

SECOND THOUGHTS

Exclusion of Medically Necessary Gender-Affirming Surgery for America's Armed Services Veterans

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Abstract

Gender dysphoria, the term used in the fifth edition of the *Diagnostic and Statistical Manual of Mental Disorders (DSM)* to describe distress at the incongruence between one's gender and anatomy, affects approximately 0.6 percent of the population. It is estimated that there are 134,000 Armed Forces veterans in the United States with gender dysphoria. Although gender-affirming surgery is widely accepted as a medically necessary intervention for appropriately selected patients with gender dysphoria, the Veterans Health Administration (VHA) Health Benefits package and VHA Directive 2013-033 specifically prohibit gender-affirming surgery within Veterans Affairs (VA) facilities or using VA funding. This policy, which has been legally challenged after being reaffirmed in January 2017, denies medically necessary care to veterans, causing harm to individual patients and reinforcing discrimination and prejudicial treatment of a minority population. We argue that the policy is indefensible as it violates the basic ethical principles of beneficence, nonmaleficence, and justice.

Introduction

Considerable data in the peer-reviewed scientific literature supports the hypothesis that a person's gender identity, i.e., where one places oneself along the male-female gender spectrum, is determined largely by biological rather than social factors and that a person's gender can be incongruent with chromosomal and anatomic sex [1-4]. In fact, this incongruence between anatomic sex and gender identity, currently termed *gender dysphoria* in the fifth edition of the *Diagnostic and Statistical Manual of Mental Disorders (DSM-5 302.85)* [5] and *transsexualism* in the *International Statistical Classification of Diseases and Related Health Problems (ICD-10 F64.0)* [6], has been recognized and documented in human populations worldwide since antiquity [7-9]. It is now estimated that 0.6 percent of the US population—roughly 1.4 million people—self-identify as transgender [10]. Access to gender-affirming treatment, however, is denied to some segments of the US population.

For the over two million active-duty, reserve, and retired Armed Services members in the United States [11], TRICARE® provides comprehensive health insurance coverage; for the approximately 22 million Armed Services veterans [12], comprehensive health care is available through the Veterans Health Administration (VHA). TRICARE [13], the VHA Health Benefits package [14], and VHA Directive 2013-003 [15] have specific policies on transgender health care that provide for coverage of mental health services and hormone therapy but specifically prohibit gender-affirming surgery. This article focuses on the medical necessity of gender-affirming surgery for appropriately selected candidates and on the evolution and ethics of the VHA policy; TRICARE's policy has similar ethical implications.

The Benefits of Gender-Affirming Treatment

For trans male patients, gender-affirming surgical procedures can include mastectomy, hysterectomy and oophorectomy, and genital reconstruction (i.e., phalloplasty, metoidioplasty). For trans female patients, gender-affirming surgery can include orchiectomy, facial feminization, thyroid chondroplasty, breast augmentation, and vaginoplasty. There is strong and rapidly accumulating evidence that patients with gender dysphoria benefit from [mental health](#), hormonal, and reconstructive surgical interventions during the social transition from their assigned to their intrinsic gender. Although there are no large multicenter studies in this area, multiple retrospective and a smaller number of single-center prospective studies on facial feminization [16-19], chest reconstruction [20], and genital sex reassignment [21] clearly demonstrate that gender-affirming surgery substantially improves the mental and physical health of transgender patients. This convincing body of evidence has led many major professional organizations, including the American Medical Association [22], the World Professional Association for Transgender Health [23], the National Association of Social Workers [24], the American Public Health Association [25], the American Society of Plastic Surgeons, the American Psychiatric Association, the American Psychological Association, the American Academy of Family Physicians, the American College of Obstetricians and Gynecologists, and the Endocrine Society to endorse the medical necessity of gender-affirming care, including gender-affirming surgery, for people with gender dysphoria [26].

Based on the preponderance of evidence and professional expert opinion, the insurance industry has, over the past 5-10 years, shifted from viewing gender-affirming surgery as "cosmetic" or "elective" to recognizing that surgery is part of the medically necessary treatment for gender dysphoria [27]. Most major health insurers, including Blue Cross Blue Shield in many states, the Kaiser Permanente system, Medicare, Medicaid (in fourteen states), and many employer plans— including those of Goldman Sachs Group and General Motors— consider gender-affirming surgery a medically necessary and covered health benefit [28-31]. This change in insurance coverage occurred prior to the passage of the Affordable Care Act (ACA), Section 1557 of which expressly prohibits the

denial of health care or coverage based on sex, gender identity, and sex stereotyping in federal agencies or in entities that receive federal funding for health coverage [32, 33]. It is also worth noting that gender-affirming care, including surgery, is a covered health benefit in most developed countries [34].

Barriers to Gender-Affirming Surgery

Although we accept the overwhelming evidence that gender dysphoria is common and that surgical gender affirmation is an effective treatment for appropriately selected patients, we acknowledge that there are strong cultural, religious, and even isolated academic opinions to the contrary [35, 36]. For example, Mayer and McHugh's special report in the *New Atlantis* states that gender dysphoria "is sometimes treated in adults by hormones or surgery, but there is little scientific evidence that these therapeutic interventions have psychological benefits" [37].

Mayer and McHugh do acknowledge what is not in dispute: that transgender people experience significant [discrimination](#) and disadvantages in the United States, with resulting impairment in physical and mental health measures [37]. Among transgender people, rates of suicidal ideation and suicide attempts (40 percent), homelessness (30 percent), HIV (1.4 percent), poverty (29 percent), and unemployment (15 percent) are many times the rates seen in the general US population [27, 38-40]. Many states have legislation that requires genital (sterilizing) surgery before transgender people can change their birth certificate, driver's license, and other identification documents [41]. And voter identification laws can potentially disenfranchise an estimated 34,000 transgender people in local, state, and national elections [42].

Of note, transgender Americans are twice as likely as members of the general US population to serve in the US military. There are currently 134,300 transgender veterans and an estimated 15,000 transgender Americans in active military service [43], so appropriate transgender care is especially critical for these populations [35, 36, 42-44].

Denial of Gender-Affirming Care to Armed Services Veterans

The VHA Health Benefits package [14, 46] and VHA Directive 2013-003 [15], first issued in February 2013 under the title "Providing Health Care for Transgender and Intersex Veterans," specify that mental health services and the prescription of hormone therapy are to be provided for transgender veterans. The specific language in Section 4.b(1) of the directive states:

Transgender patients and intersex individuals are provided all care included in VA's [Veteran Affairs] medical benefits package including but not limited to: hormonal therapy, mental health care, preoperative evaluation, and medically necessary post-operative and long-term care following sex reassignment surgery to the extent that the appropriate

health care professional determines that the care is needed to promote, preserve or restore the health of the individual and is in accord with generally-accepted standards of medical practice [15].

However, Section 4.1(C) of the directive states: "Sex reassignment surgery as defined in subparagraph 2c(4), *will not be provided or funded*" (emphasis added) [15], thereby continuing the exclusion of gender-affirming surgery from the Health Benefits package that has been in place since 1992 [47].

In response to a petition filed by veterans Dee Fulcher and Giuliano Silva and by the Transgender American Veterans Association in May 2016, the VHA undertook a review of this policy that resulted in a proposal to lift the prohibition on gender-affirming surgery. The proposed rule change was an agenda item published in the *Federal Register* in spring 2016 [33], although it appears that a formal revision of the directive was never publically circulated. News media reports at the time indicated that the new policy lifting the ban on gender-affirming surgery would become effective in 2017 [48]. In preparation, the VA National Surgery Office (NSO) conducted a survey of all VA medical centers to gauge existing expertise for gender-affirming surgery within the VA system; the results of that survey, in which the first author (WK) participated, were not made public. In November 2016, news media sources reported that a revised directive would *not* include the provision of gender-affirming surgery [49] and, in fact, the revised directive released in February 2017 maintains the prohibition on surgical procedures for the purposes of gender affirmation. The Health Benefits package therefore remains unchanged; gender-affirming surgery is not a covered VHA benefit. Budgetary concerns were cited as the principal reason for continuing the ban. The VA issued the following statement regarding the revised directive: "VA has been and will continue to explore a regulatory change that would allow VA to perform gender alteration surgery and a change in the medical benefits package, when appropriated funding is available" [49]. (It is notable that the statement used inappropriate language: surgery does not "alter gender"; surgery affirms gender by altering anatomy.) On face value, this statement is confusing because gender-affirming surgery would not require infrastructural changes or capital investment; it requires only equipment and facilities already available in VA hospitals [21, 50]. However, beginning with a scandal at the Phoenix VA Health Care System in 2014, the VHA has come under considerable criticism and pressure related to delayed access to care.

Access to Care Considerations in the VHA

In response to the Phoenix VA Health Care System scandal, in August 2014 Congress passed the Veteran's Access, Choice, and Accountability Act (VACAA), commonly referred to as "Choice" [51]. The legislation has been amended several times, but strict time requirements to complete new consults and to provide surgical services remain a centerpiece of the legislation. If a VA facility cannot provide care for a veteran within the

times specified (and if the veteran meets other criteria), the veteran can opt to receive care in the community at the VA's expense. The initial legislation appropriated \$15 billion to fund care in the community and also to expand the VA's workforce to improve access [52-54]. The initial money has all been spent, and with each additional reallocation there is increasing pressure to control VACAA-related expenditures [53, 54]. Although the results of the NSO survey were not released, it is very likely that the VHA is no different than the private sector. In the experience of the first author (WK), the number of surgeons and centers that have expertise in performing gender-affirming surgery in the US is small relative to demand. Accordingly, there is access-to-care delay for all transgender surgical candidates. The current requirement is that, for care within the VHA, the time from referral to completion of surgery should not exceed one year [55]. Of note, there is no specification regarding wait times once a veteran is referred to the private sector via Choice. Since there is a large backlog of transgender veterans who might access surgical services at the same time, the VHA would likely not meet VACAA access criteria within the VA system, creating the potential for a large expenditure for surgical care in the community via the Choice mechanism. No alternatives, such as altering VACAA access criteria to be in line with the current reality for gender-affirming surgery in the community, appear to have been considered.

How much would community care cost? There are no data specific to the veteran population, but using the employee utilization rate for gender-affirming care at large civilian employers and the cost per University of California claimant receiving gender-affirming care, Belkin [56] estimated that providing comprehensive gender care to active military personnel would cost \$438 per year per transgender service member and just \$2.64 per year per member of the military. By extrapolation, gender care for the estimated 8,800 active transgender service members [57] would surely represent a small part of \$187 billion that comprises the overall VHA annual budget [54]. In addition, Belkin's cost estimates would also likely be overestimates as the VHA has been shown to provide more cost-efficient care than the private sector [58].

As far as we can determine, gender-affirming surgery is the *only* medically necessary intervention specifically denied to America's Armed Services veterans through the VHA. The withholding of medically necessary surgery has obvious negative health consequences for our veteran population. In addition, this singling out of one minority population for denial of services reinforces and encourages the social and religious discrimination that transgender people already experience. Budgetary concerns and the ambient political climate cannot justify a policy that results in patient harm and that encourages discrimination [59]. We conclude that the prohibition on gender-affirming surgery in the VHA clearly violates the ethical principles of beneficence, nonmaleficence, and justice.

Summary and Recommendation

Gender dysphoria is a common condition, and the consensus of the scientific medical community is that gender-affirming surgery is medically necessary for appropriate candidates. Both Tricare and the VHA policy documents expressly prohibit this surgery in military and VHA facilities and deny reimbursement for gender-related surgical services in the community. Unrealistic access-to-care requirements have created a weak and indefensible justification for continuation of the VHA's ban on gender-affirming surgery. We strongly advocate the immediate revision of VA Directive 2013-003 and of the Health Benefits package to allow the provision of *all* medically necessary surgical services for America's veterans, and we advocate for a similar revision of policy by Tricare for active duty, reserve, and retired military personnel.

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Acknowledgements

The authors would like to thank Drs. Andrew Shuman and Christian Vercler for their valuable advice during the preparation of this manuscript.

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ISSN 2376-6980**