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UNIVERSITY OF WISCONSIN–MADISON

From: Marjorie Rosenberg, Chair, ad hoc Committee on Equitable & Inclusive Health Care

To: Steven K. Smith, Secretary of the Faculty
Amy Wendt, Chair, University Committee

Date: January 31, 2017

Re: **Final Report of the ad hoc Committee on Equitable & Inclusive Health Care**

This documents represents the final report and recommendations of the ad hoc Committee on Equitable & Inclusive Health Care to the University Committee.

Our committee was charged to examine two issues:

- Higher payment tier for 120 prescription medications ("Level 4"), of which 49 (the largest group) are antiretroviral medications used in the treatment of HIV.
- The medical needs of transgender community members at UW–Madison, where employer-sponsored health care plans specifically exclude coverage for care related to gender reassignment, including hormonal, surgical, and counseling treatments.

The letter of appointment detailing the committee's full charge is attached.

Our conclusions are summarized very simply: we advocate nondiscriminatory treatment for those who are treated with HIV and those who are members of the transgender community.

The charge asks whether we see any impact if the health system changes to one of self-insurance or impact with UW Health. Our response is as stated above. Those who are members of either category should be treated similarly to others.

Our report is presented in several sections that support these conclusions:

1. Policy Statement on Equitable & Inclusive Health Care
2. Health Care Coverage and Costs
3. Summary of the medications issue:
   Tier 4 Medications
4. Summary of the transgender community cost issue
   Planning for Transgender Health Benefits
   UW-Madison Transgender Cost Estimates
5. Summary of practice at comparable institutions
   Equitable Health Care Coverage at Big 10 Academic Alliance Universities

Also attached is a bibliography of sources reviewed by the committee.

We acknowledge that General Insurance Board's recent decision to remove exclusions on transgender benefits, with coverage that was to begin on January 1, 2017, may be overturned. We note that removing transgender health benefits is in conflict with our committee recommendations.

Our committee recommends that UW-Madison:

- **advocate strongly that the Wisconsin Employee Trust Fund restore Tier 2 prescription drug coverage for ARV prescription medications**
- **support and advocate for health insurance guidelines that are supportive of the full range of medical needs of transgender individuals**
- **go on record as opposing any attempt to re-introduce the transgender exclusion into State of Wisconsin Group Health Insurance Plans under ETF**
- **support steps to remove all "gender binary" assumptions in insurance payments for medical procedures, and**
- **in the event that the transgender exclusion is returned to the state health insurance under ETF, that the university adopt a plan for supplementing state health insurance with a rider with costs to be shared by all university employees to cover transgender care.**

This report serves as our final task for the Ad Hoc Committee.

Encl: Charge to ad hoc Committee on Equitable & Inclusive Health Care
Report and Recommendations of the ad hoc Committee on Equitable & Inclusive Health Care
Bibliography: Sources consulted by the ad hoc Committee on Equitable & Inclusive Health Care

c: Members of the ad hoc Committee on Equitable & Inclusive Health Care
Alina Boyden, Anthropology
Marguerite Burns, Population Health Sciences
Kaelin Grant, Surgery
Laura Gutknecht, Journalism & Mass Communication
Tracy Hanke, Environmental Sciences
Sean Hubbard, Social Work
Emma Joy Jampole, Curriculum & Instruction
Helen Kinsella, Political Science
Pamela Oliver, Sociology
Marjorie Rosenberg, Risk & Insurance (chair)
Dan Ross, Institute for Research on Poverty
Steph Tai, Law School (Committee for GLBTQ People in the University Representative)
Michael Bernard-Donals, Office of the Secretary of the Faculty (ex officio)
Lindsey Stoddard Cameron, Office of the Secretary of the Faculty (administrative support)

Aaron Hoskins, Co-Chair, Committee for GLBTQ People in the University
Tehshik Yoon, Co-Chair, Committee for GLBTQ People in the University
Gabe Javier, Director, LGBT Campus Center

WISCONSIN
UNIVERSITY OF WISCONSIN–MADISON

Date: November 2, 2016

To: Marguerite Burns, Population Health Sciences
Helen Kinsella, Political Science
Pamela Oliver, Sociology
Marjorie Rosenberg, Actuarial Science, Risk Management & Insurance *(chair)*
Steph Tai, Law School *(GLBTQ People in the University Representative)*
Kaelin Grant, Surgery
Dan Ross, Institute for Research on Poverty
Laura Gutknecht, Journalism & Mass Communication
Tracy Hanke, Environmental Sciences
Alina Boyden, Anthropology
Sean Hubbard, Social Work
Emma Jampole, Curriculum and Instruction

CC: Steven K. Smith, Secretary of the Faculty
Lindsey Stoddard Cameron, Office of the Secretary of the Faculty

From: Amy Wendt, Chair, University Committee

Re: **Ad Hoc Committee on Equitable and Inclusive Health Care**

With this memo, I am formally appointing you to the Ad Hoc Committee on Equitable and Inclusive Health Care. Thank you for your willingness to help address concerns about the availability of equitable and inclusive health care for LGBTQ members of our community. Special thanks to Margie Rosenberg for serving chair. This committee is charged with responding to the specific issues identified below, as well as any related issues identified by the committee, and formulating recommendations to the University Committee, the Academic Staff Executive Committee, the University Staff Executive Committee, Associated Students of Madison, and administrative leadership. The committee is also asked to take into account recently begun discussions about self-insurance, as well as the recent health-care merger. In light of the latter, the committee is encouraged to consider including recommendations to UW Health, as a possible model for health care providers serving the university community.

Therefore, the University Committee is specifically requesting that your committee make recommendations related to the following issues.

- Higher payment tier for 120 prescription medications ("Level 4"), of which 49 (the largest group) are antiretroviral medications used in the treatment of HIV.

- The medical needs of transgender community members at UW–Madison, where employer-sponsored health care plans specifically exclude coverage for care related to gender reassignment, including hormonal, surgical, and counseling treatments.

Many of the policy changes needed to address each of these issues will require action by authorities outside of UW–Madison. In this regard, the effort to establish equitable and inclusive health care for LGBTQ community members will face many of the same impediments as the previous campaign to secure domestic partner benefits for same-sex couples. Thus we believe a similar strategy is appropriate, although the committee is free to develop its own strategic recommendations.

Please submit your report and recommendations **to the University Committee by January 31, 2017**, in care of the Secretary of the Faculty at sof@secfac.wisc.edu. Do not hesitate to contact me or the Secretary of the Faculty if you have any questions. The Office of the Secretary of the Faculty will be in touch soon to schedule your first meeting. Thank you once again for your service.

University of Wisconsin-Madison
ad hoc Committee on Equitable & Inclusive Health Care

Final Report & Recommendations
submitted January 31, 2017

1. Policy Statement on Equitable & Inclusive Health Care

The University of Wisconsin-Madison is dedicated to equitable and inclusive healthcare. As such, the university supports the rights of all faculty, staff, and students to receive health insurance and other health care coverage without discrimination on the basis of race, ethnicity, national origin, sex, religion, age, marital status, sexual orientation, gender identity, immigration status, veteran status, or disability, because an equitable and inclusive environment positively affects the health status of all members of the University of Wisconsin-Madison community, enhances the quality of overall healthcare for members of the University of Wisconsin-Madison community, and sustains the university as a whole in terms of developing stronger intracommunity bonds. Such support means that the university is committed to providing insurance coverage of medical, physical, and mental health services relevant to all members of the University of Wisconsin-Madison community, including services related to age-related health, transgender health, veteran health, and disability, HIV, pregnancy, and pre-existing medical conditions status. As numerous studies have shown, such insurance coverage positively affects actual healthcare outcomes of all of these communities. This priority is consistent with the approach of the University of Wisconsin-Madison to equity and inclusiveness through our Office of Equity and Diversity, our Disability Resource Center, our Veteran Services and Military Assistance Center, and our LGBT Campus Center.

2. Health Care Coverage and Costs

Transgender and HIV+ individuals have previously lacked sufficient coverage within the State of Wisconsin health insurance system. This lack of coverage has—through its inequitable effects on physical, mental, and economic health—meant that these individuals have not been fully included in the University of Wisconsin-Madison community. In contrast, investment into inclusive approaches have been estimated to overall expense reductions overall with respect to risk of negative endpoints--HIV, depression, suicidality, and drug abuse. (W.V. Padula et al., *Societal Implications of Health Insurance Coverage for Medically Necessary Services in the U.S. Transgender Population: A Cost-Effectiveness Analysis*, 31(4) J GEN. INTERN. MED. (2016) 394-401; *see also* National Center for Transgender Equality, 2015 U.S. National Transgender Survey (2015) 107 (describing relationships between access to transgender health coverage and mental health). By adopting a more inclusive healthcare statement, the university commits to taking actions—including, but not limited to, providing inclusive and equitable health insurance coverage—to support all members of the university community. Affirming the efficacy, benefit, and medical necessity of providing inclusive and equitable trans health care, the university will undertake to advocate for and implement all necessary procedures ensuring coverage for comprehensive healthcare for transgender and HIV+ individuals without discrimination or prejudice.

3. Summary of the Medications Issue

Tier 4 Medications

Effective January 1, 2013 the Wisconsin Group Insurance Board (GIB), the entity that oversees program requirements for Wisconsin state employee health insurance coverage, increased patient cost sharing for prescription medications that are essential to the treatment of HIV, antiretroviral (ARV) therapy. Antiretroviral (ARV) therapy reduces the morbidity and mortality associated with HIV infection and reduces the risk of HIV transmission. Receipt of guideline-recommended treatment with ARV transforms HIV-infection from an acute, deadly infection to a manageable, chronic disease.[1] The GIB shifted ARVs from the Tier 2 prescription drug coverage payment category to a new 4th payment tier for coverage of specialty medications. As summarized in Table 1, Wisconsin state employees pay relatively more for Tier 4 than Tier 2 medications in two ways:

- higher copayments per prescription
- exposure to higher annual maximum out-of-pocket costs.

Increased patient cost-sharing for prescription medications decreases use of medications and increases the risk of adverse and costly health consequences due to treatment non-adherence.[2] Indeed, staff recommendations to the GIB regarding the introduction of Tier 4 cost sharing noted that, "higher copays for specialty medications could negatively affect the sickest members of the program." [3]

We recommend that the University of Wisconsin-Madison advocate strongly that Wisconsin Employee Trust Fund restore Tier 2 prescription drug coverage for ARV prescription medications.

Table 1. Prescription drug cost-sharing requirements for Tiers 2 and 4, *It's Your Choice* health plan, 2017 [4]

TIER 4	**Preferred pharmacy**		**Non-preferred pharmacy**
	Preferred Tier 4 drug	Non-preferred Tier 4 drug	Preferred & non-preferred Tier 4 drugs
Copayment per Rx	$50	40% coinsurance ($200 maximum)	40% coinsurance ($200 maximum)
Annual Out-of-Pocket Limit. Only Tier 4 medications accumulate toward this OOP limit.	$1,200 per individual/ $2,400 per family	No OOP Limit	No OOP Limit
TIER 2	**All network pharmacies, All tier 2 drugs**		
Copayment per Rx	20% ($50 maximum)		
Annual Out-of-Pocket Limit. Tiers 1 & 2 medications accumulate toward this OOP limit.	$600 per individual/$1200 per family		

Notes: Preferred Tier 4 drugs are covered drugs on the formulary and include generic drugs as well as some brand name drugs. They are generally lower cost alternatives to brand name drugs or are therapeutically equivalent to brand name drugs. Non-preferred Tier 4 drugs are covered on the formulary and have a therapeutically equivalent or alternative drug that is also covered on the formulary. The preferred pharmacy for Tier 4 drugs is Diplomat Specialty Pharmacy. The pharmacy benefits manager, Navitus Health Solutions, LLC., maintains a very broad network of pharmacies in the country through which Tier 1 and 2 drugs may be obtained for the stated cost-sharing level. All prescription copayments/coinsurance regardless of tier apply to the Federal Affordable Care Act annual combined medical and prescription drug maximum OOP amounts: $6,850 for an individual plan and $13,700 for a family plan.

As of January 1, 2006, the Centers for Medicare and Medicaid Services (CMS) provide prescription benefit coverage through Medicare Part D for all antiretroviral (ARV) therapy medications to treat Human Immunodeficiency Virus (HIV). Although a coverage gap results in high cost-sharing (high out-of-pocket costs) for HIV/AIDS patients, this "doughnut hole" is intended to be gradually phased out by 2020. Until that time, supplemental assistance is available for these patients, primarily through the federally-funded Ryan White AIDS Drug Assistance Program (ADAP).

CMS requires all Part D plans cover antiretroviral therapy because extensive data has shown the cost-effectiveness of antiretroviral therapy in treating HIV/AIDS. The U.S. Department of Health and Human Services provides federally-approved guidelines through the AIDSinfo group.[5] This group is administered through the National Institutes of Health Office of AIDS research. In its "Guidelines for the Use of Antiretroviral Agents in HIV-1-Infected Adults and Adolescents", the advisory panel notes that "Antiretroviral therapy (ART) has dramatically reduced HIV-associated morbidity and mortality and has transformed HIV infection into a manageable chronic condition."[6] The panel makes the following two recommendations regarding cost considerations for antiretroviral therapy[7]:

1. Out-of-pocket drug costs should be minimized to increase medication adherence. "Given the clear association between out-of-pocket costs for patients with chronic diseases and the ability of those patients to pay for and adhere to medications, clinicians should minimize patients' out-of-pocket drug-related expenses whenever possible."
2. Barriers to prescribing and obtaining ARVs should be reduced. "Prior authorizations in HIV care specifically have been reported to cost over $40 each in provider personnel time (a hidden cost) and have substantially reduced timely access to medications."

The research literature supports these recommendations. Substantial evidence exists to show that although ARV therapy is expensive, they provide significant benefit to patients including an increase in expected survival by 3.9 years in even the sickest patients.[8, 9] Studies of medications for other chronic diseases have shown that increased cost sharing for prescriptions is clearly associated with worsening clinical outcomes. Goldman, et al. suggested that these adverse effects are likely to be magnified among low-income groups.[10] At least one-quarter of people with HIV get their health care insurance through Medicare. In addition, the majority of Medicare beneficiaries with HIV are dually eligible for Medicare and Medicaid, and receive low-income subsidies under Part D.[11] Further, a meta-analysis of existing data reveals implications for public health costs that are "unambiguous." For chronically ill patients with

certain conditions, higher prescription drug cost sharing is associated with greater use of inpatient and emergency medical services.[12]

In other words, when prescriptions cost more, more people do not take their medications. The consequence is costly, as chronic conditions that could be successfully managed with medication are instead left untreated until they become an emergency, resulting in more visits to emergency rooms and inpatient stays to treat unnecessary complications.

Nationwide, the University of Wisconsin- Madison is out of sync with its peer institutions regarding coverage for HIV/antiretroviral therapies. In an informal survey of Big 10 Academic Alliance (BTAA) universities, Vice Provost Bernard-Donals asked his counterparts working in provost's offices about health insurance coverage for HIV drugs. Among the seven BTAA institutions that responded, HIV and retroviral medications are typically covered in the first or second co-pay tiers rather than the highest tier. Only two of the responding institutions reported that members face the highest co-pay tier when purchasing HIV/antiretroviral prescription medications.

We strongly recommend that the university recognize an ethical duty to provide adequate prescription coverage for the recognized standard-of-care treatment for HIV-infected employees and a fiscal duty to assure the most cost-effective use of medical resources. To meet both ethical and fiscal standards, we recommend that the university advocate strongly that ETF remove the Level 4 designation and separate out-of-pocket maximum for antiretroviral drugs used to treat HIV, reinstating Tier 2 status for these medications and limiting copays to the normal out-of-pocket limit for Tier 2 prescription benefits.

References

[1] U.S. Department of Health and Human Services Panel on Antiretroviral Guidelines for Adults and Adolescents. Guidelines for the Use of Antiretroviral Agents in HIV-1-Infected Adults and Adolescents. July 14, 2016 Update. Accessed December 6, 2016 at https://aidsinfo.nih.gov/guidelines/html/1/adult-and-adolescent-treatment-guidelines/0/.
[2] Goldman D, Joyce G, and Zheng Y. 2007. Prescription drug cost sharing: Associations with medication and medical utilization and spending and health. *Journal of the American Medical Association*. 298(1): 61-69 and E1-E18; Johnston SS, Juday T, Seekens D, Espindle D, Chu BC. 2012. Association between prescription cost sharing and adherence to initial combination antiretroviral therapy in commercially insured antiretroviral-naïve patients with HIV. *Journal of Managed Care Pharmacy*. 18(2):129-145. Luiza VL, Chaves LA, Silva RM, et al. 2015. Pharmaceutical policies: effects of cap and co-payment on rational use of medicines. *Cochrane Database of Systematic Reviews*. Issue 5. No. CD007017.
[3] State of Wisconsin Department of Employee Trust Funds. Correspondence Memorandum to the Group Insurance Board. Guidelines and Uniform Benefits for the 2013 Benefit Year. May 3, 2012.
[4] State of Wisconsin Department of Employee Trust Funds. 2017 It's Your Choice- State of Wisconsin Group Health Insurance for Employees and Retirees: Pharmacy Benefits for Active Employees. Accessed on 1/2/2017 at http://etf.wi.gov/members/IYC2017/et-2107phae.asp
[5] "The Department of Health and Human Services (HHS) Panel on Antiretroviral Guidelines for Adults and Adolescents (the Panel) is a working group of the Office of AIDS Research Advisory Council (OARAC). The primary goal of the Panel is to provide HIV care practitioners with recommendations based on current knowledge of antiretroviral drugs (ARV) used to treat adults and adolescents with HIV infection in the United States." AIDSinfo Clinical Guidelines Portal, Introduction to Guidelines. https://aidsinfo.nih.gov/guidelines/html/1/adult-and-adolescent-arv-guidelines/2/introduction. Updated 28 January 2016. Accessed 06 December 2016.
[6] ibid

[7] AIDSinfo. "Guidelines for the Use of Antiretroviral Agents in HIV-1 Infected Adults and Adolescents: Cost Considerations and Antiretroviral Therapy." https://aidsinfo.nih.gov/guidelines/html/1/adult-and-adolescent-arv-guidelines/459/cost-considerations-and-antiretroviral-therapy. Updated 14 July 2016. Accessed 06 December 2016.
[8] Bayoumi, et al. "Cost-Effectiveness of Newer Antiretroviral Drugs in Treatment-Experienced Patients with Multidrug-Resistant HIV Disease". J Acquir Immune Defic Syndr, Vol 64, No. 4. 01 December 2013.
[9] K. Freedberg, et al. "The Cost Effectiveness of Combination Antiretroviral Therapy for HIV Disease". NEJM, Vol. 3, No. 11. 15 March 2011.
[10] D. Goldman, G. Joyce and Y. Zheng. "Prescription Drug Cost Sharing: Associations with Medication and Medical Utilization and Spending and Health." JAMA, Vol. 298, No. 1. 04 July 2007.
[11] Kaiser Family Foundation. "Medicare and HIV." http://kff.org/hivaids/fact-sheet/medicare-and-hiv/ Published 14 October 2016. Accessed 06 December 2016.
[12] D. Goldman, G. Joyce and Y. Zheng. "Prescription Drug Cost Sharing: Associations with Medication and Medical Utilization and Spending and Health." JAMA, Vol. 298, No. 1. 04 July 2007

4. Summary of the Transgender Community Cost Issue

Planning for Transgender Health Benefits

In response to the May 2016 publication of federal Health and Human Services final regulations pertaining to Section 1557 of the Affordable Care Act, the Group Insurance Board voted on July 12, 2016 to bring Employee Trust Funds into compliance by removing State of Wisconsin health insurance exclusions for transgender benefits and services, effective January 1, 2017. However, Wisconsin has joined several other states in challenging this federal mandate and there are concerns that the federal mandate may be reversed. On December 30, 2016, the Group Insurance Board reinstated the exclusion of health benefits and services based on gender identity after contingencies are met. Even if these contingencies are not met and the exclusion is not reinstated, the simple removal of a sentence with no other change in the health insurance policy leaves open many matters of interpretation about which medical services will or will not be provided to transgender employees and their dependents.

Our ad hoc committee recommends that the University of Wisconsin-Madison:

- support and advocate for health insurance guidelines that are supportive of the full range of medical needs of transgender individuals
- go on record as opposing any attempt to re-introduce the transgender exclusion into State of Wisconsin Group Health Insurance Plans under ETF
- support steps to remove all "gender binary" assumptions in insurance payments for medical procedures, and
- in the event that the transgender exclusion is returned to state health insurance under ETF, that the university adopt a plan for supplementing state health insurance with a rider with costs to be shared by all university employees to cover transgender care.

There are four reasons for these recommendations. (1) Transition-related care is medically necessary for some people. (2) Excluding transgender people from receiving transition-related care is arbitrary and discriminatory. (3) Intersex people (those who are born with ambiguous sexual organs or who are born with both male and female organs) and people undergoing gender transition may have body parts and medical needs inconsistent with a binary male/female gender listed on their medical records. (4) The marginal cost of providing transition-related care is so low as to be negligible in a large group that is not selected for transgender people. This is because the prevalence of need for transition-related services is low in the general population and because the costs of transition-related services are low compared to other more common medical needs. When the GIB debated the issues earlier in 2016, the board received a report that removing the exclusion would NOT require any increase in premiums.

Transgender people are those whose innate gender identity is different from that typically associated with their assigned sex at birth. Gender dysphoria is a medical term used to describe the discomfort and distress caused for some transgender people by the discrepancy between gender identity and a person's sex assigned at birth. Some transgender people experience gender dysphoria severe enough to meet the criteria for Gender Disorder (GD), formerly known as gender identity disorder. GD is considered a serious medical condition, and individualized

medical interventions to facilitate gender transition are often medically necessary to treat this condition.[13] Necessary transition-related may include psychotherapy, hormone therapy, and a variety of possible surgical treatments. While the specific interventions are not unique to transgender people, their use to treat GD is commonly collectively referred to as transition-related or sex reassignment care.

It is difficult to estimate the prevalence of need for transition-related care because the definitions of "transgender" are varying and unclear and because changing social acceptance appears to be affecting reported prevalence rates. From .3% to .6% of the adult population identifies as transgender, or approximately 700,000 to 1.4 million adults in the U.S. These statistics could also be stated as rates of 300 to 600 individuals per 100,000, roughly comparable to the estimates generated in Olyslager and Conway's 2007 paper[14] which argues that many common estimates of transsexualism are too low. Self-identification has been rising and is somewhat more common among younger adults than older adults.[15, 16] However, only some of these people seek or need medical treatment for transition care. Some people prefer to adjust only their social gender with clothing and behavior and others prefer to present as gender ambiguous or nonbinary. The estimates of the proportion of people with transgender identities who will need or want transition-related care vary greatly. Olyslager and Conway argue that most published estimates are far too low and go so far as to argue that the proportion of male-to-female identified persons who will desire surgical change may approach 100%, while most other studies give far lower estimates of both the prevalence of transsexual identity and the desire for surgery. Most studies find that both female-to-male transgender identity and the proportion of female-to-male (FtM) transgender people who desire surgery is much lower than for male-to-female (MtF), with MtF/FtM ratios ranging from 1.6 to 3.

Some transgender people prefer to leave their bodies unmodified and need only to be non-discriminatory treatment (e.g. authorizing a mammogram or hysterectomy for someone who identifies as male). Treatments for those who do need transition-related care range widely from supportive counseling only to drug therapy to partial relatively inexpensive body modifications (breast removal or augmentation, hysterectomy, orchiectomy) to more extensive body modifications including genital surgery, facial reconstruction, or hair removal.

Studies of the costs of providing transition-related care elsewhere have shown it to be highly cost-effective with minimal charges to the employer.[17] Although insurers have sometimes added modest charges to cover projected additional expenses, the experience to date has been that actual incurred costs are far lower than these projections and are essentially negligible when averaged across large insured populations. The city of San Francisco initially imposed a modest surcharge for transgender care; insurance company surcharges took in $5.3 million in additional revenue 2001-2006 while the actual costs incurred were $386,417 or only 7% of the revenue collected on the basis of initial actuarial estimates. Based on this experience, the city stopped charging separately for transgender care.[18] The University of California (UC) eliminated transgender discrimination in 2005 without charging an additional premium. Claim cost data from the UC health plan with the largest enrollment shows that the maximum claim costs per month per member (PMPM) was $0.20 PMPM, or 0.05 percent of the total premium.[19] There are a variety of possible reasons why the cost of providing transgender services is lower than

projected from the incidence rate of transgender identity including: not all transgender individuals want or need surgery; surgery is a once-in-a-lifetime experience and some people have already had surgery; not all transgender people qualify as having a medical necessity for treatment; there may be medical contraindications for treatment.

UW-Madison Transgender Cost Estimates

The following documents two methods to estimate annual costs of providing health care for transgender individuals. The assumptions are based on published estimates when available, but are admittedly potentially out-of-date and have high variability due to the rarity of health coverage and the social stigma of identification.

Both methods provide a minimum and a maximum estimate. The minimum represents the smallest estimate in all categories, while the maximum represents the highest estimate in all categories. Thus the "true" cost would fall somewhere in between.

Method 1 is based on utilization rates and costs as published by the University of California System. Estimates for other studies (San Francisco and a sample of private employers) differed somewhat, but the UC System minimums and maximums were in between the other estimates.

Method 2 uses a bottom up approach to estimate health care costs, starting with estimating the number of covered transgenders at UW-Madison (including partners and dependents), the numbers requesting surgery, and the resulting total costs including hormone therapy.

Method 1 shows additions to health costs per subscriber from $0.66 to $5.61, while Method 2 shows additions from $1.28 to $127.50.

As one comparison, annual costs for those with diabetes (diagnosed and undiagnosed) are estimated as $11,000 per person affecting 2,716 subscribers. Thus the annual costs per subscriber are estimated as $1,085 for diabetes care.

A second comparison is for women with breast cancer. Here the annual cost per person on average is estimated as $3544. With approximately 1% of the total population living with breast cancer, the average annual cost per subscriber is $34.57 for breast cancer care.

Method 1: Utilization Rates and Aggregate Costs

Assumptions

- Numbers of People
  - # Employees = 18,232
  - # Subscribers = 29,207
- Annual UW-Madison premiums = $300,000,000
- Utilization Rates per 1,000 subscribers (estimated from University of California System)
  - Minimum = 0.022
  - Maximum = 0.187

- Range of Annual Transgender Costs
  Minimum = $67
  Maximum = $86,800
  Average = $29,929

Results

	Minimum	Maximum
Estimated # Annual Transgender Claimants	0.5	5.5
Estimated Annual Transgender Claims	$19,000	$160,000
Claims per Subscriber	$0.66	$5.61
Claims as % of Premium	0.007%	0.056%

Method 2: Utilization Rates by Component Cost

Assumptions

- Numbers of People
  # Employees = 18,232
  # Subscribers = 29,207
- Annual UW-Madison premiums = $300,000,000
- Prevalence of transgender identity
  Minimum = 0.32%
  Maximum = 0.58%
- Range of Annual Transgender-Specific Costs (Hormones, Lab Work + Office Visits)
  Minimum = $300
  Maximum = $4,400
- # of Transgender surgeries per year
  Minimum = 1
  Maximum = 6
- Cost per Surgery
  Minimum = $15,000
  Maximum = $100,000

Results

	Minimum	Maximum
Estimated # Annual Transgender Claimants	152	176
Estimated Annual Transgender Claims	$43,000	$5,800,000
Claims per Subscriber	$1.47	$198.81
Claims as % of Premium	0.015%	1.98%

References

[13] See, e.g., World Professional Association for Transgender Health, Standards of Care for the Health of Transsexual, Transgender, and Gender-Nonconforming People 16 (7th edition, 2011).

[14] Femke Olyslager and Lynn Conway, 2007, "On the Calculation of the Prevalence of Transsexualism," Paper presented at the WPATH 20th International Symposium Chicago Illinois, September 5-8, 2007. Submitted for publication in the International Journal of Transgenderism. http://ai.eecs.umich.edu/people/conway/TS/Prevalence/Reports/Prevalence%20of%20Transsexualism.pdf

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[18] "San Francisco City and County Transgender Health Benefit," report of San Francisco Human Rights Commission, 2007. Retrieved from http://www.uclgbtia.org/TransInsuranceCitySF.pdf on 1/17/2015.

[19] Department of Insurance, State of California (2012), Economic Impact Assessment: Gender Nondiscrimination in Health Insurance, available at http://transgenderlawcenter.org/wp-content/uploads/2013/04/Economic-Impact-Assessment-Gender-Nondiscrimination-In-Health-Insurance.pdf

5. Summary of Practice at Comparable Institutions

Equitable Health Care Coverage at Big 10 Academic Alliance Universities

In an informal survey of Big 10 Academic Alliance (BTAA) universities, Vice Provost Bernard-Donals asked his counterparts working in provost's offices about the health care coverage for HIV drugs, and about coverage for trans people's health care, including the costs of hormone and surgery related to transition. Seven BTAA institutions responded:

Maryland: formulary does not include HIV drugs in highest co-pay tier; care related to trans people's transitions is covered as per Justice Department ruling on ACA coverage.

Michigan: most HIV/antiretroviral drugs fall into tiers 2 or 3 of the formulary ($20 and $45 copays per month, respectively); transgender surgical procedures are generally covered, though it depends on the network through which one is insured (with a second network requiring referrals and deductibles).

Michigan State: coverage for HIV/antiretrovirals are placed on a formulary and the formulary is created based on decisions made by a pharmacy therapeutics committee; transgender care for transitions will be deemed medically necessary beginning 1 January 2017 as per the Justice Department's ruling on ACA coverage.

Minnesota: HIV/antiretroviral coverage is very similar to UW-Madison's, with some of these drugs in the highest of its three tiers (though that tier requires $75 copay); transition and other trans health care is covered when it is deemed medically necessary, though the medically necessary category will likely expand on 1 January 2017.

Nebraska: HIV drugs are covered, though on a formulary that looks very much like the one used by Wisconsin's insurance board; care for trans people for transitions is not covered.

Ohio State: HIV drugs and antiretrovirals are not excluded or in high-tiers in the formulary (typically requiring a $50 deductible and a 30% coinsurance, $100 scrip maximum); care related to trans people's transitions is covered as medically necessary.

Penn State: Both HIV/antiretroviral drugs and health care related to trans people's transitions are covered as medically necessary. Prior authorizations may be required.

Overall, transgender care is deemed medically necessary and is covered through insurance policies. HIV and retroviral drugs are very often covered in lower tiers than through UW-Madison's plans, though some of our peers include them in higher-tier, higher-deductible ranges as we do.

University of Wisconsin-Madison
ad hoc Committee on Equitable & Inclusive Health Care

Bibliography

Appointment of ad hoc Committee on Equitable & Inclusive Health Care

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Note: January 18, 2017 meeting cancelled. Minutes not yet available. Members of the ad hoc committee on Equitable & Inclusive Health Benefits listened to an audiotape of open session remarks.

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Members of the ad hoc Committee for Equitable and Inclusive Health Care also had access to documents reviewed during research conducted by Professor and Chair Pam Oliver (Sociology) and Ph.D. Candidate Alex Hanna in 2014. Materials available upon request.