TRANSGENDER BENEFICIARIES OF MEDICARE AND MEDICAID: IS THE HEALTHCARE SYSTEM WORKING FOR EVERYONE?

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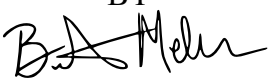

Benton Meldrum

APPROVED:

Dr. Scott Nolan
Co-Director of Thesis

Dr. Susan Hassig
Co-Director of Thesis

Dr. Red Tremmel
Third Reader

ABSTRACT

Benton Meldrum. Transgender Beneficiaries of Medicare and Medicaid: Is the Healthcare System Working for Everyone?

(Dr. Scott Nolan, Political Science; Dr. Susan Hassig, Public Health)

This thesis explores the two largest public insurance plans in the U.S., Medicare and Medicaid, through a lens of equity and accessibility for transgender beneficiaries. This thesis centers the utilization of insurance systems through examining policy and literature, conducting a survey to transgender affirming healthcare providers, and analyzing a case-study interview with a transgender affirming insurance specialist in New Orleans, Louisiana. In sum, this thesis describes what is working well for transgender beneficiaries of Medicare and Medicaid and what needs to be reformed or expanded to improve healthcare access and equity. Chapter 1 is an introduction to the thesis and Chapter 2 is a literature review of the existing discussion of the demographics of transgender Americans, the histories of Medicare and Medicaid, and health concerns relevant for transgender individuals. Chapter 3 introduces my guiding research questions and Chapter 4 outlines the methodology I utilize to answer them. Chapter 5 examines my survey results and Chapter 6 examines my case-study interview results. Chapter 7 synthesizes my findings as answers to my research questions and Chapter 8 concludes the thesis, explaining the needs for Medicare and Medicaid to be reformed and expanded to improve health care implementation for transgender Americans. Most significantly, the administration of these public insurance plans is riddled with bureaucratic barriers that disproportionately hinder transgender patients. Reforming and expanding public insurance in the U.S. are essential to establish medical and social equality for transgender people.

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Thank you to my family. My brothers, sisters-in-law, nieces, Mom, Dad, and Berkeley. You are the reasons why I am who I am and why I strive for excellence. You make me proud every day, and I hope to do the same. I would not be here without you.

Lastly, thank you to New Orleans. The city that taught me how to slow down and appreciate the stunning oak trees, how to understand myself and the world around me, and how to be resilient even when the world expects you to fail. I am forever grateful for your shining example of survival, celebration, love, loyalty, and community.

This thesis is dedicated to the beautiful queer and transgender community. I hope that one day, the systems will finally work for us and that we will be valued as complex, important, and worthy contributions to society. I hope this thesis gets us one step closer.

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CHAPTER I: INTRODUCTION

This undergraduate honors thesis examines the issue of inaccessibility of Medicare and Medicaid to transgender beneficiaries, especially regarding access to gender affirming care, behavioral health care, sexual health care, and mental health care. Medicare and Medicaid are important to study because they are the largest public insurance plans in the United States (U.S.) and they are intended to cover vulnerable populations. In order to ensure health equity across the country, the healthcare system must be reformed and expanded to adequately include all people, regardless of identity. Gender affirming care, behavioral health care, sexual health care, and mental health care are important to study because they are health issues that are relevant to transgender individuals, in particular. According to the literature, these are the areas where transgender people experience significant inequalities.

In this thesis, I address three important research questions. First, how does Medicare cover medical needs relevant to transgender people in practice? Second, how does Medicaid and its expansion under the Patient Protection and Affordable Care Act ["ACA"] cover medical needs relevant to transgender people in practice; did Medicaid expansion extend transgender specific coverages? Third, what reform needs to occur to Medicare and Medicaid to improve their coverage for transgender patients; and would universal healthcare improve coverage and outcomes for transgender people?

To answer research question one, I conducted a survey among health care providers from clinics across the country who focused on transgender health care and worked with patients who utilized Medicare. The survey asked questions about the effectiveness of Medicare in covering gender affirming care, behavioral health care, sexual health care, and

mental health care. I sent the survey to 83 clinics, hospitals, and community health centers. I received 13 responses to my survey. The responses indicated a general lack of understanding of how Medicare effectively covered transgender health issues. Because of this, I was unable to answer my first research question adequately. This question left an opportunity for further research into Medicare and transgender beneficiaries of it.

To answer research question two, I utilized the same survey instrument as mentioned above. This survey, sent out to providers at transgender focused health care clinics across the country, asked questions about the effectiveness of Medicaid at covering transgender related healthcare needs. The responses illustrated administrative barriers to care such as confusing coding schemes, too few gender affirming providers who accept Medicaid, and long waiting times to access procedures. Generally, Medicaid policies include transgender beneficiaries, but the implementation of Medicaid makes accessing care difficult. Also, providers noted that expanding Medicaid made a significant improvement in accessibility to care for transgender patients. Moreover, I conducted a case-study interview with an insurance specialist in New Orleans who provided more insight into the process of connecting clients to Medicaid. The interviewee mentioned similar significant administrative barriers but elaborated that societal inequalities and gender incompetence of providers need to be addressed in order to reach the roots of many healthcare inequality problems faced by transgender people.

To answer research question three, I synthesized the results of my literature review, my survey, and my case-study interview to discover what ways Medicare and Medicaid could be reformed or expanded to eliminate inaccessibility to care for transgender people. Through this synthesis I found that Medicaid processes should be streamlined to be as easy

as possible for patients and providers in order to make care most cost-effective and efficient for patients. Also, Medicaid should incentivize providers to undergo gender competency training so all providers can interact with their transgender patients more positively.

This thesis begins with a literature review of the demographics of the LGBT community in the U.S., the histories of Medicare and Medicaid, and the most significant health issues relevant to transgender patients (Chapter 2). Chapter 3 describes my research questions, Chapter 4 illustrates my methodological approaches to answering these questions, and Chapter 5 discusses the results I gathered from my survey to health care providers. Chapter 6 illustrates the results from my case-study interview, Chapter 7 synthesizes my results to answer my three research questions, and Chapter 8 concludes my thesis. My bibliography, appendices, and vitae appear at the end.

CHAPTER II: LITERATURE REVIEW

In this chapter, I will review the current scientific peer-reviewed literature about LGBT people and their connection with publicly provided insurance programs. I will summarize demographic data on LGBT people in the United States and discuss data about race, gender, geography, and socio-economic status. Then I will summarize health issues that are specific to transgender people and their physical, mental, and substance use health trends and needs. Further, I will provide a basic overview of Medicare and how it addresses some of the health concerns for transgender people. I will discuss who qualifies for Medicare, what it covers, and how this is relevant for transgender people. Additionally, I will summarize Medicaid as a public insurance payer and how it connects to transgender people in the country as well as its benefits and shortcomings for transgender patients.

Section 2.1: LGBT Demographics in the U.S.

Studies that center gender and sexual minorities must first summarize the demographic population data of the LGBT community in the United States. This paper will focus on the transgender community separate from the LGBT community, yet my initial research focused on the LGBT community in its entirety and I found the demographic information about the transgender community sparse on its own. I recognize that the transgender community is distinct from the cisgender LGBT community and confronts different social, political, and healthcare barriers, but I include the entirety of the LGBT community for the first section of my literature review. Although the known data on openly LGBT people is sparse, because of a lack of research interest and social stigma for those who must disclose their gender and sexual identities, data collected by institutions such as the Williams Institute at the UCLA School of Law are reliable sources. According to this data, 4.5% of

the United States' population identifies as LGBT. The distribution of this population is uneven because some states report percentages above and below this national average. For example, Washington D.C. reports the highest percentage of LGBT people at 9.8% of its population. Oregon is second highest at 5.6%. The state with the lowest proportion of LGBT people is North Dakota at 2.7% of the state's population (Williams Institute, 2019). Although an absolute causal effect has not been established, the variation across states loosely corresponds with legal social inclusions and protections for LGBT people in each state (Pollak, 2013). Additionally, LGBT people who live in states that are more accepting of gender and sexual minorities may feel more comfortable to come out and self-identify as LGBT in data collection with less fear of discrimination or social rejection. Some LGBT people migrate to states where tolerance is higher in order to find legal and social protections, too.

Further, these population data can be disaggregated by gender, race, age, educational attainment and socio-economic status. Of all LGBT self-identified people in the United States, excluding non-binary and intersex people, 58% identify as women and 42% identify as men. Additionally, LBT women are more likely to come out at a younger age than GBT men. The average age for LBT women in the U.S. is 33.8 years old while the average age for all women in the U.S. is 49.2. The average age for GBT men is 39.8 years old while the average age for all men in the U.S. is 46.8. Also, LBT women are more likely than GBT men to have an annual income lower than $24,000 but have a higher likelihood of raising children than GBT men.

Across the U.S., 58% of LGBT people identify as White, 21% Latino/a and/or Hispanic, 12% Black, 5% biracial, 2% Asian, 1% Native American, and 1% Pacific

Islander. When these percentages are compared to the racial demographics of the country, we learn that this representation is not proportional. According to the 2019 U.S. Census data, White, Black, and Asian individuals are underrepresented in the national LGBT community while biracial, Latino/a and pacific islander people are slightly overrepresented. The U.S. LGBT community – with 58% of people identifying as White - is more racially diverse that the U.S. as a whole – where 76% of the population identifies as White.

Regarding age, the demographics of LGBT people in the U.S. illustrate that younger people are more likely to identify as LGBT than older people. Fifty-six percent of the adult self-identified LGBT population in the U.S. is under 34 years old. The average age of self-identified LGBT people in the U.S. is 37.3, which is much younger than the average age of non-LGBT people in the US, 47.9 years old. This difference can be associated with generational public opinion change and continued socio-political acceptance of LGBT people, especially among younger people. As younger generations foster a more positive view of the LGBT community, social attitudes and stigmas change, thus making it easier for younger people to be accepted by their families and communities.

Regarding education, LGBT people are more likely to have a high school diploma, or some college completed, but are less likely to obtain a bachelor's degree or a graduate degree. This is generally the same across races, except for Latino LGBT people who are actually more likely than non-LGBT counterparts to obtain a bachelor's or graduate degree. When split by gender, GBT men are more likely to have a higher educational attainment than non-GBT men, but LBT women are less likely to achieve higher educational attainment when compared to non-LBT women. Additionally, some LGBT people may

only pursue undergraduate or graduate education in LGBT-friendly cities to avoid discrimination or harassment, thus limiting the pool of schools they apply to and attend (Singh and Durso, 2017).

Regarding socio-economic status, LGBT people have large disparities among socio-economic status (SES) indicators. Self-identified LGBT people are more likely to be underemployed, unemployed, uninsured, food insecure, and have an annual income less than $24,000 than non-LGBT people. The disparities in each indicator change when race and gender are included in the analysis. For example, 31% of LBT women are food insecure while 17% of non-LBT women are food insecure. This is a larger disparity than among men. Twenty-one percent of GBT men are food insecure while 13% of men in the U.S. are food insecure. These data also shift by race. Latino LGBT people are less likely to have an income below $24,000 or be uninsured than Latino/a non-LGBT people. Further, Black LGBT people fare worse in all of these indicators compared to non-LGBT Black people. White people in the U.S., regardless of sexual or gender identity, are less likely to be food insecure, unemployed, uninsured, or have an annual income less than $24,000 compared to average rates in the U.S. (Williams Institute, 2019).

The LGBT population in the U.S. is significantly different than the non-LGBT population, specifically regarding race, age, educational attainment, and socioeconomic status. Therefore, the LGBT population has different needs and a different composition than the country as a whole. In the next section, I will discuss specific health needs of the transgender population.

Section 2.2: Transgender Health Issues

This section will be a discussion of specific health needs that transgender people have physically, mentally, and with substance use. Although more identity sensitive research is needed that does not treat the LGBT community as homogenous and/or monolithic, there is evidence to suggest more physical, mental, and substance use health issues among the transgender population in the U.S.

Section 2.2.1: Physical / Sexual Health

Transgender people face unique challenges regarding their physical and sexual health when compared to cisgender people; and although all the causes for these disparities have not been determined, disparities exist. Transgender people have higher rates of joblessness and lower incomes compared to cisgender people, leaving them vulnerable in many ways including to food insecurity. This insecurity means that trans people are subject to food deserts, malnutrition, obesity, and diabetes more than cisgender counterparts. In the U.S., 11.1% of individuals are food insecure, yet 79% of trans people in the southeast U.S. self-reported some level of food insecurity or relying on federal programs to provide food for themselves or their families. Some might ask trans people to utilize food pantries and community organizations instead of federal programs, but 67% of food pantries in the U.S. are run by faith-based organizations – many of whom deny serving transgender people food on religious or moral grounds (Russomanno & Jabson Tree, 2020).

Transgender people have higher rates of heart attacks and self-reported vision problems compared to cisgender people. However, obtaining assistive equipment like wheelchairs, glasses, contacts, or Lasik is not significantly higher than that of cisgender people (Ilan et al., 2017).

Regarding HIV, some studies suggest that the prevalence among the transgender community does not differ from the cisgender community, but other studies suggest that HIV prevalence is higher among transgender people (Transgender Health Disparities, 2014). Among the studies that do suggest a higher rate of prevalence among the trans community, transgender women sex workers and Black transgender people have the highest prevalence (Leslie et al., 2012). Although there are many barriers to research because of social stigma and little desire to disclose gender identity or HIV status, this is an area for further research. Some factors could include riskier sex habits or intravenous drug use.

Further, transgender people face a unique physical health risk because of the prevalence of self-treating gender dysmorphia through unlicensed silicone injections. Transgender people experience healthcare provider discrimination and have more limited access to care compared to cisgender people, meaning that they may find unprofessional or unsanitary ways to alter their sex or gender presentation to match their gender identity. Especially for trans women, silicone injections may be utilized to shape the body in an unsafe way that can lead to adverse consequences. These adverse effects can include pain, infection, deformity, necrosis, bleeding, embolization, inflammation, organ failure, or death (Deutsch, 2016). Self-medication among the transgender community can lead to serious adverse health effects. These unique behaviors and conditions strongly suggest worse overall physical health for transgender people in the U.S.

Section 2.2.2: Mental Health

Transgender people experience higher rates of social stressors in U.S. society compared to cisgender people. This worsens mental health and can lead to the need for

mental and physical health services. Further, much of the mental health disparities found between transgender people and cisgender people are correlated with higher social stressors, including child abuse, intimate partner violence, employment discrimination, and other interactions with violence (Reisner et al., 2014). Beyond experiencing social stressors, transgender people experience higher rates of depression, anxiety, and eating disorders than the general population.

All transgender people, especially transgender youth, are at higher risk of depression, suicidal ideation, and suicide attempts compared to cisgender youth, even cisgender lesbian, gay, bisexual, or queer youth. Among transgender youth, these mental health problems are most prevalent among trans males and nonbinary youth assigned female at birth (Price et al., 2020). The higher risk for poor mental outcomes among transgender youth can be connected to the higher rates of chronic stress faced by other marginalized identities and require specialization to treat; a one-size-fits-all model to treat depressive issues among the LGBT community broadly is not enough to help transgender people or transgender youth, specifically (O'Neill, 2020).

Additionally, transgender people are at higher risk for developing and living with anxiety related disorders. Compared to the general population, transgender people are at three times the risk of developing anxiety disorders. This risk is higher for transgender men. The higher rates of anxiety can be correlated with low self-esteem and limited access to hormonal, medical, or psychiatric therapies, highlighting the need for these therapies to be easily accessible (Bouman et al., 2017). Further, the most common anxiety related issues among the trans population appear to be social phobias, panic disorders, and obsessive-compulsive disorders. These anxieties were found to be more prevalent among trans men

compared with trans women, but there is significant variance among these findings (Millet et al., 2017). More research is needed to specify the rates at which trans people experience anxiety, but all evidence suggests they experience anxiety at higher levels compared to the general public.

Reviewing the limited literature available shows that there is a significantly higher prevalence of eating disorders among the transgender community. Results from widespread surveys illustrate that trans people are more likely to receive an eating disorder diagnosis than cisgender heterosexual women. Also, trans people are more likely to self-report having used a diet pill or laxative recently (Connolly et al., 2016). Additionally, there is a heightened risk of eating disorders among transgender and gender nonconforming individuals who were assigned female at birth compared to transgender and gender nonconforming people assigned male at birth (Diemer et al., 2018). Although there is need to further research in this area, the literature suggests there is a significantly higher prevalence of eating disorders among transgender people compared to cisgender people.

With the literature available, studies suggest that transgender people have worse mental health demographics and outcomes when compared to the general public through utilizing indicators to measure depression disorders, anxiety disorders, and eating disorders.

Section 2.2.3: Substance Abuse

There is a dearth of information in the literature about substance use comparing transgender people to non-transgender people regardless of sexuality. Most studies analyze the LGBT community as a whole and combine sexual minorities with gender minorities in their analysis. There is a strong need to conduct large population studies about transgender

people's substance use that does not conflate gender identity and sexual orientation. Although the literature about the use of substances among transgender people is limited, studies suggest that transgender people use substances at higher rates than the general population, especially among transgender youth. In one study surveying transgender youth assigned male at birth, the prevalence of recent use of substances was 65% for alcohol, 71% for marijuana, and 23% for illicit drugs besides marijuana. Cisgender peers reported rates of substance use as 39% for alcohol, 23% for marijuana, and 3-9% for use of non-marijuana illicit drugs (Reisner et al., 2015). Reasons for these increased rates are likely related to minority stressors, gender dysmorphia, and internalized stigma against transgender people (Gonzalez et al., 2017).

Alcohol use among transgender people, although not researched comprehensively, is likely higher than that of cisgender people. One study based in California suggested that transgender youth utilize alcohol at earlier ages than cisgender youth and have a higher likelihood of lifetime use. The study found that the odds of lifetime use of alcohol for trans people was 1.5 times higher than that of cisgender people (Day et al., 2017). Another study analyzed the rate of experienced transphobia and its correlation with alcohol misuse. It concluded that higher experience of transphobia is correlated with higher use of alcohol but did not compare these findings with average alcohol consumption rates in the U.S (Kcomt et al., 2020). Other studies have found no statistical difference in alcohol use between transgender and cisgender people across the U.S (Blosnich et al., 2017). Therefore, further research of alcohol use among the transgender community is needed.

Tobacco use among transgender adults is higher than tobacco use among the cisgender population, but conflicting studies have decreased the significance of this

conclusion. One 2016 study found that 83% of transgender women in the California bay area reported smoking a cigarette in the past month (Gamarel et al., 2016). Also, a 2015 analysis of a 2013 national cross-sectional study found that transgender adults used cigarettes, cigars, and e-cigarettes at higher rates than cisgender adults (Buchting et al., 2017). However, an analysis of the 2015 Population Assessment of Tobacco and Health suggested that there is no statistical significance between the rates of transgender and cisgender adults in the U.S. (Wheldon and Wiseman, 2019). There is insufficient data collection regarding the transgender community's smoking prevalence, but the transgender community experiences higher rates of employment discrimination, depression, and HIV infection which are all risk factors associated with a higher smoking prevalence (Margolies, 2020). Therefore, more research is needed to determine the smoking patterns of transgender individuals compared to the non-transgender population (Valdiserri et al., 2019). Additionally, smoking prevalence among the transgender community may be difficult to determine separately from the cisgender community because smoking prevalence in the U.S. has decrease dramatically overtime (American Lung Association, 2020).

Marijuana use is higher for the transgender community compared to the cisgender community. Marijuana is used by approximately 24% of the transgender community and is used at higher rates for transgender men than for transgender women. Transgender people who report being non-heterosexual report higher rates of marijuana use, too. This use of marijuana is correlated with prevalence of depressive symptoms in the transgender population (Day et al., 2017).

Although more research in this area is needed, substance use is generally higher among transgender people compared to non-transgender people. Therefore, transgender people

have a greater need for access to rehabilitation services, support networks, and medical professionals who can address substance use issues. The underlying reasons for substance use among transgender people are highly likely to include minority stressors, and social discrimination leading transgender people to utilize substances as a coping mechanism.

Section 2.3: Transgender People and Medicare

This section summarizes trends in Medicare coverage of transgender people in the United States. I will discuss a brief history of Medicare, qualification requirements of Medicare, the transgender population that utilizes Medicare, what Medicare covers, and gaps in coverage that are specifically relevant to transgender people.

Section 2.3.1: Medicare History and Qualifications

Medicare is a publicly funded health care insurance program as part of the Social Security Act of 1965. Upon its original creation, as signed into law by President Johnson, it included only Parts A (for hospital insurance) and B (for medical insurance). It was initially intended to only cover elders over 65 years old. Over time, Medicare has expanded to include Part C (Medicare Advantage) a private insurance plan under Medicare, and Part D for prescription drug coverage and has widened its qualifications to include people with certain chronic conditions like renal disease, terminal illnesses, ALS, and more (Anderson, 2019). In 2020, monthly premiums for Medicare were between $252-$458 and it covered about 61 million Americans (Department of Health and Human Services, 2020).

Section 2.3.2: Transgender Population Covered by Medicare

The number of transgender people who participate in Medicare has increased since 2010. Much of this can be attributed to more accurate diagnosing abilities under the International Classification of Diseases -10th Revision (ICD-10) which was updated the

same year to provide a more accurate case definition of gender dysphoria (Ewald et al., 2019). Approximately 4,098 people who utilize Medicare identify as transgender (Ewald et al., 2019). About 71% of transgender Medicare beneficiaries (TMBs) are entitled to coverage because of a disability, not age. For this reason, TMBs are younger than average and have more chronic diseases that worsen over time. Lastly, transgender people on Medicare are more likely to be non-White compared to all Medicare beneficiaries (Dragon, 2017).

Section 2.3.3: Medicare Coverage for Transgender People

Before 2014, Medicare did not cover gender affirming surgery (GAS) on the grounds that it was controversial, not proven to be effective, elective, and an experimental procedure. However, efforts to prove that GAS is actually effective and medically beneficial to patients motivated the repeal of a national ban on its coverage. Now, Medicare covers GAS on a case-by-case basis, in line with how it covers most other medical treatments. GAS is now proven to treat gender dysphoria from the medical community, is illegal to ban under anti-discrimination laws, and is cost-effective according to health economists. (Defreyne et al., 2017). The procedure is covered under Medicare Parts A and B and Medicare Advantage. In addition to GAS, Medicare programs cover medically necessary hormone therapy under Part D. Medicare covers routine preventative care checks for all people regardless of gender markers on one's ID card. Therefore, pelvic exams, prostate exams, mammograms, and more sex specific care is covered for all Medicare recipients regardless of gender identity (National Center for Transgender Equality, 2020).

The Patient Protection and Affordable Care Act (ACA) bans discrimination on the basis of sex for insurance coverage, which has been interpreted to extend to gender identity,

too. Medicare has always covered preventative screening and sex specific care, but the interpretation of the ACA's ban on coverage discrimination meant that Medicare could not cover these practices for one person and not another based on gender identity (Baker, 2017). Therefore, Medicare is legally required to cover GAS and hormone therapy for transgender patients.

Regarding mental health services, Medicare Parts A and B cover many aspects of psychiatric care. Part A covers up to 190 days of residence in a psychiatric hospital over a lifetime. Part B covers one depression screening per year, individual and group psychotherapy, psychiatric evaluations, medications, diagnostic tests, and family counseling if patients utilize certain providers. Part B covers visits with counselors, psychologists, psychiatrists, social workers, nurse practitioners, and physician assistants and covers any opioid misuse treatment (Department of Health and Human Services, 2020).

Regarding substance abuse treatment and care, Medicare covers services on a case-by-case basis. Most of the coverage for substance misuse rehabilitation is covered under mental health services that Medicare covers, however substance use disorders outside what is deemed "appropriate or necessary" may not be covered. Also, Medicare covers Screening, Brief Intervention, and Referral to Treatment (SBIRT) services which are used for early intervention to prevent dependency to substances. In 2019, Medicare updated its coverage policies to provide coverage of opioid misuse rehabilitation services (American Hospital Association, 2019).

Section 2.3.4: Gaps in Medicare Coverage and Recommendations

Although Medicare may cover hormone therapy for transgender patients, it still requires expensive out of pocket costs for patients. In 2018, the median out of pocket costs for masculinizing treatments per treatment ranged from $232 to $2176 for Medicare patients. For feminizing treatments, the median costs ranged from $72 to $3792. This variability and potential for high out of pocket costs leads to unaffordability of hormone therapy even though it is covered by Medicare (Solotke et al., 2020).

Medicare does not cover drugs that are "off label" as determined by the Food and Drug Administration (FDA). Many drugs that are utilized for some transgender people during the transition process are considered off label and are not covered by Medicare. These drugs may not be utilized by all transgender people during their transition but covering the drugs would make it much more accessible to those who want to utilize them to treat gender dysphoria. The Center for Medicare and Medicaid Services should work closely with the FDA to research these drugs and seek for their approval. Once they can be considered approved by the FDA, Medicare should be willing to cover them. Or Medicare should be willing to cover "off label" drugs that are utilized for GAS (LGBT Aging Center, 2016).

As public opinion of transgender people slowly improves over time, improved Medicare coverage for GAS and mental health services should be expected.

Section 2.4: Transgender People and Medicaid

This section will parallel the above discussion on transgender people and Medicare but will focus on Medicaid. I will relay a brief history of Medicaid, who qualifies for Medicaid, the transgender population on Medicaid, what relevant healthcare options

Medicaid covers for transgender people, and highlight the gaps in coverage for the transgender community.

Section 2.4.1: Medicaid History and Qualifications

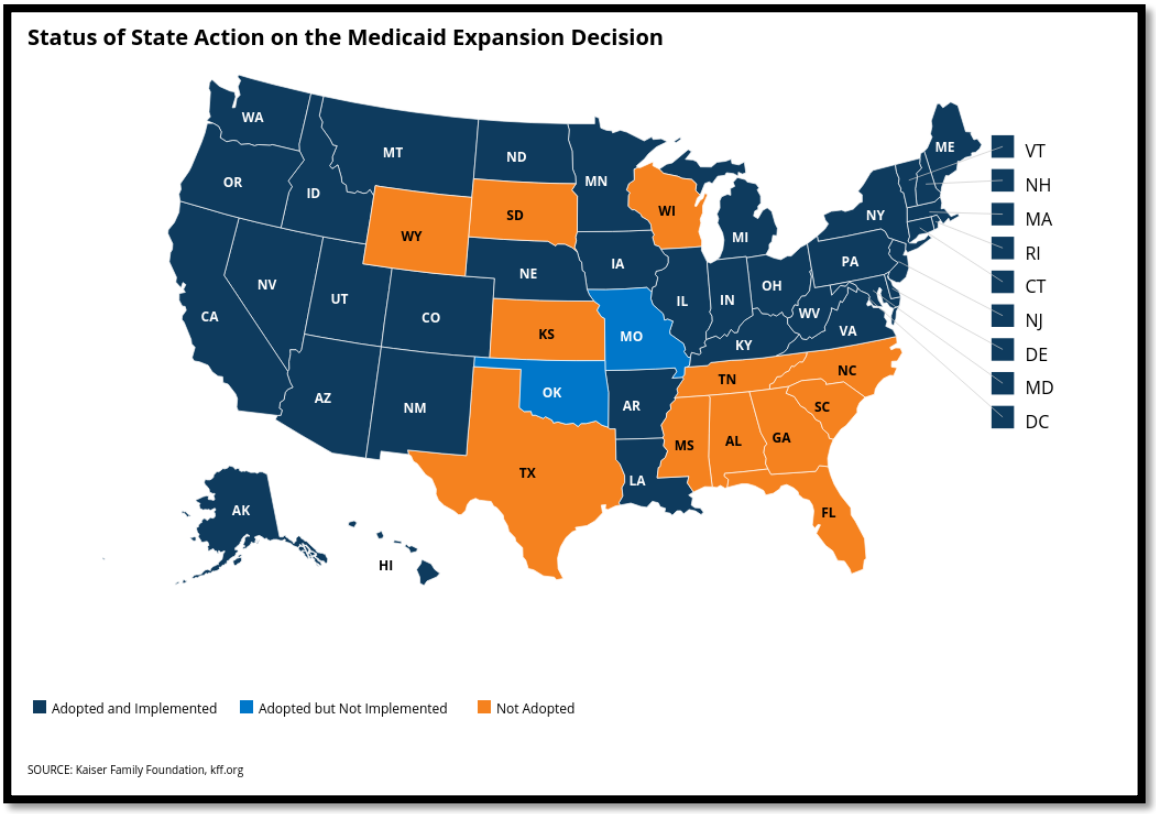
Medicaid is a publicly provided insurance program that was enacted in Title XIX of the Social Security Act of 1965. Medicaid provides health care coverage to a range of qualifying individuals including low-income families, pregnant people, those with dependent children, those living with disabilities, and more. Medicaid is administered by states within parameters set by the federal government. It is funded partially through federal funds and partially through state funds. On average, the federal government pays for 53% of state programs. Overall, about 19% of Americans utilizes Medicaid health care services (Baker et al., 2016) (KFF, 2020).

In 2010, the ACA was passed, and the federal government attempted to mandate expansion of each states' Medicaid program to include childless adults with incomes less than 138% of the federal poverty level (FPL). In *National Federation of Independent Business v Sibelius,* the Supreme Court struck down the mandate to expand the program and determined that it was up to each state to decide if they would like to expand the program on their own. This expansion, the subsidies, and other requirements found in the ACA provide comprehensive health insurance to all people under 138% FPL and subsidies for individuals and families with higher incomes. However, in states that refuse to expand their Medicaid programs there is a coverage gap for individuals who live between 100%-138% FPL who do not qualify for federal health insurance another way (Healthcare.gov, 2020). Further, the Supreme Court is considering a case to entirely strike down the ACA in 2021.

Medicaid coverage of certain services is determined by states themselves, not the federal government. Therefore, Medicaid coverage is specific and different in each state, as per the infographic below.

Figure 1

Map of State Medicaid Expansion as of February 2021



Section 2.4.2: Transgender Population Covered by Medicaid

Medicaid provides limited coverage to low-income individuals who otherwise would have no access to health insurance. Transgender people are four times more likely to be living in poverty than cisgender people, thus there is a significant number of transgender beneficiaries of Medicaid (Baker et al., 2016). According to the Williams Institute at UCLA, about 1.4 million adults in the U.S. identify as transgender and about 152,000, or 10.8%, are enrolled in Medicaid (Mallory and Tentindo, 2019).

The ability for transgender people to qualify for Medicaid has increased in recent years. *Altitude Inc. v Zarda, et al.* (2020) holds that it is a violation of federal law for private companies to discriminate against transgender people based on their gender identity. Thus, many transgender people could not access insurance through a private employer due to higher discrimination and joblessness until this year (*Bostock v Clayton County*, 2020). Further, recent changes in the Supreme Court make this reality only a current and potentially temporary trend.

2.4.3: Medicaid Coverage for Transgender People

Medicaid is unstandardized in the care that each state must provide regarding GAS although it has been generally proven to help transgender people have higher quality of life through treating gender dysmorphia.

Although *Zarda* holds that discrimination on the basis of sex extends to gender identity, many transgender people live in states that explicitly deny access to gender affirming care, including GAS and hormone therapy. As of 2020, 18 states and D.C. have explicit statements covering gender affirming care, 12 states exclude coverage of gender affirming care, and 20 states do not make it clear if gender affirming care is covered. Even though discrimination against transgender people is illegal under federal law, more than half of transgender people live in states that do not explicitly cover gender affirming care. Additionally, transgender people are more likely to be insured in states that have expanded Medicaid than in states that have not (Mallory and Tentindo, 2019).

Under the ACA directives, people with HIV can qualify for Medicaid without requiring the diagnosis to progress to AIDS. Medicaid is the largest federal funder for people living with HIV (Center for Disease Control and Prevention, 2020).

2.4.4: Gaps in Medicaid Coverage and Recommendations

Clearly there are many significant gaps in Medicaid coverage of transgender people because of the inconsistent coverage requirements across the U.S. States should expand Medicaid in order to mitigate the coverage gap for all people, especially transgender people.

All state Medicaid programs need to remove gender-affirming care exclusions and include statements of coverage for gender-affirming care. When gender-affirming care is not explicitly included in state Medicaid programs, there are political disputes that result in leaving gender affirming care inaccessible. These disputes often consider it experimental and too controversial to qualify for coverage. Therefore, gender affirming care needs to stop being considered elective, cosmetic, or experimental in public opinion. Among academics and medical professionals, it is thoroughly researched and supported to be medically necessary to transgender individuals (Sorbara et al., 2020). The federal government should take action to support its validity and require that all Medicaid programs cover it.

The antidiscrimination statements in Section 1557 of the ACA need to explicitly include gender identity and sexual orientation to solidify these protections. There is a chance that the Supreme Court could overturn *Zarda* and could retract the interpretation of sex discrimination that includes gender identity. If Section 1557 were altered to explicitly include transgender individuals, the Supreme Court would be less able to remove Medicaid coverage for transgender people.

Additionally, under the ACA, all applicants are required to utilize the federal form to streamline the process, or states can provide their own similar version of the federal

Marketplace application. On the form, there are only two gender options “male” or “female”. This does not include transgender people and leaves many confused how to respond. Additional gender identity options need to be included on the form and on future research regarding populations who utilize the program so more comprehensive data about Medicaid beneficiaries can be collected (Baker et al., 2016).

CHAPTER III: RESEARCH QUESTIONS

Based on the literature review, Medicare and Medicaid are public insurance options that provide limited coverages that are relevant to transgender people, but do not cover all needs pertinent to transgender people. In this chapter, I will propose, explain, and elaborate upon the questions at the center of this project. These research questions guided my survey questions and administration process to transgender focused health providers.

Research Question #1: How does Medicare cover medical needs relevant to transgender people in practice?

This question is significant because it aims to find the gaps in Medicare coverage of transgender specific needs. Medicare is one of the most popular public insurance options in the U.S. with over 44 million beneficiaries, therefore it is essential to examine its efficacy in practice as well as in theory. Many beneficiaries of Medicare identify as transgender and need to have their needs covered under this insurance plan beyond and including transitioning. If there are significant gaps in coverage under such a large insurer, they must be named to improve its coverage for transgender patients. In order to answer this question, I will be asking medical providers in a survey about their experiences providing care to Medicare beneficiaries who are transgender. I will gather these responses of providers who accept Medicare and compare them to their experiences providing care for patients with other forms of health insurance. If there is a noticeable disparity between what services are covered under private insurance or other forms of insurance, they must be addressed in order to establish greater health equity and access for Medicare beneficiaries who are transgender.

Research Question #2: How does Medicaid and its expansion under the Patient Protection and Affordable Care Act ["ACA"] cover medical needs relevant to transgender people in practice? Did Medicaid expansion extend transgender specific coverages?

Similar to the first research question, this question aims to examine Medicaid coverage of transgender needs in practice. Medicaid is implemented by states in conjunction with the federal government and was expanded in 2010 thus creating significant differences in coverage and processes of implementation. Many Medicaid beneficiaries qualify for the program because of low economic status, age, disabilities, and/or pregnancy, and are vulnerable to health problems going untreated. I will examine how these recent changes have adequately or inadequately insured transgender beneficiaries and if its voluntary expansion under the ACA increased or changed its coverage of transgender issues. This question is compelling because it is important to discover how processes of implementation and voluntary state expansion adequately covers or fails to cover transgender patients in practice. In order to cover and care for vulnerable and largely underserved minority populations in the U.S., Medicaid must adequately cover transgender needs and services. If it does not, it needs to be reformed or further expanded to do so. To answer this research question, I will ask healthcare providers about their experiences providing transgender specific services to patients with Medicaid and examine areas of success and failure. Also, I will contrast results between providers from states that have expanded their Medicaid program with states that have not expanded to discover if there are significant improvements in coverage for transgender people under Medicaid expansion.

Research Question #3: What reform needs to occur to Medicare and Medicaid to improve their coverage for transgender patients; and would universal healthcare improve coverage and outcomes for transgender people?

My final research question expands the scope of inquiry in this paper to advocating for broader coverage. After examining the adequacy of coverage for transgender specific needs under Medicare and Medicaid, I will examine the coverage gap and specifically analyze what care is and is not effectively covered for transgender people. This question is compelling because it deepens the analysis of my first two research questions – not only will this paper state what services are covered for transgender people via public insurance, but it will address what services are not yet covered and why they are necessary. This final research question will act as a call to action for public insurance providers to expand their coverage of services that are essential for transgender people to have access to. To answer this question, I will be analyzing my survey responses and asking questions in a case-study interview about what insurance plans should and could be expanded to better benefit the transgender community. If medical providers are aware of gaps in coverage for services for transgender patients, then they should be aware of what changes need to occur in order to better serve transgender patients with public insurance.

CHAPTER IV: METHODOLOGY

In this chapter, I will describe my methods for answering my three research questions. These methods included (a) finding health clinics across the U.S. who provide care specifically for transgender patients and accept Medicare and Medicaid insurance, then (b) administering a survey to them via email, and (c) conducting an in-depth interview with an insurance specialist from one New Orleans based organization that provides care to transgender patients. Through these methods I will address my research questions with the perspectives of health care providers in mind but analyze the results via political and public health lenses. In order to find clinics for my survey sample, I utilized the Center for Disease Control and Prevention (CDC) website. Their website page for LGBT Health Services listed websites for LGBT focused healthcare centers including clinics, hospitals, and various community centers. I created and emailed a Google survey to clinics and hospitals to collect their responses about providing care to transgender patients via Medicare or Medicaid. Once the survey was administered to 83 providers, I analyzed the data for noticeable trends and reported my results below. I conducted a case-study interview with the insurance specialist at a New Orleans, Louisiana based healthcare clinics that interacts with transgender clients to gather a deeper understanding of how care is administered to patients via Medicare and Medicaid at an LGBT focused healthcare center. Once all this information was collected, I discussed the results of my data collection below.

To find clinics for my survey sample, I utilized the CDC website that listed LGBT Health Services.[1] This list of 130 resources for LGBT people across 46 states and

[1] LGBT health services. (2020, December 21). Retrieved March 02, 2021, from https://www.cdc.gov/lgbthealth/health-services.htm

Washington D.C. included clinics, hospitals, and community centers that provide care for LGBT people. I searched through each of these resources, and I removed community centers and organizations that did not provide any medical care. Next, I removed providers who did not accept Medicare or Medicaid insurance. The remaining 115 clinics and hospitals became my target survey recipients. I emailed a Google survey to 83 clinics and hospitals through a direct email or an email via their specific website's inquiry box. The remaining 32 clinics did not have posted emails or inquiry boxes.

Later, I called some of the remaining clinics who did not post an email address on their website, but these calls did not yield a way to deliver the survey or collect responses.

Of the 83 clinics who received access to the survey, 13 responded to my emailed survey instrument, a response rate of 15.7% - much better than expected. The survey included 20 questions total; half were Likert scale questions asking their opinion on the effectiveness of Medicare or Medicaid covering certain aspects of health specific to transgender people (behavioral, sexual, mental, and physical health), half were open-ended responses to further explain their answer. The end of the survey provided a space for those who were interested in conducting a follow-up interview to leave their email address. The survey was formatted as follows:

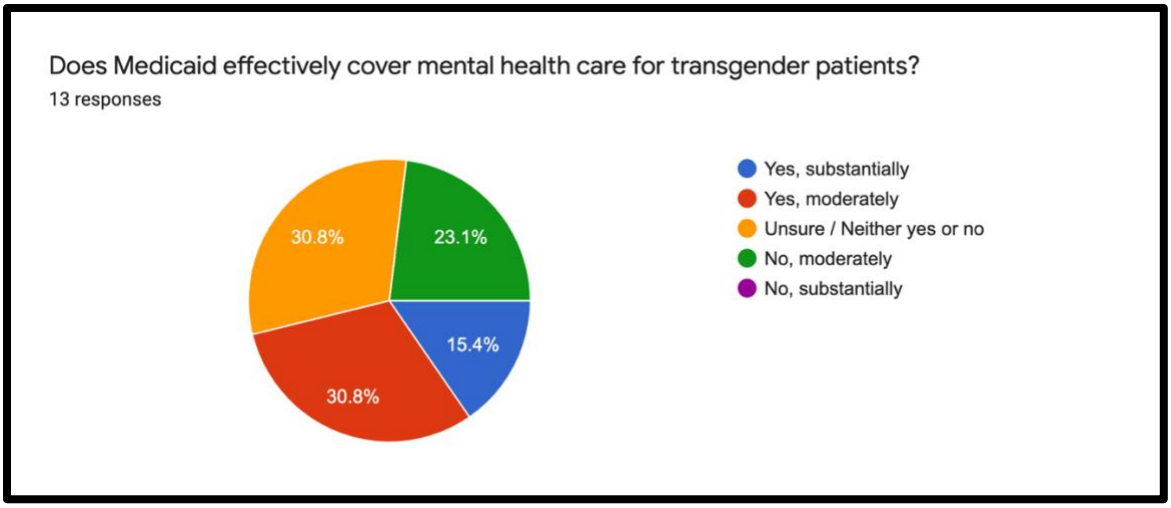
Figure 4

#1: Does Medicaid effectively cover mental health care for transgender patients?
(Yes, substantially; yes, moderately; unsure/neither yes nor no; no, moderately; no, substantially)
#2: **Please explain your answer to Question #1.**
(Open paragraph response)
#3: Does Medicare effectively cover mental health care for transgender patients?
(yes, sub.; yes, mod.; unsure/neither yes nor no; no, mod.; no, sub.)
#4: **Please explain your answer to Question #3.**
(Open paragraph response)
#5: **Does Medicaid effectively cover gender reassignment care for transgender patients?**
(yes, sub.; yes, mod.; unsure/neither yes nor no; no, mod.; no, sub.)
#6: **Please explain your answer to Question #5.**
(Open paragraph response)
#7: **Does Medicare effectively cover gender reassignment care for transgender patients?**
(yes, sub.; yes, mod.; unsure/neither yes nor no; no, mod.; no, sub.)
#8: **Please explain your answer to Question #7.**
(Open paragraph response)
#9: **Does Medicaid effectively cover sexual health care for transgender patients?**
(yes, sub.; yes, mod.; unsure/neither yes nor no; no, mod.; no, sub.)
#10: Please explain your answer to Question #9.
(Open paragraph response)
#11: **Does Medicare effectively cover sexual health care for transgender patients?**
(yes, sub.; yes, mod.; unsure/neither yes nor no; no, mod.; no, sub.)
#12: **Please explain your answer to Question #11**.
(Open paragraph response)
#13: **Does Medicaid effectively cover behavioral health care or substance use care for transgender patients?**
(yes, sub.; yes, mod.; unsure/neither yes nor no; no, mod.; no, sub.)
#14: **Please explain your answer to Question #13.**
(Open paragraph response)
#15: **Does Medicare effectively cover behavioral health care or substance use care for transgender patients?**
(yes, sub.; yes, mod.; unsure/neither yes nor no; no, mod.; no, sub.)
#16: **Please explain your answer to Question #15.**
(Open paragraph response)
#17: **Have you noticed a difference in utilization of care by transgender patients since Medicaid expansion has gone into effect as part of the Affordable Care Act in 2010?**
(Yes, substantially; yes, moderately; unsure/neither yes nor no; no, moderately; no, substantially; my state has not expanded Medicaid)
#18: **Please explain your answer to Question #17.**
(Open paragraph response)
#19: **Does private insurance cover health issues related to transgender patients better than Medicare or Medicaid?**
(yes, sub.; yes, mod.; unsure/neither yes nor no; no, mod.; no, sub.)
#20: **Please explain your answer to Question #19**.
(Open paragraph response)

CHAPTER V: SURVEY RESULTS

Below are the results from my Google survey after 13 responses from healthcare providers were collected. Each chart illustrates the responses from each question in the survey. After each chart, any elaborations that respondents provided are summarized answers from survey respondents. When noted, I add my own research and thoughts. These elaborations will be further analyzed in Chapter VII. Generally, respondents had more to say about Medicaid than Medicare, as seen by the following charts and elaborations. Although the responses are less detailed for questions pertaining to Medicare, I will be elaborating as much as possible.

Figure 5.1



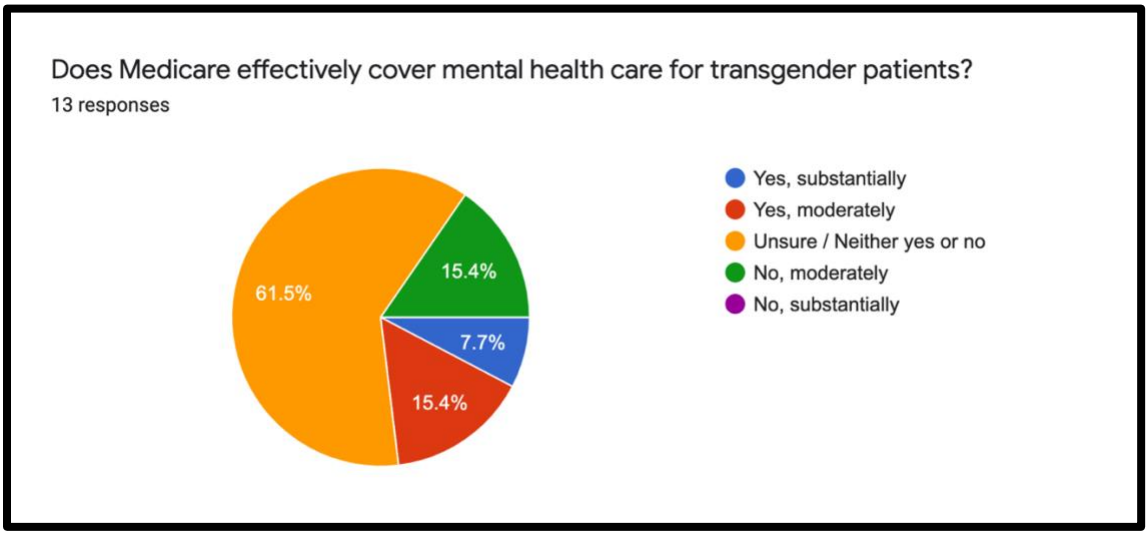
(Source: Google Survey of March 2021)

Generally, regarding Figure 5.1, Medicaid covers mental health care for trans patients, but the efficacy is nuanced. Often, providers have to absorb the costs of Medicaid's lower reimbursement rates, leading fewer providers to accept Medicaid. This means that fewer therapists and mental health care providers are geographically and financially accessible. Some transgender patients may be assigned a therapist who is a 3-

hour drive away. Telehealth appointments are not always accessible to patients who cannot afford the technology needed. This geographic barrier makes accessing care difficult even if it is covered by Medicaid. Also, therapists or other mental health care providers are not required to be trained in gender or sexuality competency, so some providers may treat mental health issues poorly for trans people. The quality of care is not regulated under Medicaid, meaning that transgender patients might be assigned a therapist who is not affirming of their gender identity.

From my research, financial incentives for providers who accept Medicaid should be implemented from the federal government to increase the number of providers who are geographically and financially accessible to patients. Additionally, although outside of Medicaid's enforceable requirements, gender competency training should be required for all mental health care providers who work with transgender patients. Mental health care must not only be accessible, but it must also be high quality.

Figure 5.2

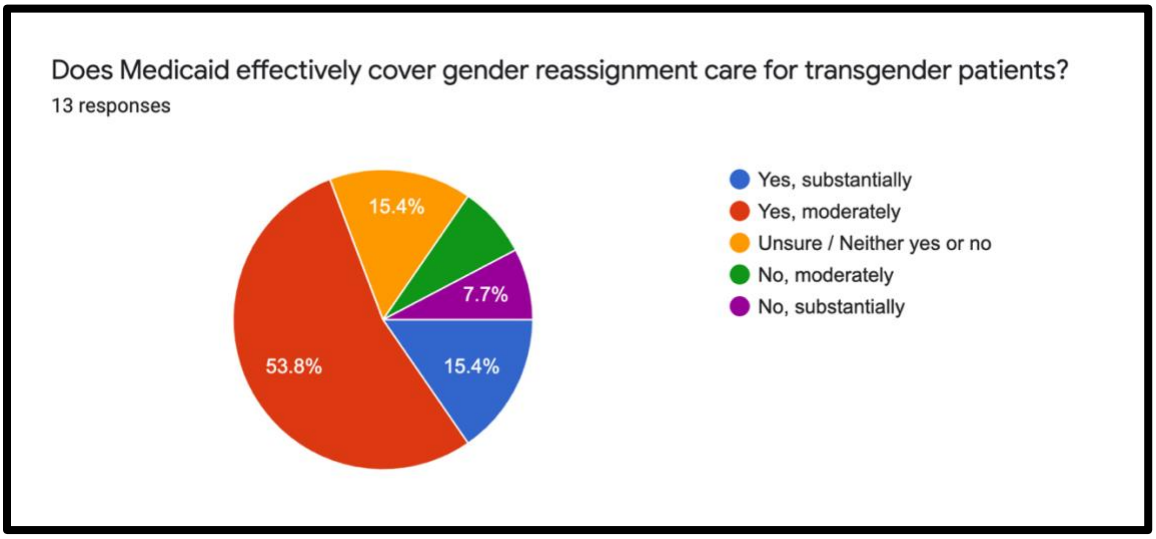


(Source: Google Survey of March 2021)

Regarding Figure 5.2, most survey respondents had limited experience with transgender beneficiaries of Medicare. Generally, they did not know how Medicare covered mental health care for transgender patients. However, some respondents highlighted competency issues with mental health care providers using incorrect coding, effectively increasing the out-of-pocket cost for the patient and making it easier for patients to reach covered limits with a single provider more quickly.

Medicare should be reformed to streamline its coding process to prioritize cost reduction for patients. Right now, the coding process places the onus on providers to not only provide care to the patient, but to know how to code the treatments for them. Medicare should provide case workers who are adept at coding to minimize the patient's out of pocket cost as much as possible. Also, Medicare should increase or abolish its covered treatment limits for mental health care so that patients can receive more mental health care.

Figure 5.3



(Source: Google Survey of March 2021)

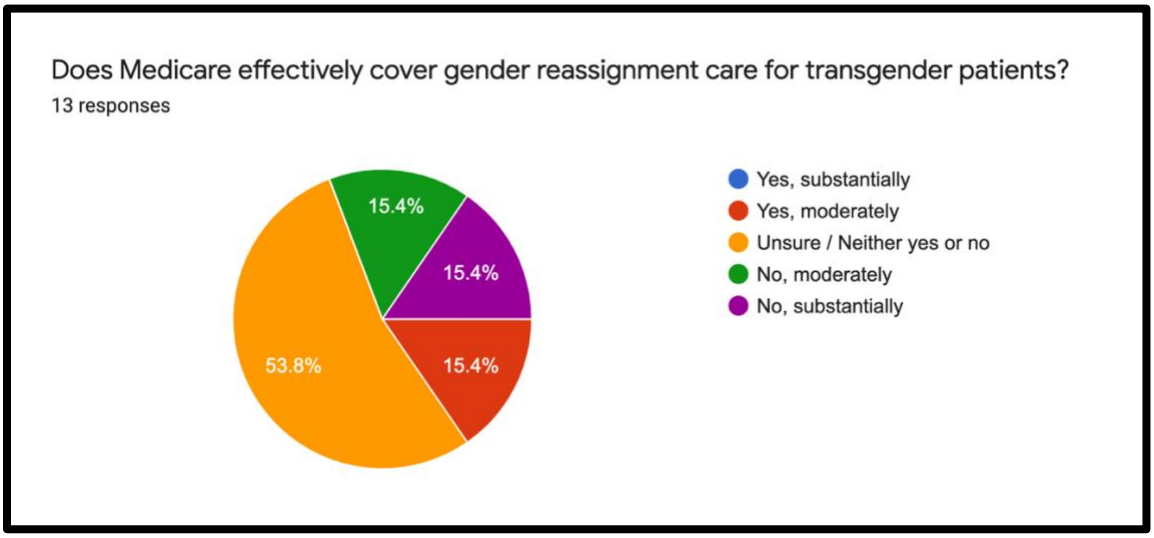
Generally, regarding Figure 5.3, Medicaid covers the more basic components of gender reassignment care such as top and bottom surgeries and hormone replacement therapy. But barriers remain for detailed aspects of gender reassignment care like electrolysis, facial feminization surgery, or body contouring surgeries. Additionally, barriers unrelated to insurance and financial barriers were mentioned. Specifically, arbitrary waiting periods, political stigma, and policies barring people from accessing these treatments without non-medical based psychological evaluations were the biggest barriers to care. Medicaid requires a significant amount of administrative back-and-forth paperwork in order to approve covering gender affirming surgeries. These back-and-forth hoops to jump through create multiple month-long waiting periods that are detrimental to patients who need gender affirming surgeries immediately.

My research illustrates that Medicaid coverage policies are determined by each state. According to the Williams Institute at UCLA, of the approximately 152,000 transgender adult Medicaid beneficiaries in the U.S., only approximately 69,000 (45%)

live in states where Medicaid policies explicitly cover gender-affirming surgeries. Approximately 32,000 (21%) beneficiaries live in states where gender-affirming surgeries are explicitly not covered and 51,000 (34%) beneficiaries live in states where there is not a specific policy regarding coverage of gender-affirming surgeries (Mallory & Tentindo, 2019). This unspecified policy area means that treatments are covered on a case-by-case basis, allowing some states' Medicaid policies to cover gender-affirming treatments but other states designating them as elective and therefore not covered. The patchwork of state-by-state policies makes enforcing and streamlining Medicaid coverage of gender-affirming surgeries difficult.

From personal research, I discovered the U.S. Department of Health and Human Services (HHS) utilizes policies that make discrimination against transgender people illegal, including the Social Security Act and the Patient Protection and Affordable Care Act. One way that Medicaid could improve its coverage of gender-affirming care for transgender patients is through improving its efficiency and administrative processes. HHS should incentivize states to explicitly include gender-affirming care in their Medicaid policies.

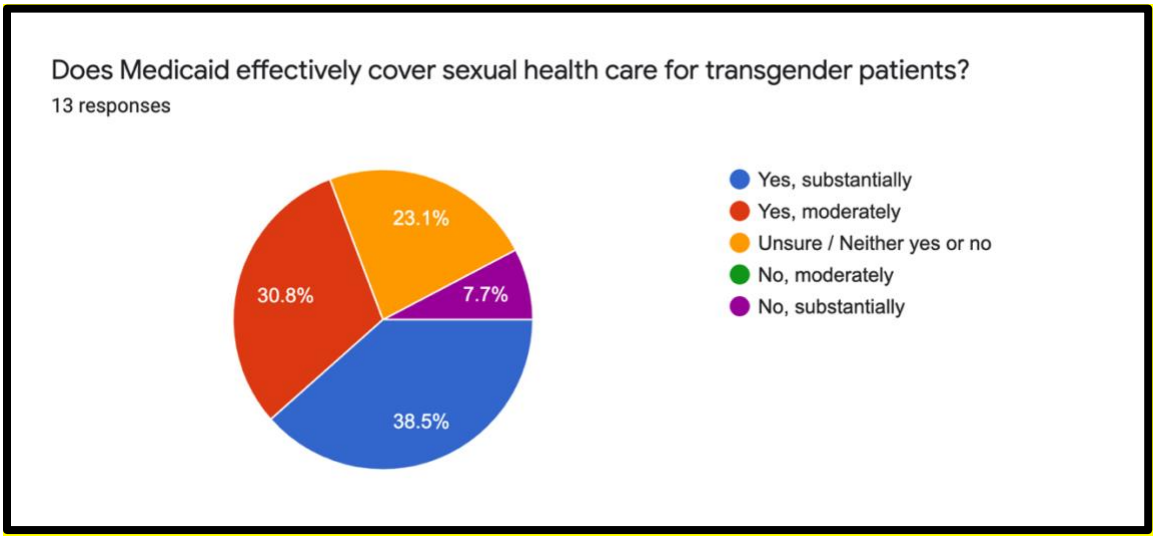
Figure 5.4



(Source: Google Survey of March 2021)

Regarding Figure 5.4, respondents who had worked with transgender Medicare beneficiaries explained that Medicare widely covers top and bottom surgeries, but incorrect and confusing Medicare coding procedures sometimes leads to patients having to pay out-of-pocket for gender-affirming care. Since Medicare bills patients after treatments occur, coding can change between the treatment and the payment, sometimes forcing patients to pay even if they cannot afford it. Additionally, coding schemes are very specific, meaning that if all the components of the treatment do not align with the code, it becomes less likely to be covered. Medicare Advantage (Part C) plans seemed to cover more gender-affirming treatments more than other Medicare plans (Parts A, B, or D).

Figure 5.5



(Source: Google Survey of March 2021)

Regarding Figure 5.5, all respondents mentioned that Medicaid generally covered most sexual health related care needs for transgender patients. According to the CDC, traditional Medicaid plans cover all STI testing for all Medicaid beneficiaries with certain usage limits. The Women's Preventative Services Guidelines as established in December 2016 are only covered by Medicaid expansion plans which, as mentioned later, only cover less than half of all transgender Medicaid beneficiaries in the U.S. (CDC, 2020). The Women's Preventative Services Guidelines provide more comprehensive sexual behavior counselling and services for people who identify as women – meaning that transgender women who do not live in states that have expanded Medicaid have more restricted access to sexual health counselling visits.

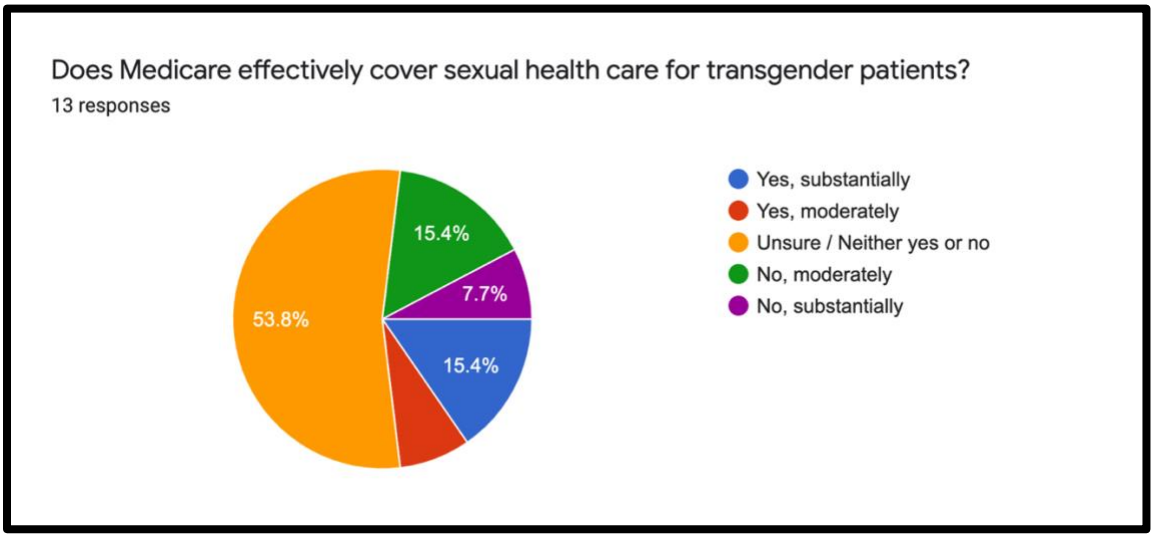
Some survey respondents mentioned problems around birth control and prior authorizations of medications. Medicaid only covers certain contraceptive plans that may not be the most effective fit for all patients. The Center for Medicaid and CHIP Services did not publish specific brand names of the kinds of contraceptives that it covers but did

publish the Maternal and Infant Initiative Program that aims to cover high- and moderate-effective contraceptives (CMCS).

Personal research shows that Medicaid plans cover Pre-Exposure Prophylaxis (PrEP) and Post-Exposure Prophylaxis (PEP), which are used to prevent HIV, a prevalent disease among the LGBT community broadly.

Under the controversial Hyde Amendment, Medicaid cannot utilize federal funds to cover abortions except in cases of rape, incest, or life endangerment. Only 16 states utilize state funds to cover other abortions for Medicaid beneficiaries, leaving beneficiaries in 34 states unable to access elective abortions. In states that do not cover abortions beyond what is stated in the Hyde Amendment, providers are able to deny patients care (Guttmacher Institute, 2021). These restrictions are especially damaging to transgender patients who may not be categorized into the traditional definitions of "women" and face social stigma for their identity, let alone the social stigma and political polarization of abortion access.

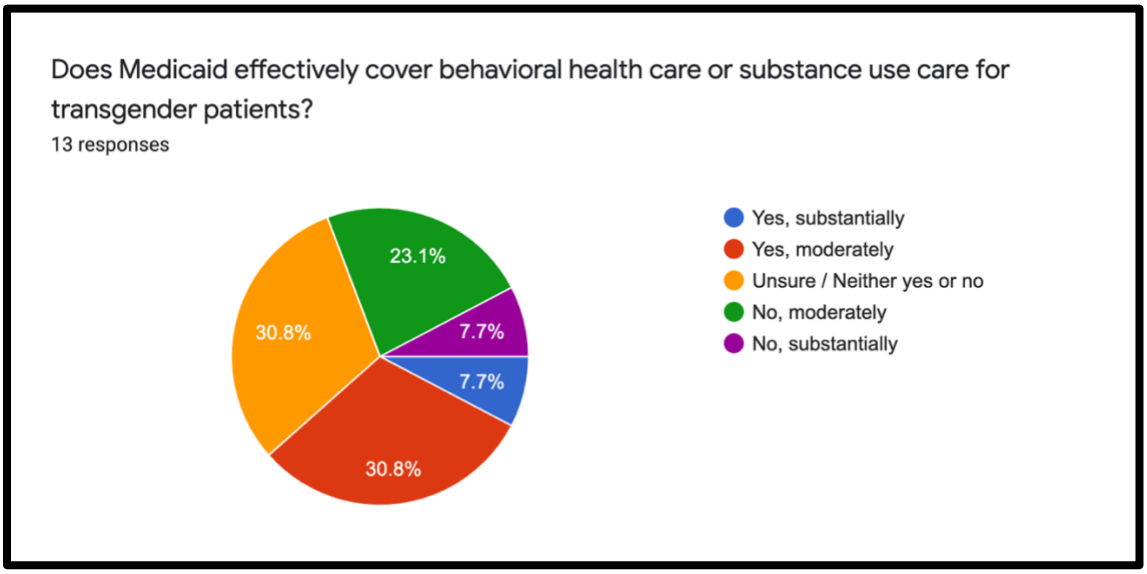
Figure 5.6



(Source: Google Survey of March 2021)

Generally, regarding Figure 5.6, responses to this question were vague, but respondents expressed similar concerns about Medicare coverage of sexual health care. Medicare does not cover contraception which is a significant concern for transgender patients who do not want to become pregnant. This is relevant because, as stated in Chapter 2, most transgender beneficiaries of Medicare qualify because of disability rather than age. Additionally, Medicare Part B covers one STI lab test and two behavioral health counselling sessions for certain patients per year (Medicare.gov, 2021). Respondents and the Medicare website do not mention covering any STI related medications. Lastly, coding schemes and post-treatment billing practices under Medicare increase the frequency with which patients are billed with high-cost treatments. The Center for Medicare Services dictate that some treatments and medications do not qualify under Medicare, leaving the cost up to the patients.

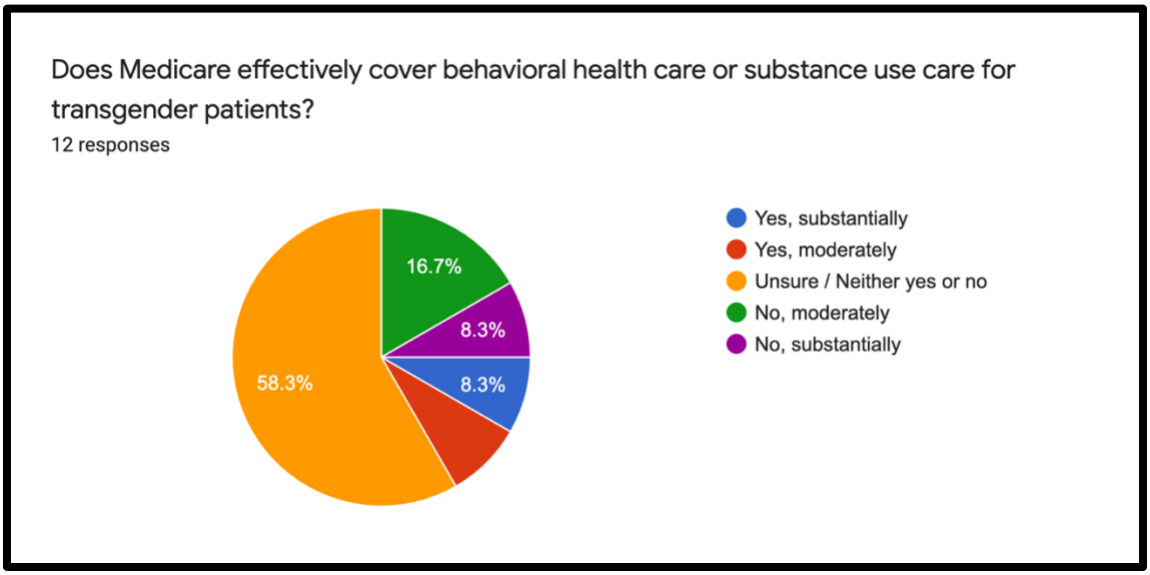
Figure 5.7



(Source: Google Survey of March 2021)

Regarding Figure 5.7, respondents highlighted problems with quantity of providers and long waiting lists as more significant barriers to care than Medicaid coverage itself. Although Medicaid limits how many behavioral health appointments it will cover per patient per year, therapeutic treatments are typically covered. More gender affirming providers who offer behavioral and substance use care are needed to better assist transgender patients. The Center for Medicare and Medicaid Services (CMS) should increase the limit of clinic visits transgender patients can have annually and it should incentivize more providers to undergo gender competency training. More affirming behavioral health specialists would be a better solution to accessibility problems than expanding Medicaid coverage of these treatments.

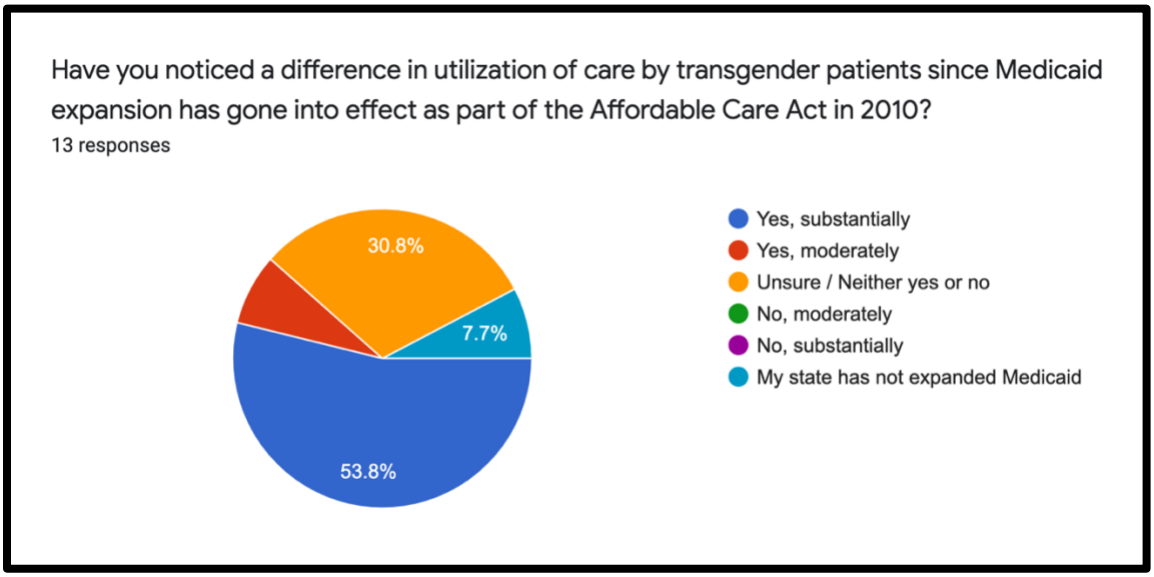
Figure 5.8



(Source: Google Survey of March 2021)

Regarding Figure 5.8, respondents mentioned the main issues with behavioral health and substance use coverage under Medicare as complexities with the coding scheme, low limits for clinic visits, and a lack of gender affirming care providers in network. Again, if treatments and diagnoses are not coded mindfully, limits can be reached quickly, and patients can be billed directly instead of billing insurance. Medicare only covers a certain number of clinic visits for behavioral health issues a year, meaning that accessibility to services becomes limited the more a person may utilize the services. Further, more gender affirming providers who accept Medicare are needed to offer more services to transgender patients. The CMS needs to increase incentives for gender-affirming care providers to accept Medicare and needs to streamline coding schemes to make them less complex.

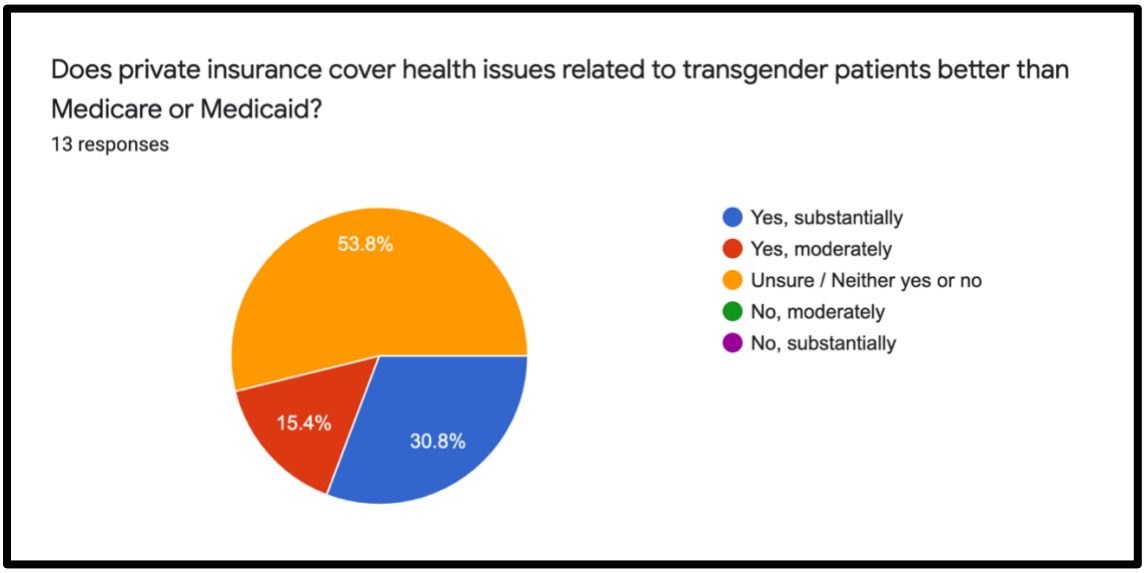
Figure 5.9



(Source: Google Survey of March 2021)

Regarding Figure 5.9, almost all responses mentioned substantial increases in utilization of care once Medicaid was expanded. Since 2010, fewer policies are transgender exclusionary, and more people have access to Medicaid because of higher income qualification thresholds. In addition to more people qualifying and utilizing Medicaid to access care, coverage of transgender specific treatments and surgeries has increased – potentially with greater social acceptance of transgender people in the U.S. Medicaid expansion under the ACA has been significant in helping transgender beneficiaries access care. All states should be further incentivized to expand Medicaid if they have not because providers see a clear increase in protections, accessibility, and utilization of care for transgender patients.

Figure 5.10



(Source: Google Survey of March 2021)

Clearly, in Figure 5.10, there is significant variance between Medicaid, Medicare, and private insurance plans making this question very broad. However, most respondents noted that Medicaid and private insurance plans generally had similar coverage for transgender patients. Medicaid (especially Medicaid expansion) has a more complex administrative overhead process making it more strenuous to utilize but is more financially accessible to transgender people who are typically poorer than cisgender people who are more likely to be able to afford private plans. According to my survey respondents, Medicare is the weakest coverage option for transgender patients. All private plans are different and should be evaluated on a case-by-case basis but seemed to cover treatments fairly well. Private plans seemed to offer more progress in expanding their coverage much quicker than public insurance, too. Per one respondent's experience, Anthem was the only private insurance organization mentioned as having especially poor coverage for

transgender patients. As of 2021, Anthem does cover gender affirming surgeries (Anthem, 2021).

My research suggests that public insurance plans need to increase their quality of coverage because there is a divide between high quality and often expensive private health insurance plans, and lower quality, less expensive public insurance plans. This means that those who can afford private plans (often white, cisgender, heterosexual people in the U.S.) receive better quality care while those who cannot afford private plans (more likely to be transgender, people of color, queer, etc.) receive lower quality, "second-hand" health care coverage and quality. It is vital that this gap be bridged in order to ensure high quality care for all people, not just those who can afford it. Implementing a Medicare-for-All type universal health care plan would provide significant strides for health equity because it would require the same coverage and quality treatment for all people regardless of income or identity. The patchwork of insurance plans that make up the U.S. healthcare system effectively reduces the importance of minority lives and identities in society. A single streamlined process that treated all people equally would improve the quality, administration, and affordability of health care to transgender individuals.

CHAPTER VI: INTERVIEW RESULTS

The following chapter recaps a case study interview I conducted with an insurance specialist at a health clinic in New Orleans on March 8, 2021. The intention of this interview was to find more context and depth to the questions I asked in my survey, my research questions broadly, and to discover more details about transgender patients and their interactions with insurance in New Orleans, specifically. For anonymity purposes, the specific clinic name will not be mentioned, and the specialist will be referred to as a pseudonym, "Taylor". Before the interview occurred, in my confirmation email to the interviewee, I let the interviewee know that the information gained from this interview is only being used for an honors thesis course at Tulane University for college credit; and none of the information gained from this interview will be publicized nor published. Further, I repeated this language verbally at the beginning of my interview on March 8, 2021, which is summarized below:

MARCH 8, 2021 – CASE-STUDY INTERVIEW WITH TAYLOR

Preface: The information gained from this interview will only be used for my honors thesis course at Tulane University for college credit and will not be publicized nor published.

Taylor acknowledged and accepted this statement.

#1: Considering your experience as an insurance specialist, and working to connect patients with insurance plans, what are the most common struggles you face connecting patients to payment plans?

Taylor cannot legally advise people to choose certain insurance plans, so most of their work is providing comprehensive information and resources to their clients. Then, the clients pick their own plans based on personal identity, financial, and medical considerations. The information that Taylor provides is not easily accessible online, so most clients have little to no prior information about Medicaid plans. Once clients choose a plan, they learn how much it costs and the details of what it covers afterwards; sometimes, clients get stuck with a plan that does not satisfy their needs for a year because clients can only switch plans during open enrollment periods for Affordable Care Act plans. These open enrollment periods are in the fall for Louisiana Medicaid enrollment.

Taylor spends time connecting clients to the plans that they qualify for. If they do not qualify for Medicaid plans, Taylor connects them to other coverage options like sliding scale private insurance plans or Ryan White coverage for HIV positive clients. Taylor's challenges include connecting clients to affordable programs and encouraging clients to self-advocate throughout the appeals process for cost-reduction and increased medical coverage.

#2: How are these struggles different for people who identify as transgender?

Taylor struggles with being unable to recommend specific plans to their transgender clients. Some plans in Louisiana are more comprehensive for gender affirming care than others, but Taylor is legally required to remain objective and allow the client to pick their own plan. If a client is insistent on choosing a plan that may not cover their needs, Taylor

is unable to overrule or veto their decision. This is especially concerning because clients are unable to switch their plans outside of the open enrollment period. Mostly, primary care coverage is similar across the Medicaid plans offered, but nuances regarding gender affirming treatments between plans can be "life and death" for transgender clients who need to receive treatment quickly.

Regarding specific Medicaid insurance plans, Taylor mentioned that Aetna (for its breast augmentation coverage) and AmeriHealth (for its coverage of trans-masculine top surgeries) offer the best coverage for gender affirming surgeries. Although there are still denials, the appeals process is more likely to work in the favor of clients with these plans. Other plans like United Healthcare will not cover most top surgeries. The insurance plan Healthy Blue will cover top surgery, generally, but will not cover nipple grafting, leaving patients in a financial and medical "gray area" with their treatment.

#3: Most of the responses in my survey regarding transgender patients and Medicaid mentioned that the coverage for trans-specific issues was effective on paper, but not always in practice. Have you experienced this? How so?

Taylor mostly works with clients at the application level but has heard information from providers in the field. From what they have heard from providers, the bureaucratic processes of appealing denials, obtaining authorizations, and applying for coverage is exhausting and confusing for clients. When clients are looking for their identity to be validated through medical treatment, they can suffer when they must repeatedly justify their treatments or must wait for months to have their treatments approved. Taylor explained that this waiting time barrier is "violent" towards transgender patients because

insurance plans will delay immediate care because of administrative overhead like applications and paperwork.

#4: Many respondents mentioned that Medicare had weak coverage for trans-specific issues and that there were coding and bureaucratic technicalities that created higher costs for patients than necessary. Have you experienced this? In what ways?

Taylor does not have a lot of experience working with patients who need Medicare. Taylor's expertise does not extend to this question.

#5: If you could change policies, procedures, or anything else about transgender care under Medicaid or Medicare, what would you change?

Taylor is not a Medicaid employee and does not work in its administration but had a few hopes for how Medicaid could be improved for transgender patients. Firstly, Medicaid should provide incentives for providers to accept Medicaid for gender affirming care. If there is no incentive, then providers will be unlikely to accept Medicaid as a payment plan because they are reimbursed less. Second, Taylor explained that flaws in administrative implementation of Medicaid are barriers. Taylor mentioned that the system does not work in a way that believes and supports the needs of each patient.

Further, Medicaid should eliminate bureaucratic red tape around accessing coverage. Specific examples include the need to obtain a letter from a therapist who may be treating gender dysphoria. This letter must use specific wording to explain what care is being provided and that it should be coded in a way that will reduce the cost to the patient. In these cases, the wait times are long because the system requires a lot of back-and-forth paperwork and treatment approval. Lastly, Taylor mentioned the confusing Medicaid treatment coding process. Not many people understand the coding process in depth, making

it easy to miscode expensive treatments that would have been covered if they were coded differently. People can find ways to code treatments accurately and in ways where they will be covered by Medicaid if they have the experience and information to code correctly.

#6: Do you believe that universal health care coverage of in the U.S. would address these issues? Why or why not?

Taylor theorized that, although universal health coverage is a broad term that could take many forms, any way to streamline processes and reduce barriers to care would address the most pressing issues from transgender patients. Fewer administrative barriers to primary care and gender affirming care would support transgender Medicaid beneficiaries. Besides increasing accessibility, Taylor noted that there are other important changes that would need to occur in order to further reduce social and financial barriers to care. These changes include radical social acceptance of transgender people in society and in the medical field and in reducing the cost of care. It is important that transgender patients have positive, validating experiences with providers in order to incentivize transgender people to seek primary and gender affirming care. This would make self-advocacy less daunting and positively influence the emotional, mental, and social health of transgender patients. Lastly, reducing financial barriers to care is a significant need that could occur through universal coverage, but Taylor did not have further details on how to achieve affordability.

#7: How can we incentivize providers to undergo gender competency training?

Taylor explained that broader social change is needed to incentivize providers to undergo gender competency training. A shift in media and social atmosphere will influence what providers learn, how they perceive what is important to their patients, and

how receptive providers can be when they encounter patients who advocate for themselves. Taylor mentioned that, already, more providers in 2021 in Louisiana are interested in receiving gender competency training than providers in 2020 – giving hope that there is a significant shift in social values occurring.

Additionally, word-of-mouth recommendations are important among the transgender community. Transgender people are less willing to go to providers that they've heard are transphobic or invalidating. Gender competency training would hopefully stop providers from acting in ways that are offensive to transgender people. Specifically, "deadnaming" – the act of calling a transgender person by their birth name they do not identify with – is prevalent in the medical field and is damaging and humiliating to transgender patients in waiting rooms and doctors' offices. Gender competency training would not fix all the issues in the medical system regarding transgender patients, but it would be a helpful step.

#8: Are there enough providers who provide transgender focused care? How do we increase the number of providers who do? Or direct transgender people to those that do provide care?

Taylor explained that, especially in the deep South, there are absolutely not enough providers who offer gender affirming care. There seem to be more and more providers who are offering gender affirming care over time, so it feels like progress is slowly being made.

Increasing the number of providers who offer transgender specific care could occur through admitting more transgender applicants into medical schools or reducing the cost of medical school overall to allow for more transgender students. Additionally, transgender

medical advocates and allies are vital in protecting and advancing social and medical rights for transgender people.

Taylor expressed the need for case managers to refer patients to gender affirming providers. Case managers often have lists of providers that transgender patients have had positive experiences with – if more transgender people can utilize these resources, they can have better healthcare experiences. The Louisiana Trans Advocates are one organization in the state that has a slightly outdated list on their website of transgender affirming providers. However, even utilizing referral lists is not always good enough for transgender patients as most providers are never perfect. These lists only help patients find providers who are better than others.

#9: Are the issues regarding transgender accessibility to care actually found in insurance plans? Or is there something else that is a bigger barrier?

Taylor explained that societal values are the biggest barriers for transgender people trying to access care. Policies reflect societal values and whose lives are prioritized in medical systems; when gender affirming care is not covered in insurance plans, transgender people are effectively told that their lives do not matter. More education about the existence of transgender people, their identities, and their importance are needed to help influence society to include transgender people in medical coverage. Another barrier is the complex Medicaid system because it is publicly funded but privately implemented. Therefore, patients may receive reduced costs but are still required to follow the restrictions of private insurance plans that are in financial competition with each other. Theoretically, people could collectively advocate for more comprehensive care of certain insurance plans, thus

influencing their coverage; but firms that are more concerned with profits than with the people they cover are difficult to motivate otherwise.

#10: Have you encountered a situation with a transgender patient that may highlight problems with Medicaid coverage for transgender patients?

Taylor expressed the importance of self-advocacy through one story about a transgender client who was a recent immigrant. The client did not have the specific documentation needed to qualify for Medicaid even though they needed health insurance. Although Medicaid covers immigrant children and emergency medical care, those in the process of applying for American citizenship are not eligible for Medicaid. The compounding identities of being transgender and an immigrant made it impossible for this specific client to access life affirming care, even though they were a staunch self-advocate and educated about their medical needs. This interaction illustrated the importance of understanding intersectionality in the medical field and how compounding marginalized identities make small barriers for some people insurmountable for others.

#11: Anything else you would like to include/mention to me?

Taylor did not have anything else to add.

CHAPTER VII: DISCUSSION OF RESULTS

In this chapter I synthesize and analyze the data from my survey and case-study interview. I list my three research questions and provide conclusions to them below each question.

Research Question #1: How does Medicare cover medical needs relevant to transgender people in practice?

Unfortunately, the data that I collected in this thesis did not generate enough data to make a significant conclusion for this research question. Most of the providers who answered my survey dealt more with Medicaid than they did with Medicare and my case-study interviewee had little experience with clients who qualified for Medicare. The data that I was able to collect would suggest that Medicare is ineffective at covering many health needs for transgender patients, but this is not a significant conclusion to make.

Future research should be conducted to find more conclusive data about effective Medicare coverage for transgender beneficiaries. Little research has been conducted about the aging LGBT community, generally, and there is a significant dearth of knowledge for the transgender community, specifically. Transgender elders are not often represented or thought of in media, policy, politics, or healthcare because social prejudices suggest that older transgender people do not exist or do not live long enough to qualify for Medicare. This is false. Transgender elders need gender reaffirming care, mental health care, sexual health care, and behavioral health care similar to younger transgender individuals. Hopefully, future research can support this claim and provide more evidence-based concern for the efficacy of Medicare for transgender beneficiaries.

Research Question #2: How does Medicaid and its expansion under the Patient Protection and Affordable Care Act ["ACA"] cover medical needs relevant to transgender people in practice? Did Medicaid expansion extend transgender specific coverages?

Medicaid and its expansion seem to adequately cover health needs of transgender patients in policy, but do not cover health needs effectively in practice. Yet, the way that Medicaid bars transgender patients from accessing high quality care is not entirely through its policies. Medicaid policies promote at least partial coverage of gender reaffirming care, mental health care, behavioral health care, and sexual health care needs, but the administration of care is flawed. There are too few providers who are competent in transgender-specific needs and are not gender affirming themselves. There are arbitrary limits placed on accessing care because of flaws in financing and complex coding schemes. Geographically, Medicaid beneficiaries are sometimes asked to travel hours away for mental health care when they do not have access to technology need for telehealth visits. These are only some examples of how Medicaid implementation is complex and cumbersome for all beneficiaries; this is extremely damaging to transgender beneficiaries who are already largely economically, socially, and politically more disadvantaged than cisgender counterparts.

Regarding the second part of my research question, Medicaid expansion did extend transgender specific coverages because Medicaid expansion increased patients' access to care when they had no coverage before. Medicaid expansion reduced the restrictions to qualify for the program and it increased the coverage for transgender specific needs.

Research Question #3: What reform needs to occur to Medicare and Medicaid to improve their coverage for transgender patients; and would universal healthcare improve coverage and outcomes for transgender people?

Medicaid needs to be expanded and reformed in numerous ways. Most importantly, the HHS should provide larger incentives for states to expand Medicaid in order to increase health insurance access for all Americans. Secondly, Medicaid needs to be reformed so that its implementation can be streamlined. Too many patients face arbitrary, solvable barriers to care such as long wait times, bureaucratic back-and-forth, and a lack of competent providers. Thirdly, providers need to be incentivized to accept Medicaid and receive gender competency training. Currently, transgender beneficiaries of Medicaid do not have access to enough transgender affirming providers and are burdened with high out of pocket costs when the confusing coding scheme is processed incorrectly by inexperienced providers. Lastly, Medicaid's coverage needs to be expanded to better cover transgender-specific needs such as detailed gender affirming surgeries (nipple grafts, facial feminization surgery, laser hair treatment, etc.), increased visits to mental health providers, and greater access to abortions and STI counselling services. Private insurance plans can provide this coverage for patients, therefore Medicaid should, too. All people, especially transgender people, should not receive lower quality health care because they are too poor to access it.

As mentioned earlier, my data did not generate enough results to confidently recommend reform for Medicare. Hopefully, future research will be able to do so.

Although not adequately addressed in my research results, I hypothesize that universal healthcare coverage would improve access to healthcare for transgender patients

because it would be more cost-effective and administratively direct, reducing the likelihood of improper coding, violent waiting times for treatments, and require that all providers accept transgender patients regardless of payment plan. Universal coverage would allow for transgender people to be treated the same as cisgender people in the medical field. This is a significant area where more specific policy analysis and research is needed.

CHAPTER VIII: CONCLUSION

In this undergraduate honors thesis, I examined the effectiveness of Medicare and Medicaid implementation for transgender beneficiaries, especially regarding the coverage of gender affirming care, behavioral healthcare, sexual healthcare, and mental healthcare. I implemented a survey to transgender affirming healthcare clinics across the country and conducted a case-study interview with an insurance specialist in order to answer my research questions.

Research question one was effectively unanswerable from my results in this paper. Not enough respondents had significant expertise in providing care to transgender beneficiaries of Medicare, making the responses from my survey largely unusable. Hopefully, future research can be conducted into the implementation of Medicare for transgender individuals and the barriers they face accessing care.

The broadest answer to research question two is that explicit exclusions to gender affirming care in 12 states in the U.S. is the most significant barrier to care for transgender beneficiaries. In the 38 states where gender affirming care is covered by Medicaid, administrative barriers to are the most significant barriers to care. Providers who responded to my survey cited confusing coding schemes that did not prioritize the patient, long wait-times to access care, and geographic accessibility barriers to care for transgender patients. Generally, Medicaid policies cover the most significant aspects of transgender specific care, but there are coverage limits for number of visits to mental and behavioral health providers that should be eliminated. Also, Medicaid should be expanded to cover more "minor" components of gender affirming care like facial feminization surgery and electrolysis. Lastly, Medicaid expansion did effectively increase access to care for

transgender beneficiaries who reside in those states. Medicaid expansion should be further incentivized because providers saw a significant increase in the utilization of care for transgender patients after it was expanded.

The broadest answer to research question three is that administrative barriers and societal inequalities need to be addressed in order to improve healthcare provision equity for transgender patients. The bureaucratic processes that complexify Medicare and Medicaid are not patient-centered, are confusing for most people involved, and are violent towards transgender people. Also, more providers need to be incentivized to accept Medicaid and to undergo gender competency training. Society needs to be more accepting and affirming of transgender people in conjunction with expanding and reforming health payment policies to cover transgender-specific issues. Universal healthcare in the U.S. would dramatically improve accessibility of healthcare for transgender people and reduce systemic inequities in the provision of care.

If I were to move forward with this project in the future, I would closely examine the coding scheme of Medicaid to better understand its complexities and sources of confusion for providers. Also, I would take more incentive to examine Medicare and transgender beneficiaries and their interaction. Transgender people who qualify for Medicare exist and deserve more attention in research and policy analysis. Additionally, I would interview more people who identify as transgender about their experiences accessing care and search for more ways to improve administration of it. The U.S. has some of the highest quality health care in the world, but the inequalities in accessing care make it exclusive to a privileged subsection of the country.

Others, including myself, should continue to study viable options for healthcare reform and expansion with a health equity mindset. The U.S. is the only developed capitalist country in the world that does not have a universal healthcare system; health and wellbeing is fundamental to quality of life, meaning that the U.S. blatantly does not care about all of its people. These social inequities and atrocities must stop because people who are already marginalized in society are further suffering because of their barriers to self-affirming and lifesaving care. The U.S. has the potential to significantly improve the wellbeing of all of its people, but we must continue to advocate for social visibility, acceptance, and inclusion of historically marginalized people for this potential to become a reality. This is the way forward for the U.S. to improve the quality of life for all of its people.

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Appendix A

Below is a list of clinics on the LGBT Health Resources CDC website I deemed fit to answer my survey. In the table, I have listed clinic names, locations, if they received the survey, and if a provider (or providers) from the clinic completed it.

Name	City	State	Sent Initial Email	Sent Survey	Survey Completed
Identity Alaska	Anchorage	AK	X	X	
Magic City Wellness Center	Birmingham	AL	Did not provide email		
Northwest Center for Equality	Fayetteville	AR	X	X	
Ozark AIDS Resources and Services	Berryville	AR	X	X	
Living Out Loud Health and Wellness Center	Tucson	AZ	Did not provide email		
Phoenix Pride LGBT Center	Phoenix	AZ	Did not provide email		
Los Angeles LGBT Center	Los Angeles	CA	Did not provide email		
Lyon-Martin Women's Health Services	San Francisco	CA	X		
One Medical Center	San Francisco	CA	X	X	
Sacramento LGBT Community Center	Sacramento	CA	X	X	
The LGBTQ Center	Long Beach	CA	X	X	X
The SF LGBT Center	San Francisco	CA	X	X	
Circle Care Center	Norwalk	CT	Did not provide email		
OutCt	Multiple Locations	CT	X	X	
The DC Center	Washington, D.C.	D.C.	X	X	
Whitman-Walker Clinic	Washington, D.C.	D.C.	X		
AIDS Deleware	Multiple Locations	DE	X		
Chase Brexton Health Care	Multiple Locations	DE	X	X	X
Christiana Care	Wilmington	DE	X	X	
26Health	Orlando	FL	X		
Care Resource	Multiple Locations	FL	Did not provide email		
Metro Inclusive Health	St. Petersburg	FL	X	X	
The Center Orlando	Orlando	FL	X	X	
Universty of Miami Hospital	Miami	FL	X	X	
AID Atlanta	Atlanta	GA	Did not provide email		
Fulton County Government	Atlanta	GA	Did not provide email		
Mercy Atlanta	Atlanta	GA	X	X	X
New Horizons Behavioral Health	Columbus	GA	X	declined	

North Central Health District	Macon	GA	Did not provide email		
Positive Impact	Atlanta	GA	Did not provide email		
Someone Cares	Atlanta	GA	Did not provide email		
West Central Health	Columbus	GA	Did not provide email		
Lavender Clinic	Multiple Locations	HI	Did not provide email		
University of Iowa	Iowa City	IA	X		
Community Council of Idaho	Multiple Locations	ID	Did not provide email		
North Idaho AIDS Coalition	Coeur d'Alene	ID	X	X	
Advocate Health	Multiple Locations	IL	Did not provide email		
Howard Brown Clinic	Chicago	IL	X		
Open Door Health Centr of Illinois	Multiple Locations	IL	X		
Damien Center	Indianapolis	IN	X	X	X
Mosaic Health	Goshen	IN	Did not provide email		
Outcare	Multiple Locations	IN	X	X	
Kansas City Care Clinic	Kansas City	KS	X		
Trust Women South Wind Women's Center	Wichita	KS	X	X	
Wichita LGBT Health	Wichita	KS	X	X	
University of Louisville Physicians	Louisville	KY	X	X	
Acadiana Cares	Lafayette	LA	X		
Crescent Care	New Orleans	LA	X	X	X
HIV/AIDS Alliance for Region Two	Baton Rouge	LA	X		
Southwest Louisiana AIDS Council	Lake Charles	LA	X		
Fenway Health	Boston	MA	X	X	
One Medical	Boston	MA	X		
Tapestry Health	Multiple Locations	MA	X	X	
A Better You Medispa and Wellness	Odenton	MD	X	declined	
Health Equity Alliance	Multiple Locations	ME	X	X	X
Mabel Wadsworth Center	Bangor	ME	X	X	X
Penobscot Community Health Care	Multiple Locations	ME	Did not provide email		
Cares	Multiple Locations	MI	X		
Matrix Human Services	Detroit	MI	X	X	
Red Project	Grand Rapids	MI	X	X	
Unified	Detroit	MI	X	X	
Family Tree Clinic	St. Paul	MN	Did not provide email		
North Memorial Health	Minneapolis	MN	Did not provide email		

Rainbow Health Initiative	Minneapolis	MN	Did not provide email		
Out, Proud, and Healthy	Multiple Locations	MO	X	X	
St. Luke's Health System	Multiple Locations	MO	Did not provide email		
Washington Universty in St. Louis Habif Health and Wellness Center	St. Louis	MO	X	X	
Open Arms Health Care Clinic	Jackson	MS	X	X	
The Western Montana Community Center	Missoula	MT	Did not provide email		
Alamance Cares	Burlington	NC	X	X	
Planned Parenthood	Ohama	NE	Did not provide email		
US Veteran's Administration	Ohama	NE	Did not provide email		
Equality Health Center	Concord	NH	Did not provide email		
Alliance Community Healthcare	Jersey City	NJ	undeliverable		
Babs Siperstein PROUD Center - RWJ University Hospital Somerset	Somerville	NJ	X		
Jersey City Medical Center	Jersey City	NJ	X		
University of New Mexico Health Services	Albuquerque	NM	Did not provide email		
Huntridge Family Clinic	Las Vegas	NV	Did not provide email		
Northen Nevada Hopes	Reno	NV	Did not provide email		
Callen-Lorde Community Health Center	New York City	NY	Did not provide email		
Gay Men's Health Crisis	New York City	NY	X	X	
Mount Sinai	Multiple Locations	NY	X		
The Center	New York City	NY	X		
Cleveland Clinic	Multiple Locations	OH	X		
Equitas Health	Multiple Locations	OH	X	X	
LGBT Community Center	Cleveland	OH	X		
Metro Health	Multiple Locations	OH	X		
HOPE	Tulsa	OK	X	X	
Prism Health	Portland	OR	X	X	X
Alder Health Services	Multiple Locations	PA	X	X	
Central Outreach Wellness Center	Pittsburgh	PA	Did not provide email		
Colours Organization	Philadelphia	PA	X	X	
FIGHT Community Health Centers	Philadelphia	PA	X	X	
Mazzoni Center	Philadelphia	PA	Did not provide email		
PERSAD Center	Multiple Locations	PA	X	X	
AIDS Project	Providence	RI	X	X	
Lifespan	Providence	RI	X		
Greenville Health System	Greenville	SC	X	X	

Low Country AIDS Services	Charleston	SC	X	X	
Palmetto AIDS Life Support Services	Columbia	SC	X	X	
Choices	Memphis	TN	X		
Nashville Cares	Nashville	TN	X	X	
OutMemphis	Memphis	TN	X	X	
Vanderbilt University Medical Center	Nashville	TN	X	X	
Alamo Area Resource Center	San Antonio	TX	X		
Legacy Community Health Services	Houston	TX	Did not provide email		
Methodist Healthcare	San Antonio	TX	Did not provide email		
Planned Parenthood	Austin	TX	Did not provide email		
Project Vida	El Paso	TX	X		
University of Utah Transgender Health Program	Salt Lake City	UT	X	X	X
Health Brigade	Richmond	VA	X	X	
LGBT Life Center	Norfolk	VA	X	X	
Tidewater Women's	Norfolk	VA	X	X	
Community Health Centers of Burlington	Burlington	VT	X	X	
University of Vermont Medical Center	Bennington	VT	X	X	
Blue Mountain Heart to Heart	Walla Walla	WA	X	X	
Country Doctor Community Health Centers	Seattle	WA	Did not provide email		
Sea Mar Community Health Centers	Multiple Locations	WA	X		
Froedtert and Meidical College of Wisconsin	Multiple Locations	WI	X		
Holton Street Clinic	Milwaukee	WI	X	X	
Madison and Dance Dount Public Health	Madison	WI	Did not provide email		

Appendix B

Below is a list of contact information for clinics who responded to my survey. Some clinics had multiple providers who responded, making my survey still 13 respondents who represented nine clinics.

Name	City	State	Website	Email
The LGBTQ Center	Long Beach	CA	https://www.centerlb.org/	mrobinson@centerlb.org
Chase Brexton Health Care	Multiple Locations	DE	https://www.chasebrexton.org/services/lgbt-health	lgbt@chasebrexton.org
Mercy Atlanta	Atlanta	GA	https://mercyatlanta.org/	PParsons@mercyatlanta.org
Damien Center	Indiap.	IN	https://damien.org/	damien@damien.org
Crescent Care	New Orleans	LA	https://www.crescentcare.org/	info@crescentcarehealth.org
Health Equity Alliance	Multiple Locations	ME	https://www.mainehealthequity.org/	form on website
Mabel Wadsworth Center	Bangor	ME	https://www.mabelwadsworth.org/	info@mabelwadsworth.org
Prism Health	Portland	OR	https://prismhealth.org/	www.prismhealth.org
University of Utah Transgender Health Program	Salt Lake City	UT	https://healthcare.utah.edu/transgender-health/	transgenderhealth@hsc.utah.edu

VITA

Benton Meldrum is an undergraduate senior at Tulane University from Denver, Colorado. As a public health and political science double major, Benton intends to enter the world of health policy, research, and health equity advocacy. He is mostly passionate about establishing domestic and global health equity for the LGBTQ+ community. After graduation, Benton will be moving back to Colorado and is actively searching for job opportunities in Denver. Benton will eventually pursue a master's degree in Health Policy, Systems, and Management after taking some time away from school to enter the workforce.

Outside of academia, Benton is the operations coordinator for the Tulane University Peer Health Educators (TUPHEs) where he distributes and coordinates safer sex supplies and health communications materials across campus. Also, he is the president of Tulane's premiere a cappella group, Green Envy. Benton recently completed a service-learning internship at a health clinic in New Orleans where he assisted with preparation and facilitation of the largest syringe access program in the state of Louisiana.

When Benton has free time, he enjoys running and hiking outdoors, singing in the shower, practicing yoga, watching Netflix with his boyfriend, drinking gin and tonics, playing piano, cuddling his dog, Berkeley, and listening to music on the porch with his friends.