Navigating Gender Affirming Care

What you need to know to be your best self-advocate.

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Nonbinary Identity

- The only regions that currently recognize and have an option to list nonbinary gender status are Oregon, California, New York, and Washington, D.C.
- There is no way to list non binary gender identity on federal documentation.
- No health insurances allow for a nonbinary gender to be listed.
- Most employers do not offer nonbinary identification or credentialing.
- Most schools do not offer nonbinary housing, bathrooms, identification, or participation in sports.

Should I Change My Gender with My Health Insurance?

Pros

> Consistency with gender identity in medical settings.
> Can be useful in getting gender-appropriate hormones covered.
> Can make coverage for services for which having gender dysphoria is a prerequisite challenging.

Cons

> Can make coverage for screening of organs retained challenging.
> Can be harmful in getting gender-appropriate hormones covered.
> Can make coverage for services for which having gender dysphoria is a prerequisite challenging.

In brief: Counsel people on pros and cons, look into their individual insurance, and expect possible challenges with insurance either way.

Surgery Navigation

Insurance

> Does your plan cover the surgery you need?
> What is your deductible?
> What is your copay?
> What problem codes are acceptable for billing for your surgery?
> Prior authorization: the process by which a medical provider gets pre-approval for a medical procedure and insurance approves coverage prior to the procedure moving forward.

Surgeons

> Finding a reputable surgeon: Look to teaching universities and established clinics. Look online for robust reviews following patient outcomes immediately, six weeks, six months, six years, and so on, after surgery.
> Check that your insurance will cover work done by your chosen surgeon.
> Consulting with a surgeon:
  – How long have you been performing this surgery for gender-diverse clients? What is your complication rate? What is your policy on revisions? Are there any papers you have written regarding gender-affirming surgery that I can read? Are you a member of WPATH (World Professional Association for Transgender Health)? Do you have experience working with insurance? What is included/excluded from the cost of surgery? Can you describe the recovery process with a timeline? Are there parts of the surgery that are considered "cosmetic" and not covered by insurance? Are these optional parts of the procedure? What got you interested in gender-affirming surgery?
  – Order of operations (typically): 1. Consultation with surgeon. At this time, you should provide required documentation (letters from therapists and medical providers, etc.). 2. Prior authorization and meeting any unmet criteria for surgery (such as hair removal). 3. Processing of prior authorization and decision by insurance. 4. Schedule surgery date. 5. Have surgery. 6. Recovery and follow-up appointments.

Troubleshooting

> Behavioral health letters: Has your therapist written this kind of letter before? Have they looked at the guidelines for what the letter needs to say? Template letters are available online and from many resources such as Fenway Health, the Center for Excellence in Transgender Medicine at UCSF, and the National Center for Transgender Equality.
> Prior authorizations: Have you met all criteria required by your insurance? Have you followed up with your insurance after an appropriate period? Has your surgeon submitted the correct procedure codes for your surgery that also align with the accepted codes by insurance?

– When you get a denial: Don't panic. Have your therapist and medical provider write a letter of appeal on your behalf (or, if they are willing, have the surgeon do it). Even better, if they are able, have the provider call the insurance company. If you have met all criteria and there are no leftover steps that you missed, it may just be a matter of having the provider consult with the insurance. If you appeal three times and still get a denial, you can appeal to an external review board that will mediate the case and make a decision. Many approvals happen in this final appeal stage.

> Pre-, Peri-, and Post- Surgical Medical Follow-Up

– Do you have a primary care provider who is experienced with gender-affirming surgeries?

– Do you have somewhere to recuperate? Do you have someone who can help you with daily activities for a little while?

– If appropriate, do you have the ability to stay near the surgical center for a week or more to do follow-up with your surgeon?

– Do you understand how your surgical recovery may impact work and school?

– Do you have a plan for seeking medical attention if you have a complication?

– Are you able to afford the dressings and other equipment needed to take care of your surgery? Most often these extras are not covered by insurance.

> International Options

– Pros

- Affordable and generally all-inclusive. This means that the surgery cost also covers lodging, sometimes food, and en-suite nursing care following the procedure.
- Contrary to popular belief, there are excellent surgeons around the world performing gender-affirming procedures. It's important to research the surgeons as thoroughly as in the United States, but just because someone is in a different country does not mean they are not an excellent medical provider.
- Many international providers have years of experience and may have shorter wait-lists than U.S. providers.

– Cons

- Insurance does not cover any out-of-country surgery, period.
- When you return to the U.S., none of your follow-up care will be covered by insurance, and often medical providers will refuse to see you if your surgery was done overseas.
- If you need revisions or help with complications, your surgeon is in another country. Even if a surgeon stateside is willing to work with you, they will generally be unwilling to perform revisions to surgeries they did not do themselves (and this is usually a good thing, as the anatomy of the surgery is best known to the person who performed it).
- If you have a complication while overseas, there is very little that can be done to provide you with emergency medical care, and insurance will not cover any such care.
- There is often expensive travel needed, and you will usually need to take more time off from work or school so that you can stay near the surgeon's office while you are in the early stages of healing.

Hair Removal *(and other unexpected criteria)*

> Hair removal is necessary and will be a required criterion for the following procedures:

– Pre-vaginoplasty

– Pre-phalloplasty

> Hair removal is also used in gender affirmation for many people—facial and body hair removal can be as important as other procedures, sometimes even more important.

– Facial and body hair removal is notoriously challenging to get covered by insurance. In Massachusetts, many plans now have an understanding of the importance of facial hair removal but do not have processes for covering it. Most commonly, when insurance coverage is possible, you must pay out of pocket for the hair removal first, then submit for reimbursement from your insurance company.

> Smoking Cessation

– Smoking cessation is often a requirement that surgeons have before they will be willing to perform surgery. The duration of smoking cessation varies from a week to several months. Most surgeons will encourage smoking cessation immediately, and strongly encourage lifelong smoking cessation following surgery. Some surgeons will even take a urine sample prior to surgery to ensure that smoking cessation has been adhered to.

- Smoking, and nicotine in general, is a vaso-constrictor, meaning that it narrows the blood vessels and the ability for the body to transport blood, especially to extremities. Smoking also introduces many poisonous substances into the body. This combination increases risks for bleeding, infection, blood clots, heart attack, healing complications, longer and less perfect healing, and many other unwanted outcomes.
- There are lots of resources available for smoking cessation. Talk to your primary care provider, your counselor, a school health center representative, or public health groups for free resources.

> Managing Costs and Preparing for Surgery

– Lifestyle Changes

- Do you need to rearrange your space so you are not lifting or reaching? Do you need to take a leave of absence from your gym/sport? Do you need to change your sleeping arrangements?

– Aftercare
  - You will need dressings, wound cleaning supplies, the ability to pick up your prescription medication, and the ability to keep the surgical site clean and cared for. The best way to plan for this is to price out the cost of supplies and find a friend/partner/family member who can stay with you and help you for the first few days after surgery.

– What Insurance Covers
  - Generally, insurance covers your surgery, anesthesia, drugs administered at the surgical center, and prescription medications to control pain and infection following surgery. Insurance typically does *not* cover travel expenses, lodging expenses, food, wound dressings, wound cleaning supplies, nonprescription medications (such as Advil), cushions, bedding, in-home nursing care, or anything else you may need following surgery.

– Assistance with Daily Living Activities
  - A friend, family member, partner, or other trusted individual can be very helpful in ensuring a successful recovery. If you do not have someone in your life who can help with aftercare, you may wish to look into in-home nursing help—in some circumstances insurance can be convinced to cover this care. Other options include having someone come by once or twice a day to check in on you, even if they're not able to stay around the clock.

– Reimbursement, Care Credit, and Other Strategies
  - Several parts of surgery preparation and post-care are not directly covered by insurance, primarily because the providers (electrologists, physical therapists, etc.) are not contracted with the insurance. In these cases, you will want to get prior approval for reimbursement if at all possible, then submit your receipts with the reimbursement form directly to your insurance.
  - Care Credit is a line of credit generally used for urgent medical care where someone simply can't meet the deductible/copay/cost of the procedure. The credit is generally zero percent interest for between six and 12 months, but then begins to accrue very high interest, often at 16 to 25 percent or higher. Care Credit is a fine option for dealing with costs where you have pre-approval for reimbursement from insurance but is often a disastrous choice for paying for an entire surgery or other procedure. If you decide to pay for your surgery deductible of $10,000 (not unheard of for some genital-affirming surgeries) with Care Credit, then can't pay it back for a couple years, you may end up paying $15,000–$20,000 or more once you are done.

– Why Do Pre-Surgical Criteria Exist?
  - There are two kinds of pre-surgical criteria: that required by the surgeon to clear you for surgery, and that required by insurance to cover the procedure.
  - Surgeon criteria usually exist to ensure your safety during the procedure, and to make sure that such an intensive surgery is appropriate and needed for your identity affirmation. These criteria may include a note from your primary care provider about your most recent physical, documentation of smoking cessation, and so on.
  - Insurance criteria is coming from several angles. 1. Do you really need the services and can you document that need with support from medical and behavioral health providers? 2. Same as the surgeon, insurance wants to know that you are a good candidate medically for surgery. 3. Insurance still looks to behavioral health to determine whether or not surgery is appropriate as a step for gender affirmation for a patient. Whether or not it is the place of behavioral health to make this determination is hotly debated, but right now insurance is going to require documentation that a behavioral health provider with experience in the area feels that surgery is the best next step for the patient.

– Last-Minute Criteria
  - Sometimes a prior authorization will go through, but in the final confirmation before surgery (often the day before or the day of), a criterion that has not been met is found.
  - The most common example of this is that hysterectomy procedures require two letters of support from behavioral health, but this requirement is rarely listed in the insurance details about the procedure.
  - If last-minute criteria derail surgery, you may have to reschedule, but you can also explore having the surgeon or your provider call the insurance company, submitting an expedited appeal, or paying out of pocket and seeking reimbursement (this is a risky choice).

Insurance

Health Insurance 101

> Private vs. public insurance: Do you know which you have?

> Federal vs. state-funded public insurance (Medicare and Medicaid)

> HMO vs. PPO vs. POS, and so on

> The Affordable Care Act and Amendment 1557 to the ACA

– This amendment states that private insurers cannot have blanket exclusions for gender-affirming care (though they can still have specific exclusions), and that all plans that are funded in full or in part by the state or federal government must provide gender-affirming care, but the criteria needed to get that care are not specified. Many plans have done an excellent job adhering to this amendment; others have used the unclear criteria guideline to create a situation where coverage is nearly impossible.

– When searching for information on insurances that will cover gender affirmation, look for "Transgender Coverage," "Gender Services," or "Transgender Surgeries."

Exclusions for Gender-Affirming Care

> Specific exclusions: "This plan does not cover gender-affirming genital surgeries including vaginoplasty, metoidioplasty, and phalloplasty, among others."

> Coincidental exclusion: "This plan does not cover surgery that is considered cosmetic and not medically necessary."

– Often insurers will view gender-affirming surgery as cosmetic until they speak with a provider or surgeon.

> Purposeful inclusion: "Gender-affirming services, including hormone therapy, genital surgeries, chest surgeries, and others, can be found on page XYZ of our benefits handbook."

"Coming Out" to Insurers

> In Massachusetts, it can often be beneficial for your insurance to know that you identify as gender diverse, as this gives them the opportunity to override automatic denials (like OBGYN care for a male-identified person) and to offer help getting services covered.

> Insurers in other states, and federal insurance plans, have an extremely variable range of responses to knowing the gender identity of their subscribers. Be careful.

Appendix

Letters

Surgery Support Letters

Gender-Affirming Genital Surgeries

> One letter and/or clinical note from a primary care provider (PCP)

> Two letters of support from qualified mental-health professionals

> Some insurances will require one of these letters to be from a PhD psychologist or MD psychiatrist.

Chest and Breast Surgeries

> One letter and/or clinical note from a PCP

> One letter of support from a Qualified Mental Health Professional

Facial Feminization/Masculinization

> One letter and/or clinical note from a PCP

> One letter of support from a Qualified Mental Health Professional

Hair Removal

> In progress—very few precedents for coverage. We send one letter from a PCP and one letter from a QMHP.

Facial Feminization, Hair Removal, and Other Tricky Letters

> Most insurance plans do not cover, or try not to cover, these procedures.

> No insurance plans have published criteria for what needs to be submitted for coverage of hair removal, either for gender-affirming surgery or for facial hair removal.

> Some plans have begun to cover pre-gender-affirming surgery hair removal, but as of today there are almost no cases of insurance covering facial hair removal.

> Other letters you may be asked to provide: letter indicating need for use of prosthetic for trans men who are traveling and do not wish to remove packer; letters documenting gender identity for youth to take to school in defense of gender expression and bathroom usage; and letters for hormones.

Calls for Appeal

> The best recourse for a denial is getting a peer-to-peer consultation with the insurance clinician.

> If you cannot get a peer-to-peer, compose a letter reinforcing your support and fill in any gaps indicated in the denial.

– For example, if someone was denied because "they don't have 12 months of 'real life experience,'" you can write a letter indicating that the person has been inhabiting their gender for the required time period.

> Three is a magic number.

– Once you've appealed a prior authorization three times, you will automatically qualify for the appeal to go through an impartial third-party insurance review. For tricky cases, this is generally where you are able to succeed in the end.

Letters in Support of Document Changes

> No letter is needed for a name change. Anyone who is a U.S. citizen can change their name to (just about) anything and for (just about) any reason.

> Clinical support letter and/or form documentation needed for change:

– Driver's/state license

– Social Security identification

• This will result in change in selective service enrollment.

– Passport

– Birth certificate

• Letter must be notarized in most states.

– Sometimes school and work