City and County of San Francisco

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San Francisco City and County Transgender Health Benefit

History:

In 2001, The City and County of San Francisco made history by becoming the first US municipality to remove transgender access exclusions in its employee health plans. Since that time, other entities have used the success of San Francisco's program as a model for their own. And, despite actuarial fears of over-utilization and a potentially expensive benefit, the Transgender Health Benefit Program has proven to be appropriately accessed and undeniably more affordable than other, often routinely covered, procedures.

Starting in 1996, the San Francisco Human Rights Commission began work on the Transgender Health Benefit Project. Working with Commissioners, staff, experts, and community members, the goal of the project was to remove exclusions from City health insurance policies so that transgender employees, retirees, and their dependents would have access to procedures that were routinely covered by health insurance plans for people who are not transsexual. Due to fiscal constraints, the project stalled, lacking adequate support from the Health Service System (HSS) Board, which is the entity responsible for overseeing the administration of City employee health benefits.

Some Board Members expressed certain fears. They wondered why the City should pay for cosmetic surgery, or why the City should subsidize a spurious alternative lifestyle choice. If the exclusions were to be removed and transgender benefits were available, it might encourage large numbers of employees, retirees, and their dependents to have "sex changes." Some people might flock to the City to get municipal employment so they could access the benefits, and other people might marry or domestically partner with City employees so they could have their transition covered.

Commission staff met with HSS staff and Board members to address key issues: Most of the procedures that are denied coverage for transgender people are routinely covered in people who are not transgender, such as mastectomy, hysterectomy, genital surgery, hormone replacement therapy, etc. Furthermore, the positive outcome for the treatment of transsexualism stipulates psychotherapy, hormone treatment, and surgery as the standard of care to achieve maximum therapeutic value for the patient, and this lengthy process is designed to cull out any potential spurious intent. Under the standard of care, hormonal and surgical interventions for the treatment of transsexualism are considered medically necessary.

Plan Design:

In 2001, with support from key HSS Board Members and staff and nine City Supervisors, the City removed transsexual exclusions from its self-insured City Plan, with a one-year pilot program to collect actuarial data. The benefit provided surgical coverage through the self-insured plan, and the HMOs joined the City Plan by covering hormone treatments and transition-related psychotherapy. Procedures such as electrolysis, facial surgery, and tracheal shaves were not included in the plan design. The HSS Board plan had some flaws – a one-year enrollment requirement and a $50,000

surgical cap. In 2004, as result of Commission advocacy, several changes happened: the one year waiting period was dropped, the surgical cap was increased to $75,000, and the benefit became available through the HMOs: Blue Shield, Kaiser Permanente, and Health Net.

Actuarial Information:

The actuaries created estimates of plan costs, basing their formula on similar coverage provided by the Canadian province of British Columbia (a population of approximately 1 million people). In BC, the Province paid for about 50 procedures per year. The City's actuaries estimated that in a member population of approximately 100,000, 35 eligible members per year would spend $50,000.

2001-2004: Employees, retirees, and their enrolled dependents were charged $1.70 per month to meet that cost projection. It should be noted that, from 2001 through 2004, the HSS Board kept the transgender benefit limited to the self-insured City Plan despite the agreement to move it into the HMOs after one year. From July 2001 to July 2004, the HSS collected approximately $4.3 million from its members specifically to cover the transgender benefit, while paying out approximately $156,000 on seven claims for surgery.

In 2004-2005, even after rolling the benefit into the HMOs, the City's surplus monies increased slightly. After negotiating with the HMOs, the cost charged to members was dropped to $1.16 per month for the benefit. The City Plan reduced its surcharge to .50 cents per member per month. Accumulatively, as of August 2005, the HSS had collected $5.6 million and had paid out $183,000 on 11 claims through the City Plan. Kaiser and Blue Shield reported no surgical claims for 2004-2005. Health Net reported that from 2004-2005, they have paid out $3,300 on behalf of 14 members for hormonal treatments and transition-related psychological services.

Unlike the fears expressed, none of the concerns came to pass. A preliminary analysis indicates that there has been appropriate utilization (the number of claims compared to the number of eligible members) and the growing surplus indicates that the benefit costs much less to provide than the rates that have been charged to cover this specific benefit.

2005-2006: The rates collected for this period have not been reported yet. The total spent was $44,117.51. The City Plan (administered by United HealthCare) paid $5,038.50 on 13 of 17 claims submitted by two individuals. Health Net paid $5,055.41 on 4 claims by an estimated two individuals. Kaiser paid $34,023.60 on 2 claims submitted by two individuals, and Blue Shield has not reported for this period.

2006-2007: Due to its obvious affordability, as of July 1, 2006, the pricing for the benefit changed. While the benefit design remained the same, beneficial cost data led Kaiser and Blue Shield to no longer separately rate and price the transgender benefit - in other words, to treat the benefit the same as other medical procedures such as gall bladder removal or heart surgery. The HSS failed to negotiate the same change with Health Net. In July 2007, Health Net was replaced by PacifiCare as one of the available HMO carriers for the City.

From July 2001 through July 2006, the grand total of reported monies collected is $5.6 million. The grand total of reported monies expended is $386, 417.