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THE TONIC GUIDE TO HEALTHCARE

WRITTEN SO YOU CAN ACTUALLY UNDERSTAND IT.

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- 00002: HEALTHCARE: IF YOU'RE ON BIRTH CONTROL
- 00003: HEALTHCARE: IF YOU HAVE A MENTAL HEALTH ISSUE
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0007: HEALTHCARE IF YOU’RE TRANS

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HEALTHCARE IF YOU'RE TRANS OR NON-BINARY

- WHO DECIDES IF I'M TRANS OR NON-BINARY ENOUGH TO GET MEDICAL TREATMENT?
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IF YOU'RE TRANS

BY GAINES BLASDEL

There is no one, correct way to transition genders or path to get there. Begin by talking it out with a trans and gender non-binary (TGNB) affirming therapist for a while? Great. Lead with hormones for six months and then see how you feel? Awesome. Start with chest surgery and a name change, then call it a day? Do you!

Regardless of what you feel your next steps are, the services you can access depend on where you live and insurance coverage. If you're feeling overwhelmed about figuring out where to begin, or just need a little help understanding the insurance aspect, trust that many other TGNB people have been in the same boat, and there are resources to help you.

Who decides if I'm trans or non-binary enough to get medical treatment?

At the end of the day, each surgeon or hormone provider makes their own choices about providing care. You might not need to see a mental health provider at all. The requirement for counseling has its roots in the university-based gender clinics of the 1960s and 70s, where a TGNB person would be tested and treated by a team of mental health providers before being deemed a "true transsexual" and granted (or, more often, denied) medical treatment.

The World Professional Association of Transgender Health (WPATH) formalized these early attempts to do TGNB medicine into a Standards of Care that gets updated periodically with changing times. The most recent version from 2011 has done away with many former requirements, like the "real-life test" of first living publicly for a specific amount of time in your identified gender before obtaining medication and surgery.

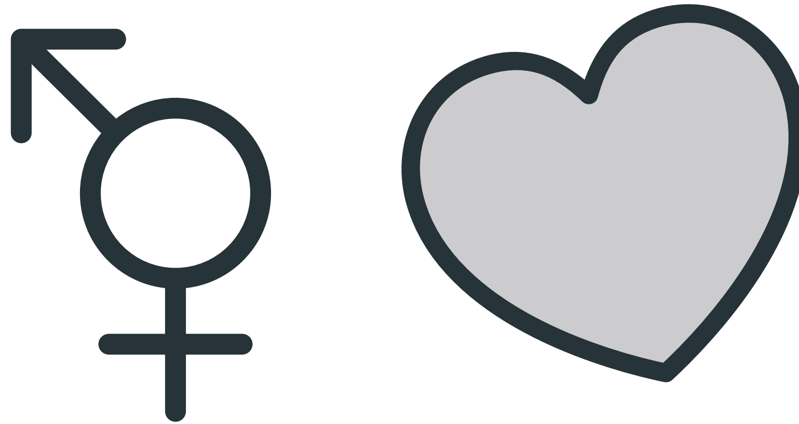
The current Standard of Care even acknowledges that "informed consent" to start hormones is a perfectly reasonable way of doing things. This is when a primary care provider assesses if you're able to comprehend the risks and benefits of treatment without a mental health evaluation. Informed consent clinics are in many major metropolitan cities, but there are still geographic areas where the only providers who will prescribe TGNB hormones require you to get a referral letter from a therapist. Some therapists, including those who work across the US via Skype or other online platforms, may write these letters after a single appointment, depending on your mental health history.

How do I find a therapist or medical provider?

WPATH maintains a directory of medical providers and therapists who are active members. Community organizers have set up a number of websites aiming to create provider directories. Word of mouth is another way to look for and vet providers, asking at in-person or online communities, like groups on Reddit and Facebook, and at LGBT organizations that serve your area.

If you are in crisis and live in the United States or Canada, the Trans Lifeline (877-565-8860, translifeline.org) is one immediate resource.

I'm nervous about my first visit!



Sadly in 2018 it's still reasonable to be worried that a medical provider won't take you seriously, will actively discriminate against you, or will simply not know how to provide your TGNB-specific healthcare. A relationship with a medical provider is a partnership with shared decision-making and shared responsibility. A good provider will be happy that you're taking the initiative to get involved in your health, regardless of their own knowledge of TGNB care. If a provider discriminates against you by not offering services they would offer a cisgender (or non-transgender) person, it could be in violation of state and federal law, in addition to being in violation of professional ethics codes. If a provider is willing to learn how to provide for your TGNB-specific needs, you can point them toward online resources for medical providers to learn more.

On a path as individual as gender transition, even with the most TGNB-informed medical providers, you still have to speak up to get what you need. Aria Sa'id, senior policy advisor at the San Francisco Human Rights Commission and founder of the Kween Culture Initiative, encourages TGNB people to get behind the wheel of their own healthcare.

"We go into medical spaces believing that medical providers are the experts on our health, and unfortunately it just doesn't work that way. Really medical providers are able to, for lack of a better analogy, sell you the car, but you have to tune it up and you have to do oil changes and tire checks. You are the expert on your own healthcare, and your medical provider is just a guide to getting better."

Will my insurance pay for this?

Regardless of whether you have insurance through your employer or you bought an Obamacare plan, it will probably cover doctor's appointments, meds, and surgery, says Noah Lewis, executive director of Transcend Legal and a legal expert on TGNB healthcare. "There might be a denial or appeal process that you have to go through, but the law is on your side and you should feel empowered to demand the coverage that you are entitled to," he says.

Lewis is one of the movement experts using the patchwork of state and federal laws to expand access for those who have an insurance policy stating that TGNB care will not be covered. Starting in 1981 the federal program for seniors and disabled people Medicare was in this category. In 2014, however, a legal challenge to Medicare's policy was successful, and we have continued to see gains in coverage since.

Transcend Legal has an easy-to-follow video guide to using insurance to access TGNB care. Federal Medicare now covers TGNB care, as does Medicaid in many states. While movement advocates are working on policy and litigation that we hope will ensure clear, national coverage, 10 states explicitly exclude TGNB care from Medicaid coverage and many private plans still carry blanket exclusions for TGNB care, according to LGBTmap.org.

The same considerations apply to using your health insurance for TGNB care as they would for any service. It is very common for requests for coverage to be given an initial denial, as Lewis notes, even if the policy says it is clearly covered. If your insurance approves the surgery or medication, it's important to know that there will still be costs like deductibles and copays built into the plan, unless you're on a version of state Medicaid. You may also be limited to in-network providers (doctors in a network that contracts with your insurance), or to services in your state if you have Medicaid. However, if your insurance covers a service but has no one in-network to provide the service, it is possible to claim a "network deficiency" to access another provider. And while it was once the most affordable option to fly overseas for surgery, if you're planning to use insurance, there is essentially no chance of being reimbursed for international care.

Do I need to change the name or gender marker listed on my insurance?

There isn't a blanket answer to this. In the course of my work as a case manager at Callen-Lorde Community Health Center in New York, I've seen billing hiccups happen both because the gender marker was changed and because it wasn't. Don't delay changing your documentation now because of a theoretical problem accessing medical care later. Do check your insurance mail, and don't be afraid to pick up the phone (or have a bossy friend help you with the call) if you get into a billing headache.

Is there a risk that insurance coverage for TGNB care will get taken away?

With news of a Trump administration memo that, if put in place, would affect the way the federal government defines sex, many people are nervous about how it could impact TGNB health insurance gains. It's important to keep in mind that the federal government's definition of sex is not the only tool advocates have been using to expand TGNB coverage.

"When you hear [that] any day now that administration is trying to roll back the nondiscrimination protections under the Affordable Care Act (ACA), you should know that it's only a proposal, not the law, and it might not go through," Lewis says. "There are many other laws that protect people, so it's a pretty minor thing. The ACA itself is still in place, you still have rights, regardless of what you hear in the news. There are many other laws and you should appeal denials and exclusions."

Other experts concur with his viewpoint while talking more specifically about the memo's possible reach. As we wait to see how this proposal will unfold, know that courts have continued to decide TGNB care must be covered.

What if I don't have insurance?

If you're trying to access primary care and medications, Federally Qualified Health Centers (FQHCs; search at findahealthcenter.hrsa.gov) and many public hospitals have sliding-scale fees for uninsured people, and they have access to government programs to make medications cheaper at their in-house pharmacies. It's also worth looking at GoodRx to see what the best prices are for your medications in your area. It might end up being cheaper to purchase insurance that covers TGNB care, especially if you expect to have bigger-ticket costs like surgery. Every year Out2Enroll reviews Affordable Care Act (ACA) marketplace plans in different states for TGNB coverage and they can help connect you to a TGNB-friendly health navigator in your state.

Some people also try to get a job at a company that's known to have TGNB-inclusive benefits, but it's still possible to experience an initial denial through any coverage. The key is understanding that it's a process, and as long as you keep on top of insurance mail and connect to one of the many advocates fighting for TGNB coverage (including Transcend Legal, Lambda Legal, and the ACLU) you should be able to come out the other end victorious.

What is the process like for getting transgender surgery?

Unfortunately, the historic lack of coverage in the United States has led to few trained surgeons and a lot of patients waiting to see them. Callen-Lorde Community Health Center, one of the largest providers of TGNB primary care in the country, published a listing of surgeons updated in 2018, including information about insurance coverage. Particularly for genital surgery, it's very common for surgeons to have waiting lists longer than a year, and the most experienced and reputable surgeons have waiting lists three years long. The waiting period can be used to get all your ducks in a row, insurance-wise, to be sure that everything goes well.

This is a boom period for new surgeons offering care in the United States, but not everyone has the same training and experience. Unlike in Europe and other countries that have been performing TGNB services in mainstream, academic medical centers for decades, surgeons in the US haven't been publishing peer-reviewed evidence about their outcomes and rates of complications until recently. There is no specific board certification or required training process that certifies surgeons offering TGNB surgery. For the time being, prospective patients need to ask careful questions, and at a certain point, go with their gut in the absence of hard data. It's best to consult with several surgeons before making a final decision.

Your surgeon and your insurance plan will likely require referral letters from mental health providers clearing you for surgery. The WPATH guidelines state that one letter is needed for chest surgery and two for genital surgeries, but insurance companies may pile on additional requirements beyond the guidelines. While this can feel like yet another hoop to jump through, ideally you'll have access to someone who can actually help you plan for the adjustment period to your new body that follows surgery, and serve as a resource after surgery if you encounter more problems than you expected. Some people experience depression after surgery, and it can be especially confusing and isolating to feel sad after you've finally gotten the procedure you've been waiting for. Set up a recovery plan, with a mix of professionals, family, and peers who can be in your corner.

You'll also need to save up to take enough time off work to recover fully. If you're eligible for the Family and Medical Leave Act (FMLA), it covers TGNB surgery leave. Additionally, any short-term disability coverage should cover leave for TGNB surgery. The paperwork to get these benefits could out you to your human resources department, but it doesn't have to. While the forms require your provider to make a statement of "relevant medical facts" regarding your need for leave, depending on the surgery, your provider may be able to find a way to describe your case without using language specific to TGNB care.

What about non-binary surgeries, surgeries sometimes considered cosmetic, voice surgery and surgeries for minors?

These surgeries have been covered by insurance in some contexts, including certain state Medicaid plans. While some plans explicitly deny that facial surgeries are a part of covered TGNB services, some individuals have fought their plans to argue for coverage. Even if your insurance says loud and clear these surgeries are covered, expect to have a harder time finding surgeons and a longer denial and appeals process. For something like Facial Feminization Surgery, your letters will need to make a persuasive argument that the procedure is treatment for gender dysphoria, not a cosmetic improvement. Minors seeking all kinds of TGNB care mentioned in this guide, from hormones to surgeries, need to have their legal guardian's consent. For other services like fertility preservation, if it's not covered for cisgender people on the same plan, it is very unlikely you will be able to win coverage. If your plan does cover those services then TGNB people have a right to them, too.

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HEALTHCARE GLOSSARY

- AFFORDABLE CARE ACT (ACA)
- ANNUAL AND LIFETIME LIMITS
- COINSURANCE
- COPAY
- DEDUCTIBLE
- ESSENTIAL HEALTH BENEFITS
- FLEXIBLE SPENDING ACCOUNT (FSA)
- HEALTH SAVINGS ACCOUNT (HSA)
- HIGH-DEDUCTIBLE HEALTH PLAN
- INDIVIDUAL MANDATE
- INSURANCE NETWORK
- MARKETPLACE
- MEDICAID
- MEDICARE
- MEDICARE FOR ALL
- OPEN ENROLLMENT
- OUT-OF-POCKET COSTS
- OUT-OF-POCKET MAXIMUM
- PREMIUM
- PREEXISTING CONDITION
- PRIVATE HEALTH INSURANCE PLAN
- PUBLIC HEALTH INSURANCE PLAN
- SINGLE-PAYER HEALTHCARE
- UNIVERSAL HEALTHCARE

HEALTHCARE GLOSSARY

BY SUSAN RINKUNAS

Let's be honest: Health insurance is confusing, so let's start at the beginning. Health insurance is a contract you buy that requires an insurance company to pay for some or all of your medical expenses. Some employers offer (heavily subsidized) insurance to their employees, some people buy their own plans, and the government provides insurance for older people as well as for low-income people and those with disabilities. Still, some people in the US go without insurance.To help you understand how it all works, here's a list of the terms you need to know, explained in plain English.

Affordable Care Act (ACA)

Really, its full name is the Patient Protection and Affordable Care Act (PPACA) and it was passed in early 2010 and fully implemented as of January 2014. It's also known as Obamacare, after the President who shepherded it and signed it into law.

People in the United States aren't guaranteed to get health insurance. They have to get coverage from their employer or spouse's employer, buy it themselves, qualify for a government program, or go without. The ACA sought to get more people covered by insurance and protect people from going bankrupt from medical bills. It did that in a few ways: It said young people could stay on their parents' plans until age 26, it expanded the eligibility requirements for Medicaid, and it banned insurance companies from discriminating against people for having preexisting conditions [see " preexisting conditions"], which range from having given birth via C-section to having diabetes and other very basic, common things.

The ACA required insurance companies to cover everyone, and charge them the same rates no matter their health history. It also mandated that plans cover, at minimum, the same set of essential services [see "essential health benefits"], including preventive care at no cost, like vaccines and a set of benefits specific to women. The ACA also banned annual or lifetime caps on those essential services.

In 2010, 48.6 million Americans, or 16 percent of the population, didn't have health insurance. In 2017, the number of uninsured had fallen to 29.3 million people (or 9 percent of the US). That's still a sizeable chunk of people without health insurance, and that's why people want to improve upon Obamacare or replace it with universal coverage.

Annual and Lifetime Limits

These are caps on the benefits your insurance a company will pay in a given year or over a lifetime; after you hit the number, they stop paying and you're on the hook.

Annual limits can be dollar amounts or a number of visits. Obamacare banned annual and lifetime limits for a set of 10 essential health benefits.
[see "essential health benefits"].

Coinsurance

The percentage of costs you have to pay for a service after meeting your deductible [see "deductible"]. Your plan will either charge a copay or coinsurance, not both. Coinsurance matters a lot if you see providers that aren't in your plan's network [see "insurance network"].

Say your copay for an in-network specialist is $25 and your coinsurance for out-of-network providers is 30 percent. If your therapist charges $250 a visit and they take your insurance but are considered "out of network" (as is common with therapists), you'll first have to pay in full out of pocket until you hit your deductible, then pay $75 a visit (30 percent of $250) after that. If you see an in-network therapist, you'd owe a $25 copay, and might not even have to pay the deductible first if your plan says office visits aren't subject to the deductible.

Copay

Short for copayment, it's a flat fee you pay for seeing a doctor or filling a prescription. Copays typically don't count toward your deductible [see "deductible"]. Usually you only pay a copay if you've already hit your deductible, but many employer plans cover things like office visits and trips to the emergency room before you meet the deductible and so, voila, you only get charged a copay. It's common to have different copays for primary care providers and specialists, so you might pay $25 to see a doctor about a suspected case of bronchitis and $50 to see a specialist like a podiatrist.

There's usually an inverse relationship between your monthly premium (the cost of a plan) and your copays: Plans with lower premiums tend to have higher copays, and plans with higher premiums usually have lower copays.

Deductible

The amount you have to pay out of pocket for medical care before your plan will start footing the bill. Unfortunately, the deductible starts over every year. Many plans cover office visits before you've hit your deductible, so you may only have to pay a copayment for those visits rather than the full cost. After you've hit your deductible for the year, you usually only pay a copay or coinsurance for care [see "copay" and "coinsurance"].

Similar to a lot of employer plans, Obamacare plans provide certain preventive health services for free, even if you haven't hit your deductible yet. These services include vaccines and certain medical tests for all adults, and a special set of services for women including birth control and an annual well-woman visit. (Contrary to popular belief, an annual physical with a primary care doctor is NOT one of the things that's required to be free, and it will cost you at least a copay. For many employer-sponsored plans, both the annual physical and also the well-woman visit are free.)

Essential Health Benefits

A set of ten services that all health insurance plans on the Marketplace [see "marketplace"] must cover as a result of the Affordable Care Act. Insurers also can't place annual or lifetime limits on these services. The ten categories are: doctors' services, prescription drugs, hospitalization including surgery, outpatient hospital care, pregnancy and childbirth, emergency room care, mental health and substance use disorder services, laboratory services, rehabilitative services, and pediatric oral and vision care.

Flexible Spending Account (FSA)

If you have employer-based insurance, you can have money taken out of your paycheck before taxes and use it to pay for approved medical expenses including deductibles, copayments, and coinsurance. It's often loaded onto a prepaid card that you can swipe at a doctor's office or the pharmacy. You can also use an FSA account to pay for other expenses like glasses, contact lenses, dental care, and health products sold on FSAstore.com, like bandaids, pain relievers, and sunscreen. In 2018, the most you could contribute to an FSA was $2,650 a year, and you can roll over $500 to the following year.

Health Savings Account (HSA)

This is similar to a flexible spending account (FSA) in that it's pre-tax money that can be used to pay for deductibles, copayments, and coinsurance. But you can only put money in an HSA if you have what's considered a high-deductible health plan (HDHP), which is generally any plan that has a deductible of at least $1,350 for one person. For 2019, you can contribute up to $3,500 to an HSA for individual health coverage. Some insurance companies offer these accounts, or you can open one with a bank. And unlike an FSA, you can roll over the account's entire balance from year to year and the funds may earn interest, which isn't taxable.

High-deductible Health Plan

An insurance plan that requires you to pay at least $1,350 out of pocket for an individual (or $2,700 for a family) before the plan starts to pay its share, though the monthly premium (or cost of the plan) is usually lower than plans with lower deductibles. Some plans sold on the insurance marketplace have deductibles over $5,000 for one person.

Individual Mandate

This is one of the linchpins of the Affordable Care Act. In order for insurance companies in the Marketplace not to be saddled with only people who have preexisting conditions—people who buy health insurance because they need to use it and cost the insurance companies more money than people who don't require a lot of care—the law required everyone in the US to either have health coverage or pay a tax penalty.

Importantly, it doesn't say that everyone has to buy a plan from the ACA Marketplace, just that they need to have coverage that meets the law's minimum standards—so getting insurance through work means you're good. The idea is that having "healthy" people in the pool of insured people helps keep costs down, but a lot of those people were mad that they suddenly had to get insurance. (Truth is, without insurance, healthy people are one accident or diagnosis away from big, big problems, physically and financially.)

Republicans effectively ended the individual mandate for 2019 in their tax bill. They couldn't erase it altogether, but they made the tax penalty for not having insurance $0. Experts believe that healthier people will be less likely to buy insurance in 2019 and premiums for others will go up as a result.

Insurance Network

A group of providers and facilities that contracts with your insurance company to provide services at a discounted price. A doctor might accept your insurance and be considered in-network, and your insurance company will incentivize you to use providers like this by charging, say, a $25 copay for visits. Other providers may accept your insurance but are out-of-network and your insurance company may charge you more money to see them, for instance by subjecting the visit to your deductible and charging coinsurance, or a percentage of the cost rather than a flat fee.

Marketplace

The health insurance marketplace, also known as the "exchange," is the service available in every state that helps people shop for and enroll in health insurance. People who are buying their own coverage (i.e., not getting it through their job, spouse, or the government) can shop for plans online, by phone, or in person. In most states, the federal government runs the marketplace and you sign up at HealthCare.gov. But 11 states and Washington DC have their own sites.

■ Medicaid

A government-run insurance program that provides low- or no-cost health insurance to some low-income people, low-income or uninsured pregnant women and children, people with disabilities, the elderly, and more. People can apply for Medicaid at any time; it doesn't have to be during the open enrollment period [see "open enrollment"]. Under the Affordable Care Act, more than 30 states expanded eligibility for Medicaid to include all adults below a certain income level—138 percent of the federal poverty level. (This is known as "Medicaid expansion.") The states that have resisted thus far tend to be in the South and Midwest.

■ Medicare

A government-run insurance program for people 65 and older and some younger people with certain disabilities and conditions. Some politicians want to make Medicare available to more people by letting them buy into it before age 65, aka a "public option," or turn it into our nation's one health insurance program [see "Medicare for all"].

■ Medicare for All

One way to achieve universal coverage is to make Medicare the insurer for everyone—not just people over 65 or people with certain conditions. Medicare allows both the government and private insurance companies to pay for care, so it's not a single-payer system. Vermont Senator Bernie Sanders has a plan that he calls Medicare for All, but if you want to get technical, his plan is actually single-payer healthcare because it would eliminate all private insurance companies, which isn't how Medicare operates now.

■ Open Enrollment

The period when you can sign up for health insurance for the following year. Each employer has its own window, but for people buying their own plans, open enrollment has run from November 1 to December 15 the past two years in the 39 states that sell their plans on Healthcare.gov. (Most of the 11 states that run their own sites have longer enrollment periods.) You can sign up for or change your insurance outside of that period if you have what's known as a qualifying life event. Examples include if you get married or divorced, have a baby, lose your health coverage, or if you move.

Out-of-pocket Costs

Also known as "cost-sharing," this is the total of what you, not the insurance company, spend for medical care. It includes deductibles, copays, and coinsurance, but not the monthly premium since that's the cost of having insurance, not for getting care.

Out-of-pocket Maximum

Yes, there is a limit to how much the insurance company can make you pay in one year. After your out-of-pocket costs hit whatever that amount is, the insurance company picks up 100 percent of any costs for covered services thereafter. And while copays don't usually count toward your deductible, they DO count toward your out-of-pocket max.

Premium

The amount you pay just to have an insurance plan, even if you never set foot in a doctor's office. If your insurance comes from your employer, the premium gets deducted from each paycheck throughout the year. (This isn't the true cost of the plan—your employer pays for some of it.) If you buy your own plan, you pay the insurance company directly every month.

Preexisting Condition

Before the Affordable Care Act, people who bought their own insurance could be denied coverage for having a preexisting condition like diabetes and Crohn's disease. Some insurers would cover you if you had a preexisting condition, but they'd charge you more than other people. The ACA banned insurance companies from asking people about their health history and required them to accept everyone and charge them the same rates.

Private Health Insurance Plan

A health plan that isn't "public," that is, paid for by the federal government. Private plans include those offered by employers and ones people buy themselves. The majority of Americans have private insurance: In 2016, 49 percent of Americans had insurance through work and another 7 percent bought their own coverage.

Public Health Insurance Plan

A health plan that's operated by the federal government—so, Medicaid and Medicare.

Single-payer Healthcare

One type of universal healthcare. The payer in this case is the government, rather than a for-profit insurance company. A single-payer system would make health insurance companies obsolete: You'd get health coverage from the government and the government would pay doctors a set price for medically necessary care. You, the user, would have no premiums or deductibles, but there would likely be some out-of-pocket costs, and not every country with single payer covers vision or dental care.

Universal Healthcare

A system that guarantees that everyone in a country, or even a single state, gets health insurance, no matter their ability to pay. The system is funded by taxes. There are several types of universal healthcare, including single-payer, where the government pays for care provided by private companies (see: Canada), or socialized medicine, where the government pays for and provides the care (see: the UK).