procedures that may be considered medically necessary in an individualized treatment program, including hormone therapies, chest/breast surgeries, genital surgeries, and other surgeries, such as facial feminization surgeries. These medically necessary treatments and procedures alleviate gender dysphoria by bringing one's physical characteristics into alignment with one's internal sense of gender.[9] For purposes of this report, these medical treatments and procedures are referred to as "transition-related health care."

In order to inform employer-based decisions regarding this type of health care coverage and current policy debates regarding provision of this coverage in public health insurance plans, this study describes the experiences of employers who have chosen to provide transition-related health care coverage for their employees through their health benefits plans. In this report, we review findings from an original survey of 34 employers who provide this health benefit to their employees.[10] First, we present prior research on cost and utilization of transition-related health care benefits and recent research on the benefits to employers of adopting lesbian, gay, bisexual, and transgender (LGBT)-inclusive workplace policies. Next, we will describe the survey methods we employed in the current study. We then describe the findings from the survey. In particular, we examine the scope of the transition-related benefit employers are providing, the cost to the employer to provide the benefit, and the utilization of the benefit. Afterward, we describe why and how employers began providing the coverage, what benefits, if any, employers report they receive as a result of providing this coverage for their employees, and what advice they would give to other employers considering adding this coverage. We conclude by discussing our findings as compared to prior research findings, the limitations of this study, and considerations for future research.

PRIOR RESEARCH

Employers who are considering adding transition-related health care benefits may be interested in understanding how much adding this benefit will cost in dollars. Prior research shows that data on costs to employers are not widely available, especially in terms of the actual cost in dollars of transition-related claims that have been paid. Data that do exist on actual costs incurred are sometimes expressed as a percentage of total health care expenditures or as a percentage of premiums per member per year or per month. Costs to employers based on actuarial projections are expressed in similar terms. In all cases, data on costs to employers are scarce. In lieu of information about the actual dollar cost of transition-related claims, we look to data on benefit utilization in terms of the number of claims and number of claimants. While data on utilization does not allow us to determine the cost of the services utilized, it can provide a description of the demand for these services. Existing data on cost and utilization together can assist in predicting what an employer can expect in terms of the cost of providing transition-related health care coverage for employees. Research also can assist employers in understanding the positive or negative impact on their business and their employees of providing LGBT-inclusive workplace policies.

Cost

The best available data on cost to employers to provide transition-related health care benefits for employees come from the City and County of San Francisco. The University of California and the cities of Seattle, Portland, and Berkeley have also released data on the costs they incurred for providing the benefit.

A 2007 memo from the City and County of San Francisco and the San Francisco Human Rights Commission describes the costs over time associated with adding transition-related health care benefits for employees as of 2001.[11] Initially, actuaries assumed that out of 100,000 enrolled members, 35 members would make claims each year under the transition-related health care benefit at a total cost of $1.75 million per year, or $50,000 per claimant. To cover the projected cost, $1.70 per month from each enrolled member's premium was allocated for this benefit.[12] Over the first three years, a total of $4.3 million was collected for this benefit from employee premiums, yet only a total of $156,000 was spent on claims under the benefit. Because actual costs of transition-related claims were so small relative to projections, these benefits were provided at no additional cost to employees as of July 1, 2006. Over five years from 2001 through 2006, $5.6 million was collected from enrolled employees to cover the cost of the benefit and a total of $386,417 was spent, or about $77,000 on average per year.

The University of California began providing transition-related health care coverage to employees in 2005.[13] The University, which has a mix of self-insured, fully insured, and managed care/HMO plans, was not charged any additional premium by insurers for adding the coverage.[14] Actual cost data provided to the Department of Insurance for the State of California reveal that claims paid under the transition-related health care benefit for one health plan represented a cost of $0.20 per member per month, or 0.05 percent of the total premium.[15] The cost of individual claims ranged from $67 to $86,800, with an average cost per claimant of $29,929.[16]

The cities of Berkeley, Seattle, and Portland, however, have absorbed premium increases of 0.2 percent, 0.19 percent, and 0.08 percent of their total health care budgets, respectively.[17] Given the experiences of the City and County of San Francisco and the University of California, these premium increases based on insurer projections may be high in relation to actual costs that will occur. Since these cities have added coverage only recently, within the past two years, actual cost data were not available at the time of the California Department of Insurance report.

Utilization

Studies of the utilization of transition-related health care benefits have analyzed data from the City and County of San Francisco, the University of California (one health plan only), and from several private employers. Findings from these studies have expressed utilization of the benefit by providing the number of individual claimants per thousand employees in the health benefits plan. A summary of the findings of this research, presenting the maximum and minimum reported utilization per year, is shown in Table 1.[18] The lowest utilization rate per 1000 employees per year (0.0015) was found in a sample of private employers in a 2009 HRC Foundation (HRCF) study conducted by Jamison Green & Associates.[19] The same study also found the highest reported utilization rate per year of 0.22 claimants per thousand employees.

To better understand the employer-level context for findings regarding utilization of the transition-

Table 1: Summary of Utilization Findings from Prior Research

Utilization Rates per 1,000 employees per year

Case	City and County of San Francisco	University of California	Sample of Private Employers
Minimum	0.074	0.022	0.0015
Maximum	0.200	0.187	0.22

Sources: State of California, Department of Insurance, *Economic Impact Assessment: Gender Nondiscrimination in Health Insurance*, April 13, 2012; Jamison Green & Associates, *Transgender-Inclusive Health Benefits: Data for Cost Calculation*, March 2012.

related health care benefit, the Jamison Green & Associates report gives utilization data by employer size for the 2009 HRCF study. Table 2 provides the findings from their 2009 sample of private employers who provided utilization data, along with data from the City and County of San Francisco and the University of California (UC). Data from private employers were adjusted to provide the average annual number of claimants per thousand employees for all employers of that size (lower bound) and for only those employers of that size reporting the benefit had been utilized (upper bound). Lower and upper bound utilization for the City and County of San Francisco are based on the average annual number of claimants divided by the lowest estimate of the number of employees over the time period (25,000) versus the largest estimate of the number of employees over the period of time (35,000).[20] An overall average utilization rate is also provided for the City and County of San Francisco, based on average annual utilization for 30,000 employees. Lower and upper bound utilization for the University of California are the lowest and highest utilization rates per thousand employees enrolled in this plan per year observed in years 2006 through 2011.[21] The overall average annual utilization is also provided for the University of California.

To provide better understanding of the practical implications of these utilization findings, André Wilson explained, "For firms with 1000-9999 employees, an upper bound or worst case is 0.22 per thousand per year. Using this data to forecast utilization, an employer with 2000 employees might expect to see about two insured persons access transition-related surgeries every five years."[22] Given that Wilson's projection presents a "worst case," he noted that the projected utilization is actually unlikely to occur. He also noted that the survey sample for the 2009 HCRF study was small and further research is needed to understand if these findings are representative of other employers' experiences.

One can see from the findings presented in Table 2, as employer size increases, utilization rates decrease. Of the private employers, utilization is highest for smaller employers, ranging from 0.074 to 0.220 claimants per thousand employees, and is lowest for the largest employers, ranging from 0.0015 to 0.0023 claimants per thousand employees. These particular employers' data suggests that projected risk decreases as employer size increases. Data from the City and County of San Francisco show they have relatively high utilization compared to similarly-sized private employers (10,000 to 49,999 employees), with average annual utilization of 0.127 per thousand employees compared to a range of 0.016 to 0.060 for the private employers. The University of California also seems to have relatively high utilization in this one health plan compared to private employers with similar numbers of employees, with an average annual 0.124 claimants per thousand employees. However, it should be noted that in order to understand the total demand for transition-related health care at the University of California, we would need to have similar data from all of the UC employee plans.[23]

Table 2: Annualized Utilization Per Thousand Employees by Employer Size

	1,000 to 9,999	(San Francisco) 25,000 to 35,000	(Univ. of CA) 43,000 to 61,000[24]	10,000 to 49,999	50,000 +
# Employers	4	1	1	7	2
Adjusted rate (lower bound)	0.074	0.074	0.022	0.016	0.0015
Average rate	—	0.127	0.124	—	—
# Employers	2	1	1	3	1
Adjusted rate (upper bound)	0.208 – 0.220	0.200	0.187	0.016 – 0.060	0.0023

Sources: State of California, Department of Insurance, *Economic Impact Assessment: Gender Nondiscrimination in Health Insurance*, April 13, 2012; Jamison Green & Associates, *Transgender-Inclusive Health Benefits: Data for Cost Calculation*, March 2012. NOTE: No data were available for employers with less than 1,000 employees. Average annual utilization rate for the City and County of San Francisco calculated by the author.

The California Department of Insurance also provided utilization data based on the estimated total number of covered lives in this health benefit plan for the University of California. In contrast to the number of enrolled employees, the total number of "covered lives" in transition-inclusive plans is a more accurate measure of the demand for transition-related health care because this number includes all individuals who would be eligible to make transition-related claims (i.e., employees and retirees plus covered dependents). Data on the number of claimants for transition-related health care, both in prior research and the current study, could include claims from employees' and employees' dependents as well.

For this University of California plan from 2006 through 2011, the average annual number of claimants per thousand covered lives is 0.062.[25] This means that in a plan with 100,000 covered lives, an employer could expect to see about 6 covered individuals make transition-related claims each year. However, as noted above, we would need to have similar data from all of the UC employee plans in order to assess total demand for transition-related health care at the University of California.

Benefits to Employers

Existing research shows that workplace policies that benefit LGBT employees are connected to positive outcomes for businesses.[26] Positive outcomes for businesses include increased job satisfaction and productivity for employees, improved health outcomes among LGBT employees, improved workplace relationships, and improving employers' bottom lines.[27] In addition to the generally positive impact of LGBT-inclusive workplace policies, research conducted by the California Department of Insurance found potential cost savings to employers that provide transition-related health care benefits for employees.[28] The California Department of Insurance describes cost savings that may result by reducing costs associated with not providing medically necessary care for people who experience gender dysphoria. These cost savings include a reduction in suicide ideation and attempts, an improvement in mental health, reduction in rates of substance abuse, and an increase in socioeconomic status for those who receive the medically necessary care needed to treat their gender dysphoria.

METHOD

Survey participants for this study were all employers known to provide transition-related health care coverage for employees through their health benefits plans. To identify these target participants, we relied on the 2013 CEI and existing knowledge networks to identify city, county, and university employers. The survey was announced via email in December 2012 to a total of 243 employers, utilizing personal contacts and LGBT employee resource groups. For employers not responding to the initial survey announcement, follow-up emails were sent in January 2013. Outreach efforts resulted in completed survey responses from 34 employers, both public and private, including corporations, law firms, universities, and cities. These employers represent 900,000 full-time employees, 2 million covered lives in their health benefits plans, 122 years of combined transition-related health care coverage experience, 191 total health benefits plans for active employees, and 150 total retiree-only plans, including Medicare supplements. These employers are headquartered in 16 U.S. states and the District of Columbia, representing all regions of the U.S., and all but five (85%) have significant operations in other U.S. locations. Table 3 provides a breakdown of participating employers by number of full-time active employees and the number of health benefits plans provided.

The survey was designed to capture details about the employers and the health benefits plans they provide. It asked for details about the transition-related health care coverage provided, such as procedures covered, limits to the coverage, and the total number of covered lives in the transition-inclusive plans. Employers were asked about the costs related to providing the coverage, including costs based on actual utilization of the benefit or costs based on insurer projections which may have resulted in premium increases, and any utilization of the benefit. Employers were also asked why they decided to provide the benefit, any barriers they experienced to adding the benefit, what benefits they receive by providing the coverage, and what advice they would give to other employers who are considering adding transition-related health care benefits for their employees. In order to protect the privacy and identities of any individual employer or employee, all data are presented in the aggregate, with few exceptions in regard to costs, and are not attributed to any particular employer.

Table 3: Participating Employers, by size and number of health benefits plans

Utilization Rates per 1,000 employees per year

Full-Time Active Employees	Number of Employers	Number of Health Benefits Plans
Less than 1,000	4	13
1,000 to 9,999	15	56
10,000 to 49,999	11	89
50,000 or more	4	33
TOTAL	34	191

TRANSITION-RELATED HEALTH INSURANCE BENEFITS POLICIES

Of the 191 health plans for active employees offered by surveyed employers, 68 percent cover transition-related health care. All benefits-eligible employees for 28 employers (82%) have access to a transition-inclusive plan. Six employers reported they had some employees without access to transition-related plans for one or more of the following reasons:

- They have HMO plans that do not include the benefit (3 employers).
- Union-negotiated plans did not provide coverage (4 employers).
- Some of their plans were subject to medical guidelines that did not include transition-related health care (1 employer).

Access to transition-related health care coverage is less common for non-Medicare retirees than for active employees. Twenty-one employers (62%) reported that non-Medicare retirees have access to transition-inclusive plans.

Employers provide transition-related health care benefits through one or more plan types: self-insured plans, fully insured plans, and/or managed care/HMO plans. Most employers (72%) provide transition-related health care benefits through self-insured plans, either alone or in addition to transition-inclusive fully insured or managed care/HMO plans. Table 4 provides the type of transition-inclusive plans participating employers offered by employer size. The most commonly used Third Party Administrator (TPA) for transition-inclusive self-insured plans is UnitedHealthcare (11 employers), followed by Anthem (including Anthem Blue Cross and Blue Shield) (6 employers), Cigna (4 employers), and Aetna (4 employers).

Table 4: Type of Transition-Inclusive Plan by Employer Size

Type of transition-inclusive plan	Number of Employers by Size			
	Less than 1,000	1,000 to 9,999	10,000 to 49,999	50,000 +
Self-insured only	—	11	8	2
Fully Insured only	3	1	—	—
HMO/Managed care only	—	1	—	—
More than one plan type	1	2	3	2

According to WPATH's *Standards of Care*, treatment of gender dysphoria should be an individualized program that meets the specific needs of those individuals seeking care.[29] Individuals and their health care providers have a range of medical treatments and surgical procedures they can consider to alleviate gender dysphoria.[30] When mental health and medical providers, in consultation with the individual seeking care, determine that particular medical treatments or procedures are needed to address an individual's gender dysphoria, these interventions are considered medically necessary care for that individual.[31] An individual in need of treatment for gender dysphoria will not need every available medical treatment or procedure for purposes of gender transition. If the medical treatments or procedures an individual needs as part of their medically necessary care are not covered by their health benefits plan, it will be up to the individual to cover any expenses incurred through their own means.

To assess whether transition-inclusive health plans would meet the range of treatment that could be deemed medically necessary for a covered individual, the survey for this study asked employers to describe the transition-related health care coverage they provide. Survey respondents were asked whether their plan(s) cover specific hormone therapies, surgeries, and other procedures that the WPATH *Standards of Care* describe as medically necessary care if clinically indicated for an individual. The survey asked for coverage limitations, including eligibility, maximum dollar limits, coverage outside of the network, and other limitations and restrictions related to travel expenses. It should be noted that the CEI requires that employers provide transition-related health care coverage consistent with the WPATH *Standards of Care* with no less than a $75,000 lifetime cap on transition-related claims. Tables 5 and 6 provide the list of specific hormone therapies, surgeries, and other procedures the survey inquired about and the percentage of employers who provide coverage for each one listed. Not all employers were able to provide an answer or adequate plan documentation to determine an answer for each item listed. Therefore, the sample size is indicated for each item.

Of employers providing answers to all listed items, only two provide coverage for all transition-related care inquired about in the survey. For most of the hormone therapies and genital surgeries listed, 100 percent of transition-related benefits plans provide coverage. However, plans are less likely to cover certain reconstructive procedures such as breast/chest surgeries, electrolysis, facial surgeries and related procedures, and voice-related care. For instance, only 59 percent of employers cover breast or chest reconstruction.

It is clear that many employers in this sample do not provide health benefits for their employees for medical treatments or procedures that the WPATH

Table 5: Hormone Therapies Covered by Employer Health Benefits Plans

Therapies	Percent Providing Coverage	Number of Companies Responding
Cross Sex Hormonal Therapies:		
Estrogen	100	25
Progesterone	100	24
Spironolactone (anti-androgen)	100	22
Testosterone	100	25
GnRH analogs (puberty suppression)	94	18

Standards of Care describe as medically necessary when clinically indicated for an individual. There may be several reasons for the limited scope of the coverage. It is possible that some of the listed procedures were not available as part of the insurance products that fully-insured employers could purchase. It is also possible that coverage is limited to standardized internal medical or clinical guidelines, which insurance carriers and TPAs develop to determine coverage and guide claims decisions, many of which exclude certain medical treatments or procedures. For instance, CIGNA's Medical Coverage Policy describes covered and excluded medical treatments and procedures for "gender reassignment surgery."[32] While CIGNA covers a number of surgical procedures under their Policy, such as mastectomy and hysterectomy for trans men and orchiectomy and vaginoplasty for trans women, there are a number of exclusions, such as breast surgeries, electrolysis, tracheal shave, facial surgeries, and voice modification surgery for trans women and certain chest reconstruction procedures for trans men, among other exclusions. Those employers with health benefits plans purchased from or administered through CIGNA may be subject to CIGNA's Medical Coverage Policy and, therefore, these exclusions.

The survey also assessed lifetime dollar limits for transition-related health care coverage. Twenty-five employers (74%) offer transition-related benefits with no dollar limit. Two employers reported a lifetime limit of $100,000, while others reported a $75,000 lifetime limit (5 employers) and a $50,000 lifetime limit (1 employer). One employer did not report a dollar limit. Since most of the employers who participated in this study received the trans-inclusive benefits points in their CEI score, it is not surprising to find that nearly all of those instituting caps established a lifetime cap at $75,000 or greater, with the vast majority providing coverage with no lifetime dollar limit.

Table 6: Surgical and Body Procedures Covered by Employer Health Benefits Plans

Procedures	Percent Providing Coverage	Number of Companies Responding
Electrolysis (hair removal):		
Feminizing (Facial/ Neck)	24	25
Pre-surgical MTF genital epilation	39	23
Pre-surgical FTM free flap preparation	39	23
Breast/Chest surgeries:		
MTF Breast augmentation (implants)	59	27
FTM Bi-lateral mastectomy	92	25
FTM chest reconstruction	59	22
FTM nipple areolar reconstruction	70	20
MTF Gonadectomy and Genital Surgeries:		
Orchiectomy	100	26
Vaginoplasty	100	27
Labiaplasty	100	27
Clitoroplasty	100	27
FTM Gonadectomy and Genital Surgeries :		
Hysterectomy/ Oophorectomy	100	27
Metoidioplasty	100	26
Phalloplasty	100	26
Penile/erectile implants	74	23
Urethroplasty	100	26
Vaginectomy	100	26
Scrotoplasty	88	26
Testicular implants	84	23
"Facial Feminization" and related procedures:		
Orthognathic surgeries (reshaping of bony structures of brow/ cheek/jaw)	26	27
Rhytidectomy (hairline advancement)	22	23
Rhinoplasty	28	25
Reduction Thyroid Chondroplasty (tracheal shave)	58	24
Voice:		
Voice retraining	9	23
Vocal chord surgery	20	25

Thirty-seven percent (37%) of transition-inclusive plans are limited to "initial surgery only" or "one transition." Forty-eight percent (48%) of transition-inclusive plans have some type of restriction on access to transition-related healthcare provided out-of-network, including restrictions of services provided outside of the United States. Of these 48 percent, only two employers noted that no out-of-network services are covered under the plan and nine reported that no services, except for emergency care in most cases, were covered outside the United States. Four employers indicated that services rendered outside the United States could be covered, but would be subject to the same reimbursement rates and limitations that would apply for care provided out-of-network. Seventeen percent (17%) of transition-inclusive plans will reimburse claimants for travel and lodging expenses for transition services. Restrictions on out of network services may impact those in need of transition-related care since providers for certain transition-related services in the United States may not participate in certain health benefits plans' networks. In this case, U.S.-based employees may seek services outside of their plan networks and/or in another country.[33]

COST OF TRANSITION-RELATED HEALTH CARE BENEFITS

Costs to an employer and/or employees of providing transition-related health care benefits are based on utilization of the benefit. Some employers, particularly self-insured employers, will see no costs until actual utilization of the benefit results in the payment of claims. Other employers may see premium increases when adding the benefit based on projected utilization. Increased costs based on projections are based on actuarial estimates by the employer's insurance provider, TPA, or, in the case of some self-insured employers, by their own actuaries of predicted benefit utilization and the costs of these predicted claims. Employers that are faced with cost increases to their plans based on projections, such as a premium increase for a fully-insured plan, can choose whether to pass along the cost increase to employees in full, in part, or to cover the full cost increase themselves. The accuracy of actuarial predictions can only be assessed in subsequent years when the actual costs of transition-related claims, or the impact of the addition of the benefit on total health care expenditures, can be known. Future premiums may be adjusted based on the actual known cost of these benefits in subsequent years or, more commonly, based on the overall impact on the total cost of the health benefits plan.

The survey asked employers about whether they incurred costs for adding transition-related health care coverage to their employee health benefits plans, and if so, what those costs were. Table 7 shows the costs employers reported by employer size; more specific information about those reporting costs is provided below. All employers that reported costs due to utilization or projections provide their transition-related health care benefits through self-insured plans, except for one employer with costs due to utilization that provides several different transition-inclusive plan types and one employer with costs based on projections that provides a fully-insured plan.

Overall, 26 employers were able to provide information about costs related to adding their transition-related health care benefit. Twenty-one employers provided information about the actual costs from employee utilization of the transition-related health care benefit. Eight employers did not know if there were costs associated with the benefit because several plan changes were made at the same time and specific costs for transition-related coverage were not separated out.

Twenty-two (85%) of the 26 employers reported no costs associated with adding the benefit, such as in premium increases in the first year. Ten of these 22 employers stated that there was no cost specifically

Table 7: Costs of Transition-related Health Care Coverage, number of employers by plan type and employer size

	Less than 1,000	1,000 to 9,999	10,000 to 49,999	50,000 +
No costs to add coverage, no subsequent costs	2	6	2	—
No costs to add coverage, unknown subsequent costs	1	3	1	—
Do not know cost, several plan changes made	—	2	3	3
Known costs due to utilization	—	2	4	1
Known costs based on projections	1	2	1	—

attached to adding the benefit and there have been no subsequent costs due to utilization of the benefit. Five of these 22 employers stated that there was no cost to add the coverage, but they did not know if there had been subsequent costs due to utilization of the benefit. Seven of these 22 employers reported no costs to adding the benefit, but did report subsequent costs due to utilization.

Of the 21 employers that provided information about the actual costs from employees utilizing the transition-related health care coverage, 14 employers (67%) reported no actual costs resulting from employees utilizing the coverage. Seven employers (33%) reported some actual costs related to benefit utilization by employees. More information about these seven employers is provided below.

No Reported Costs for Adding Transition-related Health Care Coverage (n=22)

Of the 22 employers (85%) who reported that there was no cost to adding transition-related health care coverage, six provided additional explanation as to why there were no costs to adding the benefit. One fully-insured employer remarked that their insurance provider initially stated that there would be an additional charge for adding this coverage to their plan, but after further review added the coverage at no additional cost. Two of the 22 employers reported their plans have always covered transition-related care, so there was no cost to add the benefit. One of these two employers stated their plan (a managed care/HMO plan) has been in place since the mid 1990s. Their coverage for transition-related health care has been in place since plan inception and is explicitly described in the health plan documents. The other employer's plan (self-insured) has been in place for at least 30 years and has no exclusion on transition-related care. Though coverage is not explicitly described in the plan documentation they provided for this study, they reported that certain transition-related health care benefits have been covered through this plan since the mid 1980s. Three of the 22 employers who reported no costs to adding the coverage (all three self-insured) stated the projected cost of adding the benefit was too small to justify an increase. One of these employers (~26,000 employees) explained, "Our analysis indicated that the cost would be quite small. We price based on past year costs with adjustments for estimated increases. This was too small to adjust for." Another employer (~1,500 employees) similarly explained, "The actuarial impact of adding this benefit was deemed negligible enough not to warrant a budget adjustment." The third employer (~1,600 employees) explained, "We looked at projected cost based on aggregate of total claims projected – increase was de minimis – .2% or $26,000."

"The actuarial impact of adding this benefit was deemed negligible enough not to warrant a budget adjustment."

Reported Actual Costs Based on Utilization (n=7)

Seven employers reported they incurred costs directly related to employee utilization of the transition-related health care benefit. Six of these seven employers provide transition-related health care coverage through self-insured plans and chose to absorb any costs associated with the benefit. One of the seven provides the coverage through several plan types. Three of these seven employers (each self-insured) offered more specific information on the actual costs they incurred. Only one of these employers was able to provide actual cost in dollars of transition-related claims under their health benefits plan. This employer (~10,000 employees) reported that transition-related claims cost just under $5500, or 0.004 percent of total health care expenditures, over two years. This employer's plan covers just over 21,000 individuals (employees and dependents) and total health care expenditures over the same two years were $144 million.

Two other employers gave a general impression of the costs they have incurred for transition-related claims, but did not provide enough information about their costs and their total health care expenditures in order to calculate the actual total cost in dollars. One employer (~5,000 employees) reported that the cost of the benefit was "negligible" and less than 1 percent of total health care expenditures over one year. Another employer (~2,000 employees) reported that claims paid on the benefit were "minimal" and represented less than 1 percent of total claims paid under the plan over one year.

Reported Actual Costs to Add Coverage Based on Projections (n=4)

Costs based on projections are the result of actuarial predictions of the utilization of transition-related health care benefits and what the actual cost of those claims will be. Four employers reported increased costs based on projected

utilization of the benefit. Three of these four employers cover transition-related health care through self-insured plans. The remaining employer provides a fully-insured plan. The three employers with self-insured plans provided some information about their cost increases. One of these three employers (~38,500 enrolled employees) reported a total projected increase to the plan of $100,000 per year for providing the benefit, which is substantially less than 1 percent of total health care expenditures. To date, this employer has not verified the actual expenditures for this benefit. Any actual utilization will be included in future plan costs, and, therefore, reflected in premium rates.

One employer (~1,600 employees) reported that the total premium cost per member per month of $485 was increased $5 due to adding transition-related coverage; an increase of about 1 percent. This increase occurred in the first year and will be included in future premiums as well. At a rate of $5 per employee per month, this would be a total annual increase of about $94,000 each year. This employer chose to absorb the cost of this increase, meaning employee premiums were not increased to cover the cost, and believes the benefit has not been utilized.

The remaining employer (~1,300 employees) did not provide dollar amounts in regard to the increase, but reported that their one transition-inclusive plan, their high deductible health plan, increased in cost by 1 percent as a result of adding the coverage. The employer absorbed the cost of this initial premium increase and believes the benefit has not been utilized. Future premiums will be adjusted based on review of actual health plan costs.

UTILIZATION OF TRANSITION-RELATED HEALTH CARE BENEFITS

Eighteen employers were able to provide answers to survey questions about utilization of their transition-related health benefits. Of these eighteen, three reported they had confirmed with their insurer or TPA that the benefit had not been utilized. These three employers represent over 28,000 full-time active employees, nearly 128,000 covered lives, and five and a half combined years of transition-related health care coverage experience. Five employers reported they believed the benefit had not been utilized, but were unable to confirm with their insurer or TPA. Six employers reported the benefit had been utilized and were able to provide utilization data. Four reported utilization but were not able to provide any data about the utilization. In addition to those employers that provided information about utilization, four employers reported that employees had inquired about the benefit. The remaining employers in the sample did not provide any information regarding utilization about the benefit or benefit inquiries.

Table 8 provides the average annual utilization per thousand employees for three sets of employers, using calculations similar to the 2009 HRCF study.[34] The number of employers included in the calculations for Table 8 differs slightly than the numbers of employers described in the prior paragraph. One of the six employers that provided utilization data is not included in Table 8, since that employer expressed their utilization as a percentage of all claims instead of a number of claims/claimants. Therefore, the employer did not provide data that could be compared to the other employers. Two of the five employers who reported that they believed there had been no utilization had the benefits in place for less than one year at the time of the survey. Due to the short timeframe for their transition-related coverage, these two employers were not included in the calculations for Table 8.

The top two rows of Table 8 provide "lower bound" average annual utilization rates, which includes employers who reported the benefit had been utilized and provided actual utilization data (5 employers), employers who confirmed with their insurer or TPA there had been no utilization (3 employers), and employers who believed the benefit had not been utilized without confirming with their insurer or TPA (3 employers). The middle two rows of Table 8 provide the "preferred" average annual utilization rates, which includes the three employers that confirmed they had no utilization and the five employers that provided actual utilization data. These rates are considered the "preferred" rates because they reflect all confirmed utilization data from our surveyed employers. The bottom two rows of the table include only those five employers that provided actual utilization data, which comprises the "upper bound" average annual utilization rates. One employer of less than 1,000 employees confirmed they had no utilization of the benefit.

Unfortunately, that is the only confirmed data point we have for employers of that size. We had no data points for our four largest employers, those with 50,000 or more employees.

Table 8: Average Annual Utilization Per Thousand Employees,by employer size

	Less than 1,000	1,000 to 9,999	10,000 to 49,999	50,000 +
# Employers with or without utilization (incl. unconfirmed)	2	4	5	—
Adjusted rate (lower bound)	0.000	0.027	0.044	—
# Employers with or without utilization (confirmed only)	1	2	5	—
Adjusted rate (preferred rate)	0.000	0.107	0.044	—
# Employers with utilization only	—	1	4	—
Adjusted rate (upper bound)	—	0.214	0.054	—

For employers with 1,000 to 9,999 employees, average annualized utilization was 0.107 claimants per thousand employees, with a lower bound of 0.027 and an upper bound of 0.214. For employers with 10,000 to 49,999 employees, average annualized utilization was 0.044 claimants per thousand employees, with an upper bound of 0.054. As an example of future projections based on these findings, using the preferred utilization of 0.044, an employer with 20,000 employees would see, on average, one claimant utilizing the transition-related health care benefit every 14 months. This projection is based on the "preferred" rate for similarly-sized employers, so this projection may not apply to much larger or much smaller employers, as Tables 2 and 8 suggest.

One employer was able to provide annualized transition-related surgical claims data for one of their transition-inclusive health benefits plans. For this one plan, the employer provided the number of surgical claims for gender transition that were completed in a given plan year and the number of enrolled employees for each plan year. These data are presented in Table 9. On average over five years, just over 47,000 employees enrolled in this plan and 0.06 surgical claims related to gender transition were completed per thousand enrolled employees each year. In other words, on average, there were three transition-related surgical claims per year in this plan. Notably, the highest annual utilization is found in the fourth year (2010) and the second-highest in the fifth year (2011). Due to limitations in data available to this employer, enrollment figures do not include employees' dependents that were enrolled in the plan, though surgical claims included here could have been for covered dependents. Furthermore, the employer noted that these data are for individual surgical procedures and one person could have had more than one transition-related surgical procedure. Therefore, these data should be understood as individual claims, but not individual claimants.

It is also important to note that these utilization figures are not comparable to utilization experienced by an employer with a similar number of employees (~47,000). This employer provides other transition-inclusive plans in which other employees elected to enroll. When viewed in the aggregate (if complete data were available), it is likely that the total utilization rate for all plans would resolve to a lower number. Partial data provided on the employer's other transition-inclusive plans suggest that this plan, for which we have data, may have the highest utilization of transition-related benefits of all plans, and, therefore, likely represents a "worst case" in terms of the number of claims. Average annual utilization based on partial data for the plan with the second-highest reported utilization was 0.03 surgical claims per thousand enrolled employees.[35]

Table 9: Surgical Claims, one employer plan by year

	2007	2008	2009	2010	2011	Annual Average
Total enrolled employees (dependents not included)	50,267	49,210	47,370	45,262	44,557	47,333
Surgical claims per thousand enrolled employees	0.06	0.06	0.04	0.09	0.07	0.06

Of the six employers who provided information about the utilization of the transition-related health care benefit, three provided data on how many individual claimants had utilized the benefit and the total number of covered lives (employees and dependents) in their transition-inclusive plans. This data provides the most accurate denominator to assess demand for transition-related health care benefits because it includes all individuals who are eligible to submit transition-related claims. Table 10 shows the average annual utilization for these three employers. These employers range in size from 10,000 to 15,000 full-time active employees, have only fully-insured plans, range from 22,000 to 45,000 total covered lives in their transition-inclusive plans, and have a combined 15 years of transition-inclusive health benefits coverage experience. Based on the highest utilization

rate found in Table 10, an employer with 25,000 covered lives in transition-inclusive plan could expect, on average, one claimant per year to utilize the transition-related health care benefit.

Table 10: Average Annual Individual Claimants per Thousand Covered Lives, Transition-Inclusive Plans

Employer	Average Annual Utilization
Employer 1	0.04
Employer 2	0.02
Employer 3	0.01

Four employers reported that there have been recent inquiries about the benefit, but none have yet resulted in utilization of the benefit. These inquiries represent 2 total inquiries per thousand full-time active employees for the smallest employer (less than 1,000 employees) to 0.019 for the largest employer (greater than 50,000 employees). It should be emphasized that inquiries may or may not result in actual utilization of the benefit in the future and cannot be used as reliable predictors of future utilization.

Table 11: Current Inquiries Per Thousand Employees by Employer Size

	Less than 1,000	1,000 to 9,999	10,000 to 49,999	50,000 +
# Employers	1	1	1	1
Current Inquiries	2.000	0.248	0.133	0.019

EMPLOYER-REPORTED EXPERIENCES WITH TRANSITION-RELATED COVERAGE

Employers were asked in the survey why they decided to provide the benefit, any barriers they experienced to adding the benefit, what benefits they receive by providing the coverage, and what advice they would give to other employers who are considering adding transition-related health care coverage to their employees' health benefits plans.

Reasons for Adding Coverage

Thirty-two employers responded to the survey question which asked why their business decided to provide transition-related health care for their employees. These employers provided a variety of responses. The most frequent response, with 47 percent of responses, was that employers provide the coverage to reflect their values. One employer remarked, "As a firm that highly values diversity, this was an essential step for us to take to demonstrate complete support for our LGBT population." Another explained, "Inclusion and diversity is very important to our business."

Eleven employers (34%) reported that they added the benefit to meet the needs of current and future employees. A few employers explained:

- "It is important to [us] to offer a benefits package to our employees that is competitive with the market and that is inclusive in addressing the needs of our diverse employee population. We felt that including a transition related health care provision was key to achieving this."[36]
- "[Our firm] strives to provide high value, wide ranging benefit opportunities that are relevant to our [employees]."
- Finally, one employer said they added the benefit to "provide an important healthcare benefit to current and prospective employees."

Employers provided a variety of other reasons for adding transition-related health care coverage. Eight employers (25%) said they added the benefit to remain competitive within their industry. Six employers (19%) added the benefit because employees had requested the benefit be added. Six employers (19%) responded that they added to benefit to maintain a 100 percent rating in the Corporate Equality Index, which was described as an important indicator of an employer's support for the LGBT community. Other employers responded that they wished to provide high value, current benefits (6%), they wanted to show support for the LGBT community and diversity (9%), a desire to meet WPATH standards (3%), and one employer said they took a cue from other employers in their industry that had added the benefit. One employer simply stated, "It was the right thing to do."

"It was the right thing to do."

Barriers to Adding Coverage

The survey asked employers to respond to the following question: "Were there significant barriers (either internally, for example by benefits providers/administrators, or externally, for example by regulators or insurance boards) to adding transition-related health care coverage to your business's health benefits?" Of the 33 employers responding to this question, 31 employers (94%) reported that there were no significant barriers to adding the coverage. One of the two employers who did report barriers explained:

> *"Some of the [executives] did not agree with adding this coverage. It is difficult to educate people about gender dysphoria. In addition, we are self-insured for [our] medical plans and use [our medical claims administrator's] Medical Policies to govern covered procedures. When reviewing [the] medical policy on gender reassignment surgery, we found that the policy did not cover certain... procedures required by the WPATH guidelines. [We] instructed [them] to augment the Medical Policy...to include all... surgery services and supplies that the patient's doctor determines to be medically necessary."*

The other employer reported they had to make repeated requests to their health insurance provider over several years to finally get them to provide the coverage.

The survey asked employers how they overcame the significant barriers to adding the coverage. The first employer described above noted, "This proposal was bundled with other changes related to our LGBT employees. It may not have been possible to get it approved as a stand-alone proposal because people don't understand the nature of gender dysphoria. But the costs are so minimal...it was hard for [them] to argue against it." Two other employers, who did not report significant barriers, offered their responses on how they were able to add the coverage. One remarked, "This was supported at the highest levels of the organization, so no barriers there. [We] worked with our health care provider to understand implications." The other said they were able to add the benefit "by making a strong business case and researching what our peer firms were offering in terms of transition-related health care."

Benefits of Adding Coverage

The survey asked employers to describe any benefits they receive for providing transition-related health care benefits for their employees. Like prior research on LGBT workplace policies, these responses also reveal positive benefits to employers for providing transition-inclusive health benefits. Twenty-five employers described benefits they receive from providing transition-inclusive health benefits plans. Fifteen employers (60%) stated that providing the benefits made them more competitive as an employer and would improve recruitment and retention. One employer explained:

> *"[Our firm] seeks to be an employer of choice in [our] profession and coverage for transition-related health care may help us to retain and/or recruit the best available talent in the industry. We are broadening our search for talent to include more diverse perspectives, which in turn, will contribute to the diversity of the knowledge capital we provide our clients. This deliberate search for diverse talent must be met with an equally compelling effort to be the best employer we can for our talented pool of...professionals, which includes offering relevant benefits.*

One employer explained, "It is in keeping with our philosophy of being all inclusive, non-discriminatory, and 'leading edge'."

Other employers echoed similar perceived benefits to recruitment and retention. Others added that providing the benefit allows them to be competitive as an employer. One employer remarked, "We also believe this keeps us competitive with other firms that have similar values."

Equally important to employers, fifteen (60%) stated that providing the benefit is a matter of equality or fairness, which reflects their values. One employer listed three ways providing this benefit reflects their values: "Supporting fairness through our actions. Communicating commitment to broad diversity values. Inclusive view of supporting the health and well-being of our employees."

Twelve employers (48%) stated the benefit provides for the needs of their employees and improves employee satisfaction and morale. One employer explained that "although a relatively small population would take advantage of the benefits, we felt it was a quality of life issue for them." Another employer highlighted the need to provide medically necessary care for employees and allay worries about costs:

> *The most important benefits of providing coverage for transition-related health care in our benefits plans include:*
>
> 1. *provides necessary medical benefits for transitioning employees;*
> 2. *allows employees and managers, etc. to work collaboratively through the process; and*
> 3. *reduces employee concerns about medical costs.*

Eleven employers (44%) stated that the benefit supports their commitment to diversity, supports a diverse workforce, and/or attracts diverse employees. Four employers (16%) believe providing the benefit signals to LGBT people and the general public that the employer supports the LGBT community and wants to attract talent and/or consumers from the LGBT community. Two employers (8%) said providing the benefit puts them on the "leading edge" among employers. One employer explained, "It is in keeping with our philosophy of being all inclusive, non-discriminatory, and 'leading edge'."

"Provide the coverage as it not only is minimal in cost but does provide employee satisfaction, morale and is becoming covered more often in certain industries."

Advice to other Employers Considering Adding Coverage

Finally, employers were asked to respond to the following question: "If another business asked your business for advice on whether to begin providing coverage for transition-related health care for their employees, what advice would you give them?" Twenty-five employers responded to this question. Some offered simple encouragement to provide the benefit, while others offered practical advice to other employers. Notably, no employer advised against providing transition-related health benefits for employees.

Thirteen employers (52%) said they would encourage the business to add the benefit. Employers provided encouragement for a variety of reasons, such as:

- "[T]hey should pursue this. The costs are nominal and their reputation in the LGBT community and with LGBT employees will be enhanced."
- "Provide the coverage as it not only is minimal in cost but does provide employee satisfaction, morale and is becoming covered more often in certain industries."
- "It seems to have been a non-issue for us; advise going ahead with implementation."
- "Providing coverage for transition-related health care has tremendous benefits for employees and the business."

One employer described five reasons why businesses should provide this coverage for their employees. They explained:

Yes, add this benefit because it is a low cost, high value proposition for employees.

1. *This benefit is low cost because it is aimed at a small population who will access the benefits.*
2. *Generally, when the benefit is utilized the cost is much less than treatment for diabetes, asthma...and the like.*
3. *Cost of coverage will not impact your benefit budget either because the utilization is low.*
4. *Makes many positive statements to existing and prospective clients, employees, industry and community.*
5. *Adding this benefit says: We are socially responsible. We have vision. We are ahead of the curve. We can help you make a difference. We embrace diversity in our employees. Come work for us.*

Fifteen employers (60%) offered practical advice to other employers considering adding this coverage, ranging from how to handle internal communications to strategies for negotiations with insurance providers. First, five employers (20%) suggested businesses assess whether adding the coverage is consistent with their values and practices of their competition. One employer suggested that the business "consider their philosophy regarding the value of a diverse workforce, being an employer of choice, and of delivering a comprehensive health care plan." Four employers (16%) suggested getting the support of employees and employee resources groups to help argue for the change internally. Three employers (12%) suggested working to get the support of management and executives and that promoting the business case for adding the coverage could be a part of these communications. Two employers (8%) stressed the importance of doing education and communication about the importance of providing the benefit. To the contrary, one employer suggested working internally in a quiet, "low key" manner, so as not to provoke any opposition from employees. Having faced some internal opposition, two employers (8%) advised to ignore "squeaky wheels" or those who try to thwart the inclusion of the benefit. As one employer put it, "Move forward with conviction. Find allies at the executive level, as well as within the employee population. Don't let squeaky wheels derail."

Eleven employers (44%) offered their advice on how to negotiate with insurers and TPAs to add the benefit. Five employers (25%) suggested working with insurers and TPAs to discuss the coverage they can offer and to address shortcomings in their medical guidelines, if necessary. Two employers offered the following advice:

- "They have to read their provider's medical policy closely to assure it is compliant with WPATH standards, or as we did, create an exception to their policy for these diagnoses."

- "Do your research and talk with employers who have the benefit. Look within your own industry and see who else offers the benefit. Look at different options for the plan design and follow the WPATH guidelines."

Employers also advised the business to understand the costs of adding the coverage (12%). Understanding costs would assist in negotiating with the benefits provider to add the transition-related coverage at no cost, as one employer advised. Two employers (8%) advised working with health benefits providers to provide competent customer service for their members:

- "Stress to the carrier they must have well-trained customer service staff to handle the questions from members."
- "Have your carrier provide an informational sheet to provide to employees that inquire about the benefit, who they can call with questions, etc."

Advice surrounding customer service may point to a need among health benefits providers to train staff on transition-related health care benefits.

CONCLUSION

This study provides notable findings about the transition-related benefits that employers are providing for their employees, the utilization and cost of these benefits, and what benefits employers report of providing this type of coverage. Overall, we find that transition-related health care benefits are low in cost due to low utilization yet can provide benefits for employers and employees alike.

In regard to the health benefits employers are providing, we found that many employers do not provide their employees with coverage for medical treatments or procedures that the WPATH *Standards of Care* describe as medically necessary if clinically indicated for an individual. As noted earlier, it is possible that some of the listed procedures were not available as part of the insurance products fully insured employers could purchase. It is also possible that coverage is limited to standardized insurance industry internal medical or clinical guidelines, upon which particular health benefits plan administrators rely to determine coverage. These guidelines may not include certain medical treatments or procedures. However, based on employer statements regarding negotiations with TPAs, self-insured employers may argue for the changes necessary to bring their plans into alignment with the WPATH *Standards of Care*. Fully-insured employers can request that their health insurance providers add this coverage to their plans. Clearly, as indicated in employer statements, the WPATH standards have been helpful for some employers when crafting their plans.

Costs of providing transition-related health care coverage seem very low, including for employers that cover a wider range of treatments or procedures for transition. Twenty-two surveyed employers (85%) reported no costs associated with adding the benefit, with 10 of those 22 saying there have been no subsequent costs due to utilization. For three employers reporting actual costs due to utilization, they report that the costs are very low:

- In one case, actual costs over two years comprised only 0.004 percent of total health care expenditures.
- The other two employers characterized the costs as "negligible" and "minimal" at less than 1 percent of total costs or claims paid.

In this sample, there is no relationship between the scope of the transition-related health care benefit and the cost of the coverage and there is no difference in reported costs between plans with broader coverage and plans with more limited coverage.[37]

When employers reported cost increases based on projected utilization, these projections seem high in comparison to costs reported from other employers and findings related to cost from prior research and may reflect an actuarial overestimate of the utilization of these benefits and the subsequent cost of claims. Two employers reported a 1 percent increase in total cost to their transition-inclusive plans, based on projected costs. This 1 percent increase seems high in comparison to the two similarly-sized firms that reported "minimal" and "negligible" actual costs that were less than 1 percent of total health plan costs or claims paid. In prior research, larger employers reported premium increases due to projected costs that ranged from 0.08% to 0.20% of total health plan costs.[38] Therefore, a full 1 percent increase in total cost to the plan does seem high in comparison to similarly-situated employers in this survey and those described in prior research.

Examining these increases based on what we know about utilization also reveals that these increases seem high. In the case of one of these employers, the 1 percent increase amounts to $94,000 annually. However, based on this employer's size (~1,600 employees) and using the highest observed

utilization rate for employers of that size (0.214), we would predict, in a "worst case," this employer would have one claimant for transition-related health benefits every three years. If the $94,000 increase is carried over annually, they would have predicted a cost of $282,000 for one claimant over three years. Based on prior research, the highest transition-related claim that occurred at the University of California was $86,800, with an average cost per claimant of $29,929.[39] Therefore, this 1 percent increase also seems high when we consider predicted utilization.

Another employer reported a projected cost increase of $100,000 annually for adding transition-related health care coverage to their plan, which is substantially less than 1 percent of their total health care expenditures. This employer (a private employer) has about 38,500 employees enrolled in the plan and, based on the "worst case" utilization rate for similarly-sized employers (0.054), could expect two claimants for transition-related benefits every year. According to prior research, the City and County of San Francisco paid $386,417 over five years for transition-related claims for about 100,000 covered lives in their plan.[40] This means, on average, San Francisco spent about $77,000 annually on transition-related claims. For the fiscal year ending June 2012, San Francisco reported about $620 million in health care expenditures.[41] The lowest possible annual utilization found in prior research on San Francisco is 0.074 per thousand employees, which is higher than the 0.054 observed "worse case" for similarly-sized private employers in this study. The employer with the projected $100,000 cost is of a similar size to San Francisco, in terms of total covered lives in their plan. Their annual increase of $100,000, therefore, may be slightly high given the experience of San Francisco, which we would predict would have higher benefit utilization than a similarly-sized private employer. However, future premium adjustments based on reviews of actual costs may be able to correct for any overestimate. In any case, the relative cost of transition-related health care benefits is quite low relative to total health plan expenditures.

In terms of utilization, very few people will access transition-related health care benefits when they are provided. Our findings in regard to utilization generally fit with the ranges of utilization found in prior research, though our lower bound rate was lower for one set of employers. Our study found that for employers with 1,000 to 9,999 employees, average annual utilization was 0.107, with a lower bound of 0.027 and an upper bound of 0.214 claimants per thousand employees. Prior research of private employers with 1,000 to 9,999 employees ranged from 0.074 to 0.220 claimants per thousand employees. All of the employers in this size category in our study were also private employers.

For employers with 10,000 to 49,999 employees, we found the average annual utilization rate was 0.044, with an upper bound of 0.054 claimants per thousand employees. These findings include both public and private employers and fit within the utilization ranges found in prior research on both types of employers. Prior research found utilization for private employers of this size to be 0.016 to 0.060 claimants per thousand employees and for public employers of this size to be from 0.022 to 0.200 claimants per thousand employees. Our findings fit well within these ranges. Therefore, our study appears to provide further confirmation of prior research on utilization, which can serve as a useful guide to employers who are considering adding transition-related health care coverage.

Overall, we find that transition–related health care benefits are low in cost due to low utilization yet can provide benefits for employers and employees alike.

Prior research shows employers generally benefit from providing LGBT-inclusive workplace policies. Studies found increased job satisfaction and productivity for employees, improved health outcomes among LGBT employees, improved workplace relationships, and employers improved bottom lines by providing LGBT-inclusive workplace policies.[42] Our findings from this study suggest that employers that provide transition-related health care coverage may benefit in similar ways. Employers reported that they provide the coverage to help them with recruitment and retention of employees, make them competitive as an employer within their industries, provide for the health care needs of their employees, and demonstrate their commitments to inclusion and diversity, among other reported benefits. It is notable that a majority of employers would encourage other employers to add the coverage and none would advise against adding the coverage.

Employers also provided practical guidance to other employers to aid them in adding the coverage for their employees. First, employers recommended that employers work with their insurers and TPAs to discuss the coverage they can offer and to address any shortcomings in their medical guidelines. Second, employers suggested doing research and consulting with other employers that provide the coverage to better understand costs they may incur and to be better informed when negotiating with their insurers. Finally, employers recommended working with benefits administrators to make sure they are providing competent customer service to employees who inquire about the benefits.

LIMITATIONS

This study has limitations that should be noted. Because this study is based on a survey, it has similar limitations to all survey research in that the data are self-reported and subject to respondent recall. The sample size for the survey was 34 employers, which is roughly 11 percent of the employers known to provide transition-related health care benefits for employees. Therefore, these findings may not be representative of the experiences of other employers that provide this coverage. Additionally, respondents to this survey were limited by the information or documentation available to the respondent at the time of the survey. For instance, many respondents were unable to provide specific answers about the utilization of the transition-related health care benefit due to a lack of available data. Several respondents were not able to describe the health benefit plan provisions or provide plan documentation. Employers that were able to provide information about utilization and costs did not do so in a uniform manner, which makes comparisons difficult. For instance, one employer was able to provide actual costs in dollar amount along with the total health plan costs over the same period of time the costs were incurred. However, other employers expressed costs as a vague percentage of total claims paid or total health care expenditures ("less than 1%"). These responses did not allow for comparison to other employers where actual costs were known.

In terms of utilization, all employers provided the number of full-time employees but many did not provide the total number of covered lives in their plans. While the latter would have provided a more accurate denominator to assess demand for transition-related health care, we were only able consistently to use full-time employees as a denominator since that was the only data point all employers provided. When possible, comparisons were presented above to provide context for our findings, but on occasion we were only able to describe the particular situation of a single employer.

This study also is limited by the number of years that employers have provided transition-related health care benefits. Since the benefit is relatively new among most employers, some employers had only a year or two of experience to draw on to answer the survey. In some cases, this short time frame helped in providing useful data on how this policy change came about and the cost to add the benefit for that particular employer, since these changes happened recently and the same staff members involved in adding the benefit were still on staff at the time of the survey. However, a short time frame does not allow the respondent to be able to discuss changes in plan structure, cost, utilization, and negative or positive impacts to the business over time. Furthermore, this study wasn't able to look at the cost savings in the long run of providing medically necessary care for employees in need of care for gender dysphoria.

CONSIDERATIONS FOR FUTURE RESEARCH

Findings from this report also point to considerations for future research on experiences providing this benefit and what impact providing the benefit may have on employees and employers. Researchers may want to consider the impact on employees, and by extension their employers, of not providing coverage for certain transition-related health care that may be deemed medically necessary when clinically indicated for an individual, according to the WPATH *Standards of Care*. For instance, according to the WPATH *Standards of Care*, facial hair removal through electrolysis or laser may be deemed medically necessary for some individuals as part of their individualized treatment plan for gender dysphoria. Facial hair removal for a person transitioning from male to female may be medically necessary to treat the skin of the face and neck to eliminate masculine secondary sex characteristics and bring this person's body into alignment with her gender identity, which is the goal of treatment for gender dysphoria. Seventy-six percent (76%) of employers that participated in this survey exclude coverage for facial hair removal in their health benefits plans. Not only does this mean that an employee may not be able to receive medically-necessary care, unless they are able to pay out of pocket, but the exclusion also may have related negative impacts for that employee, and by extension, her employer. For instance, a recent study found that transgender women who have had electrolysis or laser hair removal were less likely to experience harassment in public spaces than those who had not had electrolysis or laser hair removal.[43] Experiencing harassment may have a negative impact on an employee's productivity and workplace relationships, but it may also have a negative impact on the success of a person's treatment for gender dysphoria. More research on the impact on employees of not providing certain coverage can provide valuable information for

employers when considering the scope of their health benefits plans by describing the full range of costs that may be associated with exclusions.

Related to the above suggestion for future research, researchers should examine the long-term cost savings to employers that result from providing medically-necessary care for their employees. Prior research suggests that there are positive impacts on mental and physical health that result from individuals receiving the care they need for gender dysphoria.[44] To the extent that these positive impacts result in reduced need for health care related to untreated gender dysphoria, cost savings can accrue over time. For instance, if an individual experiences improved mental health as a result of receiving medically necessary care for gender dysphoria, this may result in reduced costs related to mental health services for that individual. Research on these long-term cost savings would provide helpful information to employers on the true costs and benefits of providing transition-related health care coverage.

Finally, more research is needed with employers who have a long history of providing transition-related health care benefits to employees. These employers are uniquely positioned to provide an understanding of the long term costs and benefits of providing this coverage and may help refine actuarial estimates of utilization and cost. Not only may they have better, longitudinal data on the utilization and cost of the benefit, they may also provide insight on measureable positive and negative impacts on their business, including the impact on employee job satisfaction, workplace climate and relationships, productivity, and the impact on their business's bottom line. Research conducted with these employers would help provide a better forecast for companies who have recently added the benefit or are considering adding it in the future. However, because employers may have limited access to data from their TPAs or health insurance providers, or may not be willing to share that data if they have it, future research should also focus on accessing larger claims databases that would contain data from multiple employers. Since the number of employers providing transition-related health care coverage is increasing, databases of major insurers and administrators may have compiled sufficient data for analyses in the near future.

About the author

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Notes

1 Human Rights Campaign. 2013. *Corporate Equality Index2013*. Washington, DC: Human Rights Campaign, available at http://www.hrc.org/files/assets/resources/CorporateEqualityIndex_2013.pdf (last accessed July 10, 2013).

2 Based on a review conducted for this study of cities, counties, and universities that are known to provide coverage for transition-related health care benefits for their employees, the following list of employers was compiled: the City and County of San Francisco; the cities of Berkeley, Long Beach, Minneapolis, New York, Philadelphia, Portland, Seattle, and St. Paul; Multnomah County, OR, and Macomb County, MI; American University, City University of New York, Cornell University, Harvard University, Massachusetts Institute of Technology (MIT), Northwestern University, Princeton University, Syracuse University, University of California (all campuses), University of Michigan, University of Minnesota, University of Pennsylvania, University of Vermont, and Yale University. Notably, HRC has begun rating municipal employers in a similar manner to the Corporate Equality Index. HRC's Municipal Equality Index is available at http://www.hrc.org/municipal-equality-index#.Ui-eAMasiVY (last accessed September 9, 2013).

3 Cal. Code Regs. tit. 10, §§ 2561.1, 2561.2 (2013); Brent A. Barnhart, Director, Cal. Dep't of Managed Health Care, Letter No. 12-K, Gender Nondiscrimination Requirements (Apr. 9, 2013), available at http://transgenderlawcenter.org/wp-content/uploads/2013/04/DMHC-Director-Letter-re-Gender-NonDiscrimination-Requirements.pdf (last accessed August 15, 2013); Williams P. White, Comm'r, Colo. Dep't of Reg. Agencies, Bulletin No. B-4.49, Insurance Unfair Practices Act Prohibitions on Discrimination Based on Sexual Orientation (Mar. 18, 2013), available at http://www.one-colorado.org/wp-content/uploads/2013/03/B-4.49.pdf (last accessed August 15, 2013); D.C. Dep't of Ins., Bulletin No. 13-IB-01-30/15, Prohibition of Discrimination in Health Insurance (Mar. 15, 2013), available at http://disb.dc.gov/sites/default/files/dc/sites/disb/publication/attachments/Bulletin13-IB-01-30-15.pdf (last accessed August 15, 2013); Louis D. Savage, Ins. Comm'r, Or. Ins. Div., Bulletin No. INS 2012-01, Applications of Senate Bill 2 (2007 Legislative Session) to Gender Identity Issues in the Transaction and Regulation of Insurance in Oregon (Dec. 19, 2012), available at http://www.cbs.state.or.us/ins/bulletins/bulletin2012-01.html (last accessed August 15, 2013); Susan L. Donegan, Comm'r, Dep't of Fin. Reg., Bulletin No. 174, Guidance Regarding Discrimination on the Basis of Gender Identity Including Medically Necessary Gender Dysphoria Surgery and Related Health Care; Withdrawing and Superseding Insurance Division Bulletin No. 153, Banking Division Bulletin No. 30, and Health Care Division Bulletin No. HCA-124 (Apr. 22, 2013), available at http://www.dfr.vermont.gov/sites/default/files/Bulletin_174.pdf (last accessed August 15, 2013).

4 Change to Human Rights Campaign, *see* note #1.

5 GLMA: Health Professionals Advancing LGBT Equality. 2013. *Compendium of Health Profession Association LGBT Policy & Position Statements*, available at http://www.glma.org/_data/n_0001/resources/live/GLMA%20Compendium%20of%20Health%20Profession%20Association%20LGBT%20Policy%20and%20Position%20Statements.pdf (last accessed July 10, 2013).

6 American Psychiatric Association. 2012. *Position Statement on Access to Care for Transgender and Gender Variant Individuals,* available at http://www.psychiatry.org/File%20Library/Advocacy%20and%20Newsroom/Position%20Statements/ps2012_TransgenderCare.pdf (last accessed July 10, 2013).

7 Some employers do not provide a defined benefit for transition-related care, but rather have no exclusion for this care and coverage is provided in the same manner as all other health care that is deemed medically necessary.

8 Coleman, E., Bockting, W., Botzer, M., Cohen-Kettenis, P., DeCuypere, G., Feldman, J., Fraser, L., Green, J., Knudson, G., Meyer, W. J., Monstrey, S., Adler, R. K., Brown, G. R., Devor, A. H., Ehrbar, R., Ettner, R., Eyler, E., Garofalo, R., Karasic, D. H., Lev, A. I., Mayer, G., Meyer-Bahlburg, H., Hall, B. P., Pfaefflin, F., Rachlin, K., Robinson, B., Schechter, L. S., Tangpricha, V., van Trotsenburg, M., Vitale, A., Winter, S., Whittle, S., Wylie, K. R., & Zucker, K.. 2011. "*Standards of Care* for the Health of Transsexual, Transgender, and Gender-Nonconforming People, Version 7." *International Journal of Transgenderism*, 13: 165–232.

9 *Id.*

10 The ULCA North General Institutional Review Board (NGIRB) determined this study is not human subject research and, therefore, not subject to IRB review.

11 City and County of San Francisco and San Francisco Human Rights Commission. 2007. *San Francisco City and County Transgender Health Benefit,* available at http://www.hrc.org/files/assets/resources/San_Francisco_City_and_County_Transgender_Health_Benefit_-_2007-08-10.pdf (last accessed August 1, 2013).

12 According to Jamison Green & Associates, when the Transgender Health Benefit was added to the San Francisco City and County plan in 2001, other unrelated changes in the plan resulted in a reduction of $5.95 in monthly premium charges to employees, and even greater reductions for retirees with and without Medicare.

13 Department of Insurance, State of California. 2012. *Economic Impact Assessment: Gender Nondiscrimination in Health Insurance*, available at http://transgenderlawcenter.org/wp-content/uploads/2013/04/Economic-Impact-Assessment-Gender-Nondiscrimination-In-Health-Insurance.pdf (last accessed August 1, 2013).

14 *Id.*

15 *Id.*

16 *Id.*

17 *Id.*

18 Department of Insurance, State of California, *see* note #13; Jamison Green & Associates. 2012. T*ransgender-Inclusive Health Benefits: Data for Cost Calculation*. Presented by Andre Wilson of Jamison Green & Associates to the Department of Insurance, State of California, February 2012. For Table 1, for the City and County of San Francisco and the University of California, the maximum and minimum reported utilization per year means the utilization in the year in which the highest utilization per thousand employees was observed and the utilization in the year in which the lowest utilization per thousand employees was observed. For private employers, the maximum and minimum utilization per year means the highest observed annual utilization and the lowest utilization out of the sample of individual employers. Figures for the City and County of San Francisco are taken from Jamison Green & Associates, February 2012. The Department of Insurance incorrectly cited 0.325 as the maximum utilization for private employers. The correct utilization figure, 0.22, is reported here, per Jamison Green & Associates, February 2012.

19 Jamison Green & Associates, *see* note #18.

20 *Id.*

21 Department of Insurance, State of California, *see* note #13. For the University of California, the lowest utilization per thousand employees per year (0.022) was observed in 2006. The highest utilization per thousand employees per year (0.187) was observed in 2009.

22 Jamison Green & Associates, *see* note #18.

23 The University of California (UC) currently offers five health benefits plans. All five plans include coverage for transition-related health care, including surgical claims. The health benefits plan included here currently covers 38 percent of enrolled employees in all plans. The Department of Insurance for the State of California report (*see* note #13) does not provide information to assess utilization in other UC plans. Therefore, we cannot assess whether utilization in the plan reported here is higher or lower than other UC plans. It is possible, therefore, that this plan may represent a disproportionately higher or lower number of claims within the UC system.

24 Number of employees shown is the number of enrolled employees for one of the University of California's health benefits plans.

25 Department of Insurance, State of California, *see* note #13.

26 Sears, B. and Mallory, C. 2011. *Economic Motives for Adopting LGBT-Related Workplace Policies (Updated).* Los Angeles: The Williams Institute, available at http://williamsinstitute.law.ucla.edu/research/workplace/economic-motives-for-adopting-lgbt-related-workplace-policies/ (last accessed July 10, 2013); Badgett, M.V.L., Durso, L., Kastanis, A., and Mallory, C. 2013. The Business Impact of LGBT-Supportive Workplace Policies. Los Angeles: The Williams Institute, available at http://williamsinstitute.law.ucla.edu/research/workplace/business-impact-of-lgbt-policies-may-2013/ (last accessed July 10, 2013).

27 *Id.*

Notes

28 Department of Insurance, State of California, *see* note #13.

29 Coleman, et al., *see* note #8.

30 *Id.*

31 *Id.*

32 CIGNA Medical Coverage Policy, Gender Reassignment Surgery, effective Jan. 15, 2013, available at https://cignaforhcp.cigna.com/public/content/pdf/coveragePolicies/medical/mm_0266_coveragepositioncriteria_gender_reassignment_surgery.pdf (last accessed August 15, 2013).

33 Travel outside of the United States for transition-related surgical procedures is not uncommon. *See*, for instance, Aizura, A. (2010). "Feminine Transformations: Gender Reassignment Surgical Tourism in Thailand." *Medical Anthropology: Cross-Cultural Studies in Health and Illness*, 29(4), 424-443.

34 Utilization rates in this table are the average of each individual employer's average annual utilization for employers of that particular size category for each grouping by row. For instance, annual average utilization was calculated for the four employers for the 10,000 to 49,000 size range in the upper bound row. The four individual employers' average annual utilization rates were added and divided by four to get the average annual utilization rate for that group. If one pools the number of employees, the number of claimants, and the total years of coverage across the employers of interest and then calculates the average annual utilization using those pooled figures, the results consistently reflect lower utilization than the calculations used here. All employers described in the prior paragraph are not included in these calculations. All employers had to have their benefits in place for at least one full plan year prior to the survey. Two of the five employers who reported that they believed there had been no utilization had the benefits in place for less than one year at the time of the survey. These two employers were not included in the calculation. One of the six employers that provided utilization data is not included here since that employer expressed their utilization as a percentage of all claims instead of a number of claims/claimants. This employer (between 1,000 and 9,999 employees, fully insured plan only) reported that utilization of the transition-related health care benefit represented less than 1 percent of total health benefits claims over one year. Since this employer did not report the actual number of claims or claimants, the data they provided did not allow that employer's utilization rate to be averaged among the other five employers that reported utilization. One of the five employers that provided comparable utilization data provided the number of surgical claims per year. In order to include this employer's data in the calculations for this table, we make the conservative assumption that each surgical claim represents one unique claimant. In other words, we assume an individual claimant made one surgical claim only. This employer also has other transition-inclusive health benefits plans. Partial data provided on this employer's other transition-inclusive plans suggest that this plan may have the highest utilization of these benefits of all plans, and, therefore, may represent a "worst case" in terms of utilization. All employers in the 10,000 to 49,999 size range in this table either reported actual utilization or confirmed no utilization, therefore the lower bound figure is the same as the mid-range figure.

35 Two years of data were missing for this plan, so the number of surgical claims for this plan in those two missing years were set equal to the number of surgeries approved to be performed in that year. In all cases, the number of approved surgeries each year in each plan for which there were data in a particular year were less than the number of surgical claims, meaning not all approved surgeries were actually performed. Therefore, the average annual utilization of 0.03 surgical claims per thousand enrolled employees is likely an overestimate of actual surgical claims.

36 This and other quotes have been redacted to maintain the anonymity of the employer and for clarity. Changes to quotes are indicated by brackets and ellipses.

37 Chi-square test of independence testing relationship between having a broad coverage plan and any reported costs: Ð2=0.9593, d.f.=2, p=0.619. T-test for mean difference in any reported cost by scope of coverage (broad or limited): t=-0.6814, d.f.=26, p= 0.5017.

38 City and County of San Francisco, *see* note #11; Department of Insurance, State of California, *see* note #13.

39 Department of Insurance, State of California, *see* note #13.

40 City and County of San Francisco, *see* note #11.

41 City and County of San Francisco. 2012. *Health Service System 2011-2012 Annual Report,* available at http://www.myhss.org/downloads/finance/HSS_AR_2011_2012.pdf (last accessed September 10, 2013).

42 Sears and Mallory; Badgett et al., *see* note #26.

43 Herman, J. 2013. "Gendered Restrooms and Minority Stress: The Public Regulation of Gender and its Impact on Transgender People's Lives." *Journal of Public Management and Social Policy,* 19(1), 65-80.

44 Department of Insurance, State of California, *see* note #13.