Ellen Krug sat alone at one end of a long table deep inside the offices of a large Minneapolis health insurance company. Seven health plan administrators sat at the other end. Looking younger than her 53 years, Krug, an attorney, was dressed in the outfit she wore whenever she had a jury trial—a light gray suit, white blouse, hose, heels and her lucky silver pendant shaped like a heart. “You cancelled my policy because I’m transgender,” Krug told them, “That’s discrimination.”

The insurance company had requested Krug’s medical records from her gynecologist after blood tests performed prior to a facial feminization procedure revealed high levels of female hormones, which showed that she was well into transitioning physically from a man to a woman. “Everything on my application form was truthful,” she says. “I was never asked if I was transgender or if I was planning to have any surgery, so failure to disclose wasn’t a reason to cancel my policy. I never asked them to pay for any gender-reassignment costs, and I never planned on asking because I knew they wouldn’t. Even if I had asked, they could have just denied the claims. Instead, they cancelled my policy. I needed insurance for the same reasons any 53-year-old needs health insurance. Discrimination, fear and ignorance were at work here.”

Krug’s lucky pendant wasn’t enough to get her health insurance back. But she’s now insured through an individual plan for which her employer, a Minneapolis nonprofit, pays a portion of the premium. “My health insurance story may be getting stale,” she says, “because the health insurance situation for transgender people is changing at lightning speed.”

**Adding it to the bucket**

Less than a year after cancelling Krug’s policy, that insurer started covering hormones, counseling...
Ending transgender discrimination at the clinic

In July of 2012, Ellen Krug tripped on a sidewalk and dislocated her ring finger; it was two years after she completed gender reassignment surgery. When Krug gave her full name to the emergency department intake nurse, the nurse stopped typing and in a skeptical tone asked, “Is that your legal name?” “That hurt so very much,” Krug says, but that was just the beginning. In radiology, the techs asked her to extend her finger as best she could. “Look,” said one of the techs. “He’s giving us the finger.” “My hair was long,” says Krug. “I was wearing earrings and a dress. They knew my name.”

Discrimination at the clinic is often a bigger problem than insurance discrimination, says Deborah Thorp, M.D., an obstetrician/gynecologist who created and directs Park Nicollet’s Transgender Clinic in Minneapolis. Often, what’s perceived as discrimination is ignorance and discomfort. “Transgender patients pick up on this,” she says.

To ensure such situations don’t occur, Thorp offers gender competency training. Her “Transgender 101” primer explains transgender health issues, types of treatment, proper language to use and how to view gender identity as a spectrum. “As a society, we haven’t reached the point of accepting that gender identity is not either/or. It’s a spectrum, and each person sees themselves as being at a different point along that spectrum. A lot of clinicians just don’t know how to handle that.”

Thorp says it’s common for transgender persons to go to the clinic with shoulder pain or something else completely unrelated to being transgender, and instead of being referred to an orthopedist, they get referred to Park Nicollet’s Transgender Clinic. And when they do see the right doctor, the physician often gets side-tracked by their own curiosity. “They start asking a bunch of questions about being transgender instead of treating the problem the patient came in for,” Thorp says.

“If it’s not clear what gender or pronouns the patient would like you to use, ask them. Treat them with respect, using their preferred name and pronoun. Don’t ask nosy questions that have nothing to do with the medical question at hand. Front-line staff don’t need to be asking about hormones. Nursing staff rooming a patient for an orthopedic surgeon don’t need to be inquiring about the patient’s sexual practices,” she says.

She adds that trans-women (male to female) often have a more difficult time at clinics (and elsewhere) than trans-men (female to male). “It’s much easier for trans-men to undergo masculinizing hormone treatments and completely pass as male than the other way around.”—H.B.
umbrella term that includes most people with gender dysphoria—including those who have transitioned, those who have not and those who may not want to.

Most trans-inclusive employer health insurance policies pay for surgery, if it’s deemed medically necessary, as defined by the Standards of Care prescribed by the World Professional Association on Transgender Health (WPATH), says Katie Spencer, Ph.D., coordinator of Transgender Health Services for the Program in Human Sexuality at the University of Minnesota Medical School. “That’s the tricky part,” she says. “I spend a lot of time writing letters to insurance companies on behalf of clients explaining why surgery is medically necessary. That usually works; but sometimes there’s a lot of red tape to wade through.”

It’s still common, however, for employers to add exclusions to their policies, meaning they’ll cover a transgender employee for nontransgender-related services, but won’t cover transgender-related treatments. “That’s discriminatory,” Spencer says, “because when a person has been diagnosed with gender dysphoria, treatment is considered medically necessary, according to accepted standards of care.”

**Public plans lagging**

Despite the lingering use of exclusions and cancellations, private health plans are actually ahead of public plans in providing comprehensive trans-inclusive coverage. Medicaid, MinnesotaCare and Medicare cover hormones and counseling but not surgery. OutFront tried but failed during the last legislative session to get transgender surgeries added back into all of Minnesota’s state-sponsored health plans, the way it was between 1977 and 2005. (The Legislature started chipping away at funding for such procedures in 1994 and terminated coverage completely in 2005.) “It’ll happen eventually,” says Duran, “but it’ll be a lengthy process.”

OutFront did help get the University of Minnesota’s student health plan to add reassignment surgery on the grounds that not doing so violated Minnesota’s Human Rights Act. The Act protects against discrimination based on sexual orientation, which is defined broadly to include transgender people. “The implication of this ruling,” Duran says, “is that any health plan that is subject to state law may violate the Act if it contains an exclusion for transgender services, which may prompt other health plans, public and private, to move toward trans-inclusive policies.”

Minnesota’s Department of Corrections did so in 2007 when it updated its transgender prisoner policy. Transgender prisoners housed at all state and local prisons are now entitled to transgender care but not surgery. “Several federal court rulings say that when a prisoner is denied that care, it represents a violation of the U.S. 8th Amendment that protects all citizens from ‘cruel and unusual punishment,’” Duran says.

Beginning January 1, 2014, the Affordable Care Act prohibits denying transgender people coverage for services other people are entitled to, Duran says. It also indirectly improves coverage for transgender treatments, at least in Minnesota, because the state adopted a HealthPartners trans-inclusive plan that covers reassignment surgeries to serve as its model plan, meaning all other plans that are sold on the exchange must offer the same level of coverage.

Other legal cases have expanded transgender people’s access to health insurance as well. In April 2012, a federal judge in Minneapolis ruled that Christine Radtke of Red Wing was entitled to the benefits in her husband’s employee health plan. Radtke is a trans-woman (male-to-female) whose health coverage was terminated on the grounds that her marriage constituted a same-sex marriage. The ruling, however, determined that if a man becomes a woman and marries a man (or vice-versa), it is not a same-sex marriage; therefore, each is entitled to coverage under their spouse’s health plan. Such couples in Minnesota will not need the protection of that ruling starting August 1, when same-sex marriages become legal in the state.

Duran foresees a time when all large employers will be required to provide trans-inclusive coverage because of the evolving interpretation of Title VII of the Civil Rights Act of 1964. The Act prohibits employment discrimination on the basis of sex, among other things. Sex is defined broadly to include transgender people.

Meanwhile, the Equal Employment Opportunity Commission (EEOC) takes the position that an employer-sponsored health plan that excludes coverage for medical conditions associated with protected characteristics such as race or gender may be employment discrimination. “It may only be a matter of time,” says Duran, “before these two legal analyses intersect and result in a ruling that an employee health plan that excludes coverage for transgender-related services may constitute Title VII employment discrimination. When that happens, it’ll change the playing field.”

**Benefits greater than costs**

Trans-inclusive health insurance is catching on for a couple of reasons, according to Thorp. For one thing, more transgender people are coming out, which is making for more of a mainstream discussion. Another is that large employers are realizing that adding trans-inclusive health benefits is not as expensive as they thought. Reassignment surgeries, hormones and tests to monitor the effects of those hormones cost anywhere from $25,000 to $75,000, depending on how much is done, according to the HRC. But a very small percentage of employees need these treatments, so they represent a small additional cost for employers that cover a
Transgender care

In 1966, the University of Minnesota created the second transgender health program in the United States. The first was established at Johns-Hopkins University that same year. In 1970, a medical team at the University of Minnesota successfully performed surgery on a pair of brothers who both wanted to be women.

Today, the university provides clinical services including prescription of medications; psychological, physical and psychiatric evaluations; recommendations for reassignment surgery; and sex therapy. In addition, the U runs support groups for and provides psychotherapy to individuals, couples and families; it also has programs for children and adolescents.

A handful of Minnesota primary care physicians, dermatologists, surgeons and behavioral health professionals have made transgender medicine part of their practice. Twenty-seven are listed on the Minnesota Transgender Health Coalition’s directory of trans-friendly health care providers (www.mntranshealth.org).

One physician who specializes in care of transgender patients is Deborah Thorp, M.D., who started Park Nicollet’s Transgender Clinic eight years ago because women becoming men were uncomfortable being seen in the obstetrics/gynecology department. Thorp and her colleagues refill prescriptions and monitor hormone levels and the health risks that come with hormone therapy. Hormones for trans-men and trans-women can increase risk for obesity, blood clots and stroke. “It’s not a huge increased risk,” she says. “But it’s there and it needs to be monitored.”

The Transgender Clinic provides ongoing trans-related gynecological care and cross-gender care that includes pap smears for trans-men and prostate screening for some trans-women. And they provide post-op care for those recovering from reassignment surgery. Other than the pain and swelling that follows most surgeries, Thorp says, “We rarely see serious complications.” She explains that reassignment surgeries are generally safe and effective, especially male-to-female procedures. Hysterectomies and mastectomies for trans-men and breast implants for trans-women are done in the Twin Cities, but most reassignment surgeries are done in other cities or countries, according to Thorp. Thailand specializes in vaginoplasty, but when they come home,” Thorp says, “they need post-op care just like anybody else who has surgery.”

On Thorp’s wish list is transgender-specific billing and diagnostic codes. “There’s not a good way to code hormones-for-life,” she says. “Some physicians code it as ‘medical management,’ or for trans-males, they call it treatment for male hypogonadism. We need specific codes, which will happen as insurance discrimination against transgender people continues to decline.”

She foresees a day when treating gender dysphoria will be so widely accepted that there will be a board-certified subspecialty in transgender medicine. “It’s 10 years away,” she says, then, pauses. “Make that 15. We’ve got a ways to go.” —H.B.