MIAMIBEACH

OFFICE OF THE CITY MANAGER
No. LTC # 174-2014

LETTER TO COMMISSION

TO: Mayor Philip Levine and Members of the City Commission

FROM: Jimmy L. Morales, City Manager

DATE: May 23, 2014

SUBJECT: Transgender Health Insurance Benefits

RECEIVED
2014 MAY 23 PM 3:50
CITY CLERK'S OFFICE

Introduction

To provide an accurate explanation and understanding of the subject essential to the conversation regarding the inclusion of transgender benefits in the City's health insurance coverage plans, rather than summarizing or re-stating our research, we have included excerpts from the World Professional Association for Transgender Health (WPATH) statement of the medical necessity of treatment, sex reassignment and insurance coverage for transgender and transsexual individuals.

Background

The WPATH is an international association devoted to the understanding and treatment of individuals with gender identity disorders (GID).

The criteria listed for GID, including transsexualism, are descriptive of many people who experience dissonance between their sex as assigned at birth and their gender identity, which is developed in early childhood and understood to be firmly established by age 4, though for some transgender individuals, gender identity may remain somewhat fluid for many years.

The WPATH Standards of Care for Gender Identity Disorders were first issued in 1979, and articulate the professional consensus about the psychiatric, psychological, medical and surgical management of GID. Periodically revised to reflect the latest clinical practice and scientific research, the Standards also unequivocally reflect this Association's conclusion that treatment is medically necessary. Medical necessity is a term common to health care coverage and insurance policies in the United States, and a common definition among insurers is:

> *Health care services that a physician, exercising prudent clinical judgment, would provide to a patient for the purpose of preventing, evaluating, diagnosing or treating an illness, injury, disease or its symptoms, and that are: (a) in accordance with generally accepted standards of medical practice; (b) clinically appropriate, in terms of type, frequency, extent, site and duration, and considered effective for the patient's illness, injury, or disease; and (c) not primarily for the convenience of the patient, physician, or other health care provider, and not more costly than an alternative service or sequence of services at least as likely to produce equivalent therapeutic or diagnostic results as to the diagnosis or treatment of that patient's illness, injury or disease.*

> *Generally accepted standards of medical practice means standards that are based on credible scientific evidence published in peer-reviewed medical literature generally recognized by the relevant medical community, Physician Specialty Society recommendations and the views of physicians practicing in relevant clinical areas and any other relevant factors.*

Sex reassignment plays an undisputed role in contributing toward favorable outcomes, and comprises real life experience, legal name and sex change on identity documents, as well as medically necessary hormone treatment, counseling, psychotherapy, and other medical procedures. Genital reconstruction is not required for social gender recognition, and such surgery should not be a prerequisite for document or record changes; the real life experience component of the transition process is crucial to psychological adjustment, and is usually completed prior to any genital reconstruction, when appropriate for the patient. Changes to documentation are important aids to social functioning, and are a necessary component of the pre-surgical process; delay of document changes may have a deleterious impact on a patient's social integration and personal safety.

Medically necessary sex reassignment procedures also include complete hysterectomy, bilateral mastectomy, chest reconstruction or augmentation as appropriate to each patient (including breast prostheses if necessary), genital reconstruction (by various techniques which must be appropriate to each patient, including, for example, skin flap hair removal, penile and testicular prostheses, as necessary), facial hair removal, and certain facial plastic reconstruction as appropriate to the patient.

Non-genital surgical procedures are routinely performed... notably, subcutaneous mastectomy in female-to-male transsexuals, and facial feminization surgery, and/or breast augmentation in male-to-female transsexuals. These surgical interventions are often of greater practical significance in the patient's daily life than reconstruction of the genitals.

Furthermore, not every patient will have a medical need for identical procedures; clinically appropriate treatments must be determined on an individualized basis with the patient's physician.

The medical procedures attendant to sex reassignment are not "cosmetic" or "elective" or for the mere convenience of the patient. These reconstructive procedures are not optional in any meaningful sense, but are understood to be medically necessary for the treatment of the diagnosed condition.

Professionals who provide services to patients with gender conditions understand the necessity of SRS [sex reassignment surgery]*, and concur that it is reconstructive, and as such should be reimbursed, as would any other medically necessary treatment.*

Non-genital surgical procedures along with hormone replacement therapy (HRT) and psychological counseling are required by most states before any personal documentation, such as the individual's driver's license and birth certificate, can be updated with his or her new gender.

Cost of Transgender Benefits

The city and county of San Francisco were among the first to include transgender health benefits, as a pilot program, in their self-funded health insurance coverage plans. The program was designed to collect actuarial data related to the actual cost of coverage for transgender medical benefits. The program began by including a one year enrollment requirement with individual coverage capped at $50,000. This benefit was based on similar coverage provided by the Canadian province of British Columbia. Using an estimate of 35 eligible plan members, they increased their employees' and retirees' monthly premium by $1.70 per month. Between July 2001 and July 2004, the plan collected $4.3 million in additional premiums; however, the plan incurred only seven surgical claims for a total payout of $156,000.

In 2004, the one year waiting period was eliminated and the individual coverage cap was raised to $75,000. Additionally, the benefit became available through the city and county HMO plans which until then had only covered hormone and psychological therapies. Even with the elimination of the waiting period, an increase in their medical plan's coverage maximum and the addition of surgical coverage through their fully insured HMO plans, the employees' and retirees' premium was reduced from $1.70 to $1.16 per month. Between July 2001 and August 2005, the city and county had collected $5.6 million in additional premium and paid out $183,000 for 11 claims. Due to the low cost impact to the city's and county's medical plans, both self-funded and fully insured, the additional monthly premium charged to employees and retirees has been eliminated. Additionally, cost data has led the HMOs to no longer separately rate the transgender benefit, and the fully insured HMO plans are now treating it as they do any other medical procedure.

The most recent study regarding the cost of these benefits was conducted from 2001 through 2008 by Dr. Mary Ann Horton, who is an active diversity advocate, leader, and researcher and has been recognized for her contributions in creating equality in the workplace for transgender, bisexual, lesbian and gay individuals. The goal of her study was to identify the number of surgeries and their related costs. The study was limited to US residents treated in the country. During this time period, 1,170 transsexuals underwent surgery. At the time of her study, nationally, the average cost for male to female surgery was $10,400 and the average cost for female to male surgery was $17,000. These figures are based on 740 male to female surgeries and 430 female to male surgeries, providing an average combined cost of $12,900 per surgery.

As a result, at the time she conducted her study, the actual cost impact to provide transgender health insurance coverage benefits could be projected at $.173 per year, per participant at a national level. Of this cost, $.08 or more could be contributed to services currently covered by many health care plans such as hormone therapy, doctor office visits and psychological therapies resulting in a total impact to health care plan costs of $.093 per year per participant.

The City's benefits consultant, Gallagher Benefit Services (Gallagher), has determined that the addition of transgender benefits to the City's medical health insurance plans would not result in a significant cost to the City as the majority of services recommended by WPATH are currently covered benefits under the plan. Additionally, the relatively low cost of the reassignment surgery, in addition to the low prevalence of those seeking it, would have a minimal cost impact.

Recommendation

Based on the benefits associated with providing the coverage, the County and City of San Francisco's experience and Gallagher's projections, it is recommended that the City include the coverage in its self-funded medical plans effective in the new plan year, which is scheduled to begin October 1, 2014.

If you have any questions or need additional information, please do not hesitate to reach out to me.

JLM/KGB/SC-T