TLDEF
Transgender Legal Defense & Education Fund

Trans Health Project

Working for Transgender Equal Rights

Health Insurance - Choosing a Plan

Below are some of the trans-specific factors to consider when choosing a health insurance plan. Many times you may have several options to choose from when buying a plan on the Marketplace, when choosing among options offered by your employer, or when choosing a Medicare Advantage or Medicaid managed care plan.

Review each factor by expanding the buttons below.

If you already have insurance, you can move to the next section, Understanding Your Plan.

Are my providers in-network?

If you have existing providers you are using, or know what surgeon(s) you might want to go to, go to the insurance company's website and use their find-a-doctor tool to see if that provider is in network. You can also check the in-network status of any hospitals or surgical facilities you may use.

You will often be asked to enter a specific plan, so do that if you can because networks differ across plans. There may also be a separate search tool for mental health providers.

Choosing a network with your providers in it up front will help you get coverage a lot more easily. This is often not possible, however, given that many providers still don't take insurance. This is known as **network adequacy**.

As we explain in more detail in the Applying for Coverage section, using an out-of-network provider can cost thousands of dollars more than an in-network provider and often means you have to pay upfront and be reimbursed later—often for pennies on the dollar.

Is there out-of-network coverage?

Some plans do not offer ***any*** out-of-network coverage. Even under such plans, you must be allowed to go out of network if there is no qualified provider in network. However, if there is a provider in network that the insurance company claims is qualified, they will try to make you go to that provider. You then have an additional hurdle of needing to show why that provider cannot meet your needs.

If you choose an HMO that does have a transgender program, bear in mind you will be limited to those providers. It is unlikely you will be able to go to a surgeon out of their network, so be sure to find out which surgeons they use before choosing the plan.

What is the deductible and out-of-pocket maximum?

Many people focus on the monthly premium you must pay, but the really important costs to be aware of are the deductible and out-of-pocket maximum. As we explain in detail in the Understanding Your Plan section, you will need to pay your deductible before your coverage kicks in.

If you know you will be having surgery, and especially multiple surgeries in one year, it can make sense to pay a higher monthly premium in exchange for a lower deductible and out-of-pocket maximum. If you are going to one surgeon who is in-network and one who is out of network, that is generally two separate deductibles you have to meet. But some plans have no in-network deductible, which is great.

Is there a transgender exclusion?

You will want to find out in advance if there is a blanket exclusion for "gender reassignment surgery," "sex change," "sex transformation," or some similarly-worded broad exclusion for all transgender-related care in the plan.

Very few plans sold on the Marketplace have these kinds of blanket exclusions (just 3% have exclusions). Plan documents are often available to examine before you purchase the plan. Out2Enroll has compiled many of these documents in their Trans Insurance Guide. You can also ask the insurance company before you sign up.

If the plan options are through an employer and they won't let you see the plan documents in advance, ask human resources if any of them have an exclusion. Emailing human resources is preferable to a phone conversation so that you have their response in writing.

Coverage under a Medicaid managed care plan will be governed by the state you are in, but in states with coverage, some plans may be more trans-friendly than others. Ask your provider if they know which plan is best in your area. Looking at the clinical criteria is also important, as discussed next.

What do the clinical criteria say?

As we explain in Understanding Your Plan, a key document governing your coverage is the medical policy on gender dysphoria treatments. If you're choosing between insurance companies, look at the clinical criteria for those companies to see which is most likely to cover your care without any additional hurdles.

You may find that all of the companies you are looking at say that the procedure you need is deemed "cosmetic" and excluded. That just means you will have to go through the appeals process, but it may be covered after an internal appeal or external review. If you are in that situation, it is best to seek legal assistance at the beginning of applying for coverage so your case can be as strong as possible.

Are my prescription drugs covered?

If you take any expensive prescription medications, check to see if they are included in the insurance company's list of covered drugs (known as a formulary). Sometimes certain forms of hormones may not be covered. While exceptions may be possible, you may be better off it is simply covered under the plan.

Where can I get help choosing a plan?

If you are buying a plan on the Marketplace or are eligible for Medicaid, you can find an assister to help you go through the options. Out2Enroll maintains a list of assisters, many of whom have been specifically trained on LGBTQ issues.

Now that you understand the factors that go into choosing a plan, read the Understanding Your Plan section to get more details on how to know what your plan will cover and how much you can expect to pay out of pocket.

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